Train together to work together: Reviewing feedback of community-based skills drills training for midwives and paramedics

Abstract

Homebirth is recommended in the UK for women considered low-risk, but homebirth rates remain low. With the aim of enabling women to safely achieve the birth they want, and enabling midwives to support them in this, a community-based skills drills training session was organised by midwives at Hinchingbrooke Health Care NHS Trust, and attended by midwives, student midwives, maternity care assistants and paramedics. A questionnaire was given to participants to evaluate the training. A 100% response rate was achieved ($n=36$). Results show a positive response from all parties in relation to the setting, which was deemed a more realistic environment for this workforce than that offered by hospital-based training. More funding and research to support this type of training may aid in raising homebirth rates, as well as developing midwives' and paramedics' confidence in dealing with emergencies in such settings.

Keywords: Homebirth, Emergency, Training, Skills, Midwifery

Skills drills are the accepted format by which health professionals, including midwives, learn and maintain the skills to manage a range of obstetric emergencies (Rogers, 2007). It has been suggested that skills drills training should be inter-professional (Rogers, 2007), and perhaps this ought to be extended outside of the labour ward multidisciplinary setting. This was a point highlighted in the recent National Maternity Review (2016: 10), which stated that 'those who work together should train together'. Research exploring the benefits of collaborative training would, therefore, be useful. However, such research must be conducted sensitively, assuring practitioners that the information they disclose will be kept confidential, to ensure true representation of opinions and enable further evaluation to provide the most appropriate training initiatives.

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Background

The Birthplace Study reviewed more than 64 000 births in the UK, concluding that for multiparous women, there were no significant differences in adverse perinatal outcomes between planned homebirths or midwifery units and planned births in obstetric units (Birthplace in England Collaborative Group, 2011) In fact, these women would have significantly reduced odds of an intrapartum caesarean section, instrumental birth or episiotomy. There is an acknowledged significant increased risk of adverse perinatal outcomes (intrapartum stillbirth, early neonatal death, neonatal encephalopathy, meconium aspiration syndrome, and specified birth-related injuries including brachial plexus injury) for babies of nulliparous mothers in the case of planned homebirth. However, as noted by obstetrician professor, Jim Thornton (2015):

> ***'some Birthplace "adverse perinatal outcomes", like encephalopathy and meconium aspiration, while undoubtedly serious, are things from which most babies eventually recover, and their diagnosis could also be influenced by knowledge of the intended place of birth.'***

BirthChoiceUK (2013) reported the UK homebirth rate at 2.26% for 2011. In East Anglia, homebirth was highest in Mid Suffolk at 5.4% ($n=51$ actual births) and the lowest was Luton at 1.4% ($n=49$ actual births). Nationally, it is reported that hospital-based births have only decreased by 1.6% (Health and Social Care Information

Centre, 2015) despite the work to disseminate the findings of the Birthplace Study. It is perhaps worth questioning whether there are any other factors that may also have an impact on the promotion of homebirth and observed numbers.

A survey conducted by the Royal College of Midwives (RCM, 2011), with 553 midwives providing responses, suggested that midwives were positive about the importance of homebirth and confident about their ability to support birth in the home environment. A criticism of the survey is whether it is truly representative of general midwifery opinion, as recruitment was done via the RCM website through an online survey so may not be representative of the profession as a whole. Even in this online survey, respondents suggested homebirth needed more promotion (RCM, 2011).

Some NHS Trusts have developed 'home-based' annual obstetric skills drills sessions to help increase community midwives' confidence levels not only in conducting low-risk 'normal' births, but also to improve confidence in caring for higher-risk women who were requesting homebirths. Home-based skills initiatives are implemented in the USA (Sibley et al, 2001; Sibley et al, 2004) but, despite literature on the topic (Woodward et al, 2004), there is a lack of published methods of training in the UK.

Of the midwives questioned in the RCM's online survey, 58% reported that they had not received any kind of continuing professional development training that focused explicitly on homebirth (RCM, 2011). At present, such training is not mandatory, and Trusts often focus on hospital-based skills drills. A desire from midwives for such initiatives appears to be leading to change for some. In the authors' Trust, a similar initiative was performed in 2012, with plans to replicate in 2014; however, it was not repeated until March 2015. This delay was due to difficulties in coordinating staff and availability of venue (a home in a central location) suitable for community midwives across four team areas (each team covers a region of a district county). The training was organised by staff in response to colleagues wanting training in 'home-like' settings more akin to their working environment and the realities they would face; this feedback had been gained through the platform of supervision.

