EXPERIENCES OF MIDWIVES REGARDING NURSING PRACTICE BREAKDOWN IN MATERNITY UNITS AT A SELECTED PUBLIC HOSPITAL IN KWAZULU-NATAL

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ABSTRACT

Pregnant women have certain expectations about the midwife and their skills. If such expectations are not met, substandard care occurs. Such substandard care has a negative impact on both the pregnant women and the Department of Health. The aim of the study was to explore and describe the experiences of midwives regarding practice breakdown in maternity units at a public hospital in KwaZulu-Natal in order to improve the quality of care in maternity units. A qualitative research study that was exploratory, descriptive and contextual in nature was conducted. Semi-structured interviews were conducted with 13 midwives. Data was transcribed verbatim, then organised into codes. The study revealed that the majority of the participants faced practice breakdown, which mostly starts during ante-natal care visits. Midwives who attended to pregnant women during ante-natal care did not follow set protocols and guidelines and this resulted in complications during delivery. Midwives were of the opinion that the management did not care about their challenges and did not attempt to resolve the challenges. Therefore, strategies of retaining midwives must be put

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in place by the Department of Health. Midwives must be relieved in all non-nursing-related matters to allow them to focus on the pregnant women.

Keywords: maternal units, maternal mortality, midwife, practice breakdown

INTRODUCTION

Midwifery is a caring profession. It promotes health, prevents illnesses, restores health and alleviates suffering (International Council of Nurses (ICN), 2012:1). Midwives are the centre of midwifery practice (McKerrow, 2014:1). Therefore they must continually maintain the required competence and expertise by continually learning (ICN, 2012:3; Department of Health, 2013:9). In carrying out their duties, midwives are expected to practise according to set standards and within the parameters of their scope of practice, they must ensure pregnant women's safety, and they must protect pregnant women's rights and maintain confidentiality (Department of Health, 2011:9; South African Nursing Council (SANC), 2013:4). Midwives are also expected to carry out their duties ethically since ethics is the basis of the midwifery practice (SANC, 2013:3).

Unprofessional conduct occurs when the midwife fails to perform duties as expected, and all claims of misconduct are investigated by SANC as regulating body (SANC, 2013:9). Pregnant women who either are coming for Ante-natal Clinic (ANC) or are in labour have certain expectations about the midwife and the skills of a midwife (Sengane, 2013:9). If the service rendered by the midwife does not meet expected standards, it is known as substandard care (Department of Health, 2011:9). Substandard care has a negative impact on both the pregnant women and Department of Health. The women might lose their lives or be disfigured. The department incurs huge costs due of litigations that mostly arise from unprofessional and substandard care (Moore & Slabbert, 2013: 60).

PROBLEM STATEMENT

The standard of midwifery practice has dropped and the status of midwifery as a profession has deteriorated (Department of Health, 2013:24). A rise in unprofessionalism and in unethical behaviour by midwives has been noted (Department of Health, 2013:24). South Africa, in particular KwaZulu-Natal (KZN), is facing a burden of diseases and high maternal and neonatal death rates (Department of Health, 2012:26). KZN province was a leading province in high mortality rates for the period of 1998–2003 and 2005–2010 (Department of Health, 2012:2). In 2014, uThungulu Health district was the second leading district in KZN (Department of Health, 2014:106). During analysis of maternal and neonatal deaths, most deaths are attributed to non-pregnancy-related infections, obstetric haemorrhage and

hypertension. These are classified as top three causes of maternal deaths accounting for 70% of deaths, but most of these deaths can be prevented (Department of Health, 2012:xi). During reporting of maternal and neonatal deaths, the emphasis is always on poor midwifery practice or midwives who failed to perform their duties effectively. The Department of Health in South Africa is currently facing litigation due to unprofessional conduct of healthcare workers (Department of Health, 2012:73). An increase in negligent behaviour by midwives has been noted. The SANC statistics reveal that complaints against midwives have increased three hundred fold since 1996 (Department of Health, 2013:25).

