



Exploring Women Centred Care in Maternity Care Project

FINAL REPORT

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1. INTRODUCTION

The Australian Council on Safety and Quality in Health Care funded this project through its Safety Innovations in Practice Program III.

It was a collaborative project between Health Issues Centre and the Royal Women's Hospital (RWH) in Melbourne.

It sought to document the commonalities and differences in women's and staff's understandings of women-centred care in the midwifery-led component of TeamCare at the RWH.

2. METHODS

2.1 Project aims

The project objectives were:

- To review the literature on patient centred care, understandings, definitions and models;
- To examine midwives' perceptions and current practice for promoting patient-centred care in the midwifery-led component of TeamCare;
- To consider consumers' perceptions of patient-centred care; and
- To explore the implications of the findings and assesses their applicability to the midwifery-led component of TeamCare.

2.2 Terminology

The RWH uses the term women-centred care rather than patient-centred care to encompass the care of women who are not ill. Where appropriate this report reflects this approach.

2.3 Project methods

The project had three components:

- a literature review;
- consultations with consumers and staff; and
- analysis of data, and development of conclusions and recommendations

2.3.1 Literature review

Three targeted searches of recent relevant national and international literature were performed. The project used a collaborative approach and advice from the reference group was used to identify additional studies for inclusion.

2.3.2 Consultation process

The project focused on the TeamCare program in the Royal Women's Hospital (the Hospital) that aims to provide women-centred care. It sought in-depth information from a limited number of women and staff.

Two focus group interviews using open-ended questions were conducted with a total of 13 midwives involved in the midwifery-led component of TeamCare (Team C and D) and the Outpatients Department of the Hospital.

A total of 19 women who had their antenatal care, labour and birthing, and postnatal care managed by Team C or D in the first half of 2005 were interviewed. Data were collected through semi-structured interviews on the telephone.

Recruitment

A letter inviting participation in the project's consultation was sent by the Manager of the Maternity Care Program to 60 women. The letter of invitation included a reply slip for women to indicate their intention to participate in the consultation. A signed and witnessed response was then forwarded to the Health Issues Centre in a reply-paid envelope.

Health Issues Centre directly contacted ten women who responded to confirm their agreement to participate and arrange an interview time.

As the project was seeking 20 participants, a second round of invitation letters were sent to another 40 women randomly selected by the RWH. In total, 24 women, including 11 from Team C and 13 from Team D responded to the invitation. Telephone, semi-structured interviews were eventually conducted with 19 women, including nine from Team C and ten from Team D. The others were not contactable.

Midwives that participated in the focus group were recruited through the Manager of the Maternity Care Program. In this sense the sample was opportunistic, being determined by whether the staff on duty were willing to participate in the research process.

2.3.3 Data Analysis

Qualitative content analysis — the process of identifying, coding and categorising patterns — was used to analyse the data. Once codes and categories were achieved, these were collapsed to establish patterns and themes. To analyse across interviewee categories, data were organised around the consultation questions to allow comparison between them.

Fusion of findings and development of recommendations

The findings of the literature review and the consultation process were brought together and discussed with members of the Reference Group. From the findings, a number of conclusions and recommendations were developed.

2.4 Limitations of project

The sample interviews were not necessarily representative of all women's experiences of the midwifery-led component of TeamCare. The report describes a small number of women's experiences of their pregnancy, birth, and post-birth care according to their perspectives. It includes positive and negative experiences.

A possible limitation of this study is the under-representation of women from culturally and linguistically diverse backgrounds, who comprise a significant part of the Hospital's population.

2.5 Project team

The project team comprised of Panayiota Romios, Charin Naksook, Dell Horey and Tony McBride.

3. LITERATURE REVIEW

The three targeted searches of recent relevant national and international literature that were performed included: an initial search to assist the framing of consultations; a second search to include research by Australian midwives; and finally the inclusion of publications related to the Victorian Survey of Recent Mothers 2000.

3.1 Targeted searches

3.1.1 *Search to assist framing of consultations*

The primary search sought to identify factors in patient-centred care to assist with the framing of consultations with consumers and health care professionals. The main goals of the search were to identify:

- Definitions of patient-centred care.
- Models of patient-centred maternity care.
- Staff perceptions of patient-centred maternity care.
- Current practices for promoting patient-centred maternity care.
- Principles and rationale of patient-centred care.

The search was restricted to items published in English.

Systematic search of published and indexed material

Published and indexed material was located by searching electronic databases from 2000 to 2005 in August 2005 using simple search strategies comprising either the medical subject heading (MeSH) "Patient-centred", the text word "maternity" or the text words "woman-centred" and "maternity".

The following databases were searched for research material:

- Cochrane Central Register of Controlled Trials (CENTRAL)
- Cochrane Library
- MEDLINE
- OVID
- PsycINFO
- PubMed

All retrieved abstracts and websites were scanned for relevance. The full article was retrieved if it related to patient-centred maternity care.

3.1.2 *Search to include research by Australian midwives*

An additional search was undertaken following feedback from the project reference group for publications by three Australian research midwives: Caroline Homer, Pat Brodie and Sally Tracy.

This search involved the terms "Homer C", "Brodie P" and "Tracy S" on Google Scholar and PubMed, and was undertaken in October and November 2005.

3.1.3 *Inclusion of publications from Victorian survey of recent mothers 2000*

At the request of the reference group publications from the Victorian Survey of Recent Mothers 2000 were also included (Brown 2005, Davey 2001).

3.2 Literature review limitations

The literature was limited by restricted project resources and the time available for the project.

The primary search relied on studies using the terms either “patient-centred” or “woman-centred” and did not use specific aspects of care, such as “continuity of care” as surrogate descriptors. This meant that subsequently specific searches were required to incorporate Australian studies that are considered to address women-centred care post-publication.

3.3 Findings from literature review

3.3.1 Description of literature

This review draws on a range of publications including primary research, both quantitative and qualitative, as well as reports of the evaluation or implementation of patient-centred policies.

Three relevant papers were found in the additional Australian midwives’ publication search and two additional papers describing maternity services in Victoria are included.

3.3.2 Terms and definitions used

The Cochrane Systematic Review (CSR) of interventions to promote a patient-centred approach in clinical consultations concluded that the lack of agreement on a definition of patient-centred care makes assessment of the effectiveness of strategies to implement such care difficult (Lewin 2001).

The lack of consensus to define patient-centred care extends to maternity care where the literature encompasses a range of definitions and terms to describe care that focuses on those receiving care, not those delivering it. The terms used include: patient-centred care, patient-focused care, women-centred care, mother-friendly care, individualised care, and family-centred care (see Table 1).

The Cochrane review uses a broad definition for patient-centred care that comprises one or both features of care where health care providers share control of consultations and decisions with patients, or focus on patients as people, not a disease (Lewin 2001).

Whilst terms and definitions used for patient-centred maternity care vary in the papers identified in the literature review, elements of the definition used in the Cochrane review, namely a focus on those receiving care and the sharing of information and decision-making, appear frequently. A number of papers identify elements of patient-centred care but offer little guidance on how these outcomes can be assessed objectively. These include: meeting patient and family needs; mutually beneficial partnerships, informed choices; involvement in and control over care; respect for women’s preferences; continuity of care; evidence-based practice; and information sharing.

Generally the papers appear to refer to a broad philosophical approach to care. For example, Gramling (2004) describes family-centred maternity care as “an attitude not a protocol”.

TABLE 1:

Terms and definitions used for patient-centred maternity care

Study	Terms used	Definitions used
Capitulo USA 2001	Patient-focused/ family centred care	“patient at centre of the health care system and builds services and processes to better need the needs of the patient and family”
Gramling USA 2004	Mother-friendly Family-centred care	“an approach to health care based on mutually beneficial partnerships between health professionals and families”
Harriott USA 2005	patient-centred	“includes respect for women’s preferences”
Hart UK 2002	individualised care, women-centred care	None given
Hotelling USA 2004	mother-friendly	“a wellness model of maternity care”
Johnson Sydney, 2003	Women-centred	“women making informed choices, being involved in and having control over their care, and their relationships with their primary caregiver”
Keeney UK 2005	Patient-centred care	None given
Pope UK 2001	Woman-centred care	“health care professionals must work in partnership with the patient/client” The key principles are choice, continuity and control
Tumblin USA 2001	Family-centred care	None given
Zwelling USA 2001	Family-centred maternity care	“approach to the delivery of maternity care that redefines the relationships between and among childbearing women and their families and maternity care providers. Information sharing and collaboration between childbearing women, their families and staff are the cornerstones of family-centred maternity care”

Another approach used in two papers is to list principles of patient-centred care. This approach further demonstrates the lack of agreement in this area as, although similarly described as “family-centred care”, and published in the USA in the same year, the studies’ principles do not contain comparable elements (see Table 2).

TABLE 2:

Principles of family-centred maternity care

Zwelling 2001 Principles of family-centred maternity care	Capitulo 2001 Mt Sinai Maternal Child Health Care Centre
1. Childbirth is seen as a wellness not illness.	1. Continuum of quality of care.
2. Prenatal care is personalised.	2. Caring and friendly, family-centred environment.
3. Comprehensive prenatal education program.	3. Atmosphere for optimal adjustment, growth and development.
4. Assist the family in making informed choices	4. Respect for all families, both traditional and non-traditional.
5. Mother's chosen support people are actively involved in education, labour, delivery, and postnatal and newborn care.	5. Primary nursing, coordinating care through collaboration.
6. Whenever mother wishes family and friends encouraged to be present.	6. Outreach to the community.
7. Labour and birth care provided in same location, unless a caesarean birth is necessary. Postnatal and newborn care in same location and caregivers.	7. Health education and maintenance.
8. Mothers preferred care providers for their newborn infants.	8. Scholarly clinical practices.
9. Same person cares for mother and baby even when briefly separated.	9. Fiscally responsible environment.
10. Parents have access to high-risk newborns at all times and included in their care as much as possible.	10. Care that meets individual cultural and spiritual needs.

