Midwifery Trained Registered Nurses' role in hospital-based maternity care in the Western Province of Sri Lanka: Maternity health care professionals' perceptions

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***Abstract*— Midwifery Trained Registered Nurses (MTRNs) are members of the multi-professional team providing maternity care in hospitals in Sri Lanka. The absence of defined tasks and responsibilities for MTRNs has been linked to existing conflicts among the maternity care team. The study aimed to explore team members' perceptions of the MTRNs' role within the maternity care team in the capital province of Sri Lanka. The study has an exploratory, descriptive cross-sectional design using qualitative methods. Focus group discussions (FGDs) were used as the method of data collection. MTRNs, RNs, and midwives, altogether 45 in number, from three selected tertiary care hospitals in the Western Province, participated in the Study. Data were analyzed using manifest qualitative content analysis method. The results reveal five main points of interactions: Initial care (IC) in the Labor room (LR), Pre-delivery care (PDC) in the LR, Care at the delivery, Postpartum care (PPC) in the LR and Postpartum care in the postnatal unit. In each of these categories, there were consensuses as well as disagreements regarding the MTRN's tasks and responsibilities. The strongest disagreements in tasks and responsibilities were presented under the category of care at delivery. Different groups of professionals had diverse views about the MTRN's tasks which manifested in her role being contentious and unclear at the same time. Clearly demarcated professional boundaries will help alleviate the confusion and help promote interprofessional collaboration, to improve the quality of maternity care in this setting.**

Keywords- ***interprofessional collaboration; Midwifery Trained Registered Nurse; role; conflicts***

I. INTRODUCTION

Midwifery Trained Registered Nurses (MTRNs) are members of the multi-professional team providing maternity care in hospitals in Sri Lanka. In addition to MTRNs, doctors, midwives and Registered Nurses (RNs) are involved in hospital-based maternity care. The difference between RNs and other maternity care providers, RNs usually do not work in Labour units (intranatal units) like others.

Although most developed countries have written guidelines for assigning tasks or delegating roles to each member of the health care team, this is not the case in developing countries. In many developing countries, specifically South Asian and Sub Saharan African settings, maternity care providers lack defined tasks, roles, and responsibilities [1, 2, 3]. Evidence shows that undefined scope of practice results in none of the team members taking responsibility to address the patient's issues [4].

Hence undefined tasks and responsibilities contribute to poor quality of care [5] which can compromise the safety of the patient provided by the different maternity healthcare professionals [6]. A similar situation, where the lack of defined tasks and responsibilities of the members of the maternity care team, has created conflicts among different professional categories in Sri Lanka, between MTRNs and midwives in particular. Empirical studies are lacking on this phenomenon which motivates this study aiming at clarifying MTRNs´ responsibility for the different tasks in her scope of practice as her role within the maternity health care in Sri Lanka is not defined.

Therefore, the purpose of this study was to explore team members' perceptions about the MTRN's role within multiprofessional maternity care teams in Sri Lanka addressing the research and knowledge gap in this region with regards to professional roles and responsibilities in healthcare.

II. METHODS

This study has an exploratory descriptive cross-sectional design with a qualitative approach. The data were collected through Focus group discussions (FGDs to gain an in-depth understanding as it enhances exploration of new topics and insights into attitudes, perceptions, and opinions of the participants [7]. Six FGDs were conducted with 22 MTRNs, 16 midwives and seven RNs who were working in intra-natal or postnatal units in three selected tertiary care hospital in the Capital (Western) Province. Eligibility criteria specified that participants should have at least four- year working experience to have adequate experience to talk about their role, tasks, and responsibilities [8]. Consequently, the participants were selected purposively having worked minimum four years in an intra-natal or a postnatal unit. Also, they should be able to converse in Sinhalese or English.

A semi-structured focus group guide was developed initially based on the concepts of role theory and later modified in consultation with two local subject and method experts.

