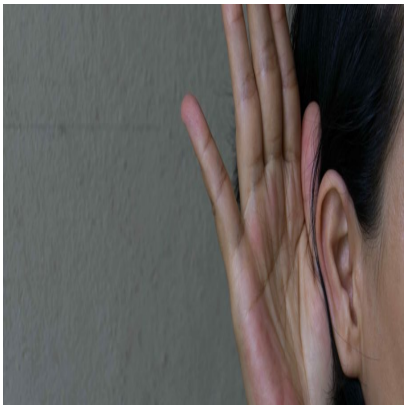


Description

De-implementing ‘fresh ears’

Dr Claire Feeley-Midwife, researcher and educator

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Summary

Dr Claire Feeley draws attention to the removal of ‘fresh ears’ for intermittent auscultation in the recently updated Saving Babies Lives bundle (v2). Claire outlines the work carried out to achieve its removal, with thanks to Carmel Lloyd and Kathryn Gutteridge at the Royal College of Midwives for their support and NHS England for engaging with concerns that were raised regarding this component of midwifery care.

Overview

At the start of 2020, pre-COVID-19, I was alarmed by a public Facebook discussion regarding the extent to which ‘fresh ears’ during intermittent auscultation (IA) was being implemented across the UK. I was familiar with the concept and practice, having worked clinically where it had been implemented. Having raised concerns at the time regarding the lack of evidence-base and potential for disruption to a woman’s labour, I was not able to follow up as I moved on from working in the hospital. However, through engaging with the Facebook discussion it became clear that action was required as the reports from clinical midwives were of great concern.



Taking action

In my capacity as a midwife/researcher, I took my concerns to a midwifery/maternity care academic discussion group to explore what could be actioned. I was encouraged to document the concerns to share with NHS England, which was facilitated by Kathryn Gutteridge and Carmel Lloyd at the RCM. Collectively, clinical and academic midwives/researchers and consumers co-authored a letter of concern which complemented similar work by the UK Consultant Midwives group. For transparency, I have included the letter (see below). It includes the background to the issue, our concerns and suggestions for moving forward. We (the co-authors) are grateful to Carmel Lloyd and Kathryn Gutteridge at the RCM who helped escalate our concerns. Further gratitude to Matthew Jolly at NHS England for receiving and engaging with our concerns, with a willingness to amend the new Saving Babies Lives Bundle (v2).

Next steps

The removal of this non-evidence-based practice marks a time for de-implementation. Although much of maternity care is about implementation, the concept of de-implementation is not as widely discussed. In the wider healthcare field, work has begun around de-implementation, which can be defined as: '… the process of identifying and removing harmful, non-cost-effective, or ineffective practices based on tradition and without adequate scientific support.'

De-implementation is a facet of evidence-based practice and requires similar approaches as used in implementation, often related to behavioural changes across all levels of an organisation. There are numerous complexities associated with de-implementation, but some researchers have developed strategies to action de-implementation while factoring in the complexities. Others provide models to guide organisations to make changes. It is imperative that maternity services are provided with the support to de-implement fresh ears. Perhaps those who did not implement fresh ears could share their guidance for IA.

However, de-implementation must be carried out whereby midwives are competent and confident to perform IA. I understand that inconsistent education and training has resulted in variations in practice which needs to be addressed. Work in the UK has been carried out to support midwives' education i.e. Consultant midwives, Christine Harding and Wendy Randall have developed an e-learning tool to help close this gap and to improve the practice of 'intelligent intermittent auscultation' as have City University of London. I urge midwives, obstetricians, managers, hospital organisations to make use of the resources available to support appropriate, safe and effective IA. See below for more resources.

Appendix- Letter of concern

Thank you so much for taking the time to consider concerns raised regarding the introduction of 'fresh ears' in Saving Babies Lives Bundle v2:

4.3 Regular (at least hourly) review of fetal wellbeing to include: CTG (or intermittent auscultation (IA)), reassessment of fetal risk factors, use of a Buddy system to provide 'Fresh Eyes (or Ears)', a clear guideline for escalation if concerns are raised through the use of a structured process. All staff to be trained in the review system and escalation protocol.

We are aware that the Consultant Midwives network is also in the process of issuing a statement of concern regarding the introduction of fresh ears with no substantiated evidence base. We, clinical and academic midwives/researchers and consumers, also wish to raise our concerns in conjunction with the Consultant Midwives. We are aware that some poor outcomes have occurred during normal low-risk labours due to clinical errors in assessing fetal heart, however, the implementation of "fresh ears" also raises concern. These were recently flagged during a recent social media discussion with clinical midwives, which I took to a midwifery-academic research group to discuss further. Below are the issues we would like to raise regarding "fresh ears":

1. Lack of clarity: V2 of the SBL bundle only refers to "fresh ears" and does not state what this entails. From the social media discussion and the audit, I have attached, this component of the bundle has been adopted in some Trusts i.e. where during normal low-risk labour, a 2nd midwife is sought to listen to the fetal heart during intermittent auscultation once an hour to confirm/dispute the primary midwives' assessment. This protocol likely came from the Every Baby Counts 2015 document:
2. *Employing a 'fresh ears' approach to intermittent auscultation, whereby a second midwife confirms the fetal heart rate pattern every hour,* ***may*** *reduce interpretation errors. (Local clinical management and midwifery staff)*

– however, our emphasis here in bold raises concerns about the evidence base for this intervention (see point 2).

