

Description

Perceptions of Midwifery

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This is a series presented by the NHS England Midwifery Ambassadors.

Introduction

The #PerceptionsOfMidwifery? Programme is one England's Chief Midwifery Officer, Professor Jacqueline Dunkley-Bent's three key ambitions. There are currently approximately 150 Midwifery Ambassadors working in NHS Maternity services across England, working together to promote, support and raise the roar for our profession.

Led by Claire Mathews, North West Regional Chief Midwife, the aim of the Midwifery Ambassadors is threefold, firstly to engage with the future midwifery workforce by sharing the art and science of midwifery with children and young people so that potential future midwifery students from all backgrounds, ethnicity and gender, may consider midwifery as a career of choice. Secondly to work with the current midwifery workforce to ensure they feel motivated, valued and proud of the work midwives do, thus improving morale and retaining midwives in the profession. Thirdly sharing the positive work midwives do and the good news stories with the media and the public so they may encourage and support both our current midwifery workforce, our future midwifery workforce and of course in turn supporting the women, babies and families we care for across the country.

Through this series we hope to show people the different paths to midwifery and the wide range of roles there are available, including the pathways to success. Midwifery can be a varied and diverse profession and we cover a myriad of roles, much more than caring for babies!

I am currently the Clinical Lead Midwife at Surrey and Sussex NHS Hospital Trust. I am part of the Maternity Improvement team and lead on service development, quality improvement and key policy initiatives. I am also the lead midwife for preceptorship programme . My previous roles have included Consultant midwife and clinical educator in India; labour ward lead midwife; labour ward coordinator and community/ homebirth midwife. I trained as a midwife when I was 25 and had 2 children during my training ! Prior to being a midwife I worked full time in restaurants, pubs and clubs.

Midwife Life – this day was a particularly busy day but it does showcase the variety involved in my role! I love my job and continue to feel privileged to witness birth and be with families in these life changing moments.

February 2020

5:30 am- Get up and get ready. Make large cup of coffee and leave for work. I live around an hour away from where I work and like to be in early to catch up with the night teams and I'm definitely more productive in the mornings.

7am- Head to the Labour ward office and check in on the labour ward. Quick chat with the labour ward co-ordinator (LWC) where we discuss a concerning CTG. We briefly review the history and CTG together on the central monitoring system and agree it needs action , the registrar is already in the room and the coordinator is heading there next.

It's the start of the month so I review the Labour ward handover log. We are currently auditing handovers and multidisciplinary (MDT) ward rounds. These were identified in the Ockenden Report (2020) as an area of national focus. The initial review shows we are not capturing all the information we need which could be a concern; I plan to review the data in more depth with the Intrapartum Matron and remind staff the importance of the audit and data needed.

Next I head around to the wards to say hello- no concerns identified at the moment. As lead for the preceptorship midwives I try to check in regularly and during my visit to the antenatal ward I have a brief discussion with one of the team about a mother who is having an induction of labour but had a caesarean in her first birth. We review the local policy, briefly discuss things to watch out for and her priorities for care on the ward that day.

8:15- Brief catch up with my team- the Maternity Improvement Team (MIT). We run through our Newborn Life Support (NLS) teaching for the afternoon.

8:45 – Quickly see the Risk Lead Midwife about a serious post partum haemorrhage which occurred last week, we discuss the learning outcomes and some of the ongoing quality improvement work in this area.

9:30- Online lecture to Surrey University students. Discussed physiological breech birth including how to support midwives and families. Focus of the sessions was developing as a practitioner so we encouraged a future outlook, how as future midwives they could build support for ideas , find their tribe and build a case for change.

10:30- Lovely cup of tea with a tearful colleague who needed a virtual hug and wanted to discuss some personnel challenges.

10:45-11:45 Senior Midwives and Matrons operational meeting with the HoM and DoM. We each run through our current priorities and challenges. As a team we discussed the current Clinical Negligence Scheme for Trusts (CNST) demands and staffing concerns.

11:50- Bleep went off. There is a client waiting to meet me who wishes to discuss a maternal request caesarean section. We are already known to each other as she has come to the Breech Clinic- the baby is now cephalic but she still wishes to have a caesarean. I have already spoken to her at length the week before and she was going to spend the weekend researching her options and we agreed to have a more in depth discussion and make a plan today.

11:45- I see the couple in the Birth centre. Monika (sedueo name) is feeling more confident about trying a vaginal birth now she has had longer to consider it . It is her first baby and she plans to have more children but is feeling very anxious about having a large baby and at 39+5 feels she needs a plan. I discuss the situation with the on call consultant. Monikas baby has consistently measured above the 90% centile and locally this would mean we offer induction of labour from 39-40 weeks. I discuss this with Monika, we also offer a scan to aid decision making. Monika and partner are really happy with this plan and if the scan is normal and the AN ward can accommodate her , Monika will be induced today. She is aware of the risks and benefits of all options and I can see a weight is lifted from her.

1pm- Host an Instagram ' live' session. This is a new initiative being led by our team of professional midwifery advocates (PMA) . We host weekly live Q and A session to connect with our local pregnant community. These sessions run for an hour and we have had great feedback from families and the local Maternity Voice Partnerships (MVP) . I was hoping the Birth centre lead would join me as it's much easier when we have two professionals but everyone is busy so it's just me talking about how to prepare for birth. Around 60 people logged on live and the video has over 750 views by the end of the day! The MVP lead and a local doula both contact me after to offer to co-host in the future. Fabulous!

14:15- Dash to other side of the hospital for the NLS teaching . Stop at the trust canteen on the way for a sandwich and drink.

14:30- Assist the Practice Development Midwife (PDM) with the preceptorship day and NLS teaching. It was a great session with lots of engagement and reflections from the team. So nice to have some face to face training for a change.

16:45- Discussion with the HoM about a difficult case and some concerns raised by the coordinator. We agree to host

an after action review (AAR) to discuss the issues and resolve any conflict. The HoM will arrange.

17:00 As I walk back to my office through the Birth Centre- the PDM grabs me and says she thinks someone who has just arrived might be having a breech baby. She already has an urge to push. We quickly move to the nearest room on the labour ward and alert the team. Fresh meconium is seen on the pad and a vaginal examination confirms the baby is Breech, the cervix is fully dilated and baby descending quickly. I reassure the family, its not what they were expecting but this baby is coming quickly and we will support them to birth as safely as possible. Plus, they are in luck! I am the breech midwife and my colleague the PDM has also had additional physiological breech training. The registrar on call is experienced and also supports with the Breech clinic so we all know each other well.

17:10- Labour progresses quickly but we identify a problem with the arms. We are using the physiological breech approaches and know we need to intervene for safety. We resolve the complication gently and the baby is born quickly after. We are prepared for initial resuscitation and the parents are expecting this. The Neonatal SHO is struggling to gain an adequate airway so we swop roles and the baby improves quickly after 2 sets of inflation breathes. The baby is passed back to the parents and congratulations all round.

We host a very quick team de-brief. Everyone is pleased, really good team work, with clear leadership and confident actions. We utilised the new Breech pro forma and algorithms provided to the team as part of the OpiBreech research project led by Dr. Shawn Walker. The consensus was overwhelmingly positive.

18:30- Still not finished! Safety Huddle on labour ward with the LWC , Consultant, HoM, Intrapartum Matron and Safeguarding lead. A very complex client is on the way in, she has a severe trauma and mental health disorder and has had minimal antenatal care. We need to ensure the team is briefed about the history and informed of the care plan overnight.

19:00- Head home. What a day!

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