Midwives are made to take responsibility for most of the incidents that go wrong in the maternal units, hence some midwives are contemplating leaving maternity units (Ndaba 2013:81). When the reports into maternal and neonatal deaths are made, those in authority usually neglect to look at contributory factors such as compliance to anti-retroviral drugs, nutritional status of pregnant women and attendance of ANC. The focus is often on poor midwifery practice and often the midwives concerned are not asked about what factors led to practice breakdown and what effect does the practice breakdown and criticism by public and Department of Health have on them. Such an omission leads to midwives feeling frustrated and demoralised; this also contributes to midwives failing to render quality service according to the expected standards (Ndaba, 2013:66). Practice breakdown has an emotional and psychological bearing on midwives. A number of studies that have been conducted focus on the causes of nursing practice breakdown and what can be done to improve service. Less is being done to investigate the experiences, the emotional and psychological problems of people who are 'hands on', who experience such breakdown almost on a daily basis. Hence, the current study seeks to describe and explore the experiences of midwives regarding nursing practice breakdown in maternity units at a public hospital in KZN.

RESEARCH QUESTIONS

- What are the factors that influence practice breakdown in maternity units at a public hospital in KZN?
- What are the experiences of midwives regarding practice breakdown in maternity units at a public hospital in KZN?

AIM

The aim of this study was to explore and describe the experiences of midwives regarding nursing practice breakdown in maternity units at a public hospital in KZN.

RESEARCH OBJECTIVES

The objectives of the study were to:

- Explore factors leading to practice breakdown.
- Explore and describe the experiences of midwives regarding practice breakdown.

DEFINITION OF KEY CONCEPTS

Maternity units

For the purposes of this study, maternity units include the antenatal care wards, labour wards, postnatal wards and neonatal intensive care units.

Maternal mortality

According to the Department of Health (2007:7), maternal mortality is the death of pregnant women or within 42 hours of termination of pregnancy, irrespective of the duration and site of pregnancy, from any cause or aggravated by pregnancy or its management but not from accident or incidental causes.

Midwife

The International Confederation of Midwives (ICM) defines a midwife as a person who has been trained in midwifery and is able to demonstrate the competency gained through training by successfully attending to pregnant women. This person is able to offer necessary supervision, care and advice to women during pregnancy, labour, and post-partum period, and conducts deliveries on her or his own responsibility and cares for the new-born and infant. The care includes preventative measures, detection of abnormal conditions in mother and child, procurement of medical assistance and execution of emergency measures in the absence of help (ICM, 2011).

Practice breakdown

According to Makhanya (2012:9), practice breakdown involves health care situations when some aspects of essential nursing practice expectations are not met. For the purposes of this study, practice breakdown refers to failure of the midwives to care for pregnant women and new born babies according to set guidelines and protocols as they are expected to.

RESEARCH METHODOLOGY

Design

A qualitative, exploratory and descriptive research design was used to explore and describe experiences of midwives regarding nursing practice breakdown in maternity units.

Research setting

The study was conducted at a public hospital under uThungulu Health District. The researcher selected the hospital because it is specialising in obstetrics and the researcher believed that he would gain rich data from the midwives practising in the institution. The selected hospital serves as a referral hospital for 17 district hospitals situated in three health districts, which are Zululand Health District, uMkhanyakude Health District and uThungulu Health District, the furthest hospital being 250 kilometres away and also serves a population of 2 443 753 under uMhlathuze municipality (Department of Health, 2015:1). This hospital is a level 2 hospital (regional hospital) specialising in obstetrics, gynaecological, neonatal care and, recently, units specialising in paediatrics have been added. The hospital has 177 midwives in its maternity units.

Population and target population

For the purposes of this study, the population was all midwives actively involved in maternal units, that is, the midwives working in the selected public hospital.

Sampling and sampling technique

Purposive sampling also known as judgemental sampling (Brink *et al*., 2012:141) was used to select a sample of midwives that would participate in the study. The sample size was determined by data saturation (Polit and Beck, 2010:321). A total of 13 midwives participated in the study.

Data collection

Personal interviews were conducted by the researcher in the participants' work area. A total of 13 interviews were conducted. Data saturation was reached between the sixth and eight interviews. The researcher proceeded to conduct five more interviews just to ensure data saturation. All interviews were audio taped with consent of midwives and field notes were taken. Data was collected from the 20th to the 24th of December 2015.