However, the two definitions for "family" found in these studies are consistent and use a broad scope in describing family members. Both studies use a definition that is determined solely by the woman giving birth (see Table 3).

TABLE 3:

Definition of "family"

Capitulo USA 2001	Patient-focused/ family centred care	"anyone who is designated by the patient to have a significant role in her or his life."
Zwelling USA 2001	Family-centred maternity care	"those persons who are identified by the childbearing woman as providing familial support, whether or not they are biologically related."

No Australian study was found that defined either "women-centred" or "patient-centred" care. The focus of the three papers by the Australian midwives was the organisation of midwifery-led care. Whilst there is reference to the inclusion of women in the process of implementing a new caseload model there is no description of who took part, how they were selected and what contribution they made (Tracy 2005).

3.3.3 Understanding what is meant by patient-centred or women-centred care

Other than the difficulty in assessing the effectiveness of strategies to promote patient-centred care identified in the Cochrane review (Lewin 2005), two other problems are identified in the literature arising from the lack of an agreed definition of "patient-centred" or "woman-centred" maternity care.

The first problem relates to conflicting understandings that can arise between staff about what is meant by "patient-centred" or "woman-centred" care and what is expected from them. In a recent small study that looked at the perceptions of health professionals and women receiving maternity care about trained health care assistants, Keeney (2005) found that those with the most frequent and direct contact with women, that is the health care assistants, were task-orientated rather than patient orientated. Health care assistants were introduced because of midwifery shortages. While the health care assistant role may not yet exist in Australian maternity services the study raises an important issue about how patient-centre care is delivered in practice, and who is responsible for it. Keeney suggests that without a framework defining the concepts of patient-centred care role ambiguity and role conflict can arise, which could be important if "patient-centred" or "woman-centred" care is seen to "belong" to a specific model of care (Keeney 2005).

The second problem concerns criticisms around inconsistent practices among services purporting to offer patient-centred care (or its equivalent). When Zwelling (2001) suggests that "providers often lack an understanding of what FCMC [family-centred maternity care] really is" the implication is that consensus exists about what is meant by this form of care. People can have strong beliefs about what is meant by "patient-centred" or "woman-centred" care without a shared understanding of how this translates to practice.

These issues are important to those who wish to implement any form of "patient-centred" or "woman-centred" care because different understandings may lead to inconsistency in practice and failure to meet expectations, for both those receiving care and those providing it.

A number of questions arise from the range of definitions found in the literature. First, how is the practice of maternity “patient-centred” or “woman-centred” care envisaged? Next, what components or combination of components are believed to be essential for maternity care to be “patient-centred” or “woman-centred”? How do these differ from care that is not “woman-centred”? Some of the “patient-centred” or “woman-centred” factors identified in the literature are not specific to “woman-centred” care alone, for example, informed consent would be considered an essential component of all Australian health care.

It is also important to consider who determines what the components of “patient-centred” or “woman-centred” care should be. Have the views of those who use the services been included in determining what is important in “woman-centred” maternity care?

Consideration of the components of “patient-centred” or “woman-centred” care also raises the issue of how these components are themselves conceived and applied. The characteristics of patient-centred care described in the literature include concepts for which there is a lack of a consensus definition. This means that they are subsequently open to interpretation and variable implementation. Two evaluations of English midwifery services following the Changing Childbirth policy revealed considerable variation in the practice and application of policy (Pope 2001; Hart 2002). In response to policies related to the care of disadvantaged women, Hart (2002) found midwifery practices to provide “individualized” or “women-centred” care were often influenced by personal biases and beliefs. Women who were able to identify needs and articulate them were more likely to attract resources, including the attention of midwives, than women who “did not complain” and who had lower expectations of care and greater levels of disadvantage.

3.3.4 Women’s views of women-centred maternity care

The literature search did not find any studies that explicitly sought women’s views on what they saw as “patient-centred” or “woman-centred” care and what they would expect from such care. However, two studies did investigate women’s views on what was important to them about their care in hospital and a third study sought parents feedback on postnatal care options. A third Australian study was also included on advice from the reference group.

Harriott (2003) investigated women’s evaluations of maternity care in 44 military hospitals in the United States. More than 2000 women took part in the study, which used a multivariate analysis to determine the factors that influenced women’s unqualified willingness to recommend a particular maternity service to others. The predictors were: being treated with respect and dignity; involvement in decision-making; confidence and trust in care provider; coordination of care; courtesy and availability of staff; physical comfort; information and education; and involvement of family and friends. Three dimensions of care that were not significant in the final model were: respect for patient preference, emotional support, and continuity and transition (Harriott 2005).

Women’s views were critical in the redesign of services to patient-focused, family-centred care at Mount Sinai Hospital, New York. Focus groups were used to elicit women’s input to two main questions “What do we do that we should change?” and “What do we do well that we should keep?” (Capitulo 2001).

Women were unhappy about the restricted visiting hours, the lack of a comprehensive breastfeeding program, fragmented nursing care, that mothers and their babies were transferred separately from the labour and delivery wards to the

postnatal ward, and with the dated facilities. In the neonatal intensive care unit parents wanted more chairs, more clocks, and better continuity of nursing.

In response, an open visiting environment was implemented with partners welcomed any time during the day. Children, who previously could only visit for two hours in the afternoon, could now visit at any time and could go to the labour and delivery wards. New policies on the definition of family were instituted. Mothers could nominate primary visitors (spouse, significant others, partners, or others) who could visit at any time. At the same time it was recommended to families that they keep visits short to promote rest and limit numbers in rooms for safety reasons. A Breastfeeding Committee was established to promote a "baby friendly" environment and appropriate resources were allocated to the paediatric and neonatal areas (Capitulo 2001).

Poor information and a lack of real choices were evident in the Swedish study in which parents were asked about their two options for postnatal care, family suite or early discharge. In focus group interviews four months after birth parents were unhappy with the limited information given to them in pregnancy and felt the absence of night staff for the family suite, and its closure over the summer limited the practical options available to them. They felt that they had no real choice (Fredriksson 2003).

The postnatal care of women in Victoria was affected by their interactions with care-givers including the degree to which they were seen to be sensitive and understanding; how rushed they seemed; the helpfulness of advice and support they gave; and whether advice and support was offered. The Australian study draws on a sample of women who gave birth in Victoria over a two-week period in September 1999. Women in the study were largely representative in terms of parity, method of birth, baby's birth weight and place of residence (rural or metropolitan) but unrepresentative in terms of non-English speaking background, age less than 25 years and unmarried status (Brown 2005).

3.3.5 Fathers' needs

The changing status of fathers in childbirth has implications for maternity services. The encouragement of men into labour wards since the 1970s raises issues about their needs in maternity services. While some men are comfortable in the delivery room, others are not and there is uncertainty about the role that men can take in childbirth. For example, the role of men as a "birth coach" has been re-evaluated. Men themselves may feel unable to meet expectations (Early 2001). Men questioned about postnatal care options felt that they should be present to support their partner and baby, and allow them the closest contact (Fredriksson 2003).

Current practices offer three main alternatives; to consciously maintain women as the focus of care; to facilitate a couple-centred approach with greater recognition of the father; or to promote a greater autonomy for men with antenatal groups for fathers, male mentors, and postnatal follow-up of fathers (Early 2001).

3.3.6 Models of care

The literature search attempted to identify models of maternity care that were ascribed as being "patient-centred" or "woman-centred". Only three types of maternity care were explicitly described in this way in the literature search. Other models were identified through the additional search for recent publications by Australian research midwives, and the inclusion of publications from the Victorian

Survey of Recent Mothers 2000. These latter models are not described as “patient-centred” or “woman-centred”, rather as offering continuity of care or carer.

It is interesting to note that the discussion of models of “patient-centred” or “woman-centred” maternity care in the literature is limited by a number of implicit assumptions and methodological issues. First it appears that there is an assumption that certain models of care are “woman-centred” without any explanation of why this term applies to these models of care. Second, there is an assumption that “patient-centred” or “woman-centred” maternity care is strongly related to the provision of some form of continuity of care, although the concept of continuity of care is used in a different ways. More recently there has been differentiation between continuity of care and continuity of “carer” but this is not consistently applied. While continuity of care, however defined, is implicitly assumed to be a fundamental aspect of woman-centred care it is not universal to definitions of patient-centred care or women-centred care in the literature. Third, models of care may share terminology, such as continuity of care, but this appears to be applied differently in practice. For example, a midwife can provide continuity of care for 40 women per year (Tracy 2005) or 50 women per year (Homer 2000). There can also be variation in how “low-risk” is assessed which will affect eligibility for some forms of care. Finally, most attention in the literature is given to forms of care that are available to a small minority of women. For example, less than one per cent of women in the 2000 Victorian Survey of Recent Mothers received either team midwifery care or caseload midwifery care (Davey 2001).

The strongest evidence supporting a model of maternity care offering continuity of care that was located comes from a randomised trial of 1089 women accessing community based antenatal care, although this model was not described as either “women-centred” or “patient-centred”. (Homer 2000; Homer 2001). In this trial “continuity of care” was defined as “a consistent team approach” rather than care being provided by the same midwife (Homer 2000; Homer 2001). Women were ineligible for inclusion in the trial if a significant maternal disease was present, such as diabetes or essential hypertension, and if they had had two previous caesarean deliveries or a previous classical caesarean incision. However, women who developed complications during their care continued to receive care from the midwifery team with the obstetric support available.