Role theory defines the concept of role as a description of behaviors, characteristics, norms and values of a person or position [9]. In developing the focus group guide, key terms of .the role concept such as role performance, expectation, role stress (conflicts, ambiguity) and strain were included [10]. The open-ended questions were therefore focusing on information about participants´ perceptions of MTRN's role, tasks, and responsibilities.

A. Data collection

Data collection was done between August 2013 and January 2014. A total of six FGDs with six to eight participants were conducted; three with MTRNs, two with Midwives and one with RNs. A room within the hospital premises that was a convenient place for participants was selected to conduct the FGDs. Each FGD lasted approximately one and half hours and was carried out in the local language spoken by the majority Sinhalese. Participants completed a short demographic questionnaire before the discussions to gather details such as age of the participant, religion, length of professional work experience, educational qualification, special training on midwifery, current workplace, length of the time working at the current workplace. An assistant (Observer) took down notes during each FGD. All FGDs were recorded with the permission of the participants.

B. Ethical Considerations

The study protocol methods and tools were approved by the Ethics Review Committee (ERC) of the Faculty of Medical Sciences, University of Sri Jayewardenepura, and permission to conduct the study was obtained from the Ministry of Health and the relevant hospital authorities. Participants were informed about the study verbally and via consent form; participation was voluntary, and the participants could withdraw from the study at any time. The confidentiality of the information gathered from the discussions was ensured by not including names of persons or places in the transcripts or quotes used in reporting results.

C. Data Analysis

All recorded FGDs were transcribed verbatim from Sinhalese into English. Manifest, qualitative content analysis based on the inductive approach [11] was used in analyzing the data. The transcripts were read several times by the researcher and one of the supervisors. After that, meaning-bearing units were identified, condensed, and coded. Similar codes were grouped into sub categories based on similarities and differences between the codes. Similarly, subcategories were pooled into main categories. Out of the different strategies available to ensure trustworthiness of the findings; prolonged engagement, persistent observation, triangulation, peer debriefing, member checks, and thick description [12], prolonged data discussions with supervisors were used here. Furthermore, by getting different professionals views regarding the role of the MTRN, a method of source triangulation [13], was used to enhance the credibility of the study findings. In addition to these methods, quotations from the interviews which supported the interpretations of the data were used to illustrate the findings.

III. RESULTS

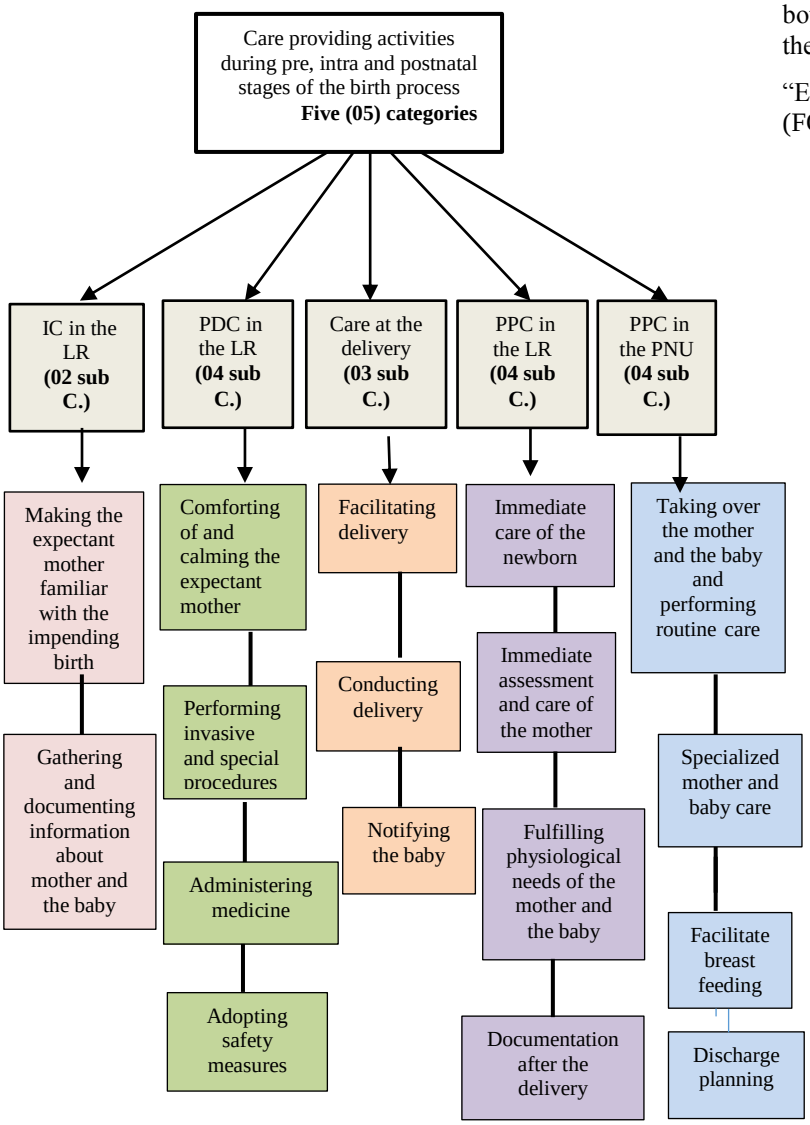
Out of 45 participants, the majority (68%) worked in the labor rooms. Forty percent of the participants were aged between 41 and 45 years, the majority (60%) was nursing diploma holders and had more than ten- year work experience in an LR or a postnatal unit (51%) at the time of the study (Table 1).

