

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

Ndumiso Mbonisi Mhlongo

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of Technology in Nursing in the Faculty of Health Sciences at the Durban
University of Technology

Supervisor : Prof. M.N. Sibiya

Co-supervisor : Dr R.M. Miya

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Declaration

This is to certify that the work is entirely my own and not of any other person, unless explicitly acknowledged (including citation of published and unpublished sources). The work has not previously been submitted in any form to the Durban University of Technology or to any other institution for assessment or for any other purpose.

Signature of student

Date

Approved for final submission

Prof. M.N. Sibiya
RN, RM, D Tech: Nursing

Date

Dr R.M. Miya
RN, D.Litt Phil

Date

Abstract

Introduction

Registered midwives are expected to practice their duties within the parameters of their scope of practice. 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 for both the pregnant woman and the Department of Health.

Aim of the study

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

Methodology

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.

Results

The study revealed that the majority of the participants faced practice breakdown almost daily and most of the midwifery practice breakdowns start during antenatal care visits. Midwives who attended to pregnant women during antenatal care did not follow set protocols and guidelines and this resulted in complications during delivery. Most midwives were emotionally stressed and did not wish to continue practicing midwifery. Midwives were of the opinion that the management did not care about their challenges and did nothing to resolve the challenges.

Dedication

I dedicate this dissertation to God who gave me an opportunity and the ability to take advantage of it. My loving family, my mother Mrs G.C. Mhlongo, my wife Hlengiwe, my son Lubanzi and my daughter Nonkazimulo for their patience, love, motivation and encouragement during this long process. To Mbongolwane sub-campus personnel especially Mrs S.I. Mkhwanazi, Mrs N.M. Nsibande, Ms P.P. Buthelezi thanks a lot for your understanding and support. To all midwives who on a daily basis put their lives at risk to save other people's lives – your efforts are noted and this is for you.

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Glossary of Terms

Maternity units

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

Maternal mortality

According to the RSA 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. Maternal deaths may be divided into:

- Direct causes: resulting from obstetric complications of pregnancy, labour or the puerperium, from interventions, omissions, incorrect treatment or from a chain of events resulting from any of these; and
- Indirect obstetric deaths: resulting from previously existing disease which was aggravated by the physiological effects of pregnancy.

Midwife

Midwife means a person registered as such in terms of Section 31(1) (RSA 2005: 6). The midwife is a person who has been trained in midwifery and is able to demonstrate the competency gained through training by successfully attending to pregnant women being able to offer necessary supervision, care and advice to women during pregnancy, labour, and post-partum period, conduct deliveries on her or his own responsibility and care for the new-born and infant, 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 (Bailliere's Nurses' Dictionary 2010, International confederation of midwives (ICM) 2011).

Negligence

Negligence is failure to do something that a reasonable person of ordinary prudence would in a certain situation, or doing something that such a person would not do. Negligence would provide basis for a lawsuit where there is legal duty, as in the duty of a doctor or nurse, to provide reasonable care to patients and when negligence result in damage to the patient (Bailliere's Nurses' Dictionary 2010: 269).

Nurse

A nurse means a person registered in a category under section 31(1) in order to practise nursing (Republic of South Africa 2005: 6).

Unprofessional conduct

According to the SANC (2013a: 9), unprofessional conduct means conduct which, with regard to the profession of a practitioner, is improper, dishonourable, disgraceful or unworthy.

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 patients according to set guidelines and protocols as they are expected too.

List of Acronyms

Acronym	Full term
AIDS	Acquired immune deficiency syndrome
ANC	Antenatal care
ART	Antiretroviral therapy
CINAHL	Cumulative Index of Nursing and Allied Health Literature
CTG	Cardiotocography
DENOSA	Democratic Nursing Organisation of South Africa
DUT	Durban University of Technology
EAP	Employee Assistance Programme
HB	Haemoglobin
HIV	Human immunodeficiency virus
HPCSA	Health Professions Council of South Africa
ICM	International Confederation of midwives
ICN	International Council of Nurses
KZN	KwaZulu-Natal
MDGs	Millennium Development Goals
NICU	Neonatal Intensive Care Unit
NWU	North-West University
PMTCT	Prevention of mother-to-child transmission
RSA	Republic of South Africa
SANC	South African Nursing Council
SFH	Symphysis fundal height
UNISA	University of South Africa
WHO	World Health Organization

CHAPTER 1: OVERVIEW OF THE STUDY

1.1. INTRODUCTION AND BACKGROUND

The midwife has a responsibility of promoting the health and wellbeing of both the pregnant women and the newborn baby, within their families and communities (ICM 2014: 1). The midwife is renowned as a responsible and accountable professional who works in partnership with pregnant women to render the necessary support, care and advice during pregnancy, labour and postpartum period. The midwife conducts births and provides care for the newborn and the mother. This care includes promotion of normal births, prevention and early detection of complications in both mother and foetus, providing access to medical care or other appropriate assistance and where appropriate carrying out of emergency measures (ICM 2011: 1).

Midwives are expected to continually maintain their required competence and expertise by continually learning so as to have up to date knowledge (ICN 2012; RSA Department of Health 2013b, ICM 2014). In their practice, midwives are expected to practice according to certain set standards (RSA Department of Health 2011: 9). Midwives are also expected to carry out their duties ethically since ethics is the basis of the nursing profession (SANC 2013a; ICM 2014).

The midwife remains personally accountable for all her actions or omissions (this includes delegated duties) while carrying out midwifery responsibilities; as a result midwives must perform their duties with great caution (SANC 2013a; ICM 2014). It is the duty of the midwife to ensure the safety of the patient, protection of the patient's rights while maintaining confidentiality (SANC 2013a; ICM 2014). If the midwife caring for the patient whether directly or indirectly does not do what is expected of the midwife as a professional, this results in what is called 'unprofessional conduct'. SANC as a regulating body has powers to investigate all claims of unprofessional conduct by midwives. If the individual is found guilty of the offence that midwife can either be cautioned, suspended

for a specific period, removed from the roll or register or be fined by the professional body (RSA 2005: 33).

All midwives are expected to practice their duties within the parameters of their scope of practice (SANC 1991; RSA 2005; ICM 2014). Women during pregnancy, birth and womanhood who are coming for antenatal care (ANC), prenatal care (PNC) or are in labour have certain expectations about the midwife and their skills (Sengane 2013: 9). In their practice, midwives must encourage minimum expectations that no pregnant women would be harmed during child bearing (ICM 2014: 2). When the service that is being rendered by the midwife does not meet the expected standards, it is known as substandard care (RSA Department of Health 2011: 9). Such substandard care has negative impact for both the pregnant woman and Department of Health. The pregnant woman might lose her life or be disfigured. The Department faces huge costs because of litigation and most of these arise from unprofessional and substandard care (Moore and Slabbert 2013: 60).

An increase in negligent behaviour by midwives has been noted. According to the RSA Department of Health (2013b: 25), the SANC statistics reveal that complaints against midwives have increased three hundred fold since 1996. During the period of May 2008 to May 2012 which is a four year period a total of 50 cases were lodged of which 21 were maternity cases which is about 13 cases of which five would be maternity cases per year (SANC 2012: 1). During the period of June 2013 to December 2013 (six months period) 21 cases were reported of which 10 were maternity cases (SANC 2013b: 1).

UThungulu Health District is one of the leading districts in KwaZulu-Natal (KZN) province in maternal and neonatal mortality rate (KZN Department of Health 2014: 106). Most of maternal and neonatal deaths can be prevented by better obstetric care and rapid response to reduce intrapartum complications, including reducing delays in recognition of complications at home and transportation to hospital (Ndlovu 2011: 215). Midwives are the centre of health welfare in country especially if reproductive health, parenthood and child care is

concerned (ICN 2009: 1). For the health system to function efficiently, midwives must improve their practice (McKerrow 2014: 1). High maternal and neonatal death rates is often attributed to the underlying diseases, environment and faulty equipment. Less is often said about midwives, yet midwives have a measure role in the prevention of maternal and neonatal mortalities (RSA Department of Health 2012c: xiii). Negative reporting about the nursing practice and lack of support by supervisors is having a bearing in the psychological and emotional state of the midwives hence most midwives feel frustrated and demoralised and some leave the maternal units (Ndaba 2013; Nkosi 2014).

1.2. PROBLEM STATEMENT

According to the RSA Department of Health (2013b: 24), the standard of midwifery practice has deteriorated and the status of midwifery practice as a profession has declined. Various media reports highlight a lack of professionalism and rise in unethical behaviour by midwives which is characterised by poor communication and incidence of violence and abuse. Ways of restoring pride in midwives and improving ethical behaviour are to be encouraged.

South Africa, in particular KwaZulu-Natal (KZN) faces a high burden of disease and high maternal and neonatal death rates (KZN Department of Health 2012: 26). In South Africa, KZN was the leading province in terms of mortality rates for the periods 1998-2003 and 2005-2010 (RSA Department of Health 2012c: 2). For the period of 2011/2012, KZN was the second highest in terms of maternal mortality rates (RSA Department of Health 2012a: 94). UThungulu Health District in KZN was the leading district in maternal and neonatal mortality rates in 2012 (KZN Department of Health 2012: 35). In 2014, uThungulu Health District was the second leading district in KZN (KZN Department of Health 2014: 106). South Africa did not meet the 2015 deadline of the Millennium Development Goals (MDGs) especially goal four and five which aimed at reducing child mortality and improving maternal health (Parliament of South Africa 2011: 20). The focus now has shifted from MDGs to Sustainable

Development Goals (SDGs) especially goal number three which aims at reducing the global maternal mortality ratio to less than 70 per 100,000 live births, end preventable deaths of newborns and children under 5 years of age, reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being the targeted time frame for these is 2030 (United Nations [UN] 2015).

When causes of maternal and neonatal deaths are analysed the main causes are reported as being: non-pregnancy related infections such as HIV/AIDS, TB, obstetric haemorrhage and hypertension. These are classified as the top three causes of maternal deaths accounting for 70% deaths but most of these deaths can be prevented (RSA Department of Health 2012c: xi). When these causes of maternal and neonatal deaths are presented the emphasis is always on poor nursing care or midwives who failed to do their job effectively.

The Department of Health in South Africa is currently being sued for millions of Rands due to the unprofessional conduct of healthcare workers. This total seems to be growing every year. For the period of 2011/2012 R9 678 500 was paid (KZN Department of Health 2012: 73). For the period of 2012/2013 R1 000 637 280 was claimed of which R49 400 941 was paid (KZN Department of Health 2013: 37). During the period of 2013/2014 R4,9 billion was claimed all due to negligence of health care workers (KZN Department of Health 2014: 238).

The SANC affirmed the problem with nursing practice by publishing statistics of nurses who went before disciplinary hearings due to unprofessional conduct, and an increase in statistics was noted especially in maternity units. For the period of May 2008 to May 2012 a total of 50 hearings were held of which 21 were maternity cases, which is about 13 cases of which five would be maternity cases per year (SANC 2012: 1). For the period of June 2013 to December 2013, 21 cases were reported of which 10 were maternity cases (SANC 2013b:

1). The KZN Department of Health dismissed 64 employees and gave 57 employees final written warnings because of misconduct (KZN Department of Health 2014: 230).

Midwives are always blamed for everything that goes wrong in the maternal units hence some midwives are contemplating leaving maternity units (Ndaba 2013: 81). Contributory factors to poor outcomes are often overlooked such as absence of or faulty equipment (Ndaba 2013; Gladys 2014). Often we do not analyse the factors that affect the practice breakdown including the effect the practice breakdown has on midwives. Such an omission leads to midwives feeling frustrated and demoralised which 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 nurses. According to Ndaba (2013: 80), high stress levels of midwives emanate from poor support from management, lack of equipment and drugs and high volumes of patients in maternity units. This leads to fatigue, burn out, midwives moving to other units or resigning which further contributes to shortage of personnel and leads to an increase in the number of nursing practice breakdown cases. Midwives are exposed to practice breakdown almost daily especially in maternity wards since maternity units are described as busy units, high risk and where normal deliveries are described as rare occurrences (Ndaba 2013: 80). Some of the cases of nursing practice breakdown start during the antenatal care (ANC) period and are caused by a number of factors which are usually not investigated since the blame is laid on the midwife in maternity units.