Homer (2000, 2001) looked at a team midwifery approach to care. Two teams of six midwives aimed to provide care for 50 women per midwife per year. The trial showed that giving women team care was achievable with nearly 90 per cent of women in the intervention group receiving the model of care to which they were allocated.

There were significant differences in outcomes for women in each group. The caesarean delivery rate was reduced among women in the intervention group (13.3 per cent compared with 17.8 per cent in the control group, $p=0.2$) for both elective caesarean delivery (3.8 per cent vs 6.3 per cent) and emergency caesarean delivery (9.5 per cent vs 11.5 per cent).

Interestingly, women in the intervention community care group were less likely to say that continuity of carer was important (54.7 per cent compared with 64.2 per cent in control group, $p=0.007$). This suggests that team approach provides women with something that is more important to them than seeing the same carer. An explanation is apparent in the significant differences found in the communication elements of the antenatal visits which strongly favour the intervention. Women in the intervention group were more likely to feel that someone would listen to them (90.3 per cent compared with 68.1 per cent, $p<0.001$), that they could ask

questions (91.3 per cent compared with 67.9 per cent, $p < 0.001$), that someone explained things (94.5 per cent compared with 77.0 per cent, $p < 0.001$), and someone who remembered them (70.4 per cent compared with 42.6 per cent, $p < 0.001$).

Although women who accessed the team midwifery model were significantly more satisfied with antenatal visit arrangements, such as waiting time, and suitability of clinic times ($p < 0.001$), this was not true for postnatal care. The authors report that "(p)ostnatal care was the most difficult service to provide" and inconsistent advice in the postnatal period was reported by women in both the intervention and control groups. This in part was explained by the attitude of the midwives who were felt to possibly value postnatal care less than the more rewarding components of antenatal and intrapartum care (Homer 2000).

The terms "patient-centred" or "women-centred" are not used in the report of Victorian Survey of Recent Mothers 2000 although eleven different models of care are described in terms of how they facilitate care through the same care-giver or small group of care-givers (Davey 2001). Other aspects of continuity of care such as consistent approach or continuity of information are not addressed. The survey highlights several difficulties in achieving continuity of midwifery care throughout pregnancy, labour and postnatal care.

Private maternity care almost always was able to provide antenatal care from the same care-giver (around 90 per cent) with the majority of women feeling always remembered by them. This compares with less than 20 per cent of women receiving public clinic care, who always saw the same midwife or doctor, and an even smaller proportion always seeing the same midwife among those attending midwives clinics (8 per cent) or birth centres (11 per cent), although women were more likely to always see the same doctor in these settings (11 to 23 per cent). Continuity of midwife in labour and for postnatal care was most often achieved for those women attending a birth centre. However only a quarter of women who attended the birth centre felt that they knew the midwife who attended them in labour well (Davey 2001).

Despite its availability to only a very small proportion of women in practice, considerable attention in the literature has been given to the caseload midwifery model in Australia. Unfortunately neither of the two papers report sufficient information to allow comparison. For example, there it is not possible to assess how the caseloads vary in size, clinical assessment, or the proportion of births attended by the caseload midwife or transferred to other forms of care.

In a poorly described paper Johnson (2003) compared a "partnership caseload model of midwifery-led practice" or Primary Health Midwifery Care (PHMC) with standard hospital care in a Sydney hospital. There are few details about how the two care models operate. For example, the number of midwives involved in the PHMC is not reported. There were no differences in clinical outcomes although significant differences for some outcomes were found. Unfortunately selection bias makes the results difficult to interpret. Women self-selected to receive PHMC and places were limited. This meant that some women who received standard care could have preferred PHMC, influencing their assessment of satisfaction with their overall pregnancy care. Further problems arise because more women having their first baby in the PHMC group were much more likely to attend antenatal classes (74 per cent compared with 35.8 per cent of those receiving standard hospital care) making it difficult to judge the affect of PHMC (Johnson 2003).

In the second paper related to caseload Tracy (2005) describes the transition of a small metropolitan maternity service to a caseload midwifery model in terms of organisational changes. The caseload model required significant changes to midwifery working practice including the introduction of an annualised salary, attendance at all antenatal visits and screening procedures, from the onset of labour till delivery, and providing postnatal care at home for the "first few weeks". Although described as a caseload model, only six full-time-equivalent (FTE) midwives work in caseload while eight FTE "anchor" or "core" midwives operate on a rotating roster at the unit. Another four other midwifery positions are the unit manager, antenatal clinic midwife, visiting postnatal midwife and lactation consultant. Caseload midwives provide care for 40 women per year per midwife and backup care for a further 40 women. Only women with no identified risk markers, no history of caesarean birth, and who willing to forego epidural anaesthesia are eligible for caseload care. The change to a caseload model began in March 2004 included agreed guidelines for consultation and referral based on a consensual risk assessment process. No outcome data are presented in the paper although a brief report of the first 100 caseload bookings says that the quality and safety checks have been integrated into daily practice and that the rates of transfer and operative delivery are "well below projected levels" although these are not reported (Tracy 2005).

The "named midwife" model is identified in studies in the United Kingdom that evaluated the effects of policies related to woman-centred maternity care. Pope (2001) sought to understand how this concept was interpreted and experienced in practice and found enormous variation its operation. Commonly, the named midwife provided antenatal and postnatal care in the community but did not always provide care in labour. In some areas women were allocated a named midwife on a "visit to visit" or "shift to shift basis". The researchers found midwives interpreted what "knowing" a midwife meant widely, and that in general their priority was that care be provided by someone who was "caring, kind, and competent" (Pope 2001). Hart (2002) argued that the promotion of the midwife as a "professional friend" idealises the relationship between midwives and their clients, a relationship that in reality is not always met and may in fact detract from exploring other models of care such as building peer relationships between women (Hart 2002).

The final patient-centred model identified was hospital-based and arose from the redesign of a traditional obstetric program to one that is specifically patient-focused and family-centred. The formation of a "mother-baby nursing model" included the introduction of a primary nurse role with responsibility for coordinating all care for women and their babies in a self-selected caseload including direct communication with doctors and other health professionals. A limited number of associate nurses were also nominated to provide backup and continuity. Postnatal units were renamed Mother-Baby Units. The report contains no detail about the organisation of antenatal or intrapartum care (Capitulo 2001).

3.3.7 Assessment tool

A questionnaire, "Is Your Perinatal Practice Mother-Friendly?" produced by the Coalition for Improving Maternity Services (CIMS) in the USA purports to offer a self-assessment tool to determine whether a maternity service can be designated "mother-friendly". CIMS, whose mission is "to promote a wellness model of maternity care that will improve birth outcomes and substantially reduce costs" developed the tool, which is endorsed by 26 organisations and 31 individuals, though these appear to hold similar philosophies about childbirth. The "Ten Steps of Mother-Friendly Care" is available on-line at: <http://www.motherfriendly.org/MFCI/steps/> (Hotelling 2004). There is no information given about how the questionnaire was

developed and there may be some bias in the selection of evidence used to support it.

3.3.8 Staff perceptions

There are a number of lessons about staff attitudes to patient-centred care that can be drawn from the literature.

The impetus for the redesign of New York's Mt Sinai Hospital to a patient-focused program was low patient satisfaction but the change to a decentralised model of governance was met with resistance from some staff, in particular there were doctors who were sceptical about the devolution of power and autonomy to local units. It was considered important that doctors were included on every redesign group (Capitulo 2001).

The Mt Sinai experience approached conflict resolution by refocusing attention on the bigger issue of improving patient satisfaction using all available data, such as admission data and feedback from patient focus groups, to guide decisions (Capitulo 2001).

Resistance to changing visiting hours by some doctors at Mt Sinai was justified as being in the best interests of women and their babies. The change to more liberal visiting was finally achieved through use of data from the patient focus groups and identifying allies to champion change among the medical staff (Capitulo 2001).

Nursing staff were generally happy with the program redesign especially with the role of primary nurse but there were complaints about the integration of mothers and babies and some staff resorted to complaining to patients. It was made clear that such behaviour was unacceptable. The restructure included a redesign of job roles to better meet work needs so nursing staff spent more time in direct patient care (Capitulo 2001).

Other barriers to family-centred care identified are the lack of coordination of services and health professional roles (Gramling 2004), poor documentation and dissemination of best practice, and the unwillingness or inability of some midwives to work across all areas of care (Keleher 2002).

There are difficulties coordinating health services and as Gramling notes "(t)he complexity of delivery systems can immerse providers in a culture of routines, where individual patient issues are lost in the assembly line of care" (Gramling 2004).

Pope (2001) and Hart (2002) found that the reality of achieving policy ideals needs commitment from managers, education of staff, and protocols that are clearly understood. Midwives did not know what was expected of them in their practice, and need to develop skills so that they can translate policy into action systematically (Pope 2001; Hart 2002). Issues such as managing differences among the women they care for, including addressing the needs of different religious, cultural and ethnic backgrounds can be difficult and midwives were found to be sometimes insensitive and irritated about being expected to do it. It is important to identify the educational needs of midwives and design a curriculum to enhance their capacities to provide more integrated woman-centred services (Pope 2001).

The experience at Mt Sinai required all staff to undertake education to prepare for their new role including interdisciplinary work and to build relationships. Monthly

staff meetings were held and attention given to the celebration of key events. The centre's newsletter published all positive letters about staff (Capitulo 2001).

Tracy (2005) identified that a major barrier to establishing a caseload model of midwifery care was concern expressed by medical professionals about the safety of a service in which they were not involved. The lack of anaesthetic cover was the impetus for the change to a midwifery-led model and its absence led to visiting obstetricians withdrawing their services, and continuing to express their concerns about the safety of the services at the hospital. These issues were picked up by local media and potentially undermined confidence in the service and the morale of staff (Tracy 2005).