TABLE 1. SOCIO DEMOGRAPHIC CHARACTERISTICS (N=45)

Variable	**Professional category**			**Total**	
	MTRNs (n=22)	RNs (N=07)	Midwives (N=16)	Number (N=45)	Percentage
Age (Years)					
>30	02	01	0	03	6.7
31-35	03	02	02	07	15.5
36-40	01	01	01	03	6.7
41-45	09	03	06	18	40.0
>45	07	0	07	14	31.1
Workplace Experience (Years)					
>5	06	06	06	14	31.1
6-10	06	01	01	08	17.8
11-15	04	0	0	09	20.0
16-20	05	0	0	09	20.0
>20	01	0	0	05	11.1

Workplace					
Labour Room	16	0	14	30	66.7
Postnatal unit	06	07	02	15	33.3
Highest Education Level					
Certificate	0	0	16	16	35.6
Diploma	20	07	0	27	60.0
Degree	02	0	0	02	4.4

The analysis revealed five main categories related to care providing activities: Initial care(IC) in the Labor room (LR), Pre-delivery care (PDC) in the LR, Care at the delivery, Postpartum care (PPC) in the LR and Postpartum care in the postnatal unit. The respective subcategories are illustrated in Figure 1 below.



Category =C

FIGURE 1. DEVELOPING CATEGORIES AND SUBCATEGORIES

The findings illustrate maternity healthcare professionals' perceptions of MTRNs responsibilities for selected tasks within her scope of practice. Direct quotes from the participants are used to confirm findings. The numbers within brackets refer to a particular maternity healthcare professional's (P) statement during the specified FGD.

A. Category 1: Initial care in the Labour Room

The initial care in the LR starts when the expectant mother enters the delivery room.

Subcategory: Making the expectant mother familiar with the impending birth

Midwives did not give any comments related specifically to MTRNs' responsibility for the above task as they perceived both MTRNs and midwives to be responsible for "making the expectant mother familiar with the impending birth".

"Everything is done with the help of both categories" (FGD-01 with midwives: P3).

However, MTRNs perceived them as responsible not only for making the expectant mother familiar with the impending birth but for all tasks of the caring process.

