A year in Provence

Well not quite Provence, but just as restorative! In the second half of 2014 I was fortunate to be granted leave from Deakin University and spent nine weeks ‘returning to the fold’, embedded in three midwifery settings in regional Victoria, metropolitan Melbourne and south-west UK.

This was a wonderful opportunity and the generosity (and curiosity!) of midwives I worked alongside was greatly appreciated. I reflect on three observations I found most striking.

Same, same... but different

Firstly, it was remarkable how some experiences were so familiar to me- the vulnerability of a woman in pregnancy, the intense focus of a labouring woman, the complexities of the lives of some women and the privilege of providing midwifery care, all evoked powerful memories.

Some things however had changed, measuring a temperature temporal rather than tympanic methods are now used; incident reports are now ‘Riskmans’; and an overview of the woman’s plan of care has moved from the whiteboard to the journey board. While these are really minor applications of technology, I am not convinced that the provision of safe, quality care has advanced.

The risk environment

Secondly, it was striking to note that the safety paradigm seems to have hijacked commonsense. The universal application of the Australian Commission on Safety and Quality in Healthcare’s (ACSQHS), National Safety and Quality Health Service Standards to the maternity environment provides a case in point. In clinical environments that are already busy, a requirement to assess a young fit childbearing woman for a falls risk and pressure care injury and then apply the appropriate sticker to specific sheets so compliance can be assessed needs to be questioned. I ponder the motivation of the universal application of these safety standards. Is a default to guard against a poor assessment and care and if so, is this an appropriate response?

The early warning chart to assist clinicians detect a woman’s clinical deterioration by providing graphical representation of variances in vital signs and other measurements appears a useful innovation. However there needs to be modifications to parameters to accommodate the physiological changes that occur in pregnancy and with little evidence to guide practice there is widespread disagreement on measures. Standardised processes are recognised to decrease risk and this area warrants development so that all services in the same jurisdiction are using and documenting the same reference points, with adjustments for individual women made by the collaborative team. In Victorian and UK maternity services, significant variations also exist in the systems response to detection of clinical deterioration.

Documentation

Thirdly, I recall the frequent complaints from past colleagues of too much paper-work- now I think it is worse!

There is an overwhelming amount of paper-based and electronic data entry and much of it continues to be documented distant from the data source. In these times of lean thinking, a critical lens applied to identifying the minimum data set required to inform care would seem a significant advance. With each data point entered there exists a potential for error so the nature of the information we record and how we document is critical.

Technology abounds. There have been new generations of cardiotocography machines and in some services these can be viewed from the tea-room or desk, clocking on or off shifts can now be performed with a digital reading and all clinical environments are more secure, yet we are still grappling with blended use of paper-based and electronic data sources. Every time we transcribe a blood group or Group B streptococcus result, are we relying on the original pathology or referencing a secondary source? I reflect on the significant risks of poorly integrated software, multiple entries of the same data and the significant need for digital data entry at point of care. Because of the significant cost of this investment, the UK service I visited has returned to paper-based documentation- the resultant reduction of risk is not known. Regardless of the method of data capture, the quality of what is recorded remains variable in quality and an area for continued professional development.

The most enduring legacy of my professional practice is a conviction of how meaningful midwifery is as a career. In environments where we can be distracted by the untapped potential of midwifery led care, increased rate interventions, increased acuity of the woman in our care and other challenges, there remains the truism that each of us can make a difference. How we make advances in safety and quality in midwifery care requires us all to be engaged, curious and questioning.

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