3.3.9 Conclusions

The review of the literature shows that the transition to "patient-centred" or "woman-centred" care needs careful management. It requires a good conceptual framework to describe what is meant by "patient-centred" or "woman-centred" care in the particular health service and good documentation to show how it translates to practice. It is important that there is agreement in the understanding of key concepts that are applied to "patient-centred" or "woman-centred" maternity care, such as continuity of care, partnerships and involvement in care, including explicit statements of the assumptions underpinning these concepts. This is important to the consistency of service delivery and for ongoing evaluation.

The results from the randomised controlled trial of community based antenatal care suggest that a consistent approach from a care team, and being listened to, is more important to women than care from the same person (Homer 2001).

The conceptual framework could include a clear statement of the health service's principles of women-centred care and documented protocols for how those principles are expected to work in practice. Patient data and women's views about existing services and preferred practices should guide decision-making. Women are more likely to reflect on their experiences of direct patient care than the organisation of that care. It would be useful to know what is important to women about their care, what they like about existing services and what they would like to change.

Staff need skills in communication, working in multidisciplinary teams, and cultural competence. The acquisition of these skills is important to "patient-centred" or "woman-centred" care and needs to be facilitated and rewarded.

4. CONSULTATION

Nineteen women who had their baby in the first half of 2005 through the midwifery-led component of TeamCare were interviewed. Twelve of the women interviewed had given birth to their first baby. All of the women were English-speaking.

4.1 Consultations with women

4.1.1 Reasons for choosing the RWH

Women provided the following reasons for choosing to give birth at RWH:

- **Medical facilities**

Several women stated they came to the RWH because of the medical facilities; they saw these as ensuring the safety of mother and baby, especially in cases of complicated births.

Because I am 39 and he was my first baby. I wanted to be in the centre of excellence where there were all the facilities that might be needed, and I didn't want to change hospitals or things like that if things became complicated.

Because I had all the other kids here, and also because of the Genetics Unit.

- **Previous experience/RWH's reputation**

Seven of the women interviewed had given birth at RWH before and were satisfied with their experience of care.

Because I had my other babies there, I thought it was the best place, the most experienced hospital for that sort of thing, in case something goes wrong. And because I'd been there before and I was happy with it.

Because I had my first child there, and all my family had been there and had their kids there.

Some women were aware of the Hospital's excellent reputation including specialist back-up services from relatives or friends who had used the RWH.

My sister had babies there. She had a good experience.

My mother-in-law had her baby there. She was happy with the service. Best hospital in Melbourne.

- **Having no private health insurance cover**

Six women identified that they had no private health insurance and considered the RWH as the best possible choice for public patients.

I was looking for a public hospital and I just thought it had a good name and good reputation

Being a public patient and being close to where I live.

- **Location**

Four women lived or worked in close proximity to RWH. It was convenient for them to attend antenatal sessions.

Yes, I work in the city and it was easy for me to get to appointments there.

It was fairly local and I could get there by public transport and I thought it would be one of the better hospitals because they specialise in women's medicine.

- **Women to women services**

Three women cited specifically that RWH is the hospital with the expertise in servicing women.

I believed that RWH was expert in women's birthing services. It's a hospital for women. Not knowing very much as the first time mum, it's a comfort to be cared for by a women's hospital.

Because I associate it as a major women's hospital for Melbourne and I had my previous child there.

4.1.2 Important aspects of care — expectations before coming to RWH

Women's expectations of maternity services at RWH were:

- **Safety and quality of care**

Safety in pregnancy and during labour and birth, the health of the mother and her baby, including specialist back up services in the case of complications were aspects of care nominated by 10 of the women interviewed.

The best technology and the best advice.

My health and health of my baby.

I don't know really, just that the baby would be safe and okay. I don't really have other expectations.

- **Thoroughness of care**

Four women identified thoroughness of care as an important aspect of care.

To have regular check ups so I knew everything was going okay.

Thoroughness of health professionals, hands-on care.

That things are thorough, that everything gets checked out, regular check- up.

- **Being treated as an individual**

Several women talked about being listened to, feeling welcome, good communication with staff, staff being approachable and giving them time and taking interest in them.

Having people listen and feeling there were genuinely interested and concerned about you.

Because it's such an important time in your life, and a very special time, and you just want support I guess, and understanding and caring. You just want people to care about you and your baby, and just what's going on.

Everything should be discussed. All aspects covered. Being informed of everything about birth, things that will happen so that I am well prepared.

- **Midwifery care**

The way in which care was provided was important to several of the women interviewed. They held the view that midwifery care would offer them with more time with the care providers. They said:

I used to get stressed having to wait for a long time to see doctors. So I wanted to see midwives.

I wanted more time from carers, therefore I chose to be seen by midwives.

One woman specifically chose midwifery care.

I wanted a natural birth and I wanted to have midwifery care as opposed to obstetric care.

4.1.3 Communicating important aspects of care with midwives

Most women were positive about their communication with midwives. They had established good interactions with midwives; that the midwives explained information well and answered all their questions.

No problem. They answered my questions. I was really pleased with them. Things were explained thoroughly.

Yes. I wanted to be able to ask a lot of questions, have them answered and I was able to do that.

They answered all my questions, gave me all the options and explained each option very thoroughly and made sure that I was completely aware of what treatment I was receiving.

They made me feel relaxed, ...the midwives were reassuring and knowledgeable. They put me at ease. I felt I was able to talk to them about anything.

Five women reported some degree of communication problems with midwives. Two women said:

There was an assumption that because it was my second baby I knew already. In fact I need a refresher. I felt that I didn't get the information I wanted. I had to push for it.

[So you weren't always able to tell midwives what you thought or wanted?]

Well I did but they didn't listen and when you are having your fourth child you sort of know the process of what is going on and you sort of know, but I really felt they didn't listen...but because I was so long in labour I just wanted her [midwife] to leave me alone.

Another woman felt that she was never asked how she felt, and the midwife who attended to her during delivery did not take her opinions seriously. This woman wanted to have external stitches after her delivery but the midwife refused her preference.

What I expected is the job done properly and I felt it was not necessary to tell me that I've had four kids and I shouldn't expect anything now, that I should expect down there to be horrible ... and no ... I just felt very bitter actually.

One woman reported that the doctors caring for her did not treat her with respect. She was quite distressed because she felt that she was not properly told about the problems with the delivery:

The worst thing about it was he [Specialist] had a training doctor with him and he treated me really abominably.

Another woman experienced rudeness of hospital staff on the phone when she rang for information. The conversation was cut short and she did not receive the information she wanted.

The scheduling of the first antenatal visit at 12 weeks resulted in one woman feeling that she missed out on information such as diet precautions during early pregnancy. She said:

I might have done a lot of things before that 12 week appointment having been given this literature, looked at it and suddenly thought oh no I've been drinking some sort of herbal tea in the last 12 weeks and that is going to do some damage to the baby.

4.1.4 Continuity of care and continuity of carer

Seventeen women reported they saw the same midwives more than once.

I saw the same midwife a few times, the same doctor a few times.

Some of the midwives I saw more than once, others I just saw once.

I saw the same midwife three or four times during antenatal visits. Then I saw her again on the ward.

Of these, ten felt continuity of care and seeing the same midwives was important. They said:

I found that really important. You build up your trust and it's just nice to see a familiar face. It's human connection because you generally don't get that at a public hospital.

Very important. I was so lucky. We got on very well. I was a bit disappointed that I don't have her in the delivery room.

Important because I was scared. I became friendly with [the midwife]. She reassured me.

Some women thought it would have been desirable to be cared for in the delivery by the midwives they had met during antenatal care.

I would have liked to see one specific midwife that I was seeing in early days, and she was just wonderful... I actually didn't have her so I was disappointed about that.

It was nice to see the familiar face when you walk into the labour ward, when you're unsure of what is happening, and if it's your first time like it was for me, it was just a reassurance.

Several women expressed they had not expected to see the same midwife throughout pregnancy, labour and birth as they were public patients.

Of the seventeen women who had seen the same midwife more than once, six said that seeing the same midwife was not important to their care.

It wasn't really crucial to me. I did have one of them two or three times.

It really wasn't important.

Two women said it was not really important so long as it did not influence the quality of care received. These women were concerned that discontinuity of carer may affect the information transfer and coordination of care over time. They said:

It doesn't really concern me but it would help because the midwife would know how your pregnancy is going. If there's a complication they would know. You don't have to explain time and again to different midwives.

It would be good to have the same midwives. She would know every thing about you. But it really does not matter. It's not that crucial, as long as each midwife has your details correctly. ... I didn't feel I missed anything.

Two out of 19 women interviewed, including one each from Team C and D, did not see the same midwives during their experience of maternity care at RWH. Both said

that seeing the same midwives was not necessary, and in fact one thought it was beneficial.

It doesn't really matter. I had check up each time with different midwives. Each had varied experiences. That was good because it broadens my knowledge.

Importantly the women's understanding of continuity of care emphasised the maintenance of a consistent approach to care between midwives to meeting personalised needs during the pregnancy, birth and post birth rather than continuity of individual carer. They said:

By being gentle and by being interested and having a gentle approach, being genuine when listening.

I guess what is important what was most important to me ...you are in such a vulnerable situation, you just feel really vulnerable and you just want people to just keep you informed and just have that support really, so that is what is important to me.

4.1.5 Pregnancy and birth options

Fifteen out of 19 women interviewed remembered that they received some information about pregnancy and birth options on their first antenatal visits. They said:

Yes she did. She went over all of that, it was actually very helpful the first time I went there.

They did. The birth centre was one of the options.

Yes I got all the booklets. It was great.