Ethical considerations

Prior to the commencement of data collection, ethical clearance was obtained from the Durban University of Technology Ethics Committee (REC 124/15). Permission to conduct the study was obtained from the Chief Executive Officer of a selected hospital and KZN Department of Health, respectively. After the permission was granted by the above-mentioned gate keepers, the researcher then approached potential participants in their work institution face to face. Potential participants were provided with an information and consent sheet, which made the specific reference to the following: voluntary participation and right to withdraw from the study even if the study was not completed without any fear of any possible repercussion; participation and non-participation to the study have no influence on the participants employment, there being no direct benefits from participation in the study; anonymity and coding of data (participants' responses) ensuring no direct link between individual participants and their responses. Only the researcher and research supervisor would have access to raw data and they gave their assurances of their commitment to confidentiality.

Trustworthiness

According Lincon & Guba (1985 cited in Polit & Beck, 2008:539), four criteria to develop trustworthiness were met. These included credibility, dependability, confirmability and transferability. All interviews were audio taped and field notes taken as back-up. Once audio recordings and transcribed data were examined by the supervisors, they were handed over to a private independent decoder who further examined the data to ensure exclusion of bias. The points in which the private decoder, the researcher and the supervisors differed were discussed further to reach a consensus and points in which there was agreement were taken as correct data. This was done in order to ensure accuracy of the data collected (Polit & Beck, 2008; Brink *et al*., 2012). Testing of data collection was done to ensure that the research tool is accurate and can give results that can be transferable to other settings.

ANALYSIS

Interviews were transcribed and proofread against audio taped interviews. Data was coded and categorised according to relevant themes by the researcher (Brink *et al*., 2012:193). Tesch's eight-step procedure of data analysis was applied (Tesch, cited in Creswell, 2009). This procedure includes: transcribing data verbatim, reading the transcripts and comparing them with the audio-taped interviews, re-reading the transcript for the second time and identifying the underlying meaning, selecting the most interesting and informative interview and making notes in the margins of the transcribed interview, repeating the process for the rest of the interviews, clustering similar topics together under one topic, forming themes and sub-themes from the

topics previously formulated, handing over the analysed data to an experienced person in the field of qualitative research to further analyse the data and discussing any themes or sub-themes where there are differences, thus ensuring reliability of data, reviewing literature to verify findings.

Demographic data

As mentioned above, a total of 13 interviews were conducted. Participants were midwives of ages between 29 to 53 years with experience of 7 to 28 years in maternity units.

RESULTS AND DISCUSSION

A Donabedian framework was utilised during data collection. Data is presented in three main components: structure, process and outcome (Donabedian, 1980:1066). Structure means the relatively stable characteristics of the physical and organisational setting in which nursing care takes place and includes health care providers, equipment and resources they have at their disposal. A process standard refers to skills used to provide health care that could be preventive, diagnostic, therapeutic and rehabilitative. Outcome standards refer to a change in a pregnant woman's current and future health status that can be attributed to received health care and its effectiveness, including the pregnant woman's wellbeing and satisfaction (Donabedian, 1980:1066).

Themes and sub-themes

Table 1: Themes, sub-themes, relation to Donabedian framework and exemplar verbatim statements from participants

Theme identified	Sub-themes	Relationship to the Donabedian Framework	Examplar verbatim statements from participants
Administration	• Staffing of maternal units. • Support offered by nursing management. • Referral system.	Structure	*The unit is understaffed. One midwife is expected to progress and deliver more than three pregnant women at the same time.* *Our maternity unit is very busy since it is a referral to three districts and at times we end up looking after 70 women in post-natal ward while its only three midwives.*
Resources	• Condition and availability of equipment.	Structure	*Most of the equipment that we are using is old and not functioning well.* *If you send it for repairs you are told no funds available.*
Knowledge & skills	• Guidelines and policies. • Training. • Scope of practice.	Structure	*Most midwives especially during ANC do not practice within maternal or prevention of mother to child transmission of HIV (PMTCT) guidelines.*
Service delivery	• Poor service delivery. • Rise in complaints and litigation.	Process	*The service that is rendered by state institutions is very poor.* *I do not wish that a relative of mine should deliver in government institution.*
Impact on midwives	• Increase in stress levels. • Escalating levels of absenteeism. • Burn out.	Outcome	*I am one of the midwives who are severely stressed.* *We are working under stressful and risky conditions a person can be charged at any time.*

Impact on pregnant women	• Maternal or neonatal death. • Disability of both mother and child.	Outcome	*It is sad really to see both pregnant women and new born dying because of wrong decisions taken during delivery.* *I have witnessed a 23 year old female woman having uterine rapture and she will never have children again.*

DISCUSSION OF RESULTS

Results are discussed according their objectives as follows:

Objective number 1: Explore factors that influence practice breakdown in maternity units at a public hospital in KZN.