There is literature from the USA suggesting that attitudes to homebirth are linked with exposure to it (Vedam et al, 2010). There is a need to further research midwives' perspectives on the area of supporting homebirths in the UK, to better understand what barriers exist to the promotion and availability of homebirth. If measures are put in place to build on midwives' confidence levels, it is plausible that they will be better placed to support and promote homebirths and midwifery-led birth units, which may result in an improvement in rates for both. Midwifery-led units currently serve only 9% of births in the UK, but 49% of women have said they would like to give birth in such a unit (National Maternity Review, 2016). The UK homebirth rate is around 2%; however, 10% of women suggested they would like a homebirth (National Maternity Review, 2016).

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Evidence and training costs

The need for a better evidence base and preparation to deal with community-based obstetric emergencies is evident from the emergence of courses now advertised to attract maternity health professionals (Advanced Life Support Group, 2011). However, securing funding to enable staff to attend is difficult for NHS Trusts. Upon enquiring with practice development leads at the authors' Trust, there tended to be more emphasis placed on securing places on mentorship or leadership courses. Eleven years ago, Woodward et al (2004) had hoped that their publication would stimulate collaborative practice with other health professionals, such as paramedics, who are likely to be on the sharp end of childbirth emergencies alongside midwives. However, in many NHS Trusts, mandatory training is not done on a collaborative basis; given the points made by the National Maternity Review

(2016), there is hope that this may now change.

Without the relevant evidence, heads of midwifery will likely utilise training resources elsewhere and stick to mandatory methods within the Trusts themselves; training is expensive and clinical hours are lost as a result. In a survey with heads of midwifery, 44.7% stated they would spend less on their next year of training and 36.9% of midwives would receive no training other than that which was mandatory (RCM, 2010). It has been suggested that when practitioners lack confidence, it can affect birth in a negative way. Odent (2013: 82) discusses the concept of the 'mirror neuron system', emphasising the importance of birth attendants keeping their own adrenaline levels low because it may be 'contagious' and thus have a negative impact on the birth.

Working patterns and staff shortages

There may be more factors, however, than confidence levels alone; working patterns and staff numbers may be another explanation for the lack of homebirth promotion. For midwives working in community settings, there is concern about how to get the work–life balance right (Fereday and Oster, 2010). It is not unusual for community midwives to work all day and then be on call. If they are called out in the night, 'compensatory rest' should be granted and agreements are encouraged to be worked through by RCM workplace representatives (RCM, 2011). However, in reality, many NHS Trusts are faced with staff shortages and clinics that need covering the next day. The most recent RCM report estimated a shortfall of 2600 midwives, and also noted that 42% of midwives were aged 50 or over (RCM, 2015). Therefore, midwives have to juggle the demands placed on them to support homebirth, without adding further to their colleagues' workloads the following day. Management will often strive to avoid on-calls for staff expected to run clinics the following day. Midwives have to live up to the requirements of the *Code*, which states the importance of being safe and not putting others at risk (Nursing and Midwifery Council, 2015). It is clear that working all day, then at night and the following day, may have an impact on safe practice and pose a risk to women; staff have a responsibility to consider this.

It is apparent that midwives' confidence levels, working patterns and training needs are important aspects in the promotion of normal childbirth.

Training

As a supervisor of midwives, the second author wanted to promote skills drills in the home for two reasons:

- To enable women to achieve the birth they want, and to do so safely
- To enable midwives to fully support these women.

It has been indicated that as many as 49.4% of women fall into category IV or V—considered higher risk (RCM, 2016)—most of whom will be recommended to have their babies in hospital. Planning a homebirth for women considered high risk may make midwives uncomfortable, as they are required to step outside of Trust guidelines, yet must balance their need as a midwife to act as advocate, ensuring women are making fully informed decisions, and support them in this. Therefore, it is hoped that sessions building staff confidence will enable these women to achieve the birth they desire, while ensuring outcomes are as safe as possible.

Training sessions

In 2015, to address these issues, midwives (including both authors) planned skills drills in the community. Having liaised with the nearby Ambulance Trust, we found there was an interest in paramedics attending. Having paramedics attending the sessions raised an awareness of the work involved for both parties, and what expectations they had of each other when attending obstetric emergencies. Knowledge and confidence were gained from both sides.

The authors helped to facilitate one half-day training session for community-based staff. There were 36 participants in total, comprising midwives ($n=26$), paramedics ($n=3$), maternity care assistants (MCAs) ($n=2$) and student midwives ($n=5$). The training was facilitated with four other midwives leading on skills drills scenarios. Those skills drills included shoulder dystocia, postpartum haemorrhage, breech, neonatal resuscitation and cord prolapse.

Each scenario had a facilitator rather than a 'teacher' leading the group. The aim was to make the sessions as interactive as possible, rather than a taught pedagogy format. To begin each scenario, discussions were held around predisposing factors, to stimulate thinking on which type of emergencies would be most likely for which women.