Four were not sure whether information was provided to them at any stage. One woman said:

I can't really remember. I was given a lot of information. I don't think they told me about different models of care.

Another woman felt that staff concentrated on giving so much information in the booking visit rather than discussing options with her.

I was given options but I didn't like it. It was really like she had to tell you all those things. She didn't really engage me. She ignored what I was saying. I felt I missed the opportunity to get the information. Quite disappointed.

4.1.6 Reasons for choosing the midwifery-led model of care

When asked why they chose the midwifery-led component, the majority of women said they had not intentionally chosen this model:

I am not sure, I think I just said I wanted to do it all through the Hospital.

I remember at my first appointment I saw a doctor and he looked at my history and he was the one that said I could have a midwife-led thing so I booked in for that.

In two cases the women hadn't even realised they had a choice.

I didn't know it was a choice. I thought from the start that I would be see midwives at the hospital. I thought all public patients see midwives.

I went with standard care at hospital because it was what you call normal. All babies [are born] with midwives.

Hospital-based care

It appears fourteen women participated in the midwifery-led component because either they preferred hospital care or a lack of alternative options defined their choice.

Several women stated that they did not necessarily need to see doctors or specialists because their pregnancy was normal and they did not anticipate birth to be complicated.

I don't know. I think because I had an uncomplicated pregnancy and that was the option. I did want to be able to use pain killers during birth.

I wanted options of pain relief ... I felt I would have more options at the Hospital ... I didn't know I was cared for by a midwife team.

At least five women mentioned medical facilities at the RWH as a motivation for their decision. Two said:

I felt that doing everything at the hospital would be convenient. Getting everything done in one place.

Facilities. To be in the best spot for facilities. I was close to any care I needed.

Others thought of pain relief and medical assistance available at labour if they had complications.

The Hospital's facilities in case anything goes wrong.

I was close to any care I needed. Birth does not necessarily go as planned so it is safest to be in hospital.

Some women chose the midwifery-led component because they were not able to access other types of care.

- **Birth centre**

My first time [previous pregnancy] was supposed to be at the birthing centre but I didn't end up having it there because

they decided to induce me ... this time the birthing centre wasn't an option for me.

- **No general practitioner**

Several women had no general practitioner or their general practitioner was not registered with RWH as a share-care practitioner.

Because I don't have a general practitioner.

I didn't have a regular general practitioner therefore I didn't choose the shared care model.

Preference for midwifery care

Five women were clear about the pregnancy and birth options available and expressed a clear preference for midwifery care. They said:

I was just comfortable with them [midwives], I had them all the way through so I felt comfortable being with them and could tell them....

*[Did you consider other options, like the birthing centre?]
I did but I just wanted to go with the midwifery thing.*

I wanted a natural birth and I did want to have midwifery-led care as opposed to obstetric care. ... It's better. They had more time to spend with you. Equal relationship between carers and patients.

Midwives are more positive, more reassurance. They see patients all the time.

Midwives have more time to spend with you. More focused on women care. It is women to women.

It appears they chose midwifery care because they perceived it to be more women centred.

4.1.7 Communication with midwives during pregnancy, labour and birth

Most women felt when they had questions they could easily ask midwives, and that the answers received from them were thorough and easy to understand. They felt comfortable asking further questions if they did not understand and had their opinions taken seriously. Attitudes of staff were thought to influence the communication and decision-making choices available to birthing women.

Women reported midwifery practice promoted discussion and informed choice. They said:

Yes, particularly with midwives than with any other doctors. I found them much better in explaining things.

In general it was good. If I didn't understand I asked again and they would explain it to me.

Yes, everything was in terms I could understand. When I went in they went through a few terms that they would be using between the staff and what they meant, so if I heard these words I wouldn't be alarmed, but I can't remember what they are now.

There are a few women who had mixed experiences and said that it depended on who they saw.

Some midwives didn't take my requests seriously. On one of the visits the midwife had a student with her. I didn't want students to see me...I had to tell her that I am happy to have a student here today but not next time. The midwife ignored me completely when I said that.

There was one midwife who wasn't polite to me when I asked questions about breastfeeding. She was harsh to me, not polite. Others were helpful. They took my opinions seriously.

One woman felt that she was not listened to while cared for by the midwives during labour. She said:

They were treating me like an irritating whinger...I should just learn to deal with it, if you are going to go and have a baby then learn to deal with the pain because that what you get.... It was just a normal labour I wouldn't have worried about it so much, but because it wasn't then it makes me feel my concerns that I had [were] ignored.

Another woman had no problems with asking questions of midwives, however was disappointed with the hospital management because her wishes were not respected. She and her husband had arranged for umbilical cord blood to be collected privately. She understood from communicating with hospital staff that the collection of cord blood was allowed. However the decision was overturned by the hospital later, when their baby was about to be born.

4.1.8 Being involved in the care planning after birth

Most women interviewed felt they were involved in the planning of their care after their babies were born. They reported midwives having discussions with them about different aspects of care for example, breastfeeding after discharge.

The asked me if I had proper space, about plans for feeding, plans for the future. They were helpful.

Yes. Definitely.

Some women were not sure if they were really involved in this process. Five women did not feel that they were consulted about the care plan. They said:

Not really, in terms of care plan. They gave me books to read. I thought what I got was standard, same as anybody else. I can't say the care I received was what I needed. No I don't think so. Things just seemed to happen, but I don't remember anybody sitting down with me and going through

things with me or asking me what I wanted. ... It would be good if I was involved.

However, time pressures limited discussion and adequate support was not available in practice. One woman stressed the difference between before and after birth care received.

I was involved.... But the care you received afterbirth was less than what you got before. The staff [were] really stretched themselves. They were too busy with mothers and babies who had caesarean births.

4.1.9 What made a difference

Women were asked to identify the most important thing about their experience of maternity care at RWH. Most of their answers related to the midwifery support they received. They said the following about midwives:

- **Understanding, having empathy, knowing women's situations**

They reassured you that everything would be OK. I had a caesarean birth and they did make sure that I wasn't in too much pain.

I guess for me personally, it's more about the caring...that they care for the women in their time of need, because you do really need people to care for you when you are pregnant.

- **Good communication, giving women information**

The communication was important. Both the midwives I had were very thorough which was really good. They checked up on me quite often.

Regular communication with patients.

- **Reassuring women**

Considering young mothers' feelings and lack of knowledge. Reassuring that things will be fine.

Encouragement from the midwife, telling me I am doing a good job or you look well. Positive reassurance.

- **Friendliness and politeness**

That they are caring and friendly. It makes all the difference, more pleasant.

- **Being responsive, prompt and attentive**

Promptness, attentiveness of care, it was important to have the staff's attention.

Responsive staff. My baby was large. I needed an ultrasound. They always made sure I got seen

Just the contact they had with me and the care they took of me, and how they spoke to me and made me responsible for my things and being able to go to them at anytime if I had trouble.

- **Respecting individuality**

I wasn't just a number and I got that from everybody. It was very much where people treated me like an individual.

- **Listening to women**

Two women who had a negative experience communicating their needs to staff stated that staff listening to women was the most important thing for them. One said:

It frustrated me that they didn't listen to me. They should have done an extra check when I said I felt something was wrong. They weren't listening to me.

- **Continuity of carer**

Two women, both of whom had seen the same midwives more than once, cited continuity of care as important.

In the hospital, the consistency in having the same nurses was important to me because I knew at night time I was having the same nurse.

Seeing the same midwife is important especially in the public system.

Another woman raised lack of continuity of care post birth a problem.

Seeing too many midwives after birth was a problem for me. They gave confusing information.

4.1.10 Things women would change if they come back to RWH

Women were asked what they would like to see changed at RWH, if they came back to have another baby, or for other women to have better experiences of care. Most of the answers related to the support and information received from the midwifery team, including:

- **Better communication**

I would probably want to get a bit more information about care. I found it fairly difficult because I had an emergency caesarean. I had to spend a bit of time away from the baby when she was first born which I thought was quite upsetting, so maybe if they could do something different in that way next time.

My baby had to be in special care on the third day after birth. I wasn't told the reasons. It shocked me. I was really worried. The midwife just said they were going to take my baby to

special nursery I had to wait until his father arrived. Then we were told straight away that he had some infection but they didn't explain how he got that infection.

Probably communication and looking at individual needs.

- **Continuity of carer(s)**

Seeing the same midwives more often.

To have the same midwife from start to finish.

It would be better to see the same midwife.

- **Consistency of information**

Information from the various midwives varied and was inconsistent.

Consistence of care and advice.

Thoroughness of care and politeness, which didn't happen when I was there...more consistence of care.

- **Staff attitudes**

It did really affect my time so that is something I would change. I would get rid of those sort of attitudes ...that is patronising, inappropriate, unprofessional.

Respect I guess and confidence. [Confidence in you?] In them and the patient.

I found the younger women (midwives) were just more helpful. It is strange because you'd think the older women would be but it is like they're just...there was just...some are just very abrupt and just quickly tell you what you need and they just go off and half the time you do have the information and half the time they are too busy they don't have the time.

- **Responsive to individual needs**

Probably communication and looking at individual needs.

I think just to be acknowledged as people and individuals and that you feel the care I receive takes into account my needs, that I am fitted into a system that is flexible enough to accommodate any different needs I have.

- **Midwives given more autonomy**

One woman stated specifically that she wanted midwives to have more autonomy in their provision of care, i.e., making decisions while women are in labour and not waiting for doctors' instructions.

Women identified several other aspects of their care, relating to care management and hospital facilities, that they felt needed to be improved. These included:

- Food
- Overcrowding in maternity wards
- Cleanliness of toilets
- Length of waiting time
- Ability for partner to stay with women
- Disorganised and rushed antenatal visits.