The researcher identified a gap in most studies previously conducted, hence most studies that have been conducted previously focus on the contributory factors to midwifery practice breakdown, they don't focus on the support that can be offered to midwives thus reducing practice breakdown. The researcher believes that the inadequate or lack of support for midwives at the point of midwifery practice leads to further practice breakdown. The researcher also believes that there was a great need to investigate the factors that influence practice breakdown, experiences of midwives, the emotional and psychological

problems of people on the ground that are hands on, who experience such breakdown almost on a daily basis (Reising and Allen 2007; Bosch 2013; Bradshaw 2011; Sibiyi, Cele and Ngxongo 2015; RSA Department of Health 2012c; RSA Department of Health 2014; Gcawu 2012; McKerrow 2014; Ndaba 2013; Ndlovu 2011; Sengane 2013). The researcher then felt that he should take an initiative by conducting the current study so as to describe and explore the experiences of midwives regarding practice breakdown in maternity units at a public hospital in KZN.

1.3. AIM OF THE STUDY

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

1.4. OBJECTIVES OF THE STUDY

The objectives of the study were to:

- Explore factors that influence practice breakdown in maternity units at a public hospital in KZN.
- Describe the experiences of midwives concerning practice breakdown in maternity units at a public hospital in KZN.

1.5. 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?

1.6. SIGNIFICANCE OF THE STUDY

The researcher noted that there is a rise in complaints from the community including the stake holders such as the RSA Department of Health and the SANC about the quality of service rendered by midwives. The researcher also

noted that very little is being done to research the challenges and emotional impact of the challenges that midwives are encountering. Maternity units are one of the most important and busiest departments in most hospitals. Because of the perceived risk associated with working in maternity units it makes the department unattractive to most midwives which leads to shortage of personnel (Ndaba 2013: 80).

This study seeks to describe in detail what midwives are facing regarding practice breakdown in maternity units and what impact such practice breakdowns have on their psychological, emotional and professional lives. Midwives always put their lives at risk (ICN 2009: 1). It is important for hospital administrators to understand what midwives are going through in their daily practice so as to offer relevant support (Nkosi 2014; Gcawu 2012). This study will assist midwives in sharing their experiences about all the negative incidences that are reported against them and what must be done to prevent such dangers in the future. The findings of this study will also assist policy makers to understand what midwives at the ground level are going through so that they will come up with a strategy that will assist midwives in dealing with psychological and emotional traumas (Nkosi 2014; Gcawu 2012). The study will also be beneficial to the patients who receive care from the midwives because satisfaction levels of midwives will improve the number of midwives willing to work at the maternity units (Gcawu 2012: 66).

1.7. OUTLINE OF THE DISSERTATION

Chapter 1: Introduction and background.

Chapter 2: Literature review.

Chapter 3: Research methodology.

Chapter 4: Presentation of the results.

Chapter 5: Discussion of results.

Chapter 6: Conclusion, limitations of the study and recommendations.

1.8. CONCLUSION

This chapter introduced the reader to the background of the study and the problem statement, the aim of the study, research questions and the significance of the study. The next chapter will focus on relevant literature that was reviewed in order to gain more insight and understanding and to support the relevance of the study.

CHAPTER 2: LITERATURE REVIEW

2.1. INTRODUCTION

Chapter 1 presented the background to the study and the problem statement that set the basis for the study of experiences of midwives regarding nursing practice breakdown. This chapter presents a literature review, which focuses specifically on related literary sources that look at nursing practice, ethical and professional nursing practice, quality nursing care and specific challenges that are facing the RSA Department of Health. As acknowledged earlier, research on nursing practice and quality of nursing care revealed that the standard of nursing care in South Africa is low which is evidenced by the rise in complaints and litigation against nurses and the high maternal and neonatal mortality rates. Although midwives are exposed to practice breakdown almost daily, very little is said about the experiences of midwives who experience such breakdown. To foreground this noted knowledge-gap, the current review of literature aims to provide a comprehensive overview of current viewpoints and existing research evidence, to determine prominent viewpoints in this study area.

Brink, Van der Walt and van Rensburg (2012: 71) offer a definition of literature reviews as being written sources relevant to the topic of interest. A literature review involves finding, understanding and forming conclusions about the published research and theory as well as presenting it in an organised manner. It is a systemic search of what is known about the topic of interest. A literature review aims to provide the researcher with the foundation and the existing evidence of the problem being addressed and to develop an argument that demonstrates the need for the new study. Polit and Beck (2008: 106) further state that a literature review offers guidance to the researcher as to which gaps exist and how best to fill such gaps for example which methodology or conceptual framework to utilise.

In addition to the synthesis function, this review is concerned with drawing attention to the range of previously published issues related to practice breakdown in maternity units. According to Brink, Van der Walt and van Rensburg (2012: 76), for the reviewer to get accurate literature she/he must first clarify the research topic, identify the keywords and concepts so as to be able critically present insight and awareness of the different arguments, approaches and theories.

2.2. FORMAT OF LITERATURE REVIEW

This review will include a number of key sections such as an overview of a data search strategy, a tabular summary of reviewed sources and the review proper of related literary sources. The presentation of literature will be under thematic headings related to the study of experiences of midwives regarding nursing practice breakdown. Before the formal review of literature, an introductory section will be presented in which prevalence issues related to nursing practice and professionalism in nursing are discussed.

2.3. DATA SEARCH STRATEGY

Initially the university library was used to search for books and journals that related to the topics of experiences of midwives regarding nursing practice breakdown. The use of libraries simultaneously with the use of electronic databases is seen as an excellent starting point as it allows the gathering of information and access to alternative sources. The researcher must be able to identify the literature that is relevant to the study topic (Brink, Van der Walt and van Rensburg 2012: 76). Before engaging in the searches, a set of keywords and concepts were decided upon. In order to assemble the group of keywords that would be used in the search, a mind map was drawn so that all relevant publications in the area of interest could be identified (Brink, Van der Walt and van Rensburg 2012: 76). Relevance of the publication refers to how closely the information relates to the topic. As highlighted earlier, very little has been written on experiences of midwives regarding practice breakdown but the researcher was able to find studies which were relevant to the study that he

intended doing. Identifying keywords for the subject before initiating any literature search would ensure that correct results are obtained. The following keywords and phrases were used:

- Complaints against midwives.
- Ligations against nurses in maternity units.
- Quality of nursing care in labour wards.
- Standards of nursing care in labour wards.
- Ethical nursing practice.
- Professionalism in nursing.
- Nursing practice breakdown.

The resources that were available for the literature search were books and journals, which included hardcopy and electronic databases. The initial hard-copy library search did not reveal many current sources, and therefore, primary focus was on searching various electronic databases as summarised below:

- Unabridged Medline (Jan1976-May 2015).
- Cumulative index of nursing and allied health literature (CINAHL) (Feb 1965-2015).
- OVID database (searches across several medical and nursing online sources) (1984-2015).
- EBSCOhost search engine (1980-2015)
- Cochrane database of systematic reviews (1996-2015).
- A physical search of local South African journals at the local health authority library.

Vast array of library resources of Durban University of Technology (DUT) were optimally utilised for international, regional and local input through the inter-library loan (ILL) system which did not yield many results in terms of hard copies. Various electronic library databases were consulted including those of the DUT, University of South Africa (UNISA) and North-West University (NWU). The archives, databases and websites of other local and international sources of information, such as the SANC, the Health Professions Council of South Africa (HPCSA), DENOSA (Democratic Nursing Organisation of South Africa,

Stats SA (Statistics South Africa), the International Council of Nurses (ICN), and the World Health Organisation (WHO) were consulted in the quest of obtaining a multi-perspective approach to the research topic.

2.4. CRITERIA FOR INCLUSION AND EXCLUSION OF LITERATURE

The initial search, using each of the primary search terms independently, identified over 500 potential sources. However, the inclusion of other parameters, such as 'primary research' and 'English', led to an enormous reduction in the potential references of interest to 64. This reduction was accomplished when detailed inclusion and exclusion criteria, listed below, were applied to the literature or studies obtained for review. Inclusion criteria: studies focussing on

- Nursing practice.
- Quality of nursing practice in maternity units.
- Standards of nursing practice of midwives.
- Complaints against midwives.
- Ethical and professional nursing behaviour.
- Studies published in English.
- Given the difficulties that exist in authenticating data from the worldwide web (internet), only literature from validated academic databases such as OVID via Athens and CINAHL were considered for inclusion within the review.

Furthermore, the reviewer as a means of validating their existence, where possible, sourced hard copy paper versions of studies retrieved from Internet sources.

The following exclusion criteria were applied to literary sources:

- Studies whose academic credibility could not be authenticated.
- Studies written in languages other than English.
- Studies published before 1980. This is largely because the theoretical positions related to sexual health issues have changed significantly in

recent years and studies older than 1980 are likely to have limited direct relevance to the current study.

After applying each of the above criteria, only 32 literary sources (23 of which were original research) met the strict criteria for inclusion, and also satisfied the academic and scientific rigour expectations for inclusion in the review. The primary research studies that fully satisfied the inclusion criteria are reviewed in this chapter. Data is categorised according to global, regional and local perspective.

2.5. APPRAISAL OF IDENTIFIED STUDIES FOR THE LITERATURE REVIEW

Table 2.1 below offers a summary of ten of some of the primary research studies included within this literature review. These ten literatures were randomly picked by researcher to be added in the table. Once identified for inclusion within the literature review, the process of reviewing each study was based on established and validated models of critical appraisal; in essence, the review of individual studies was weighted according to the knowledge-contribution made to the current understanding of midwifery and implementation issues related to this area of health care. To be more specific, the studies were evaluated in terms of their rigour, validity, reliability, dependability and transferability to the practice context (Polit and Beck 2008: 107). Additional factors explored within the review process included the researcher(s)' apparent clarity in their formulation of the study question(s), whether or not the methods of data collection adopted were scientifically sound and appropriate to the issue under investigation. Further attention was given to the handling of data within each of the reviewed sources, including how well researchers addressed potential limitations of their studies.

Table 2.1: Summary of primary research work reviewed

Author/Date	Title of paper/Aim of study	Key findings
Bosch (2013)	Effective staffing model for a private hospital.	The findings of the study revealed that the current staffing model is not accurate since personnel are staffed according to the number of patients. The model which considers the condition of the patient rather than the number is to be adopted. Midwives are to be relieved from all non-midwifery related duties and services of support personnel to be utilised. Services of nursing agencies to be utilised to staff wards.
Dlamini (2012)	An evaluation of postnatal care rendered to HIV positive women and their infants. Swaziland	Results show significant poor nursing care rendered during postnatal period; these include the omission to take vital signs which include temperature, pulse, respiration and blood pressure as well as omission to ensure uptake of prophylaxis during labour. This contributed to the increase of maternal and neonatal deaths.
Fentianah (2012)	Impact of nursing competence on quality of nursing care and safety of nursing practice. Phoenix, USA	The study revealed that midwifery competence is associated with the midwife's knowledge, skills, and attitudes in performing assigned jobs efficiently and safely. Findings confirm other studies which agree that the concept of midwifery competence focuses on the ability of midwives to present knowledge, demonstrate skills, and display attitudes appropriately for specific activities in specific situations. The absence of a midwifery competence assessment of knowledge, skills, and attitudes may lead to poor decisions, serious malpractice, midwifery practice errors, and negative outcomes to the pregnant women and foetus
Gladys (2014)	Intrapartum clinical guideline for monitoring and managing a woman during labour.	The findings of the study revealed that partographs were not completely filled; assessments and interventions of midwives during labour (such as condition of pregnant women pain tolerance and nurses) are

		not recorded. Vital signs such as blood pressure pulse, respiration and urinalysis are not recorded during labour. Such omission makes management of labour difficult and maternal or neonatal deaths more likely.
Hoque, Hoque and Kader (2008)	Audit of ANC in rural district of KZN, South Africa.	The study revealed that ANC in KZN was below required levels. The majority of pregnant women attended ANC but midwives omitted to do the testing that should have been done including haemoglobin levels and syphilis testing.
Moates (2014)	Association between nurse staffing indicators, patient falls and hospital acquired pressure ulcers in the acute care setting. Kennesaw State	The study revealed that where the nursing staff was low patients were much likely to fall since one nurse is responsible for many patients and pressure ulcers had a greater chance of developing since time to check pressure ulcers is limited. This results in poor nursing care.
Ndaba (2013)	Lived experiences of newly qualified professional nurses doing community service in the midwifery section in one of Gauteng's hospitals	The findings of the study revealed that most midwives working in maternity unit were stressed and felt that they were not supported as they should be. The study also revealed that the midwifery section was under staffed and most of the midwives wanted to leave that section.
Ndlovu (2011)	Factors contributing to high neonatal death rates in a district hospital in Mpumalanga province.	The findings of the study revealed that the neonatal death rate was higher than the norm. The younger the mother the higher was the risk of neonatal death. Foetal movements were not recorded in most ANC visits. Partogram was not used to monitor labour. Most neonatal deaths can be prevented by improving the quality of care rendered to pregnant women.
Ngwenya (2009)	Discontent among nurses in the public health sector in Tshwane metropolitan area.	The study revealed that midwives in the public sector have low morale due to low salaries and the intolerable levels of stress. The study also revealed that most of the midwives felt that management was not supportive enough and most midwives wished to leave the profession.