The grand tour question that was used for this section was: What are the factors that influenced practice breakdown? The following factors were identified:

a. Delays associated with management and care

Delays in rendering care to the pregnant women often lead to complications during delivery (Ndlovu, 2011:104). Because there are many pregnant women in the unit, it becomes impossible for the midwives to render care timeously. The study confirmed the findings of (Hoque *et al*., 2008:66c), which state that most of the women who come into the institution are from deep rural areas, which makes it difficult for transport to come in (due to the roads) should an emergency arise. This makes the pregnant women to report late at the clinic, which might make the complications during delivery inevitable. Delays associated with management and care occur due to a number of reasons, which include pregnant women reporting late to the health facility, non-availability of transport or delays or non-availability of the ambulance that will take the pregnant woman to the health facility. Delay in seeking antenatal care, ignoring danger signs and delay in seeking medical care can lead to complications and deaths that could have been avoided by early referral (Ndlovu, 2011; Department of Health, 2014).

b. Poor midwifery management during ANC

Most cases that end in complications during delivery were cases that were poorly managed during ANC. Poor management of pregnant women during ANC is when a midwife fails to manage a pregnant women according to set protocols and guidelines, for example, for some pregnant women, blood samples are not taken, a urinalysis is not done, and neither are ultrasounds done for those on anti-retroviral therapy as per guidelines (Gcawu, 2013:49). ANC visits reduce chances of complications during delivery, hence risk factors are identified and dealt with during delivery.

During ANC the general appearance of the pregnant woman must be assessed as far as it points to good or poor health. This includes weight, height, heart rate, colour of mucous membranes, blood pressure, oedema, and palpation for lymph nodes. A systematic examination of teeth, breasts, thyroid, heart and lungs must be conducted. A gynaecological examination should be undertaken, including an inspection of the pregnant uterus, a measurement of the SFH in centimetres and listening to the foetal heartbeat after 26 weeks (Department of Health, 2007:20).

c. Pregnant women and compliance-related matters

Some pregnant women choose not to comply with the treatment regimen and advice given by midwives during ANC for various reasons that include culture, religion and finances, especially if the pregnant women have to travel for the ANC or is referred by a local clinic to the hospital. The study revealed that some pregnant women test HIV positive and are put on PMTCT programme as per guidelines but do not return for follow-up and this contributes negatively during labour. According to Ndlovu (2011:131), each person should attend at least four ANC visits and women who had attended the minimum recommended antenatal services were three times more likely to deliver babies with normal birth weight than mothers who had not. HIV is still the highest contributor in many maternal and neonatal deaths, especially if compliance levels are low. Almost 4 out of 5 women who died in pregnancy, childbirth or the puerperium were HIV positive (Department of Health, 2012:1).

Emotional status and psychological related matters of midwives

Most midwives are having high stress/emotional trauma, which is work related. Most midwives interviewed concurred that maternity units are very busy and risky units, as a result they are either burned out or no longer want to practise midwifery. The findings of the study are consistent with findings of Ndaba (2013:80), which reveal that most midwives are having high stress levels that originate in the midwives' working conditions. This stress levels lead to fatigue, burnout, midwives moving to other units or resigning, which further contributes to a shortage of personnel and leads to an increase in the number of midwifery practice breakdown cases.

d. Staffing

The study also revealed that there is the shortage of midwives, especially specialised midwives. Shortage of midwives makes the remaining work force to be overworked, which might lead to fatigue and thus practice breakdown. A number of reasons were raised for such shortage. Some of them include high stress levels, poor working conditions, and the slow process of training midwives. These findings confirm the findings of the World Health Organization (WHO), which state that a shortage of

midwives has been noted worldwide (WHO, 2013:29). The Department of Health (2013:31) stated that there was a gradual decline in the number of nurses with specialised qualifications such as critical care nursing, child care nursing, operating theatre nursing, advanced midwifery and advanced psychiatry. Hospitals with higher pregnant women turnover are not well staffed to accommodate frequent pregnant women transfers, hence staffing is not based on pregnant women turnover (Quinn, 2013:128). Heavy workloads as a result of shortage of midwives cause midwives to fail to offer high quality midwifery practice (Bradshaw, 2011:39).