4.2 Consultations with midwives for the midwifery-led component of TeamCare and outpatients

A total of 13 midwives were interviewed in two focus groups. These included nine from Team C and D in the midwifery-led component of TeamCare and four from the Outpatients Department of the Hospital.

4.2.1 Women-centred care

The midwives defined women-centred care as comprising the following:

- **A focus on women's needs and supporting their needs and decisions.**

" I think we are trying to form a model of care looking at the needs of what women and the support people surrounding the women need from us, rather than what we think they may need."

- **Women focus rather than health professionals' focus.**

- **Continuity of care.**

"Synchronising consistency of care and continuity of care...the delivery of information by each staff may be different but the guidelines are designed to fill the gaps."

- **Individualised care.**

"Treating women as individuals."

- **An informed choice by women; information provision and education to facilitate choice and options; supporting women to voice their options.**

"The woman is the focus so you give information to the woman and she makes an informed choice as what care she gets, anything throughout the pregnancy that she wants and what she doesn't want, and she gets an opportunity to voice that."

- **Information sharing and collaboration between women, their families and staff.**

- **Family-centred; encouraging women's support people, e.g. women, family, partner to be involved, to be proactive.**

"We have to educate them to know what their needs are."

- **A wellness model; birth as a normal process; different from patient-centred care because patients are sick.**

"Absolutely, patient-centred care means the patient is usually a sick person who needs a hospital, a woman having a baby doesn't necessarily need to be in hospital, but today here in Australia that is what is recommended."

"Different from patient-centred care because patients are sick."

4.2.2 Midwives perceptions of what women considered women-centred care to be

The midwives defined women-centred care as defined by women comprising the following:

- **Continuity of care; a preference for the same carer; building rapport with one midwife.**

"Continuity. I think it is difficult to talk about continuity, so they are familiar with their carer then it is much better than having a different person each time looking after them—stranger that they have to build up another rapport with. So if they have the same midwife looking after them antenatally, and then they are lucky enough to get one of the midwives that they saw in the clinic to look after in labour, then their satisfaction goes up tenfold."

- **Women see themselves as individuals, not as a number in a large organisation; individualised care.**

"I and my baby. I am important. My needs and thought matter."

Several of the midwives interviewed perceived hospital systems and processes to result in inconsistent practices being offered through the midwifery-led component of maternity care, that is, they felt that they did not meet women's needs. They said:

"There are constraints from the organisation. There are lot of women. All those making appointments and asking; 'Are we going to get these choices we need?' You don't know where to fit all those needs or how you will fit all those needs."

They also suggested that this often prevented women from gaining an understanding of women-centred care as implemented through the midwifery-led component of maternity care.

4.2.3 Principles of women centred care

The midwives articulated the following women-centred care principles:

- Treat women as individuals; focus on the women's needs in consultations; understanding of her needs.
- Health education and information provision to enable women to make an informed choice.
- Consistency of care; coordinating consistency of approach and continuity of carer.

4.2.4 Link between continuity of care and women-centre care

The workings of women-centred care related to a continuity of care approach are as follows:

- **Individual and family's needs.**
"I think it makes the women see themselves as individuals and not feel vulnerable walking into a huge organisation like this, you leave your name at the door, you put on your gown and you become a number, where as midwives we try to make them feel they are an individual."
- **Mutually beneficial partnerships; both women and midwives value continuity of carer.**
- **Health education and information provision.**
"And it is encouraging them to learn as well as taking responsibility in their pregnancy and making decisions about it. To point out them in the right direction of the library, but not giving them the book and say read this chapter, getting them to think about what they would like to do."
- **Informed choices.**
- **A better understanding of issues by midwives; involvement in and control over care.**
"Leaving the satisfaction aside I think for midwives it is important that you get continuity because then you get to know that woman, you get to know the issues that women has and you are able in clinic, because clinic is basically the place where you counsel women and speak to them a lot...if you have that continuity of care then you are likely to pick a lot more things that may be happening in their lives that could impact on their pregnancy and their birth."

4.2.5 How midwifery-led component of TeamCare provides women-centred care as compared to previous practice

Midwives thought this included the following:

- **Midwives get more professional satisfaction from this model of care.**
"As midwives we have more input. It gives me that satisfaction that I can practice what I've been taught."
- **Midwives work more independently and are able to share control of consultations, decisions about interventions or the management of care with the women.**
- **Continuity of care.**
"There wasn't such continuity of care."

- **Health education and information provision is more consistent.**

“Women now get more information. More talking time about what women want”.

- **It is women-centred care for women.**

- **Outcomes are better and safer for women.**

“Because the outcomes are better, because all the research shows that the outcomes are actually better for the women. They feel much happier, they have less analgesia, their perineums are much better off ...can individualise the care of the women, like asking them what do you want, what do you like.”

4.2.6 Effectiveness of this model of care and suggestions for changes

The midwives interviewed were generally happy with the midwifery-led component of TeamCare especially with their role as primary carers. Also the recent changes of creating smaller teams within the program were welcomed by two midwives. One said:

“I really like the idea that we are now breaking up into smaller teams ...and I am looking forward to seeing things change with that because I often find it difficult to try and keep track of the amount of women that you see and then you’re trying to see women twice hopefully in your clinics and you don’t get the opportunity because someone has to do the clinics so you’ve to fill the gaps...and you miss your women all the time.”

However, they made suggestions about the further integration of midwifery care across all areas of care, e.g., midwives from the teams should conduct the booking visits.

“One of the problems is none of us does the clinic, at women’s first visit, at the pregnancy booking. The hospital should put us there. We should see women from the beginning.”

They also expressed concerns about what they saw as unnecessary transfers of midwives from the midwifery-led component to other hospital areas. One said:

“They [midwives] can do everything, which means that when the hospital is under stress and there aren’t enough people to look after the women, the midwives that have worked so hard in the clinic to make relationships are pulled out to work in other areas.”

This in turn impacts on their capacity to practice in the way that they want and decreases the time they can spend with women.

“We are not concentrating our efforts on the right area. We can’t concentrate our effort on individual women.”

Several midwives reported difficulties in coordinating health information to women. They said they often felt besieged by the amount of information they needed to deliver to women. One expressed it this way:

"Information. We feel overwhelmed giving it. So how can they receive it?"

This at times can result in midwives feeling that they are drowning in information provision routines at the expense of catering to individual women's issues.

Several midwives commented that the reality of achieving program goals requires the education of staff as they were confused and protocols were not clearly understood. That is, the system is very complex and midwives did not know what was expected of them in their practice. One said:

"Simplify it. Keep it simple, it has become so complicated."

Other barriers to midwifery-led component of care identified were:

- The lack of coordination of services, i.e. women not returning to the program after their visits with doctors.

"And you see that in clinic, we send a woman for her routine visits of 36 weeks to the doctor, the doctor decides to keep her and she goes back to see the doctor at 38 weeks, 40 weeks when really he should have sent her back to the midwives."

- The geographical catchment area of the RWH that results in some women having to travel long distances.
- The spatial design of services which prevents the delivery of services in one area, e.g., labour wards, delivery rooms should be located in one centre.

"Architectural, geographical elements of this place. We don't have all birthing facilities in one spot to make it easy for women."

- Current labour ward environment excludes family/father involvement.

"I think if we had a better environment it would help, like if we had a nice couch for the father to be on or a double bed where he can lie down and do what he needs to do to help support birth, bathrooms that fit two people in a bath, a space for a sibling or toddler to come in and join in. The facilities we work with are appalling in a way."

4.2.7 Most effective methods for providing women-centred care to different groups of women

Issues such as managing differences among the women they care for, in particular addressing the needs of different religious, cultural and linguistic backgrounds can be difficult. Some midwives reported that sometimes the midwifery-led component of TeamCare was not accessible to these groups as the decision-making required in the program can be complicated. One said:

"We do explain to them when they come in. It is complicated for them to understand what we require (of them and their understanding of their health issues) and then we expect them to make decisions based on this information. But a lot of them are often confused when they walk out."

Other midwives consulted disagreed, arguing the underpinning principles of the program addressed the midwifery care issues of all women. One said:

"All women need a midwife — well some don't, some women birth without midwives but most women need support from somebody who is either midwife or someone... and all women have that interaction with someone when baby comes and so I don't think cultural issues should come into the relationship of requiring care from someone who has learnt about midwifery."

And another,

"I think it is totally suited to everybody regardless even though they don't speak English and you know when you've looked after a woman who doesn't speak a language and it is just you're doing what you are doing is so powerful, just being there with them, helping them, you don't even have to speak."

"All women need midwifery care, regardless of cultural issues. It goes beyond languages – eye contacts, holding hands, suits every body."

The use of languages services was also identified as crucial support in caring for CALD women. One said:

"I think utilising the interpreters are really important because I've noticed when looking after women who have enormous cultural differences from my own culture and everybody else's culture that conversation with interpreters just fixes everything, even when a woman speaks English, when their language is another language besides the one you are speaking in, having an interpreter speaking in their mother tongue helps identify issues that are really close for that woman."

Issues of providing appropriate information to CALD women they cared for were also raised. One said:

"There is back up information available for CALD women but it is very hard to read all that information. It is hard enough for literate, English-speaking women to read all of that."

5. DISCUSSION

This discussion presents the key findings from the women and midwives who took part in the consultation. The study offers a unique insight into the experience of pregnancy and childbirth from those receiving and providing care at the RWH. However a limitation of the study is that those that took part are not necessarily representative of either the women who give birth at the RWH or the midwives that work there. In particular women from culturally and linguistically diverse backgrounds were not involved.

Women's knowledge of models of care

Women interviewed for this study appeared to have little knowledge about the midwifery-led component of TeamCare they received. While current hospital processes may aim to inform women about the different models of care available, in interviews women did not appear to have knowledge of their options or to have made an informed choice of the midwifery-led component of TeamCare.