> *"After coming into our labor room, we take the responsibility of welcoming the mother, ensuring safety, fulfilling her needs, preventing complications and all. A patient always comes to the labor room with a lot of fear. What we do first is to reduce the fear of the mother" (FGD-03 with MTRNs: P2).*

B. Category 2: Pre-delivery care in the Labor room (LR)

The preparatory care for childbirth begins after initial care is completed. Pre-delivery care consists of four subcategories namely comforting of and calming the expectant mother; performing invasive and special procedures; administering medications; and adopting safety measures.

Subcategory: performing invasive and special procedures

Both midwives and MTRNs viewed cannulation and blood drawing are unique tasks of MTRNs,

> *"Inserting cannula is done by the MTRN. After mother is seen by the doctor if blood is to be taken, such things are also done by the MTRN" (FGD-01with midwives: P7).*

> *"We normally insert wide bore cannula. As we insert the cannula, simultaneously we take blood for DT. Meanwhile, if blood for other investigations is required, we can take the sample. If it is breech, twins or malpresentation, we take blood for DT when the cannula is inserted whether doctor says or not. IV line is maintained" (FGD-01 with MTRNs: P 6).*

Subcategory: Administering medicine

According to midwives, administering medicine is a specific task of the MTRN, however, MTRNs perceived this to be their main responsibility

> *"Doing ST (Sensitivity Test), giving drugs prescribed by the doctor, and if any injections are written administering them are responsibilities of the nursing officer (MTRN). Administering these drugs is definitely done by MTRNs" (FGD -01 with midwives: p3).*

> *"Administration of medicine is invariably done by us" (FGD-01with MTRNs: p3).*

C. Category 3: Care at the delivery in the LR

Care at the delivery in the LR includes all care including episiotomy which is provided during the delivery of the baby and the placenta. This category consists of three sub categories: Facilitating delivery, performing delivery and notifying the baby (Identification of the baby).

Subcategory: Facilitating delivery

There were different views among the midwives as whose responsibility it was to perform the episiotomy. The midwives meant that performing episiotomy is the MTRN's duty but one midwife said it is the doctor's responsibility and not the MTRN's.

> *"Epis (episiotomy) is given at the delivery by MTRNs" (FGD-02 with midwives: P7).*

> *"Now we (midwives) can give the epis, but we are not allowed to give. It also does not belong to MTRNs. They also cannot give the epis (episiotomy). Normally a doctor should give" (FGD-01with midwives; P3).*

MTRNs claimed that performing episiotomy is their sole responsibility.

> *"Episiotomy is definitely done by a nurse (MTRN). After administering local anesthetic drugs, episiotomy is performed by a nurse" (FGD-01 with MTRNs: P4).*

Subcategory: Performing delivery

Midwives did not comment on the role of the MTRN in conducting delivery. Midwives held the opinion that conducting the delivery is the sole responsibility of the midwife. MTRNs meant that conducting the delivery is the responsibility of both MTRN and midwife.

> *"..the thing called delivery is part of our duty. It belongs to the midwife. They (MTRNs) have more work than that in the labor room" (FGD-01 with midwives: P3).*

"The responsibility of conducting deliveries is between MTRN and the midwife" (FGD-01with MTRNs; P8).

> *"At a normal delivery, every responsibility is shared similarly between nurse and the midwife" (FGD-02with MTRNs: P1).*

D. Category 04: Postpartum care in the LR

Postpartum care in the LR begins after the delivery of the baby and the placenta. This category consists of four subcategories: immediate care of the newborn, immediate assessment and care of the mother, fulfilling physiological needs of the mother and baby, and documentation after the delivery.

Subcategory: Immediate assessment and care of the mother

Post-delivery assessment is one of the MTRNs responsibilities according to most of the participating midwives.

"Checking BP (Blood Pressure), pulse, and bleeding. All these things are observed by MTRNs" (FGD-02 with Midwives: P1).

However, one midwife expressed a different view.

"BP, pulses are checked by the MTRN but mostly bleeding is checked by us midwives" (FGS-02 with midwives: P2).

MTRNs viewed the responsibility of post-delivery assessment as theirs.

"After the delivery, they (midwives) do not have a big responsibility. That responsibility is in the nurse's hand" (FGD-02with MTRNs: P5).