2. Lack of evidence: regarding its use, effectiveness, efficacy and whether potential unintended consequences such as disturbances to the labouring women have been considered. Without evidence for or against its use, this raises ethical issues regarding its introduction. Some midwives, via social media, have reported their Trusts have introduced it on a 'trial' basis, however, as a service evaluation/auditing process, this would not be subjected to the rigorous ethical procedures and approvals that is usually required of intervention research. For those of us who are currently researchers, we are especially concerned about the lack of adherence to ethical approval processes, including full information to women about the current lack of evidence for the benefits or harms of this procedure, and consent for it to be undertaken.
3. Resources: Its implementation and available resources i.e. a second midwife is not usually present at a homebirth until birth is imminent, or birth centre midwives may not be able to leave the women in their care to carry out "fresh ears" for another colleague. Increases to staffing to carry out "fresh ears" is unlikely in the current climate, and without an evidence-base, may put undue pressure on already strained services.
4. Accountability and professional behaviour: Of grave concern is the report from one midwife, via social media, that she and her (homebirth) team have been compelled by the Trust to phone the labour ward coordinator so they can conduct fresh ears over the phone. This raises serious accountability concerns, particularly if a poor outcome ensues. We are not aware that medical or health professionals would be expected to take responsibility for care for clients not in their presence, and may have adverse legal ramifications. Moreover, it has the potential to undermine the relationship between the labouring woman and midwife, as this type of phone call does not imbue confidence nor does it seem like professional behaviour. In addition, it is very poor practice to make a judgement on the wellbeing of the fetus in the absence of the assessment of other clinical parameters, and the woman's current situation, and wishes.
5. 4. Assumes compliance by women receiving care: Some women prefer midwives to use pinards, rather than doptones/ sonic aids, and a 'fresh ears' policy does not account for this.

Our position:

We strongly advocate and support midwives to have robust training in IA. We believe they should be actively encouraged to seek a second opinion should they have any concerns during intermittent auscultation. We also

understand for newly qualified or inexperienced midwives the value of seeking supportive second opinions to help develop their skill-set. Our concerns about fresh ears do not negate the importance of learning, development and escalation when required.

However, a fresh ears policy as a wide-scale national introduction is not currently evidence-based. As for other technologies that have been introduced because they seemed like a good idea in the absence of formal evidence of benefit or harm (including routine use of CTG for healthy women and babies) should a fresh ears approach be shown to be ineffective or harmful, de-implementation can take a long time. Therefore, we request that this component of SBLv2 be revised and removed until formal research has been conducted.

General comments arising from this particular situation:

Over time, a number of interventions and practices have been introduced into maternity care without good evidence, and with potential for unexpected harmful, or resource-intensive consequences. The introduction of fresh ears is just the latest of these. To ensure compliance with best practice and good quality care, we propose that the introduction of any new technique or process needs to be, firstly, **formally** considered for all the potential anticipated and unanticipated consequences, short and longer-term, based on previous evidence/experience and biological and organisational plausibility. This includes an examination of what is likely to happen given what we know about human biology, and about the way organisations function in response to risk, staffing allocation, shifting of resources away from other valuable processes towards this new one, and the potential health and social consequences of that for the service user group in question, and for other service user groups that the organisation has responsibility for.

This should be undertaken by a group of local stakeholders, with a range of experiences, views and expertise on the topic in question, in a meeting of at least half a day, to give time for discussion, and then the results should be written up, to include consideration of the formal evidence what local service users value, and the, feasibility, acceptability, and equity consequences of both introduction and non-introduction, before a recommendation is made for or against a technique. Then, if the balance seems to be on the side of the intervention, a proposal for research next steps can be agreed.

Once again thank you for taking our concerns forward. Please do let us know whether you need any further information, or how we can support the revision of SBLv2.

Yours Sincerely,

Dr Claire Feeley

Midwife/Researcher

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>30 clinical midwives and several service-users from the social media discussion which I've opted to keep anonymous.

Resources for IA

Understanding intelligent auscultation by Dr Claire Feeley

Intermittent Auscultation skills Study Sheet

Category

1. News & Views

Tags

1. De-implementation
2. fresh ears
3. Intermittent auscultation

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