While the women appeared to lack of knowledge, midwives reported problems in giving women the information they needed, particularly in regard to coordinating the amount of information, and ensuring that women received all the information they needed. Some midwives said they had particular problems explaining the TeamCare option of midwifery-led care to women of different religious, cultural and linguistic backgrounds.

A number of obstacles to women's understanding of the model of care were apparent in the interviews. These ranged from a lack of awareness of the options among women to how information was presented to them, for example, several women felt not listened to by hospital staff. Midwives felt that pressures on time and issues with the hospital environment limited discussion with women. At the same time the system had become very complex which made it difficult to explain options simply.

Midwives felt that improved integration of midwifery care from the time of the booking interview would enhance information provision, assist decision-making, help establish good communication, increase opportunities to follow-up issues and allow consistent advice about the models of care available.

Influences on women's decisions

Women who participated in the interviews gave several reasons for their care choices, such as their previous experience of childbirth, advice from relatives, and the absence of other birthing options. The reputation of the hospital as a centre of excellence was a factor in the decision-making of some women. The role of women's perceptions in their decision-making is an important finding particularly as it affects the advice they give to others.

Women's expectation of care

Data from the interviews shows women are more likely to reflect on their direct experiences of care than on how the care is organised. For example, women were more likely to raise issues relating to staff attitudes than about whether services were integrated. Fundamental to women's expectations of care was safety. Above all, they expected care to be safe for themselves and their baby.

The women interviewed identified a number of other expectations for care. They wanted and expected:

- To receive appropriate and timely use of health interventions, and essential care based on their own and their baby's needs.
- To have their diagnosis, treatment and procedures explained to them.
- To be treated with respect and empathy.
- To be given opportunities to offer their opinions.
- To receive personalised care.
- To have confidence and belief in the care providers.
- Staff to be polite and available.
- To be given information and education.
- The involvement of family and friends during labour, birth and post birth.
- To be given reassurance and support.

These expectations of care may provide a useful starting point for a definition for 'women-centred' care. Midwives identified three additional dimensions of care that they believed women expected, although they were not overtly identified in the consumer interviews. These were: respect for patient preference and decisions; continuity of care, that is, integration of services and coordination of care; and midwifery only care.

Midwives perceptions of women-centred care

Midwives who participated in the focus groups felt that women-centred care should focus on the individual needs of each woman. The midwives highlighted the importance of involving women and their families in decision-making. They saw their role as providing information, education and support. Midwives also emphasised that continuity of care - in terms of a consistent approach in care — was critical to a women-centred approach. The other important component of women-centred care midwives identified was a wellness model of maternity care.

The midwives felt the goal of woman-centred care was often unattainable because of overriding workforce issues.

Women's assessment of care

The women interviewed were not directly asked about their perceptions of women-centred care. Nevertheless in response to questions about their expectations of care a number of underlying values and priorities which are related to women-centred care were apparent. Women highly valued aspects of care such as: good communication and information; reassurance and support; and a good relationship with staff. There were consistent messages from women about aspects of care they felt needed to be improved: inconsistency in care; long waiting times; and care that was not focused on them as an individual. Women were dissatisfied with their care when there was poor communication with staff and when they felt there was a failure to take account of their perspectives.

A number of women expressed a preference for seeing the same midwives during the different phases of care. However, from the women's perspective, continuity of care did not appear to rely on the relationship between themselves and a single midwife but had more to do with a consistent approach from a team of midwives¹.

¹ This is consistent with the findings from the randomised trial of community-based team midwifery care. See Homer C.S, Davies G.K., Bodie P.M., Sheehan A., Barclay L.M., Wills J. and M.G. Chapman (2001)"Collaboration in maternity care: a randomised controlled trial comparing community-based continuity of care with standard hospital care." BJOG 108(1):16-22.

In the interviews women suggested that the quality of the midwife-woman relationship is important to enable them to exercise informed choices, to be involved in their care and to have some influence over the direction of care².

A shift occurs in women's expectations of their care once their initial priorities around safety and access to back-up specialist services are fulfilled by the hospital. Once these basic needs are met women are able to broaden their expectations to include aspects such as being listened to by care providers, and participation in decision-making. This has important implications for the assessment of continuity of care and women-centred care as it suggests that aspects of care are valued differently.

Midwives assessment of care

The midwives who took part in the focus group were positive about the midwifery-led component of care and the potential for two core elements of continuity of care — information continuity and consistency in approach to deliver women-centred care.³ However, midwives felt that the organisational and hierarchical structures of the RWH's maternity services worked against maximising the potential of the program.

Such criticism suggests that while midwives may agree about what constitutes women-centred care, they feel they lack the power and status needed to initiate the changes necessary to achieve it.

Women with culturally and linguistically diverse (CALD) backgrounds

Whilst the findings from this study are not specific to the experiences of CALD women, the interviews with the midwives raised some concerns about how much CALD women know about the midwifery-led component of TeamCare. The findings suggest there may be significant barriers to their knowledge of this model of care. Two possible reasons emerge. First, the problems around informing women about the models of care available to them are particularly acute for women with CALD backgrounds. As discussed earlier, some midwives raised this as a specific issue. Second, as many women make their decisions about their care on the basis of their previous experience or the advice of family and friends, if knowledge of the program is not high among women with CALD backgrounds this is likely to continue. More work needs to be done to understand this group of women's needs, experiences and priorities in regards to women centred care and to ensure consistent practice amongst midwives.

² The literature supports that continuity of care and continuity of carer do not have to go together and neither ensures women centred care. See Green J.M. Renfrew M. J and P. A. Curtis " Continuity of carer: what matters to women? a review of Evidence in *Midwifery* (2000) 16, 186-196

³ Information from the literature identifies three types of continuity of care: information continuity,. management continuity and relational continuity. See Haggerty J.L., Reid, R.J., Freeman G. K. , Starfield B. H., Adiar, C. E. and R. McKendry "Continuity of care: a multidisciplinary review" in *BMJ* 2003 , 327:1219-1221 (22 November)

6. CONCLUSION AND RECOMMENDATIONS

Women's choices and decision-making about the midwifery-led component of TeamCare seemed to be circumscribed by the processes of information dissemination in the RHW. There is little evidence from this study that women are making active decisions to choose the midwifery-led component of TeamCare. Only a minority of women from the interview group purposefully chose this model of care. This suggests that women were either uncertain about the choice they made, unclear that they had a choice, or made the choice based on their trust of their health professionals.

The findings from this study suggest that the RHW needs to develop a structured system for the provision of consistent information to women throughout pregnancy, so that it is clear what information is given, when it is given and by whom. The current practices around information giving about the models of care available to women appear unlikely to lead to informed decision-making. At the same time midwives report difficulties with the amount of information they need to provide women and their families. Some midwives felt they lacked the skills and time to communicate effectively with all women in their care. These issues need to be addressed further by the RHW. Some midwives raised particular concerns around explaining the midwifery component of TeamCare to women with CALD backgrounds.

In this study we found that women's initial expectations of care were not about how the care is organised but around their priority for a safe pregnancy and birth in a hospital setting. On the other hand midwives showed an understanding of care from a midwifery notion of service delivery. It is likely that they are already confident about safety issues. The analysis of the data shows both groups identified issues that overlap or are linked. For example, the women wanted personalised care which midwives identified as a fundamental component of midwifery-led care. This is important because it shows that while the perspectives of women and midwives may be different, common goals exist. These specific components provide a useful starting point for a definition for 'women-centred' care in a midwifery model.

The interviews with women indicate that good communication is important in building good relationships. Midwives also strongly implied that relationships are important to their care. They said they were interested in establishing an understanding of each woman's pregnancy issues and concerns, and finding out about their information needs. The midwives saw these issues as important to women-centred care.

The concept of continuity of care was important in this study. Women who participated in the study saw continuity of care as either seeing a small number of midwives during pregnancy or as seeing a midwife they knew during labour. However, in this study women did not see continuity of carer as important as a consistent approach to care from all midwives who provided care. For midwives continuity of care was described as involving both continuity of carer and consistency in approach. From these perspectives, three aspects of continuity of care are apparent: consistency of care; continuity of carer; and good communication. Any assessment of the care provided through the midwifery-led model of TeamCare needs to explore the relationship of these components with women-centred care to determine which are most important to women.

Recommendations

That the Royal Women's Hospital:

1. define the concept of women-centred care within the TeamCare context, and reflecting the community that use the Hospital, and to do so in collaboration with women and staff
2. develop an overview of the structure of the provision of information to women that includes what information is given routinely, who gives it and when
3. identify barriers to women making decisions about their pregnancy care, with particular regard to CALD women
4. develop mechanisms that use and encourage systematic feedback from women in relation to the care they receive at RWH
5. enhance communication skills for clinicians through training and education sessions

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APPENDIX A: QUESTIONS FOR INTERVIEWS WITH WOMEN

1. *Why did you decide to have your baby at the RWH?*
2. *Before the birth of your baby what things did you think were important to you about your health care during pregnancy, labour and birth?*
3. *Were you able to communicate these to the midwife?
If not, why not?*
4. *During your pregnancy, labour/birth and discharge did you see the same midwife more than once?*
5. *How important is it to have the same midwives care for you? Why?*
6. *At your first visit did the midwife discuss the pregnancy and birth options available to you?*
7. *Were you given information about different models of care?*
8. *What did you think about this?*
9. *Why did you choose the midwifery-led model of care?*
10. *During pregnancy, labour and birth when you had questions to ask the midwives, did you get answers you could understand?*
11. *Were your opinions taken seriously?*
12. *Once you had your baby were you actively involved in planning your own and baby's care and follow-up plan?*
13. *Thinking about the experiences you have had with the midwives, please tell us what has been the important aspects of the care?*
14. *What made a difference?*
15. *Thinking forward, if you came back to the RWH to have another baby, what do you think should be the most important aspects of the way you and your baby are cared for?*

What would be one thing you would change?
16. *Any other comments?*

APPENDIX B: QUESTIONS FOR FOCUS GROUPS WITH MIDWIVES

1. *What do you think women-centred care means?*
2. *What do you think women consider women-centred care to be?*
3. *What principles does the concept women-centred care encompass?*
4. *How does 'continuity of care' link with what you see as women-centred care?*
5. *In what ways does the midwifery-led model of care provide women-centred care as compared to previous practice?*
6. *How do you view the effectiveness of this model of care and what suggestions do they have for changes?*
7. *What are the most effective methods for providing women-centred care to different groups of women, e.g. CALD women? What are the barriers?*
8. *Any other comments?*

RWH AND HEALTH ISSUES CENTRE LOGOS

7 October 2005

Exploring Woman-Centred Care in Maternity Care as a Vehicle for Safety and Quality Project

Dear

As someone who has recently used the midwifery-led component of part of our maternity care program, we have randomly selected you to be invited to participate in a study currently being undertaken by the Royal Women's Hospital and Health Issues Centre.