e. Equipment related

Midwives find it difficult to perform their duties because of either faulty or non-availability of equipment and materials especially in government-owned hospitals. If equipment is broken and it needs to be repaired, they often faced a problem because there is usually no one within the institution who is skilled to repair such equipment and the service providers often take a long time to repair equipment. In most cases, it can take up to six months to replace equipment because of the lengthy procedure in the supply chain. The findings of this study confirm the findings of the study by Gladys (2014:105), which revealed that equipment that is essential for health service provision is not available in most health institutions. If equipment was available, it was not in good working order. Lack of resources was contributing to poor nursing practice. Some equipment that was reported to be unavailable at times included basic material such as case books, photocopying machines, CTG machines and urine testing strips.

f. Nursing management support mechanism

The study also revealed that most midwives feel that their supervisors, including the Department of Health, as a whole do not understand and do not care about their needs. Some midwives during the interviews stated that the nurse managers and Department of Health often turn a blind eye when it comes to their needs as midwives and the only time they come to midwives is when a negative incidence has occurred. Most midwives reported that they were not supported as they should be by the SANC, Department of Health and management of the institution where they are employed. Most midwives felt that the managers did not care about their needs and they resorted to bullying tactics instead of providing support to midwives (Ngwenya, 2009; Nkosi, 2014). This is supported by the findings of the study conducted by Dorse (2008:87), which revealed that no midwife would be comfortable to work where there is no support of staff as this leads to feelings of discomfort at work. It is therefore, the responsibility of the managers to ensure that the working environment is conducive for the midwives. If the midwife is not receiving appropriate support

from supervisors, that midwife is very much likely to develop burnout (Gcawu, 2013: 47).

g. Training and skills related matters

The study also revealed that some midwives, especially the senior ones, felt that the junior midwives were not appropriately trained and exposed to midwifery. They reported that when a new midwife was appointed, they had to teach and orientate that particular staff member. They further reported that the current midwifery curriculum is congested and does not expose students sufficiently to the requisite skills in clinical areas. They were of the opinion that newly appointed midwives lacked confidence in their performances. In maternity it is important to be knowledgeable, highly skilled and competent (Gcawu, 2013:61). Competence is associated with the midwife's knowledge, skills and attitudes in performing assigned jobs efficiently and safely. The absence of a nursing competency assessment of knowledge, skills, and attitudes may lead to poor decisions, serious malpractice, nursing care errors, and negative pregnant women outcomes (Fentainah, 2012:220). The study also revealed that most midwives have outdated knowledge. Lack of appropriately trained midwives were thought to be a significant contributory factor in 15.6% and 8.8% of assessable maternal deaths, up from 9.3% and 4.5% in 2008–2010, respectively (Department of Health, 2012:1).

Objective number 2: Describe the experiences of midwives regarding practice breakdown in maternity units?

The grand tour question that was used for this section was: What are your experiences regarding practice breakdown in maternity units?

a. Emotional status and psychological-related matters of midwives

The study revealed that midwives were experiencing high stress/emotional trauma, which is work related. Most midwives interviewed concurred in stating that maternity units were very busy and were risky units. The stress they experienced was high, to such an extent that most participants are either burnt out or no longer wanting to practise midwifery. The participants were of the opinion that they were neglected and abused. This confirms the findings of the study of Ndaba (2013:80), which revealed that most midwives have high stress levels that originate in their working conditions. During the interviews, participants reported that absenteeism levels were very high among midwives, resulting in increased stress levels. Increased stress levels lead to fatigue, burn out, midwives moving to other units or resigning, which

further contributes to a shortage of midwives and leads to an increase in the number of midwifery practice breakdown cases.

