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MIDWIFERY TRAINED REGISTERED NURSES PERCEPTIONS' OF THEIR ROLE IN MATERNITY CARE TEAMS: A QUALITATIVE STUDY

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INTRODUCTION

In developed countries healthcare professionals such as nurses and midwives have well-established and clearly defined legal and professional boundaries (Sharma *et al.*, 2012). For example in Canada, the College of Registered Nurses of Nova Scotia (CRNNS) and the College of Licensed Practical Nurses of Nova Scotia (CLPNNS) have written guidelines providing a frame work for assigning or delegating tasks and roles to different professional groups within the health care team (CRNNS AND CLPNNS, 2012). The situation is different in many developing countries. For example, in India the role of auxiliary nurse midwives working within hospitals is unclear and poorly defined (Sharma *et al.*, 2012). Even though midwives and nurses play a pivotal role in maternity health care teams, their role and scope of practice is not clearly defined and this can be a contentious issue among multi-professional healthcare teams.

In Sri Lanka, a Midwifery Trained Registered Nurse (MTRN) is a registered nurse with a one-year specialized training in midwifery. In hospitals, MTRNs work with other healthcare professionals such as doctors, midwives and nurses who have not had midwifery training, to provide maternity care. MTRNs' role is not clearly defined in these settings and there are no guidelines for them to follow. There have been frequent conflicts between different healthcare professionals in maternity care units in Sri Lanka and those among MTRNs, non-midwifery trained nurses and midwives, have been particularly severe, leading to trade union actions.

Because MTRNs in Sri Lanka share training pertaining to two professional groups-nurses and midwives, they hold a unique position in the health care team. The ways in which MTRN's perceive their role in maternity care team and how they define their scope of practice has not yet been studied in the Sri Lankan context. To address this knowledge gap, we conducted a study among MTRNs in three tertiary care hospitals in the Western province of Sri Lanka with the aim of describing how they perceive their role in providing intra-natal and post-natal care.

METHODOLOGY

An explorative qualitative study was conducted using focus group discussions (FGDs) as the method of data collection. FGDs allow in-depth exploration of experiences and perceptions of new topics, and gathers qualitative data that provides insights into the attitudes, perceptions and opinions of participants (Krueger, 1994).

Twenty two MTRNs from selected hospitals participated in the study. Participants were purposively selected. Inclusion criteria specified that participants should have more than four years experience in an intra- natal or a post- natal unit. Three FGDs were conducted by the first author using a semi-structured interview guide. The interview guide was evaluated by two clinical experts in qualitative research. The interview guide consisted of eight open ended questions which were focused on what MTRNs perceive as their role in this setting and their

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experiences in provision of care with other care providers. Six to eight MTRNs participated in each FGD which were about one and half hours in duration. Each FGD was conducted in Sinhala medium and audio recorded with permission of the participants. Note taking was done by a note taker during the each FGD. Data were collected from August 2013 to January 2014.

The audio recordings from the FGDs were transcribed into text, verbatim, in Sinhalese and translated into English. The text was analyzed using conventional qualitative content analysis method as described by Graneheim and Lundman (2004). The transcribed data were coded, similar codes were pooled into categories and eventually themes were generated according to the objective of the study.

Ethical approval for the study was obtained from the Ethics Review Committee (ERC), Faculty of Medical Sciences, University of Sri Jayewardenepura and the ERCs of the relevant hospitals. Permission was also granted from the Ministry of Health for conducting the study.

RESULTS AND DISCUSSION

MTRNs who joined the study were aged between 29 to 55 years and their average duration of nursing and midwifery experience was 17 years and 10 years, respectively. Out of 22 participating MTRNs, 2 were nursing degree holders and the others were nursing diploma holders. The result of the data analysis is presented as three themes: 'my role: what we have to do' which refers to the tasks and responsibilities identified and encompassed as their own by the MTRN; 'overlapping roles' which refers to the tasks performed by MTRNs as well as others in the team; and 'role disagreements' which refers to instances where MTRNs were confused about the role and/or perceived a situation of conflict.

'My role: what we have to do'

Participants perceived their own role in terms of individual tasks and responsibilities identified by them as specific MTRNs duties. In doing so they placed themselves in an exclusive group described as 'we' and 'us', that is separate from others such as doctors and midwives in the team. For example, as shown in the excerpts below, MTRNs take on the responsibility of welcoming, explaining and comforting a woman when she arrives in the labour room for the delivery and in the post-natal ward after the delivery of the baby. In being able to recognize these as exclusively as their duties, tasks and functions, MTRNs demonstrate a strong sense of responsibility and belonging.