Quinn
(2013)

Throughput and nurses
workloads: influences on
nurse and patient
outcomes.

The study revealed that most
hospitals with high patient
turnover are understaffed. This
leads to poor nursing care.

2.6. THE GLOBAL PERSPECTIVE

2.6.1. THE DIFFERENCE BETWEEN A NURSE AND A MIDWIFE

According to Nursing and Midwifery board of Australia (2013: 1) there is a difference between a nurse and a midwife. These two practices are distinct for overlapping to take place. There are two different national registers for each category. Nursing has its own scope and work specifically related to nursing and midwives has their own scope of practice and work specifically related to midwives though at times there are common grounds for both categories. To show the difference between two categories their definitions are listed below.

The ICN (2010) states that nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness and care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management and education are also key nursing roles

The ICM (2011) defines a midwife as a person who has successfully completed a midwifery education program that is duly recognised in the country where it is located and that is based on the ICM essential competencies for basic midwifery practice and the framework of the ICM global standards for midwifery education, who has acquired the requisite qualifications to be registered and or legally licensed to practice midwifery and use the title “midwife” and who demonstrate competence in the practice of midwifery.

Although midwifery and nursing are distinct professions but the ICN (2007: 1) argues that nurses and midwives share, a common purpose that is the promotion of health, the prevention of illness and the alleviation of suffering.

However, the focus of the practice of midwives encompasses the care of the child bearing family, the promotion of safe motherhood, and the health of women and children throughout the life span. According to Nursing and Midwifery Board of Australia (2013: 1) common areas for both categories include:

- Counselling,
- Patient education,
- Wound care and infection control,
- Administration of medicines and
- Care of gynaecological surgical patients.

2.6.2. THE MIDWIFERY PRACTICE

As shown above for a person to be registered as a midwife, she has to have been trained and completed training in midwifery education programme, licenced by regulating body of the country in which she practices and must be able to show evidence of competency in midwifery practice (ICM 2011). For midwifery practice to be up to required standards the midwife must give respect to the following:

- Scope of practice of the midwife,
- Competencies of midwife and
- Ethics of midwifery practice.

a. Scope of practice

To ensure pregnant women safety, the midwife should practice within the parameters of scope of practice and it is illegal for a midwife to practice above her scope of practice (ICM 2014; London et al. 2011). In midwifery practice, pregnant women safety has been identified as the important responsibility of the midwives.

According to the ICM (2011), scope of practice states that the midwife is recognised as a responsible and accountable professional who works in partnership with pregnant women to give the necessary support, care and

advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and child care. A midwife may practise in any setting including the home, community, hospitals, clinics or health units. According to the ICM (2014: 1) Inherent in midwifery practice is respect for human rights, including cultural rights, the right to life and choice, the right to dignity, justice, to be granted equity in access of health care services and to be treated with respect irrespective of age, colour, creed, culture, disability or illness, sexual orientation, nationality, politics, race or social status. Midwifery practice is about looking after pregnant women's physical, psychological, emotional and spiritual well-being (ICM 2014: 1).

b. Competencies of the midwife

According to the ICM (2013: 4), midwives competencies in social, epidemiological and cultural context of maternal and newborn care include:

- is responsible and accountable for clinical decisions and actions.
- acts consistently in accordance with professional ethics, values, human rights and with standards of practice.
- maintains/updates knowledge and skills, in order to remain current in practice.
- is respectful of individuals and of their culture and customs, regardless of status, ethnic origin or religious belief.
- maintains the confidentiality of all information shared by the woman and works in partnership with women and their families, enables and supports them in making informed choices about their health, including the need for referral or transfer to other health care providers or facilities for continued care when necessary.
- works collaboratively (teamwork) with other health workers to improve the delivery of services to women and families.

According to the ICM (2013: 7), midwives competencies in pregnancy includes:

- take a comprehensive health and obstetric, gynaecologic and reproductive health history.
- perform a physical examination, including clinical breast examination, focused on the presenting condition of the woman.
- perform common laboratory and screening tests (e.g. hematocrit, urinalysis dip-stick for proteinuria, TB, HIV, STIs).
- provide care, support and referral or treatment for the HIV positive woman and HIV counselling and testing for women who do not know their status.
- take or order cervical cytology(Pap) test.

According to the ICM (2013: 9), midwives competencies in provision of care during pregnancy includes:

- take an initial and on-going history each antenatal visit.
- perform a physical examination and explain findings to the woman.
- take and assess maternal vital signs including temperature, blood pressure, pulse, nutritional status, a complete abdominal assessment including measuring fundal height, lie, position, and presentation.
- evaluate foetal growth, placental location, and amniotic fluid volume, using ultrasound visualization and measurement (if equipment is available for use).
- listen to the foetal heart rate; palpate uterus for foetal activity and interpret findings monitor foetal heart rate with Doppler (if available).
- perform a pelvic examination, including sizing the uterus, if indicated and when appropriate during the course of pregnancy.
- calculate the estimated date of birth.
- Identify abnormalities during pregnancy and manage them according to guidelines and refer where necessary.

According to the ICM (2013: 11), midwives competencies in provision of care during labour and birth includes:

- take a specific history and maternal vital signs in labour.
- perform a focused physical examination in labour, including abdominal assessment for foetal position and descent.
- time and assess the effectiveness of uterine contractions.
- perform a complete and accurate pelvic examination for dilatation, effacement, descent, presenting part, position, status of membranes, and adequacy of pelvis for birth of baby vaginally.
- monitor progress of labour using the partograph or similar tool for recording.
- provide physical and psychological support for woman and family and promote normal birth.
- facilitate the presence of a support person during labour and birth.
- provide adequate hydration, nutrition and non-pharmacological comfort measures during labour and birth.
- provide for bladder care including performance of urinary catheterization when indicated.
- promptly identify abnormal labour patterns and initiate appropriate and timely intervention and/or referral.
- stimulate or augment uterine contractility, using both pharmacologic and non-pharmacologic agents.
- administer local anaesthetic to the perineum when episiotomy is anticipated or perineal repair is required.
- perform an episiotomy if needed.
- perform appropriate hand manoeuvres for a vertex birth.
- perform appropriate hand manoeuvres for face and breech deliveries.
- clamp and cut the cord.
- institute immediate, life-saving interventions in obstetrical emergencies (e.g., prolapsed cord, malpresentation, shoulder dystocia, and foetal distress) to save the life of the foetus, while requesting medical attention and/or awaiting transfer.
- manage a cord around the baby's neck at birth.

- support expectant (physiologic) management of the 3rd stage of labour.
- conduct active management of the 3rd stage of labour, following most current evidence-based protocol.
- inspect the placenta and membranes for completeness.
- perform fundal massage to stimulate postpartum uterine contraction and uterine tone provide a safe environment for mother and infant to promote attachment (bonding) estimate and record maternal blood loss.
- inspect the vagina and cervix for lacerations.
- repair an episiotomy if needed.
- repair 1st and 2nd degree perineal or vaginal lacerations.
- manage postpartum bleeding and haemorrhage, using appropriate techniques and uterotonic agents as indicated.
- prescribe, dispense, furnish or administer (however authorized to do so in the jurisdiction of practice) selected, life-saving drugs (e.g., antibiotics, anticonvulsants, antimalarials, antihypertensives, antiretrovirals) to women in need because of a presenting condition.
- perform manual removal of placenta.
- perform internal bimanual compression of the uterus to control.
- perform aortic compression.
- identify and manage shock.
- insert intravenous line, draw blood for laboratory testing.
- arrange for and undertake timely referral and transfer of women with serious complications to a higher level health facility, taking appropriate drugs and equipment and arranging for a companion care giver on the journey, in order to continue giving emergency care as required.
- perform adult cardio-pulmonary resuscitation.

According to the ICM (2013: 14), midwives competencies in provision of care for women during the postpartum period labour includes:

- take a selective history, including details of pregnancy, labour and birth.
- perform a focused physical examination of the mother.
- provide information and support for women and/or their families who are bereaved (maternal death, stillbirth, pregnancy loss, neonatal death, congenital abnormalities) assess for uterine involution and healing of lacerations and/or repairs.
- initiate and support early breastfeeding (within the first hour).
- teach mothers how to express breast milk, and how to handle and store expressed breast milk.
- educate mother on care of self and infant after childbirth including signs and symptoms of impending complications, and community-based resources.
- educate a woman and her family on sexuality and family planning following childbirth provide family planning services concurrently as an integral component of postpartum care.
- provide appropriate and timely first-line treatment for any complications detected during the postpartum examination (e.g., anaemia, haematoma maternal infection), and refer for further management as necessary.
- provide emergency treatment of late post-partum haemorrhage, and refer if necessary.

According to the ICM (2013: 16), midwives competencies in provision of postnatal care of the newborn includes:

- provide immediate care to the newborn, including drying, warming, ensuring that breathing is established, cord clamping and cutting when pulsation ceases.
- assess the immediate condition of the newborn (e.g. APGAR scoring or other assessment method of breathing and heart rate).
- promote and maintain normal newborn body temperature through covering (e.g. blanket, cap), environmental control, and promotion of skin-to-skin contact.

- begin emergency measures for respiratory distress (newborn resuscitation; suctioning in case of airway obstruction), hypothermia, hypoglycaemia.
- give appropriate care including kangaroo mother care to the low birth weight baby, and arrange for referral if potentially serious complications arise, or very low birth weight.
- perform a screening physical examination of the newborn for conditions incompatible with life.
- recognize indications of need, stabilize and transfer the at-risk newborn to emergency care facility.
- educate parents about danger signs in the newborn and when to bring infant for care educate parents about normal growth and development of the infant and young child, and how to provide for day-to-day needs of the normal child.
- assist parents to access community resources available to the family.
- support parents during grieving process for loss of pregnancy, stillbirth, congenital birth defects or neonatal death.
- support parents during transport/transfer of newborn or during times of separation from infant (e.g., NICU admission).
- support and educate parents who have given birth to multiple babies (e.g. twins, triplets) about special needs and community resources.
- provide appropriate care for baby born to an HIV positive mother (e.g. administration of ARV and appropriate feeding).

c. Ethics of midwifery practice

According to the WHO (2013: 8), midwifery practice has to be regulated by the governing body which will set the rules and regulations as well as standards of midwifery practice. Ethical midwifery practice also includes holding in confidence all patients' personal information confided to the midwife (ICN 2012; ICM 2014). According to the ICM (2014: 1), the midwife must promote the wellbeing of the pregnant women and newborns within their families and communities. Ethics has to do with doing what is best for the pregnant women and avoiding harm (ICM 2014: 2). An informed consent is part of ethics, it

protects the human right to autonomy and self-determination (London et al 2011: 11).