Groups of approximately four to six were formed, then moved on to discuss who does what and when, using cards with prompts. This enabled groups to think about the order in which to respond to emergencies with clinical skills and consider individuals' roles, across professions, within the home setting.

Skills drills were followed by a brief break for refreshments and general discussion. There

were some noted concerns about the ambulance service response; from open discussion between midwives and paramedics, it was realised that response times were not as long as some midwives feared. Discussions were also held on the issue of geographically remote areas and arriving in time, particularly in the case of multiparous mothers, those indicated by the Birthplace Study to benefit most from homebirth.

The groups used equipment provided from the practice development team. Obstetric emergencies were linked for a 'mega emergency' situation, e.g. a breech birth followed by need for neonatal resuscitation. Each participant adopted a role within the scene and attendees simulated using their own equipment. The facilitators had local Trust guidelines to refer to, if required for any prompts or queries.

While in the home setting, simulation arms were also put out to enable intravenous cannulation training, so that staff could practice cannulation skills on the day. It had been mentioned by community midwives on the skills drills training held in 2012 that they did not get much opportunity to update their cannulation skills.

Evaluation of the training

In order to ascertain whether staff felt that the training sessions were of any additional benefit beyond hospital-based mandatory training or Ambulance Trust training, the organising midwives designed a questionnaire to evaluate the training and to assess whether this multidisciplinary approach to training should be repeated.

At the end of the training session, evaluation forms were given out and completed anonymously to ensure confidentiality. Consent was gained from staff and by management to publish the findings.

Results

Respondents were asked to select one of five responses—definitely yes, yes, unsure, no, or definitely no—to each of the following questions:

- Have you learnt something from the skills drills session today? Thirty-four participants (94%) answered 'definitely yes' and the other two (6%) answered 'yes' (*Figure 1*)
- Was there a benefit in attending the skills drills in a home setting? All 36 (100%) participants answered 'Definitely yes'
- Were the emergencies covered appropriate? All 36 (100%) participants answered 'Definitely yes'
- Would you be prepared to attend annual update training in a community setting like today? All 36 (100%) participants answered 'Definitely yes'.

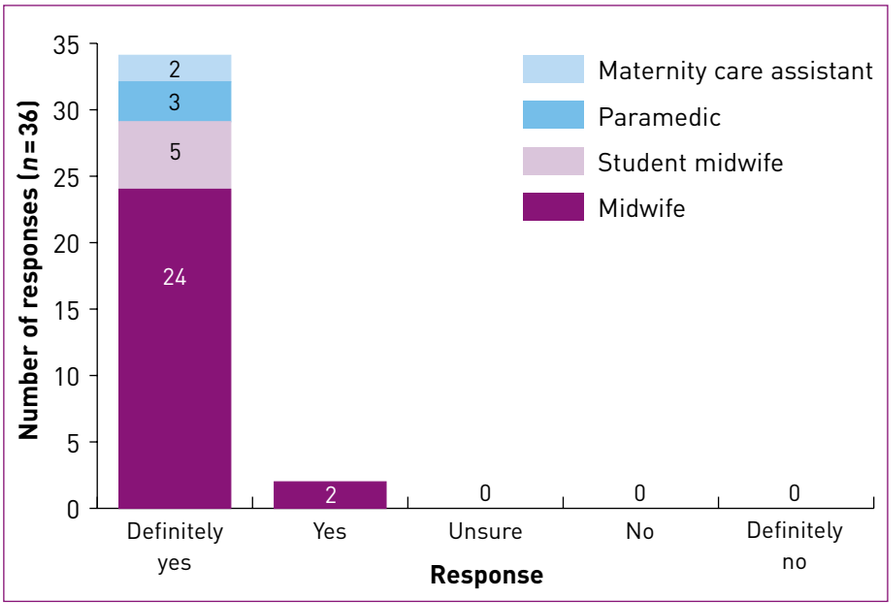

Figure 1. Responses to: 'Have you learnt something from the skills drills session today?'