b. Attitude related matters

According to Louw and Edward (2011, cited in Ndaba, 2013:58), 'attitude' is described as irreverent and resistant behaviour. The study revealed that because of all the hardships that midwives had endured, many of the participants had developed a negative attitude. Midwives were of the opinion that the management does not want to listen to their concerns, and they also have developed the 'I do not care attitude'. Some stated that they only feel pity for the pregnant women and their new-borns who will suffer in all this mess. According to the midwives, they cannot help to control their attitudes anymore because it is more than what they can bear. An elevated stress level has led to midwives developing negative attitudes towards management and unfortunately to pregnant women (Ndaba, 2013:59). Such an attitude can lead to serious omissions and negligent behaviour. The negative attitude of a midwife can lead to ill-treatment of pregnant women, poor midwifery practice and ultimately the occurrence of complications (Ndaba, 2013:59).

RECOMMENDATIONS

Guidelines and policies that talk about the wellbeing of midwives need to be formulated. The National Department of Health must come up with a strategy of attracting and retaining midwives. A compensation model for midwives who work especially in rural areas must be developed since the rural allowance and occupation specific dispensation models are ineffective. We need to ensure a working environment that is conducive for the midwives to work in. Nurse administrators must offer emotional and physical support for the midwives. The administrators must organise debriefing sessions with midwives, nurse administrators and psychologists. An implementation of the employee assistance programme may be effective in this regard (Gcawu, 2013:51). Procurement procedures must be simplified. All equipment must be serviced timeously. Midwives must be trained to utilise any new equipment. A properly arranged and written referral system must be established in the health district.

Midwifery training period should be extended from one year to 18 months to those who are doing post basic diploma in midwifery and those who specialise in midwifery, and from six months to one year to those who are doing a four-year course. Policies regarding selecting midwives for post basic courses should be amended and midwives must be encouraged to do maternity-related post basic courses. The office of the midwifery specialist in the district office must utilised effectively and continuous refresher courses and workshops must be done. According to the

Department of Health (2007:8), midwives must be knowledgeable, skilled and have equipment to perform a clean and safe delivery and offer appropriate postpartum midwifery practice to both mother and baby. Constant skills assessment by the health district office must be done on the institutions under the district's supervision to ensure quality of knowledge and skills of midwives. A quality assurance practitioner must constantly assess the quality of work done in maternity units. All newly qualified midwives must work in maternity units under supervision of specialised midwives and under no circumstances should the newly qualified be left alone, and this includes newly qualified midwives at least for one year.

The researcher concurs with the recommendations of Dorse (2008) and Nkosi (2014), which state that the Department of Health should relook at the issue of flexi-hours so as to attract retired midwives, the issue of overtime must be relooked and implemented in such a way that it does not become a burden to the midwives, and overtime money should be paid timeously. Career development should be considered as another option to attract and maintain more personnel. All vacant posts must be filled timeously, and failing to advertise vacancies will always lead to delays and prolong the process of filling vacancies. This will cause great pressure on the existing workforce. Staffing should be based on pregnant women turnover, for example, if the selected hospital is a referring institution (since it is a level two institution specialising in obstetrics and gynaecological services) then it should be having enough midwives (Dorse, 2008; Nkosi 2014). Midwives must be relieved from all non-nursing duties. Support staff must be employed to include ward clerks, store controllers and general workers, which will assist the midwives in relieving the unnecessary burdens and allowing midwives to only focus on the pregnant women and foetus.

STUDY LIMITATIONS

Firstly, the study was done in one selected hospital, thus it is unlikely that the sample represents the whole province of KZN and findings cannot be generalised to other provinces in South Africa. Secondly, although reassurances of confidentiality and anonymity were addressed in the information and consent sheet, it is possible that participants' answers might reflect social desirability bias, given the content of the transcripts – this is considered to be a small possibility. The study was qualitative and the results cannot be generalised; there is a need to conduct similar studies in other areas of KwaZulu-Natal utilising other study designs.

CONCLUSION

Nursing is a caring profession. All midwives in the profession were trained to care and to render safe and efficient health care. It is important to note that if nursing

practice breakdown is to be stopped in maternity units, the government/Department of Health, midwives and pregnant women must all co-operate in order to improve the health care system. Working conditions of the midwives must be improved so that they will render the care that is necessary to pregnant women. Pregnant women must take advice given by midwives. Midwives concerns must be addressed, which may motivate midwives who will be willing to serve in the maternity wards.

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