According to the ICM (2014: 1), midwives code of ethics includes:

- developing a partnership with individual women in which they share relevant information that leads to informed decision-making, consent to an evolving plan of care, and acceptance of responsibility for the outcomes of their choices.
- supporting the right of women/families to participate actively in decisions about their care.
- empowering women/families to speak for themselves on issues affecting the health of women and families within their culture/society.
- respectfully working with other health professionals, consulting and referring as necessary when the woman's need for care exceeds the competencies of the midwife.
- Midwives have responsibilities to themselves as persons of moral worth, including duties of moral self-respect and the preservation of integrity.
- providing care for women and childbearing families with respect for cultural diversity while also working to eliminate harmful practices within those same cultures.
- using up-to-date, evidence-based professional knowledge to maintain competence in safe midwifery practices in all environments and cultures.
- responding to the psychological, physical, emotional and spiritual needs of women seeking health care, whatever their circumstances (non-discrimination).
- acting as effective role models of health promotion for women throughout their life cycle, for families and for other health professionals.
- holding in confidence client information in order to protect the right to privacy, and use judgment in sharing this information except when mandated by law.
- Midwives are responsible for their decisions and actions, and are accountable for the related outcomes in their care of women.

- Midwives may decide not to participate in activities for which they hold deep moral opposition; however, the emphasis on individual conscience should not deprive women of essential health services.
- understanding the adverse consequences that ethical and human rights violations have on the health of women and infants, and will work to eliminate these violations.
- participating in the development and implementation of health policies that promote the health of all women and childbearing families.

2.6.3. THE ART OF CARING

According to Lindeburg, Hunter and Kruwseki (1994) as cited in Bradshaw (2011: 9), caring is more than just performing midwifery practice procedures, it is an act of nurturing and helping another person to grow. Midwives should consciously initiate caring relationships and create caring environments, and thus enhance healing (ICM 2014: 1). Bradshaw (2011: 45) concluded from their study regarding the term 'caring' in midwifery practice that the main quality defining someone as being caring is genuine concern for another's wellbeing. The consequences of caring includes an increased sense of personal joy and professional satisfaction for midwives and an increased ability to assist the pregnant women. In each instance, there appeared to be beneficial effects for pregnant women and midwives alike.

Caring is composed of: listening, communication, eye contact, touch, and calling each other by name. Caring is both an innate and a learned quality, or virtue. Qualities and characteristics of caring behaviours exist in varying degrees, influenced by such variables as environment, culture, and motivation (Bradshaw 2011: 44). No matter what degree of caring a midwife innately possesses, there is evidence to support the idea that caring can be learned or enhanced. The demands for cost-effective measures and more efficiency do not allow midwives sufficient time to offer the personal care which they feel is the primary responsibility of their profession. Caring is valued as an essential component in the midwifery practice (Bradshaw 2011: 45).

By providing midwifery practice, the midwife promotes an environment in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected (ICN 2012: 2). When caring for the pregnant women, the nurse must ensure that the use of technology and scientific advances are compatible with the safety, dignity and rights of people (ICN 2012: 3).

According to the WHO (2013: 35), good quality care during pregnancy is fundamental to the health, well-being and survival of mothers and their babies. Antenatal care can save lives. According to the United Nations [UN] (2014: 25), the best way to prevent neonatal death is investment in maternal care during the first 24 hours after birth, particularly in labour and delivery care.

2.6.4. QUALITY IN MIDWIFERY PRACTICE

Quality midwifery practice is in demand world-wide. Quality refers to the degree of excellence and the extent to which an organisation meets clients' needs and exceeds their expectations, in accordance with approved standards (WHO 2013: 4). Quality midwifery practice includes making the patient comfortable, teaching and informing the patient about health related matters relevant to the patient's condition and meeting their emotional needs. The terms 'quality' and 'standards' are interrelated and work interchangeably. Quality nursing care is measured by set standards (ICM 2011).

According to the WHO (2006: 9), there are six areas/dimensions in which health systems in the world should seek improvement in order for quality midwifery practice to be provided to pregnant women. These six areas or dimensions are as follows:

- *Effective* i.e. based on the needs of the individuals and should be evidenced based and result in improved health outcomes.
- *Efficient* i.e. maximises resource use and avoids waste.
- *Accessible* i.e. timely, geographically reasonable and provided in a setting where skills and resources are appropriate to medical need.

- *Acceptable/patient-centred* i.e. takes into account the preferences and aspirations of individual service users and the cultures of their communities.
- *Equitable* i.e. does not vary in quality because of personal characteristics such as gender, race, ethnicity, geographical location or socioeconomic status.
- *Safe* i.e. minimises risks and harm to service users.

For quality of midwifery practice to improve, midwives must make it their responsibility to maintain or update their competence/skills by continual learning (ICN 2012: 3). Bradshaw (2011: 9) concurs saying that nursing is frequently difficult and challenging work because midwifery practice requires an up to date knowledge of illness, medications and technology. Mali and Mali (2014: 621) added that most midwives do not have up to date knowledge when it comes to pregnant women care.

Nurses use judgement regarding individual competence when accepting and delegating responsibility. One of the duties of nurse managers is to see to it that personnel have up to date knowledge and skills. Fentianah (2012: 253) proposes that in order to ensure quality nursing practice, nurses/midwives competence programmes should be designed which should start during recruitment where nurses would be hired based on their competence and skill.

2.6.5. STANDARDS IN MIDWIFERY PRACTICE

Standard of midwifery practice establish minimum criteria for competent and proficient delivery of midwifery practice. Standards are designed so as to protect the public against all improper management they could receive. Standards in midwifery practice are used to judge the quality of care provided by midwives. Policies and guidelines and protocols provide appropriate guidelines for care standards in midwifery practice. Though standards do not carry any force from the law, they have important legal significance. The legal interpretation of actions within standards of care is based on what a reasonably prudent midwife with a similar education and experience would do in a similar

situation. Any midwife who fails to meet appropriate standards of care invites allegations of negligence or malpractice and practicing within the guidelines established by the regulating body or following local or national standards decreases the potential for litigation (London et al 2011: 11).

2.6.6. CHALLENGES FACED BY THE GLOBAL HEALTH SYSTEM

Health system is facing major challenges globally hence it is forced to expand because of population size and it must increase the services it provides, which demands increment of the number of midwives at different levels. Health system also aims at ensuring more equitable access to midwifery practice. This calls for action on commitments to scale up the development and implementation of high-quality midwifery education and practice (WHO 2013: 10).

According to the WHO (2013: 6), although midwifery practice is the key function in health system it is facing serious challenges globally. These challenges include:

- Inadequate human resources at all levels of the health-care system;
- Difficulty in retaining health-care workers in rural areas after completion of training;
- Increased migration within countries, regions and globally;
- Low salaries, lack of career incentives, an ageing workforce, poor professional image;
- Poor working conditions/environments;
- Difficulties implementing and reinforcing existing policies;
- Lack of high-quality local education programmes;
- Delayed or inadequate responses to crises and/or disasters;
- Limited access to information and communication technologies;
- Funding and training resource constraints exacerbated by the global economic situation.

a. Shortage of midwives

This is a worldwide phenomenon, shortage of midwives is experienced worldwide (WHO 2013: 29). The existing health workforce shortage which is mainly caused by persistent prevailing funding constraints, poses many challenges to the midwifery workforce and to service delivery globally. Greater investment in attracting and sustaining midwives is urgently needed to enable equitable access to health-care services (WHO 2013: 10).

Quinn (2013: 128) argues that staffing should be based on patient turnover and hospitals with higher turnover of pregnant women should be prioritised when hospitals are being staffed. Currently hospitals with high turnover of pregnant women are not well staffed to accommodate frequent patient transfers. Bradshaw (2011: 39) suggests that heavy workloads as a result of shortage of midwives cause midwives to fail to offer high quality midwifery practice.

Bartels and Bednash (2005) as cited in Fentianah (2012: 251) state that shortage of midwives has pressured nursing leaders to increase the number of midwives neglecting to place emphasis on the competency of those midwives in providing quality and safe midwifery practice. According to Moates (2014: 49), improved nurse staffing is crucial in creating a safe patient environment.

b. Poor midwifery practice standards

According to Reising and Allen (2007: 7), 'standard' is an expected behavior that is in line with policies and acts. Standards may originate from several sources. 'Standard of care' is the care a patient should expect to receive under similar circumstances. Standards are based on the professional literature, protocols, and expert opinions. Standards of nursing practice derive from facility policies and procedures, job descriptions, professional standards and scopes of nurses, state nurse practice acts, and expert nurses who provide information on what is reasonable, careful, and prudent care. Failure to follow

guidelines, protocols and procedures means failure of the midwife to practice within set standards (London et al 2011: 11).

c. Increase in the number of complaints and litigation

Most complaints and litigation originate from malpractice. According to Reising and Allen (2007: 4), malpractice is defined as “negligence, misconduct, or breach of duty by a professional person that results in injury or damage to a patient”. In most cases, it includes failure to meet a standard of care or failure to deliver care that a reasonably prudent nurse would deliver in a similar situation. Reising and Allen (2007: 4) further state that to prove malpractice of the midwife, the plaintiff (the party who initiated the complaint) must prove all of the following:

- The nurse had a duty to the patient. By taking on the care of a patient, the nurse assumes a legal duty.
- The nurse breached that duty. To establish breach of duty, the standard of care must be known.
- A patient injury occurred. The nurse’s failure to carry out a professional duty caused patient injury. No injury means no malpractice even if the three other malpractice elements are present. However, not all patient injuries necessarily involve malpractice.
- A causal relationship exists between breach of duty and patient injury. The nurse’s deviation from the standard of care could reasonably have caused the patient’s injury.

The five most common malpractice claims against nurses as identified by Reising and Allen (2007: 4) are:

1. Failure to follow standards of care: Standards of care apply to numerous patient-focused or nurse-focused actions; some may change from year to year or even month to month. These standards might include procedures and protocols.
2. Failure to communicate: An element in most malpractice suits, poor communication may exist between a nurse and a physician, a nurse and

other healthcare providers (including those to whom she/he has delegated a task), or a nurse and patient. This includes failure to report abnormalities.

3. Failure to document: In the court of law, if nursing action was not documented in patient's records, that nursing action was not done.
4. Failure to assess and monitor: Determining the frequency of patient assessment and monitoring is a nursing judgment. Sometimes a facility's policy or written standard specifies how often to perform patient assessment, but this is more the exception than the rule. Failure to assess and monitor will lead to malpractice
5. Failure to act as patient advocate: Failure to act as patient advocate is an increasingly common element in malpractice suits. Frequently, patient advocacy relates to challenging physician orders. Physician challenges may involve medications, respiratory management, discharge decisions, and many other aspects of patient care. It may also involve a request that the patient be moved to a different unit or even a different facility to receive optimal care.

d. High neonatal and maternal mortality rate

Giving birth with assistance of a skilled midwife or nurse reduces risk of preventable death or disability (WHO 2013: 29).

According to London et al (2011: 9), maternal mortality is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes. Maternal deaths may be divided into:

- *Direct obstetric deaths*: Resulting from obstetric complications of pregnancy, labour or the puerperium, from interventions, omissions, incorrect treatment or from a chain of events resulting from any of these; and
- *Indirect obstetric deaths*: Resulting from previously existing disease which was aggravated by the physiological effects of pregnancy.

The world has made the commitment of reducing numbers of both maternal and neonatal deaths in the world by providing Sustainable developmental goals which aims at reducing maternal and neonatal deaths by 2030 (UN 2015).

2.7. REGIONAL PERSPECTIVE

Although the world made the commitment of reducing numbers of both maternal and neonatal deaths in the world by 2015 but Sub-Saharan Africa is facing a serious challenge concerning maternal and neonatal death rates. These high rates could be attributed to shortage of midwives, poor working conditions and low socio economic status. The sub-Saharan Africa death rate is 16 times higher than the rest of the world (WHO 2013: 24). Sub-Saharan Africa has the highest child death rate in the world. Almost 300 000 women died globally in 2013 from causes related to pregnancy and child birth (UN 2014: 28). Most neonatal and maternal deaths result from non-communicable diseases, which nurses and midwives in community can easily manage by screening/early detection and treatment, promotion of health and disease prevention (WHO 2013: 21).

Giving birth with assistance of a skilled midwife or nurse reduces risk of preventable death or disability (WHO 2013: 29).

2.8. LOCAL PERSPECTIVE

2.8.1. THE DIFFERENCE BETWEEN A NURSE AND A MIDWIFE

In South Africa, an individual is trained either as a registered or enrolled nurse before he/she is trained as the midwife of which these categories are controlled by the SANC as a regulating body which issues the scopes of practice for both categories (SANC 1991: 1).