"After coming into our labour room we take the responsibility of welcoming mother, ensuring safety of the mother, fulfilling her needs, preventing from complications and all". (FGD-03)

"we insert a canula and explain it to the mother this is inserted to give drugs and saline. Next we auscultate fetal heart sounds and inform the doctor. We monitor fetal heart sounds every fifteen minute. Getting an idea about the condition of the mother, start oxytocin drip according to the prescription." (FGD-03)

"After the mother and the baby were sent to the postnatal ward, taking over the baby by checking sex of the baby, disc number and checking whether baby has been fed are our responsibilities. After keeping the mother in the bed, bleeding is observed. If it is a forceps or vacuum, antibiotics should be continued. In addition, whether vaginal pack is inserted, If so when it will be removed, we have to give over and document after checking the BHT. If mother does not have any food, we find and offer something to eat and give the baby to the mother for breast feeding again. If the baby is with poor sucking, PHO is informed. Baby's ticket is kept in the PHO file and maintained". (FGD-01)

There is an overreaching sense of pride and belonging in the way in which MTRNs showcase their enormous responsibility towards the mother and the baby while describing these tasks.

"Whole responsibility of the mother and the baby, are upon us, whether mother has had her meals, how is the blood pressure? Has the baby been fed, has the baby been examined by doctor, all these tasks are done by us". (FGD-01)

'Overlapping roles'

According to the participants there were a set of tasks and duties to be completed by "others". For the MTRN's, the others' roles were not clear and it was not well demarcated from their own roles. Midwives, nurses and doctors tasks and responsibilities were often seen as overlapping with their own. This meant that some of the work done by MTRNs were 'hidden' or 'minimized' by the overlap with others roles.

"Although we work hard our role is always hidden. We do half of the doctor's duties, do nurse's part completely, do more than half of midwife's duties. But including their (midwives') name for the delivery means the most important part has been done by them. We have done nothing". (FGD-02)

MTRNs felt that others accepted MTRNs performing these tasks when everything was in order, however, when 'something went wrong' this created problems because they had to bear the sole responsibility for it. MTRNs sensed unfairness in being 'blamed' in this manner.

"Things go smoothly as long as there is no problem. When a problem arises, the ball is always passed. Why didn't you do? At the end the ball is passed to the nurse." (FGD-02)

"Her (Midwife's) responsibility is similar to that of a midwifery trained nurse. She can check FHS, deliver the baby, remove urine, and put the CTG". (FGD-02)

'Role disagreements'

The third category that emerged was the situations in which the roles were clearly conflicted. MTRNs perceived some situations as being clear disagreements with regards to roles and responsibilities resulting in confusion, frustrations and conflicts. This was of particular significance around their role in the delivery of the baby. Lack of a clear understanding about who is responsible for attending to a delivery created conflicting situations.

"The midwife came and told me why are you doing these things? Don't you have other work to do like giving injections? This is our duty. This is when problems begin". (FGD-02)

"One day I went for a delivery. When I was getting ready to perform the delivery, the midwife was doing another delivery. At the moment I was holding the skin to give the epis a midwife came from the antenatal side, pushed me away blaming me aggressively and did the delivery". (FGD-01)

MTRNs displayed a sense of belonging and esteem when performing roles and responsibilities clearly identified as being their own. However, when their roles overlapped or conflicted with others their contribution was perceived as being 'minimized' by others. This was particularly significant when there were failures or break down of processes. Moreover, role disagreements around the time of the delivery and in competing essential tasks means there are implication for patient safety. Lack of clarity with regards to each professional groups' role meant that opportunities to examine reasons for omissions and and/or break down in processes were often missed.

CONCLUSIONS AND RECOMMENDATIONS

Lack of clarity with regards to each professional group's roles has been reported as a reason for conflict among team members. (Oelke et al , 2008; Nayanga et al ,2012). This is particularly common in labour rooms because midwives, nurse-midwives and obstetricians are known to compete for professional space around child birth (Sharma et.al. 2012). When different professional groups lacked clarity regarding their own roles and responsibilities it also affected their self-esteem and ability to develop as an individual as well as a team identity in a multi-disciplinary team. Defining Midwifery Trained Registered Nurse's scope of practice and clear delegation of responsibility using written protocols and guidelines will help improve team dynamics within similar maternity care teams.

REFERENCES

College of Registered Nurses of Nova Scotia (CRNNS) and College of Licensed Practical Nurses of Nova Scotia (CLPNNS) (2012). *Assignment and Delegation Guidelines for Registered Nurses and Licensed Practical Nurses*.

Graneheim, U. H., and Lundman, B. (2004) Qualitative content analysis in nursing research: concepts, procedures and measure to achieve trustworthiness, *Nurse Education Today*, 24, 105-112.

Krueger, R. A. (1994). *Focus Groups: A practical Guide for Applied Research*. 2nd ed. SAGE, New Delhi.

Nayanga, T., Mudhovozi, P. and Chireshe, R., (2012). Causes and Effects of Role Ambiguity as Perceived by Human Resource Management Professionals in Zimbabwe. *Journal of Social Science*, 30(3):293-303.

Oelko, D., White, D., Besner, J., Doran, D., Hall, L. M., and Giovannetti, P. (2008). Nursing workforce Utilization: An examination of Facilitators and Barriers on Scope of Practice. *Nursing Leadership*, Volume 21, Number 01.

Sharma, B., Johanson, E., Prakasama, M., Mavalankar, D., and Christensson, K. (2013). Midwifery Scope of practice among Staff nurses: A grounded theory Study in Gujarat, India. *Midwifery*, 29, 628-636.

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