Subcategory: Immediate care of the newborn

Both midwives and MTRNs perceived that managing complicated newborn care is done by MTRNs.

"If the baby is not crying, one should go for resuscitation. All those things are done by the MTRN (FGD-01 with midwives: P8).

"If there is a need to resuscitate the baby, we take the responsibility until the doctor takes over. Doing resuscitation, informing the doctor and the rest of the observation, all should be done by us" (FGD-02 with MTRNs: P5).

E. Category 05: Postpartum care in the postnatal unit

Postpartum care begins when the mother and baby are brought to the postnatal unit from the LR or operating theatre. The category of Postpartum care in the PNU consists of four subcategories: Taking over the mother and the baby and performing routine nursing care, specialized mother and the baby care, facilitate breastfeeding and discharge planning.

Subcategory: Taking over the mother and the baby and performing routine care

Midwives felt that MTRNs have similar responsibilities as them. But, MTRNs meant that they were responsible for taking over the care of the mother and the baby and all their concerns were handled by them.

"When a mother who has had caesarian section is taken over, both categories do it with the help of each other. Assessing baby's condition is done by both categories together. Both we and they monitor the baby" (FGD-01 with midwives: P3).

"After the mother and the baby are sent to the postnatal ward, taking over the baby by checking gender, identification band and inquiring if the baby has been fed are our responsibilities. If the baby has poor sucking, the doctor is informed" (FGD-01with MTRNs: P6).

Importantly, the participating RNs were not aware of MTRN's tasks and responsibilities because they had not worked with MTRNs in their workplace. Therefore, they described what they do and take responsibility for in the PNU.

"We do not have MTRNs in our units" (FGD-05with RNs: all participants).

"When we take over the mother, we check whether there is PV bleeding and if the mother has undergone cesarean section, we check bleeding at the incision site. Then we check pulse, BP, and respiration of the mother. When we examine the baby, we check the color of the baby, and any abnormalities in the respiratory rate of the baby" (FGD-05with RNs: P7).

Subcategory: Facilitate breast feeding

The midwives perceived that they and MTRNs both were responsible for helping the mother with breastfeeding. However, MTRNs considered themselves to be responsible for facilitating breastfeeding.

"There are some nurses (MTRNs) who educate mothers for feeding as well as help mothers in that" (FGD- 02 with midwives: P2).

"We educate the mother on feeding, how to feed the baby, the importance of giving breast milk and encourage the mother to breastfeed" (FGD-06with MTRNs: P3).

Even though RNs acknowledged that they have a responsibility regarding breastfeeding they stated that it was mainly the midwife's responsibility.

"Although we observe feeding of the baby and we help the mother for breastfeeding, we think it is the responsibility of the midwife. We ask midwives to see to the feeding" (FGD-05 with MTRNs: P3).

IV. DISCUSSION

The findings of the study show that maternity healthcare professionals perceived MTRN's role differently as there were consensus as well as contradictory views regarding tasks and responsibilities within her scope of practice.

However, there were a few tasks, mostly medical technical tasks, which all professionals agreed upon as being the responsibility of the MTRN, namely administering medicine, cannulation, blood drawing for investigations and immediate care of the newborn. This finding corroborates with Papagni and Buckner [14] who identified somewhat similar task responsibilities of the intrapartum nurse, which included:

administering drugs and intravenous fluids, assessing both mother and baby and stabilizing the newborn.

In contrast, there were several disagreements between the different professionals of the maternity team about MTRNs´ responsibility related to several tasks, such as conducting deliveries, performing the episiotomy, facilitating breastfeeding and taking over mother and performing routine care. Midwives and RNs had different expectations of the role of the MTRN. Moreover, the MTRN too was confused about their professional role according to the findings of the FGDs with the MTRNs. Furthermore, participated RNs did not have a clear understanding about MTRN's scope of practice. All in all, nobody had a clear understanding of who the responsible person for a particular task is. For instance, Midwives thought MTRNs are also responsible for helping mothers with breastfeeding meanwhile MTRNs felt that it is their responsibility. However, RNs viewed it as a responsibility of a midwife. This example highlights the problem of overlapping tasks which have not been legally allocated to a specific category of maternity health professionals.