The RSA Nursing Act 33 of 2005 provides the following definitions:

A midwife means a person registered as such in terms of section 31 and midwifery refers to a caring profession practised by persons registered under this Act, which supports and assists the health care user and in particular the

mother and baby, to achieve and maintain optimum health during pregnancy, all stages of labour and the *puerperium*.

A nurse means a person registered in a category under section 31(1) in order to practise nursing or midwifery and nursing means a caring profession practised by a person registered under section 31, which supports, cares for and treats a health care user to achieve or maintain health and where this is not possible, cares for a health care user so that he or she lives in comfort and with dignity until death.

According to the definitions above an individual can be registered as nurse without being a midwife but cannot be registered as a midwife without being a nurse. There is one register where one is entered with different categories. In South African context there is a registered midwife who is a registered nurse and there is an Enrolled midwife who is an Enrolled nurse (SANC 1991: 4). The only distinct given is that the midwife though she supports the health care user but her main focus is on the pregnant women and the foetus.

2.8.2. THE MIDWIFERY PRACTICE

According RSA act no 33 of 2005 a midwife is a person who is qualified and competent to independently practise midwifery in the manner and to the level prescribed and who is capable of assuming responsibility and accountability for such practice. According to SANC 1990 there are conditions under which a registered midwife may carry on his profession these include:

- a. **Equipment and materials:** in the course of his practice a registered midwife shall at all times have available the equipment and materials that are required for the practice of midwifery, including:
 - an intravenous infusion set and at least 2 x 1 000ml of 5% dextrose in a normal saline solution,
 - the equipment and material necessary to perform an episiotomy and to suture an episiotomy or a first or second degree tear of the perineum.

- b. **Records:** a registered midwife shall keep clear and accurate records of the progress of pregnancy, labour and the puerperium and of all acts, including emergency acts, which he performs in connection with a mother and child.
- A registered midwife shall retain the records for at least three years and shall produce the records to the council when required to do so.
- c. **Breast-feeding:** a registered midwife shall promote breast-feeding unless it is contra indicated.
- d. **The antenatal period:** on being engaged to attend a pregnant woman, a registered midwife shall:
- advise the patient to be examined by a medical practitioner and undergo a blood test at least once during her pregnancy;
 - ascertain whether any abnormality which could have an adverse effect on the present confinement has occurred during a previous pregnancy, labour or puerperium and, if so, advise the patient to seek medical advice;
 - in the case of a primigravida, make all the assessments required to ascertain whether the pelvis is adequate for a normal delivery and where any doubt exists immediately refer the case to a medical practitioner;
 - instruct the patient in antenatal exercises, including preparation for labour and preparation for breast-feeding.
- e. **Labour:** a registered midwife in attendance upon a patient in labour shall not leave the patient without giving an address at which he can be reached without delay.
- When the second stage of labour is imminent the registered midwife shall stay with the patient till after the birth of the foetus and for as long thereafter as the condition of the woman or the neonate may demand: Provided that he shall stay with the patient for at least one hour after the expulsion of the placenta and membranes.
 - A registered midwife shall, in a case of postpartum haemorrhage when a medical practitioner is not available or pending the arrival of a medical practitioner, administer not more than 10 units of oxytocin at a time by

intramuscular injection, but the administration may be repeated at intervals if and when necessary.

- An internal examination shall not be carried out by a registered midwife in the case of vaginal haemorrhage.
- An episiotomy may be performed by a registered midwife to prevent a severe tear of the perineum or complications relating to the newborn, provided the head is on the perineum.

f. **Puerperium:** during the puerperium the registered midwife shall-

- attend the mother and newborn at least once a day and shall not discharge them from his care until such time as the condition of both is satisfactory,
- if possible, continue such attendance daily for at least the five days following the birth of the child,
- if it is not possible to attend the mother and child at least once a day for at least the five days following the birth of the child, endorse the record of the case accordingly, giving reasons,
- instruct the mother in:
 - post-natal exercises and breast-feeding unless contra-indicated;
 - caring for herself and her child during the puerperium;
 - recognising abnormalities that may occur, and when and where to obtain assistance;
 - oral rehydration therapy for the child.

The RSA act no 33 of 2005 gives power to SANC as a regulating body to issue the scope of practice for all categories. The scope of practice is binding to all practitioners including the midwives and it is a criminal offence to practice above the scope of practice. In all her practice the midwife must practice within the scope of practice, ethical grounds and competencies.

a. Scope of practice

As mentioned above scope of practice is not optional. All midwives must practice within their scope of practice. According to SANC (1991: 3) scope of practice of the registered midwife includes:

the diagnosing of a health need and the facilitation of the attainment of optimum physical and mental health for the mother and child by the prescribing, provision and execution of a midwifery regimen or, where necessary, referral to a registered person or by obtaining the assistance of a registered person, as the case may be,

- the execution of a programme of treatment or medication prescribed by a registered person,
- the prevention of disease relating to pregnancy, labour and the puerperium and the promotion of health and family planning by teaching and counselling individuals, families and groups of persons, by implementation of family planning skills and by monitoring the health status of the mother and neonate,
- the monitoring of:
 - the progress of pregnancy, labour and the puerperium;
 - the vital signs of the mother and neonate,
 - the reaction of the mother and child to disease conditions, trauma, stress, anxiety, medication and treatment;
- the prevention of complications relating to pregnancy, labour and the puerperium including:
 - the performance of an episiotomy,
 - the suturing of first and second degree tears or an episiotomy,
 - the administration of a local anaesthetic,
- the administration of medicine to the mother or neonate,
- the prescribing, promotion or maintenance of hygiene, physical comfort and reassurance of the mother and neonate,
- the promotion of exercise, including ante-natal and post-natal exercises, rest and sleep,
- the facilitation of body mechanics and the prevention of bodily deformities in the execution of the midwifery regimen,

- the supervision over and maintenance of oxygen, fluid, electrolyte and acid base balance of the mother and neonate,
- the facilitation of the healing of wounds, the protection of the skin and the maintenance of sensory functions in the mother and neonate,
- the facilitation, maintenance and, where necessary, the improvement of the nutritional status of the mother and neonate,
- the promotion of breastfeeding,
- the supervision over and maintenance of elimination by the mother and neonate,
- the facilitation of communication by and with the mother and father or family in the execution of the midwifery regimen,
- the establishment and maintenance, in the execution of the midwifery regimen, of an environment in which the physical and mental health of mother and neonate is promoted,
- preparation for and assistance with operative, diagnostic and therapeutic acts for the mother and child,
- the co-ordination of the health care regimens provided for the mother and child by other categories of health personnel,
- the provision of effective advocacy to enable the mother and child to obtain the health care they need,
- care of the dying patient and a recently deceased patient within the execution of the midwifery regimen.

b. Ethics in midwifery practice

According to the SANC (2013a: 30), ethics is an integral part of the midwifery practice and forms the foundation thereof. Mulaudzi, Mokoena and Troskie (2011: 25) concur by stating that ethics is the essence of midwifery practice. Ethics in midwifery practice includes being a patient's advocate as appropriate (SANC 2013a: 6).

Ethics has to do with doing what is good and avoiding harm. A midwife is always faced with a task of making decisions that will affect pregnant women and foetus lives. The nurse must take a decision that will promote the life of a

patient. The good or harm of the decision taken by a nurse depends on the knowledge and values the nurse has (Mulaudzi, Mokoena and Troskie 2011: 11).

According to Jooste (2009: 272), Mulaudzi, Mokoena and Troskie (2011: 34) and SANC (2013a: 4) ethical principles include:

- *Autonomy*. This provides the pregnant women the right to choose and this right has to be respected at all times. The pregnant women must be involved in decision making with matters pertaining to her/his care. The pregnant women has a right to consent or not to consent to treatment.
- *Beneficence*. Beneficence simply means doing good. The midwife is at all times expected to promote the well-being of the pregnant women and foetus. The midwife must do good at all times and avoid doing harm to the pregnant women.
- *Non-maleficence*. Non-maleficence prohibits deliberate harm to the pregnant women and foetus. Midwives must at all times weigh risks against benefits of proposed treatment. Failure to care for the pregnant women with infectious disease thus endangering oneself and other pregnant women is the opposite of non-maleficence.
- *Justice*. Justice requires that individuals be given what they are entitled to, deserve or can legitimately claim. Pregnant women have a right to considerate and respectful care. Midwives are entitled to a safe working environment.
- *Advocacy*. Midwives represent the pregnant women and are health advocates who work in the direct pregnant women care environment. Failure of a midwife to stop what can be deemed as abuse or violation of pregnant women rights by anyone means failure on the part of a midwife in advocating for the pregnant women. According to Mulaudzi, Mokoena and Troskie (2011: 90), advocacy has to do with protecting the pregnant women from harm. This means that a midwife is legally bound to ensure the protection of the rights of the pregnant women. Whether the pregnant women is conscious or unconscious their rights have to be protected and if

the midwife fails to protect such vulnerable people then the nurse would have failed in their nursing duties.

Searle, Humans and Mogotlane (2009: 268) identified 14 common core concepts of midwifery practice ethics that are applicable in almost all countries which include:

1. The fundamental responsibility of the midwife is to conserve life, promote health and alleviate suffering.
2. The midwife must provide midwifery practice in accordance with human need and with respect for the dignity of the human being without consideration of race, creed, nationality and social or political and economic standing.
3. The midwife does not use her/his knowledge to the detriment of society.
4. The midwife keeps in confidence all confidential information about the pregnant woman.
5. The midwife must be a law-abiding citizen.
6. The midwife has a duty to uphold the efforts of her/his profession.
7. The midwife must continue to develop her/his professional competence and assist others to do the same.
8. The midwife helps to establish and maintain professional standards.
9. The midwife must be concerned with all legislation affecting the health care of the human being.
10. The midwife does not advertise.
11. The midwife has a duty to teach those she/he works with to try to prevent unskilled or unauthorised persons from performing tasks that may harm patients.
12. The midwife collaborates harmoniously with other members of the health team.
13. The midwife does not participate in unethical practices.
14. The midwife is accountable.

To ensure patients' safety, the nurse should practice within the parameters of scope of practice relevant to the nurse's qualifications (SANC 1991: 2). According to Dorse (2008: 82), midwives do not always practice within their scope of practice; some of the things nurses do in their practice are above the midwives scope of practice and this puts patients' lives at risk. According to the RSA (2005: 25), it is illegal for a midwife to practice above her/his scope of practice.

c. Competencies of midwives

According to SANC (2014: 3) the a qualified midwife must possess certain competencies which include:

i. Professional practice

- Advocates for the Midwifery Philosophy and Model of Care [International Confederation for Midwives (ICM)] in all aspects of care, education, research and policy making.
- Acts as a role model to the rest of the professional community in the use of this model Fosters and strengthens certain personal traits, abilities and competencies that put him/her at an exceptional level of performance and development as a role model in Midwifery e.g. passion, commitment, accountability, innovation, creativity, assertiveness, empathy, leadership and management competencies.
- Supports and encourages team members in promoting excellence in Midwifery.
- Demonstrates ability to analyze factors influencing Maternal, Neonatal, Child and Women's Health (MNCWH).
- Engages in policy development at a Local, National, Regional, and International levels to position Midwifery in the health care system at all levels.
- Conducts auditing of appropriate documentation and level of care.

ii. Ethical practice

- Advocates implementation of Code of Ethics for Midwives, including all aspects like confidentiality, autonomy and accountability.
- Utilizes Bio-ethical decision-making models in Midwifery.
- Advocates for and maintains and strengthen Human Rights e.g. safe motherhood as a Human Right, respectful birth, informed consent, choice of birthplace and continuity of care in Midwifery.
- Evaluates and reinforces Basic Midwifery Ethical Practice.
- Actively participate in projects such as advocacy campaigns to enhance women, newborn and childbearing family's health.
- Reinforces principles of appropriate documentation.
- Enforces implementation of National Core Standards.

iii. Legal practice

- Acts as a role model of professional conduct within legal framework despite moral/religious convictions.
- Acts as a quality assurer of principle of appropriate documentation.
- Reinforces the integration of National and International Regulations, Standards, protocols, guidelines and policies into Midwifery Practice.
- Applies all legislations relevant to health and the Practice of Midwifery.

iv. Health Promotion and Prevention

- Provides plans, culturally sensitive health education and services to all in the community in order to promote healthy family life, planned pregnancies, infertility and positive parenting on local, national, regional and international levels.
- Actively participates in projects and advocacy campaigns.

v. Assessment

- Assesses, analyses and interprets community health needs relevant to Maternal, Neonatal, Child and Women's Health (MNCWH).
- Assesses and screens streams of health care user of Reproductive Health Services, preconception care, Antenatal care, intrapartum care and the care of the neonate to maximize health during these periods.
- Conducts community profile and establishes community diagnoses.
- Detects high risk factors and/ or complications of pregnancy, labour and puerperium.

vi. Planning

- plans appropriate programs to address care for maternal, neonatal child and women's health.
- plan reproductive services, preconception care. Antenatal care, intrapartum care, postnatal care and care of the neonate to maximise health.

vii. Implementation

- facilitates efficient integrated implementation of appropriate packages of care to ensure good outcomes e.g. PMTCT.
- implements high quality, midwifery care to pregnant women.

viii. Evaluation

- Develops and reinforces good clinical governance and accountability standards in midwifery.
- Evaluates the appropriateness and effectiveness of assessment, diagnostic, interventions and treatment.
- Evaluates the appropriateness and effectiveness of midwifery services.