The study is called 'Exploring Patient-Centred Care in Maternity Care as a Vehicle for Safety and Quality' and is funded by the Australian Council on Safety and Quality in Health Care. It aims to better understand what kind of care women want when they have their babies, and midwives experiences of providing women centred care. The findings of the research will be used to improve women-centred care in the maternity care program of the Hospital.

If you are interested in being involved, please read the attached information sheet and fill out the consent form. If you still remember what care team you belonged to when you gave birth at the Hospital, please indicate it on the consent form. Kindly send the completed consent form in the enclosed envelope to Health Issues Centre by **20 October 2005**.

A Health Issues Centre researcher will contact you to arrange a convenient time for an interview. You will be interviewed over the telephone for 30 minutes about your views of the care you expected and received from the Royal Women's Hospital. You will be paid \$25 for your participation in this study.

Please note that where there are more volunteers than required for the sample size (20 women in total), the first 20 women who express their interest will be chosen.

If you require any further information please contact Ms Panayiota Romios at Health Issues Centre on 9479 5824.

We hope you will be able to assist us (but of course any future care you get from the hospital will in no way be affected by your decision to accept or not accept this invitation).

Please accept our sincere apology if your circumstance has changed and this letter causes you distress.

Yours sincerely

Ms Trish Ryan
Manager, Maternity Care Program
Encl: Information Sheet
Consent form
Self addressed envelope



Exploring Woman -Centred Care in Maternity Care Program Research Project

An invitation

You are invited to be part of a project exploring women's experiences of 'woman-centred' care in the midwifery-led maternity care program at the Royal Women's Hospital. The Health Issues Centre, in conjunction with the Royal Women's Hospital, is undertaking this research project which is funded by the Australian Council on Quality and Safety in Healthcare. The Health Issues Centre is an independent non-government research organisation that specialises in undertaking research from the consumer perspective. (You can find out more about them by looking on their website: www.healthissuescentre.org.au or ringing them on 9479 5827.)

What is the project about?

The project aims to document and compare women's and midwives' understandings of women-centred care in the midwifery-led component of TeamCare in the maternity care program of the Hospital.

Who can be part of the project?

Women who have used midwifery-led component of TeamCare, in the maternity care program of the Hospital, in the first half of 2005.

How can you help?

If you are interested in being involved, you will be interviewed over the telephone by one of the Health Issues Centre project team. They will ask you a number of questions that will allow us to understand both your experiences of pregnancy, labour and birth in the maternity care program, and what you think ideal 'patient-centred' care would look like. The interview will last approximately 30 minutes. Only if you permit, the interview will be recorded for transcribing purposes.

Benefits

Your opinions are very valuable in developing an understanding of the kind of care the hospital should be aiming for, and an understanding of women's actual

experiences of care in the Hospital. The findings of the research will be used to improve women-centred care in the midwifery-led component of the maternity care program of the Hospital. You will be remunerated \$25 each for your participation in an interview.

Risks

You should not experience any problems by being part of this research project. The interview will be like a normal, friendly conversation over the phone. However, during the interview, if you feel that the subject matter is uncomfortable, you can stop whenever you wish and we will respect your decision. Or a referral can be made to a counsellor.

Voluntary Participation

You do not have to be part of the research project if you do not want to be. Being part of the study (or not) will not affect your current or future care or relationship with staff at the Hospital. If you decide to join but later change your mind, you are free to withdraw from the project at any stage.

Confidentiality

We will ask for some of your personal details, for example, age. All participant information collected through the interviews will be de-identified (your name removed) and remain confidential. All interview tapes will be locked in the investigator's filing cabinet for seven years, and then they will be destroyed.

Findings of the research may be presented at conferences and published in journals but your identity will not be revealed in any way, and all information will be de-identified.

Questions or concerns

If you would like more information about the project, or if there is any matter about it that concerns you, please do not hesitate to ring:

- Panayiota Romios, Senior Project and Policy Coordinator, Health Issues Centre, telephone number 9479 5824.

Thank you for your time.

October 2005

APPENDIX E: REPLY SLIP/CONSENT FORM FOR WOMEN

RWH/ HEALTH ISSUES CENTRE LOGO

Exploring women's experiences of 'woman centred' care in the midwifery-led maternity care program at the Royal Women's Hospital

CONSENT FORM TO PARTICIPATE IN RESEARCH

I have read the Information Sheet and I freely agree to participate in the interview. I understand that I can withdraw from the project if I wish to do so.

I understand that, with my permission, the interview will be audio taped. However the researcher has agreed not to reveal my personal details or my identity to any third party, nor will he/she identify me in any published reports or presentations about the project.

Participant name: (printed)

Signature:

Date :

Address:

Telephone:

CareTeam when admitted at the Royal Women's Hospital (please circle)

C

D

Name of witness to participant's signature (printed)

Signature

Date

Researcher's Name (printed)

Signature

Date



Exploring woman-Centred Care in Maternity Care Program Research Project

An invitation to Midwives

You are invited to be part of a project 'Exploring women's experiences of 'patient-centred' care in the midwifery led maternity care program at the Royal Women's Hospital'. The Health Issues Centre, in conjunction with the Royal Women's Hospital, is undertaking this research project which is funded by the Australian Council on Quality and Safety in Healthcare. Health Issues Centre is an independent non-government research organisation that specialises in undertaking research from the consumer perspective. (You can find out more about them by looking on their website: www.healthissuescentre.org.au or ringing them on 9479 5827.)

What is the project about?

The project aims to document and compare women's and midwives understandings of woman-centred care in the midwifery-led component in the maternity care program of the Hospital.

Who can be part of the project?

Midwives in the midwifery-led, maternity care program of the Hospital, and other relevant RWH staff.

How can you help?

If you are interested in being involved, you will be invited to a focus group interview to be conducted by the Health Issues Centre project team. They will ask you to discuss a number of questions on woman-centred care as it relates to the midwifery-led in the maternity care program of the Hospital. The focus group interview will last approximately 30-45 min. Only with your permission, the interview will be tape-recorded for transcribing purposes.

Benefits

Your opinions are very valuable in developing an understanding of the kind of care the hospital should be aiming for, and an understanding of the midwives actual

experiences of the midwifery-led component of TeamCare. The findings of the research will be used to improve woman-centred care in the midwifery-led component of the maternity care program of the Hospital.

Risks

You should not experience any problems by being part of this research project. The focus group interview will be like a group discussion however, during the interview, if you feel that the subject matter is uncomfortable, you can leave whenever you wish and we will respect your decision.

Voluntary Participation

Of course, you do not have to be part of the research project if you do not want to be. Being part of the study (or not) will not affect your current or future status or the nature of any relationships at the Hospital. If you decide to join but later change your mind, you are free to withdraw from the project at any stage.

Confidentiality

All participant information collected through the interviews will be de-identified (your name removed) and remain confidential. All interview tapes will be locked in the investigator's filing cabinet for seven years, and then they will be destroyed. Findings of the research may be presented at conferences and published in journals but your identity will not be revealed in any way, and all information will be de-identified.

Questions or concerns

If you would like more information about the project, or if there is any matter about it that concerns you, please do not hesitate to ring:

- Panayiota Romios, Senior Project and Policy Coordinator, Health Issues Centre, telephone number 9479 5824.
- Trish Ryan, the Manager of the Maternity Care Program, telephone number, 9344 2029

Acceptance

If you wish to participate, please let Trish Ryan know and a focus group time will be organised.

Thank you for your time.

October 2005



CONSENT FORM

Health Issues Centre in conjunction with the Royal Women's Hospital is conducting this research project. This project was funded by the Australian Council on Safety and Quality in Healthcare. It aims to explore women's and midwives' experiences of patient-centred care in midwifery-led component of TeamCare in the maternity care program of the Hospital.

I, have read (or, where appropriate, have had read to me) the Information Sheet and understood the information within it, and any questions I have asked have been answered to my satisfaction. I agree to participate in the interview, realising that I may withdraw at any time and request access to my interview transcript. I agree that information provided by me during the interview may be presented at conferences and published in journals on the condition that neither my name nor any other identifying information is used.

Please tick the following boxes to indicate that you consent to quotes being published in a de-identified form, and that you agree for the interview to be audio-recorded.

I give my permission for information, including quotes of what I have said, to be reported and published in a way that does not identify me.

I agree to the audio recording of this interview, and understand that any written transcript of the interview will not contain any information that allows any individual to be identified.

NAME OF PARTICIPANT:

Signature Date