According to the findings, there were many overlapping tasks within the multi-professional maternity healthcare team. As a consequence of the ambiguity concerning the responsibility of different tasks and activities related to midwifery care, conflicts arose amongst different professionals, mainly between the midwife and the MTRN. MTRNs believed that they are responsible for performing the delivery that is on par with those of the midwife and perceived, midwives intentionally prevented them from performing deliveries because midwives identified this task as being their sole responsibility. This finding corresponds to similar findings in other settings where role confusion was most prominent during childbirth because of the considerable overlap in the scope of practice of doctors, staff nurses, and midwives [15].

Moreover, several studies reveal the potential for role conflicts among professional groups due to overlapping tasks without any identification as to what professional category is responsible for the tasks within the scope of practice [16, 17, 18, 19].

The finding of task overlap among healthcare professionals within maternity care settings is congruent with many studies conducted in different parts of the world. In India, the roles overlapped between staff nurses, [who are RNs and registered midwives (RMs)] and doctors [15]. In Morocco, similar overlap was reported among obstetricians and midwives [20], and in Canada, overlapping tasks has been reported among obstetric nurses and the midwives [21, 22].

Dissatisfaction with work is another reported consequence of overlapping tasks and subsequent role confusion, and conflicts among healthcare professionals [23, 20, 24]. Moreover, Hotepo et al. [25] claimed that conflicts affected to poor performance, lack of cooperation, wasting of resources, and productivity.

The reason for role conflicts due to unidentified responsibility for overlapping tasks between maternity care professionals in this study is mainly because in Sri Lanka, either MTRNs nor healthcare professionals in the hospital sector have specific job descriptions in difference to Medical officers of Health (MOHs), Public Health Nursing Sisters (PHNS), Public Health Inspectors (PHIs), and Public Health Midwives (PHMs) who have defined job descriptions [1]. A similar situation is reported in Nepal by Bogren et al. [3] where the auxiliary nurse midwife or nurses who provide midwifery care did not have a specific job description.

Several studies have revealed a significant relationship between job ambiguity and job performance of employees and that vagueness leads to less effective job performance [26, 27]. Consequently, a job description which clarifies the responsibilities of the different categories of maternity health care professionals is therefore, a necessity in providing safe care for birthing mothers which is confirmed by Hassan-Bitar and Narrainen [28] who found the absence of job descriptions for midwives and nurses to be a barrier to quality care. This conclusion corroborates with Bodnarchuk [29] who revealed that having no job description would cause a lot of ineffective work and confusion and further stated that having a job description brings a feeling of clarity and security to the employee. This conclusion is further confirmed by Fort and Voltero [30] who found that having a clear job description is most important factor for optimal work performance.

The main limitation of this study is related to the generalizability of these results. The study involved three tertiary care hospitals in the Western Province. Health professionals working in the Western Province may not be representative health professionals elsewhere. Further, study findings could have been strengthened by perceptions of doctors however, this could not be done due to practical problems in accessing them.

V. CONCLUSION AND RECOMMENDATIONS

The main conclusion that can be drawn from the findings of the current study is that the role of the MTRN in hospital based maternity care is debatable and unclear as different professional groups had diverse views on MTRN's tasks and responsibilities. Furthermore, the absence of a job description which clarifies the boundaries of different categories of maternity health care professional regarding responsibility for various tasks within maternity care will enhance role confusion followed by subsequent conflicts among the professionals as a result. For the promotion of inter-professional collaboration, which is a prerequisite for high quality and safe maternity care delivery clearly demarcated professional boundaries for MTRNs through guidelines issued by the ministry of Health to clarify MTRN´s role is therefore recommended.

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