2.8.3. PROFESSIONALISM IN MIDWIFERY PRACTICE

The midwife has to practice midwifery within the constraints and boundaries of the laws of the country and within the Code of Ethics as set out by the regulating body (SANC 2013: 30). Professionalism in midwifery has to do with conducting midwifery practice or oneself in such a manner that promotes the image of the midwifery as a profession. Do what is expected when it is expected. The midwife has the responsibility of maintaining the good image of the profession. This means that the midwife has to practice her/his profession in a manner that will protect the pregnant women physical and emotional wellbeing (Searle, Humans and Mogotlane 2009: 268). Searle, Humans and Mogotlane (2009: 280) identified core concepts of professional conduct of a midwife which they must always abide by and these include:

- Be a law abiding citizen of the country.
- Refrain from purporting to be any category other than the one you are registered for with the regulating body (SANC).
- Work with other members of the multidisciplinary team to ensure safety and better management of patients' conditions.
- Act within the range of her/his professional ability to safeguard the physical and mental well-being, the personal rights and the dignity of the patient.
- Protect the good name of the patient and avoid all discriminating gestures.
- Maintain professional confidentiality.
- Remain professionally competent and up to date with knowledge.
- Observe the provisions of the nursing acts and all other regulations, policies and guidelines.

2.8.4. THE ART OF CARING

Midwifery practice is caring. Midwives are required to demonstrate the art of nurturing by both applying professional competencies and positive emotions that will benefit both the nurse and the healthcare user with inner harmony. Without the attitude of caring the midwife cannot render quality midwifery practice (SANC 2013a: 4). Mulaudzi, Mokoena and Troskie (2011: 119) in their definition of caring identified five C's of caring which can be called characteristics of caring and they include the following: a) confidence, b) compassion, c) conscience, d) competency and e) commitment. Communication forms the link to all these characteristics. Caring is composed of: listening, communication, eye contact, touch, and calling each other by name (Bradshaw 2011; Mulaudzi, Mokoena and Troskie 2011).

2.8.5. QUALITY MIDWIFERY PRACTICE

Quality refers to the degree of excellence and the extent to which an organisation meets clients' needs and exceeds their expectations, in accordance with approved standards (Jooste 2009: 303). Banamwana (2011: 78) stated that quality midwifery practice should include individualised care and should be knowledge based. Quality midwifery practice includes making the patient comfortable, teaching and informing the patient about health related matters relevant to the pregnant women condition and meeting their emotional needs. The terms 'quality' and 'standards' are interrelated and work interchangeably. Quality nursing care is measured by set standards.

According to the RSA Department of Health (2011: 5), quality midwifery practice is of great importance in changing the current state of affairs. Midwives must be able to get the best results using the available resources. The RSA Department of Health (2007: 9) stated that midwives administering care to pregnant women must demonstrate respect and a genuine interest in their clients and avoid an arrogant, rude or judgmental attitude. Nurses use judgement regarding individual competence when accepting and delegating

responsibility. One of the duties of nurse managers is to see to it that personnel have up to date knowledge and skills.

2.8.6. STANDARDS IN MIDWIFERY PRACTICE

A standard is a written description or statement of the expected level of performance with reference to structure, process and outcome (Muller, 2002: 204 as cited by Jooste 2009: 304). It is a desired, achievable level of performance against which actual performance is measured. Standards are another way of measuring performance (RSA Department of Health 2011: 9). The RSA Department of Health (2011: 10) identified seven areas that needed urgent attention and improvements so as to meet required quality care. The Department of Health refers to these areas as domains. These areas include:

1. *Patient's rights*. This area covers what hospitals or clinics must do to make sure that patients are respected and that their rights are upheld, including getting access to needed care and to respectful, informed and dignified attention in an acceptable and hygienic environment, seen from the point of view of the patient, in accordance with the Batho-Pele principles and the Patient Rights Charter.
2. *Patients' safety, clinical governance and care*. This area covers how to ensure quality nursing and clinical care and ethical practice; reduce unintended harm to health care users or patients in identified cases of greater clinical risk; prevent or manage problems or adverse events, including health care associated infections; and, support any affected patients or staff.
3. *Clinical support*. This area covers specific services essential in the provision of clinical care and includes the timely availability of medicines and efficient provision of diagnostic, therapeutic and other clinical support services and necessary medical technology, as well as systems to monitor the efficiency of the care provided to patients.
4. *Public health*. This area covers how health facilities should work with NGOs and other health care providers along with local communities and relevant sectors to promote health, prevent illness and reduce further

complications as well as ensure that integrated and quality care is provided for the whole community, including during disasters.

5. *Leadership and corporate governance.* This area covers the strategic direction provided by senior management through proactive leadership, planning and risk management, supported by the hospital board and the clinic committee as well the relevant supervisory support structures, and includes the strategic functions of communication and quality improvement.
6. *Operational management.* This area covers the day-to-day responsibilities involved in supporting and ensuring delivery of safe and effective patient care, including management of human resources, finances, assets and consumables, and of information and records.
7. *Facilities and infrastructure.* This area covers the requirements for clean, safe and secure physical infrastructure (buildings, plant and machinery, equipment) and functional, well managed hotel services; and effective waste disposal.

2.8.7. CHALLENGES FACED BY THE DEPARTMENT OF HEALTH

The Department of Health faces challenges which make rendering of quality maternal service difficult. The challenges faced by the Department of Health render it impossible for the Department to accomplish its vision of ensuring a long and healthy life for all South Africans (RSA Department of Health 2011: 8). Challenges faced by the Department of Health are discussed below.

a. Shortage of midwives and equipment

The issue of shortage of resources is not limited to South Africa only. It is a worldwide phenomenon (WHO 2013: 29). South African health care institutions grapple with work-related issues such as poor working conditions which can result in demoralisation of nurses (Jooste 2009: 29). Poor working conditions are associated with heavy workload, excessive mandatory overtime, lack of basic resources and equipment (Mokoka, Oosthuizen and Ehlers 2010; Klopper, Coetzee, Pretorius and Bester 2012). The SANC (2015a: 1) statistics

reveal that currently the registered midwives population ratio is at 1:367 contributes to poor nursing care and thus practice breakdown. The age statistics SANC (2015b: 1) further reveal that in South Africa, most midwives are between the ages of 50-64 which makes up about 46% of all nurses/midwives. This means that there is a shortage of nurses/midwives. Heavy workloads suggest that the ratio of midwives to patients is inadequate to provide quality care.

According to the Department of Health (2013b: 31), there is 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. The Human Resources for Health Strategy for the Health Sector 2012/2013-2016/2017 cites poor nurses' conditions as one of the reasons why nurses want to leave the profession (RSA 2012).

Dorse (2008: 82) concurs by stating that inadequate staffing can result in poor nursing care and burnout of nurses. According to the RSA Department of Health (2013b: 24), shortage of staff and equipment, and inconsistent staff patient ratios impact negatively on service delivery and nursing morale. Nkosi (2014: 65) came to the conclusion that another reason for shortage of personnel is because vacant posts are not filled timeously, at times because they are not advertised. If posts are to be filled, the process often takes a long time before it is completed. This causes great pressure on the remaining workforce.

Equipment that is essential for health service provision is often not available; if available it is not always in good working order and this leads to even more staff leaving. Procurement procedures must be improved to ensure that equipment is available and in good working condition. Gladys (2014: 105) concurs by stating that in her study midwives verbalised lack of resources as contributing to poor nursing practice. Some equipment that is said to be unavailable is basic material like case books, photocopying machines, cardiotocography (CTG) machines and urine testing strips.

According to the RSA Department of Health (2013b: 28), nurses are overloaded with non-nursing duties due to shortage of support staff. Reasons for such shortages can be summarised as follows:

- Financial constraints which have caused many people to resign in order to access their pension money.
- Unsatisfactory work conditions.
- Heavy workloads due to shortage of staff and equipment.
- Burnout.
- New technology or programmes with only a few people trained to use it/them.
- Low salaries.

Nkosi (2014: 66) stated that the employees are of the opinion that the managers do not care about their needs. This leads to employees feeling unsatisfied and leaving their health institution for other better places. Ngwenya (2009: 206) came to the conclusion that poor working conditions and low salaries lead to many nurses/midwives having low morale and emigrating as they are unsatisfied.

Dorse (2008: 83) suggested that the government should re-look at the issue of flexi-hours so as to attract retired nurses, overtime must be implemented in such a way that it does not become a burden to nurses and overtime money should be paid timeously. Career development should be considered as another option to attract and maintain more personnel.

b. Poor midwifery practice standards

According to the RSA Department of Health (2013b: 24), the standard of midwifery practice in South Africa has deteriorated and the status of midwifery practice as a profession has declined. Various media reports highlight the lack of professionalism and a rise in unethical behaviour by midwives as characterised by poor communication and incidents of violence and abuse. Poor midwifery practice standards can be attributed to poor management skills. If midwifery practice standards are to improve collective efforts from all

managers is needed (RSA Department of Health 2011: 5). According to the RSA Department of Health (2007: 10), poor management has been identified as a major weakness of health services in the country. Proper financial planning and optimal management of staff and resources are keystones to a fully functional district or provincial health system.

Ngwenya (2009: 201) states that nursing services managers use bullying tactics instead of providing support to midwives poor management practise. Dorse (2008: 87) stated that no midwife feels comfortable working where they feel unsupported because this leads to feelings of discomfort at work. A midwife in this situation is likely to leave. It is the responsibility of the managers to ensure a conducive working environment for the nurses. Gcawu (2012: 47) concurs by stating that if the midwife is not receiving appropriate support from supervisors that nurse is likely to develop burnout.

According to the RSA Department of Health (2007: 8), midwives serving pregnant women must be knowledgeable, skilled and have equipment to perform a clean and safe delivery and offer appropriate postpartum nursing care to both mother and baby. Gcawu (2012: 49) states that most midwives do not perform or assess pregnant women according to set policies and guidelines which leads to poor management of pregnant women.

c. Increase in the number of midwives going for disciplinary hearing

According to the Department of Health (2013b: 25), SANC statistics reveal that complaints against midwives have increased three hundred fold since 1996. Most of these disciplinary hearings originate from malpractice.

d. Litigation

According to Moore and Slabbert (2013: 60), the RSA Department of Health is facing massive costs because of litigation against the Department. Litigation keeps on rising in volume and amount. Most litigation arises from unprofessional and substandard care rendered by midwives. According to Ndaba (2013: 80), maternity units are very busy and risky and understaffed

units which make the units more susceptible to occurrence of medico-legal hazards. The RSA Department of Health has admitted that litigation against it is high (RSA Department of Health 2013b: 24).

e. High neonatal and maternal mortality rate

According to the RSA Department of Health (2007: 7), maternal mortality is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes. Maternal deaths may be divided into:

- *Direct obstetric deaths*: Resulting from obstetric complications of pregnancy, labour or the puerperium, from interventions, omissions, incorrect treatment or from a chain of events resulting from any of these; and
- *Indirect obstetric deaths*: Resulting from previously existing disease which was aggravated by the physiological effects of pregnancy.