At the end of the evaluation, space was left for participants to add comments. These were overwhelmingly positive. It was clear that participants had learnt a great deal from the training and it had increased their confidence. Comments included:

'Really liked everything, can't think how it could be improved, it was really relaxed and learned lots. Cannulation was fab too.' (Midwife ID#11)

'Really helpful to have paramedics present to help understand how we work alongside each other in emergencies. As a newly qualified midwife, good to prompt me to think about managing emergencies in community.' (Midwife ID#19)

'Excellent day—builds confidence.' (Midwife ID#30)

'A skills drill in a home setting was very beneficial as it highlighted more practical issues to consider, real time practice, using equipment assisted understanding of both time and communication requirements.' (Student midwife ID#8)

'Very useful and informative day, from an ambulance perspective it gives us a better insight into what could be required from us and how

Key points

- Joint training was established to implement the National Maternity Review's recommendation that those who work together should train together
- The aim of promoting skills drills in the home was to enable midwives to support women to achieve the births they want
- There is scope to organise skills drills in home settings with multidisciplinary teams
- The community-based skills drills training in this Trust was attended by student midwives, midwives and paramedics, who all gave positive feedback
- Further research around such models of training should be considered

we can best help. Also gives valuable information on how to deal with obstetric emergencies pre-midwife arrival.' (Paramedic ID#1)

Discussion

There was a 100% response rate on evaluation forms and learning was identified by all. Such reported benefit, along with a unanimously positive response to the question about whether participants would attend again, would suggest that utilising such models of training may be beneficial.

It should be noted that some participants attended during their days off or even designated annual leave, so that they had the opportunity to be there. Comments on the evaluation questionnaires clearly stated, in some cases, that individuals felt more confident following attendance. However, such training is only plausible if staff are available as facilitators, if someone is willing to provide a venue, and if management is prepared to support the training.

Conclusion

The 'home-based' skills drills sessions and the feedback collected demonstrates the positive response to community-based training with multidisciplinary teams. The authors suggest that more funding and research should be invested in the value of not only conducting multidisciplinary training within hospital settings, but also into community settings. Research into attitudes around and benefits of such collaborative working may, in turn, help to raise homebirth rates and implement the findings of the Birthplace Study into clinical practice.

The team involved in the training are currently planning for the 2016 session, with higher numbers of paramedics and student midwives already scheduled to attend. **BJM**

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Advanced Life Support Group (2011) Pre-Obstetric Emergency Training. www.alsg.org/uk/POET (accessed 16 May 2016)

BirthChoiceUK (2013) Home Birth Rates for the Anglia Region. http://tinyurl.com/ha2qdla (accessed 11 May 2016)

Birthplace in England Collaborative Group (2011) Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study. *BMJ* **343** doi: 10.1136/bmj.d7400

Fereday J, Oster C (2010) Managing a work-life balance: the experiences of midwives working in a group practice setting. *Midwifery* **26**(3): 311–8. doi: 10.1016/j.midw.2008.06.004

Health and Social Care Information Centre (2015) *Hospital Episode Statistics. NHS Maternity Statistics – England, 2014–15*. HSCIC, Leeds

National Maternity Review (2016) *Better Births: Improving outcomes of maternity services in England. A Five Year Forward View for maternity care*. http://tinyurl.com/NMR2016 (accessed 11 May 2016)

Nursing and Midwifery Council (2015) *The Code: Professional standards of practice and behaviour for nurses and midwives*. NMC, London

Odent M (2013) *Childbirth and the Future of Homo Sapiens*. Pinter and Martin, London

Rogers K (2007) Skills drills training: the way forward. *Midwives* **10**(5): 218–9

Royal College of Midwives (2010) *Evidence to the NHS Pay Review Body: November 2010*. www.rcm.org.uk/sites/default/files/2010%20Submisssion.pdf (accessed 11 May 2016)

Royal College of Midwives (2011) *The Royal College of Midwives survey of midwives' current thinking about home birth*. RCM, London

Royal College of Midwives (2015) *State of Maternity Services Report 2015*. http://tinyurl.com/RCMsoms15 (accessed 11 May 2016)

Royal College of Midwives (2016) *Working with birthrate plus: how this midwifery workforce planning tool can give you assurance about quality and safety*. http://tinyurl.com/zk3v8c7 (accessed 16 May 2016)

Sibley L, Buffington ST, Beck D, Armbruster D (2001) Home based life saving skills: promoting safe motherhood through innovative community-based interventions. *J Midwifery Womens Health* **46**(4): 258–66

Sibley L, Buffington ST, Haileyesus D (2004) The American College of Nurse-Midwives' home-based lifesaving skills program: a review of the Ethiopia field test. *J Midwifery Womens Health* **49**(4): 320–8

Thornton J (2015) Safety of home birth. https://ripe-tomato.org/2015/04/15/safety-of-home-birth (accessed 11 May 2016)

Vedam S, Aaker J, Stoll K (2010) Assessing certified nurse-midwives' attitudes towards planned home birth. *J Midwifery Womens Health* **55**(2): 133–42. doi: 10.1016/j.jmwh.2009.05.003

Woodward V, Bates K, Young N (2004) *Managing Childbirth Emergencies in Community Settings*. Palgrave MacMillan, Basingstoke