The number of women delivering in hospitals is high in South Africa (RSA Department of Health 2012a: 87). However, the maternal and neonatal death rate is still high. This suggests poor quality of nursing care during labour or post-delivery. According to the Saving Mothers Report on Confidential Enquiries into Maternal Deaths, Africa is not on track to achieve MDG 5's aim of reducing maternal deaths by three quarters by 2015 (RSA Department of Health 2012c: 84). Poor management has been identified as one of the causes of such high neonatal and maternal deaths (RSA Department of Health 2007: 10). The Province of KZN is one of the leading provinces in terms of maternal and neonatal mortality in South Africa (KZN Department of Health 2014: 106). The Department of Health Annual Report confirms KZN had high maternal deaths for the period 2011 to 2013 with 964 deaths (RSA Department of Health 2014: 2). The RSA Department of Health (2014: 6) classification of the causes of maternal deaths from 2011 to 2013 is outlined in Table 2.2.

Table 2.2: Summary of the causes of maternal deaths

Underlying obstetric cause	Number	Percentage
Direct causes	2155	49.73%
Hypertension	640	14.77%
Obstetric haemorrhage	684	15.79%
Ectopic pregnancy	102	2.35%
Miscarriage	185	4.27%
Pregnancy related sepsis	226	5.22%
Anaesthetic related	105	2.42%
Embolism	102	2.35%
Acute collapse	106	2.45%
Hyperemesis gravidarum	5	0.12%
Indirect causes	2178	46.09%
Non pregnancy related infections	1504	34.71%
Medical and surgical conditions	493	11.385%
Unknown	181	4.18%
Total	4333	100.00%

Ndlovu (2011: 215) states that all these maternal and neonatal deaths can be prevented by improving the standards of nursing practice. According to Ndlovu (2011: 228), poor monitoring of neonates during and post-delivery results in neonatal deaths. In her findings, Ndlovu states that 64% latent phase cases and 74% active phase cases of labour that were not carefully monitored and plotted in partograph ended up in neonatal deaths.

A national strategy for maternity care was adopted to improve maternal services(RSA Department of Health 2007: 7). The summary of the national strategy is discussed as follows:

- *Promotion of community participation.* Women, families and communities must be empowered to contribute actively to improving maternal, perinatal and family health. Conditions that adversely affect the outcome of pregnancy, such as sexually transmitted diseases, unwanted pregnancies and lack of transportation should be addressed within the communities involved.
- *The inclusion of supportive legal framework.* Legislation and policies must be in place to support the national strategy, in terms of free care, termination of pregnancy services and protection of women. Politicians should publicly commit themselves to support improvements in health care for pregnant women.

- *The adaptation to local realities.* Some of the underlying causes of maternal and perinatal mortality, such as poverty, illiteracy and other national priorities, must be taken into account in the consideration of inadequacies in the health service or the utilisation thereof by pregnant women.
- *Improvement of quality of care.* Midwives administering care to pregnant women must demonstrate respect and a genuine interest in their clients, and avoid an arrogant, rude or judgmental attitude. This applies even in the context of a poor working environment or perceived unsafe practices of certain pregnant women.
- *Improvement in the status of women.* Active efforts must be made to improve the status of women in society, especially in education, reproductive choice, employment and the prevention of abuse.
- *Provision of skilled midwifery and obstetric services.* The three levels of the district health care pyramid (family and community, health centre, and district hospital) must function in an efficient and cost-effective manner. Midwives and doctors are the best equipped to provide technologically appropriate care to women during their reproductive lives. To prevent maternal deaths, all hospitals must offer caesarean section and blood transfusion facilities. The practice of home deliveries, whether by professional or lay midwives, is not encouraged.
- *Introduction of clinical guidelines.* The development of management guidelines for normal and high risk pregnancies will provide a framework for a high standard of maternity care.
- *Regionalised care and referral systems.* The district is the basic unit of a health care region, served by a district hospital and a number of health centres. A well-coordinated referral system, with access to transport and facilities, is essential for the provision of optimal care to all pregnant women in the district.
- *Improvement of management capacity.* Poor management has been identified as a major weakness of health services in developing countries. Proper financial planning and optimal management of staff and resources are keystones to a fully functional district.

- *Continuing audit of services.* It is essential to review and audit all maternal services and practices rendered in districts and provinces, to improve current services and to develop new services where necessary. Perinatal meetings should be held at all levels of the health care system.
- *Promotion of research.* Important areas for research include evaluation of the impact of community involvement as a strategy for improving maternal and neonatal health, operation and evaluation of reorganised ANC, and cost effectiveness studies of various interventions provincial health system.

2.9. THEORETICAL FRAMEWORK WHICH GUIDED THE STUDY

This study makes use of the Donabedian's framework. This framework (Figure 2.1) is relevant to the study as it offers a structure to measure quality of implemented processes through evaluation of structure, process and outcome standards. Donabedian breaks down the quality of care into three main components, structure, process and outcome, to reflect the whole production process for comprehension (Donabedian 2005: 700).

As displayed in Figure 2.1, *structure* means the relatively stable characteristics of the physical and organisational setting in which care takes place and includes in the first instance, providers of care and the equipment and resources they have at their disposal. In addition, structure standards also refer to administrative organisation including management, economic and environmental conditions of the environment (Donabedian 1980: 1066). Structure, therefore, influences process and in turn outcome and is based on assumptions that when certain standards are in place good care is more likely to be provided (Donabedian 1980: 1066).

Process standards refers to skills used to provide health care that could be preventive, diagnostic, therapeutic and rehabilitative services, including procedures and activities required to deliver health care by providers (Donabedian 1980: 1067).

Outcome standards refer to a change in a patient's current and future health status that can be attributed to received health care and its effectiveness (Donabedian 1980: 1067), and includes patient well-being and degree of satisfaction (Donabedian 1980: 1067). The outcome component has limitations in that the patient's outcome health status does not depend only on direct care received, but also on other influencing factors that need to be considered such as social and emotional factors, input from the body's mechanisms, the patient's own contribution, medication and her/his family's contribution.

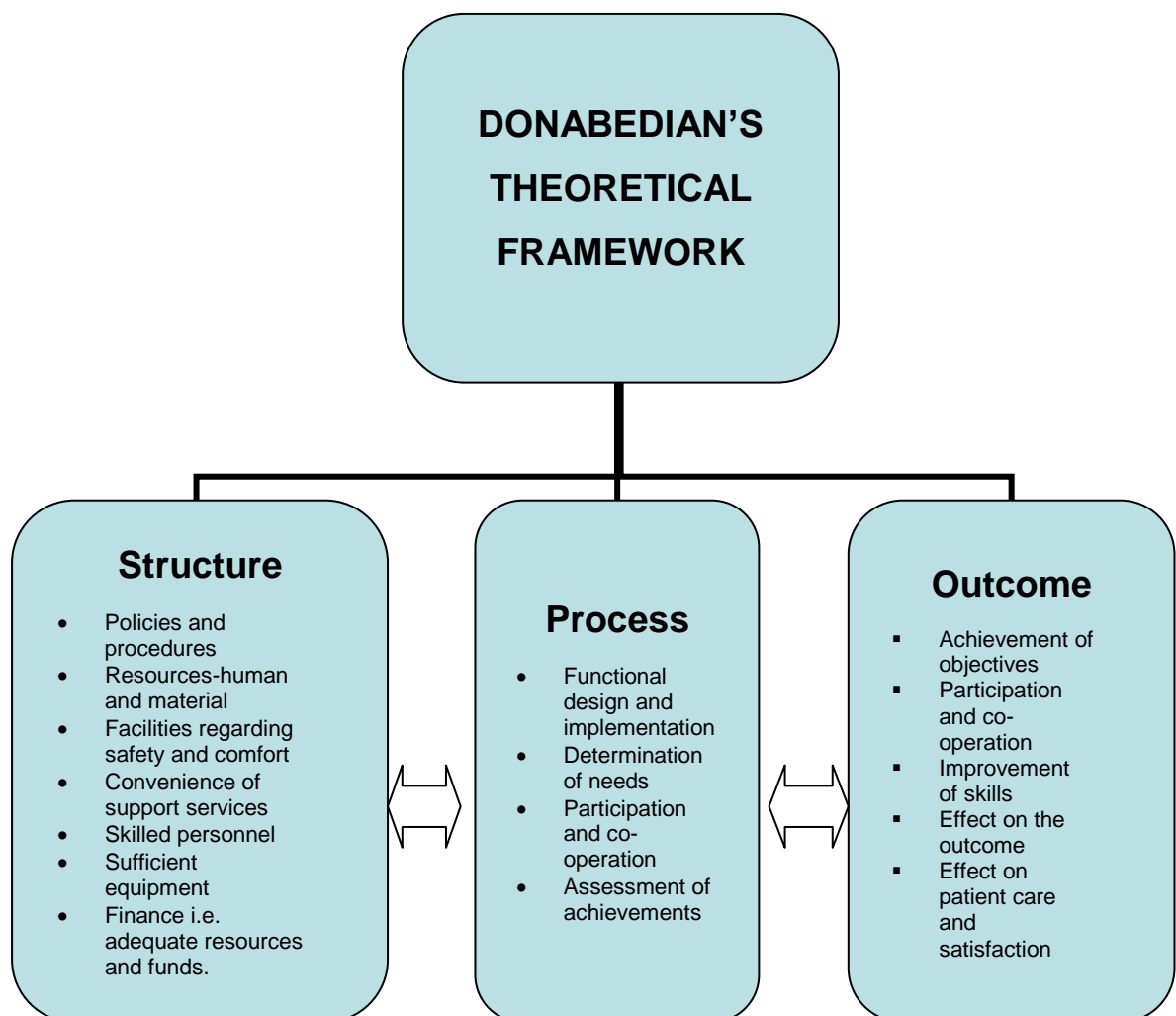


Figure 0.1: Donabedian's tripartite framework

2.9.1. The unfolding of the theoretical framework in this study

Principles from the framework will be integrated into the study inductively for example important concepts highlighted within the framework will be used as reference points to inform the design of data collection and analysis tools. This framework is relevant to the study as it offers a structure to measure quality of implemented processes through evaluation of structure, process and outcome standards. Developing insights into the experiences of midwives regarding nursing practice breakdown in maternity units will be undertaken broadly in line with the 'structure, process and outcome standards' prioritised by the Donabedian framework.

The model identifies three important influences on care quality and these, as already noted, are structure, process, and outcome. In this study, 'structure' refers to the relatively stable characteristics of the physical and organisational setting in which maternal care takes place and includes the providers of care (the midwives), the equipment and resources they have at their disposal, and management of the maternity units. The structure in this study will include midwives, nurse managers, the maternity units and availability of equipment. 'Process standards' refers to the policies, guidelines, knowledge of midwives and implementation of such guidelines and policies in maternity units. 'Outcome standards' in this study refer to a change in maternity patients' and their babies' current and future health status. The research questions and study outcomes shall address structure, process and outcome as perceived by the participant midwives. The research question number one which is: what are the factors that influence practice breakdown in maternity units at a public hospital in KZN? Shall address the structure and the process hence this question seeks to identify the structural problems either in midwifery practice or in fixed structure which influence the midwifery practice. These will also reveal the manner in which they influence the midwifery practice hence the process of the framework. The research question no two: describe the experiences of midwives regarding practice breakdown in maternity units at a public hospital in KZN? This question seeks to look at the outcome of the both the structure and process in the midwifery practice.

A maternal service is a programme aimed at ensuring safety of both mother and foetus during pregnancy, labour and the post-natal period. Its effectiveness depends on the skills of midwives, which in turn relies on pregnant woman compliance and equipment supplied by the management to execute duties. The Donabedian model represents an important guiding concept within the current study as it addresses all components of a programme. Proper management during pregnancy, labour and the post-natal period ensures a healthy new generation without deformities.

2.10. CONCLUSION

This chapter highlighted what is relevant to the topic of interest. A number of studies have been conducted by the RSA Department of Health and other researchers regarding the standard and quality of nursing care that is rendered to patients but little has been done to investigate the experiences of midwives who are hands on, the nurses/midwives who experience this entire practice breakdown. Hence this study aims to explore and describe the experiences of midwives regarding practice breakdown.

CHAPTER 3: RESEARCH METHODOLOGY

3.1. INTRODUCTION

The previous chapter focused on a review of the literature with the aim of establishing the relevance of the study by comparing it to previously researched information. The purpose of this chapter is to describe and justify the research design and methodology adopted in this study. This will be followed by a description of the research method for theory generation and measures to ensure trustworthiness.

3.2. RESEARCH METHODOLOGY

This is a step by step systematic process that the researcher took to solve the problem or to answer the research question. The research methodology section includes population, sampling frame, approach and technique, sample size, data collection method, data processing and analysis and report (Brink, Van der Walt and van Rensburg 2012: 199).

A qualitative design is useful when the researcher wants to examine the experiences of human beings in their natural environment. Qualitative researchers often collect data in the field at the site where participants experience the problem under study (Polit and Beck 2012: 221). Hennink, Hutter and Bailey (2011: 9) argue that qualitative researchers study people in their natural settings, to identify how their experiences and behaviour are shaped by the context of their lives, such as the social, economic, cultural or physical context in which they live. A qualitative research approach was selected because the researcher wanted to explore and describe experiences of midwives regarding nursing practice breakdown in maternity units. These experiences were captured through in-depth semi-structured interviews that are representative of qualitative methods of data collection.

3.3. RESEARCH DESIGN

Research design spells out the basic strategies or logical steps that researchers adopt to test their hypotheses (Polit and Beck 2010: 222; Brink, Van der Walt and van Rensburg 2012: 96). Research design guides the researcher in planning/designing and implementing the study in a way that is most likely to achieve the intended goal (Burns and Grove 2009: 218; Schmidt and Brown 2009: 123). A qualitative research study that was a phenomenology, exploratory, descriptive and contextual in nature was conducted to explore and describe experiences of midwives regarding nursing practice breakdown in maternity units.

3.3.1. Exploratory research

An explorative research seeks to gain insight into a situation, phenomenon and a community (De Vos, Fouche and Delport 2011: 95). A study of this nature is designed to increase the knowledge of a particular field of study (Grove, Burns and Gray 2013: 694). In the current study, the researcher explored the experiences of midwives regarding nursing practice breakdown. During the interview sessions, the researcher used probing questions to explore and gain deeper understanding into the participants' experiences. The researcher listened for unanticipated material and examined their relevance to the study through probing questions (Grove, Burns and Gray 2013: 694).

3.3.2. Descriptive research

Descriptive research presents a picture of the specific details of a situation and focuses on the deeper meaning and intensive examination of the phenomenon under study. This leads to a thicker description of the phenomenon (De Vos, Fouche and Delport 2011: 96). Descriptive research provides an in-depth description of participants' experiences in a narrative type description. In this study, the researcher intended to explore and describe experiences of midwives regarding nursing practice breakdown.

3.3.3. Contextual research

A study is contextual when it focuses on a phenomenon in its structural coherence that is of interest to the researcher. Qualitative research studies are always contextual as data is only valid in a specific context (Botma, Greef, Mulaudzi and Wright 2010: 195). This study is contextual since the researcher sought to explore and describe experiences of midwives regarding nursing practice breakdown in a public hospital.

3.4. RESEARCH SETTING

The study was conducted at a public hospital in the uThungulu Health District. According to the KZN Department of Health (2015: 1), this selected hospital serves as a referral hospital for 17 district hospitals, the furthest being 250km away and serves a population of 2 443 753. The hospital is situated in the middle of the KZN town of Empangeni, about one and a half hour's drive away from Durban and half an hour away from Richards Bay. It is a Level II hospital specialising in obstetrics, gynaecological and neonatal care employing 177 midwives in its maternity units. Although this hospital is a Level II hospital, the community and clinics around Empangeni use it as a Level I hospital and as a mother hospital.

The researcher selected the public hospital because it specialises only in midwifery practice and it is the biggest hospital receiving referrals from three health districts which uThungulu, Zululand and uMkhanyakude Health districts. The researcher felt that he would receive quality data from such an institution.

3.5. SAMPLE AND SAMPLING PROCESS

3.5.1. Population and target population

Population is entire group of persons or objects that the researcher is interested in studying, and sets boundaries for the elements or participants to be studied (Brink, Van der Walt and van Rensburg 2012; Polit and Beck 2008). 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. Currently, the hospital has 177 midwives in its maternity units.

3.5.2. Sampling

According to Brink, Van der Walt and van Rensburg (2012: 131), a sample is a part or fraction of the whole population. A sample is selected from a population in order to obtain information regarding a phenomenon in a way that represents the population of interest. Purposive sampling also known as judgemental sampling was used to select the sample for the study. The researcher chose the purposive sampling in order to select participants who can meet the study objectives. Purposive sampling allows the researcher to select a sample that is knowledgeable about the phenomena being studied (Brink, Van der Walt and van Rensburg 2012: 141).

The sample of the study consisted of midwives who were located in the maternity units of the selected hospital. The sample size was determined by the number of midwives that were actively involved in maternal units and were available and willing to participate in the study. The sample comprised 13 participants from the Labour or Delivery Unit, ANC/ high risk unit, the Neonatal Intensive Care Unit (NICU) and Postnatal Care Unit. The researcher chose four departments which were labour ward, postnatal ward, neonatal ICU and high risk clinic. The researcher chose three midwives in labour ward, three in neonatal ICU and four in postnatal ward and three in high risk clinic. The researcher chose one midwife per shift per department and came in different days and shifts including night duty so as to get as rich data as possible. The midwives were recruited until saturation of data was reached. In qualitative research studies, there is no set sample size as in quantitative research studies.

3.5.2.1. Inclusion criteria of participants

- All midwives working in maternity units at a selected hospital.

3.6. DATA COLLECTION PROCESS

Once ethical approval was received from DUT Ethics Committee (Annexure 1), permission was sought and granted by the District Manager (Annexures 2a and 2b), KZN Department of Health (Annexures 3a and 3b) and the Hospital CEO (Annexures 4a and 4b). Data was collected through individual semi-structured interviews with selected midwives. Semi-structured interviews assisted in gaining in-depth knowledge since questions were clarified where necessary, using probing and follow up questions (Brink, Van der Walt and van Rensburg 2012: 158). Interviews is one of the most important ways of gathering data in a qualitative study (Yin 2009: 106).

The in-depth semi-structured interviews were conducted using an interview guide (Annexure 5) in a face to face encounter at the side ward and some were conducted at a vacant office in the maternity units. The questions were formulated using the research question of the study, the theoretical framework and the literature review as a guide. Each participant was visited in their work place and the information (Annexure 7a) and consent sheets (Annexure 7b) were delivered by hand. Time was provided to read the information sheets and to answer questions of participants. The interviews were conducted in English language and all participants were comfortable in speaking the language. Participants were interviewed for about 30 to 45 minutes.

The interview sessions were audio taped and field notes taken as backup. The participants were encouraged to continue talking using necessary probing questions. Permission was sought from the participants to use a voice recorder to capture the interview data. Field notes were documented by the researcher. After each interview the interview content was transcribed by the researcher, using the actual words of the participants in order to ensure confidentiality as

participants may have felt audio taped records could lead to their identification via voice recognition.

Data was collected over five days period from 21 to 23 December 2015 in which both day and night shift staff were interviewed and on the 28 to 29 December 2015 only day shift was done in which a total of 13 participants were interviewed. Data saturation was achieved after conducting eight interviews with the midwives but the researcher proceeded to do five more interviews before cessation of the interviewing process to further confirm that saturation had indeed been achieved. The researcher stopped scheduling interviews when the content of the interviews was not providing new information and thus saturation had been reached. A grand tour questions were asked followed by probing questions to get more data. The following research questions guided the individual interviews:

- *Grand tour question number 1:* What are the factors that influence practice breakdown in maternity units?
- *Probing questions used:*
 - In your experience as a midwife, what are the factors that contribute to practice breakdown?
 - What could be done in future to prevent such occurrence?
 - What impact do these have in your practice as a midwife?
- *Grand tour question number 2:* What are your experiences regarding practice breakdown in maternity units?
- *Probing questions used:*
 - In your experience as a midwife, have you ever been involved in any act that suggests practice breakdown?
 - What was the practice breakdown that you were involved in?
 - What was the factor(s) leading to practice breakdown?
 - What was your emotional, psychological or physical state after the event had happened?
 - In your views, what can be done to revive the nursing profession?

3.7. PRE-TESTING OF THE DATA COLLECTION TOOL

The data collection tool was pre-tested so to assess whether the research questions were realistic and understood by the participants. The pre-test was conducted by the researcher on 15 December 2015. Three midwives were selected by the researcher for semi-structured interview. Midwives that were selected for the pretesting phase were employed at the selected hospital. Necessary amendments were made to the interview questions to further ensure that they were understood by participants.

3.8. DATA MANAGEMENT

Research data required proper management to ensure anonymity, usability, long-run preservation and access and indeed the research content can be very sensitive and must be handled with care at all times (Brink, Van der Walt and van Rensburg 2012: 158). Transcribed notes were coded to ensure confidentiality and kept in a password coded laptop, with only the researcher and the research supervisors having access to the material. The original tape recorded data and transcribed data were examined by both the supervisors to ensure that data was transcribed correctly and to exclude bias.

All information shared by the participants was treated as confidential. In all transcripts the original name and registration number of participant did not appear. Code names and numbers were used as names for participants. All lists with true identities of participants whether in laptop, audio recorder or written list of participants will be kept privately by the researcher in a safe place. The data will be kept for a period of five years in a secure location with arrangement by the supervisor at DUT and will be disposed of by incineration. Electronic data is kept in a password protected computer.

3.9. DATA ANALYSIS

Data analysis involves a systematic application of a process or processes of managing and organising qualitative data, which brings order, structure and meaning to the mass of data collected (Brink, Van der Walt and van Rensburg 2012: 193). Qualitative data analysis is an active process where the researcher has to scrutinise carefully and deliberately data that she/he has gathered often reading data over and over again until meaning or deeper understanding of data is achieved (Polit and Beck 2008: 508). Analysis of qualitative data involves categorising data into segments with symbols or abbreviations used to classify words or phrases. This is known as coding (Brink, Van der Walt and van Rensburg 2012: 193).

In qualitative research studies data analysis is done concurrently with data collection and is done throughout the study (Brink, Van der Walt and van Rensburg 2012: 193). Qualitative analysis techniques make use of words rather than numbers as a basis and this strategy is contextual in nature. Analytical reasoning skills are required when conducting content analysis (Burns and Grove 2009: 105). In this study, data was analysed using Tesch's method of data analysis for qualitative research (Tesch, cited in Creswell 2009). Tesch's steps that were followed and their application to this study are indicated in Table 4.2, to allow the reader to understand how the results were obtained. As previously discussed in this chapter, interviews were voice recorded to ensure accuracy of data. These are the main source of data in qualitative studies (Polit and Beck 2008: 508). The researcher transcribed data verbatim. Both the transcribed material and audio tapes were examined by both supervisors independently from each other to exclude bias. The points in which the supervisors and the researcher 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 and Beck 2008: 509).

Table 3.1: Tesch's steps and their application to this study

Tesch's Steps	Application to this study
<ul style="list-style-type: none"> • Reading through all transcripts carefully so as to get a sense of what was contained in them. • Picking one transcript randomly. Going through it and asking one-self "what is it about?" Thinking about the underlying meaning of the interview 	<p>Each interview conducted was recorded by audiotape. The researcher listened to the audiotapes to check the sense of the whole, to internalise the content and then transcribed the contents verbatim. The researcher also read and re-read all the verbatim transcripts carefully to get an understanding of the interviews and to familiarise himself with the data. Ideas were jotted down as they emerged. Field notes were used as additional data to support that contained in the transcripts.</p> <p>The researcher picked up the verbatim transcripts randomly and re-read them.</p>
<ul style="list-style-type: none"> • Jotting down thoughts in the margin. • Repeating this process with all the transcripts and making a list of all topics. Clustering similar topics together into columns, which consisted of themes and sub-themes. • Taking this list of topics and going back to the transcripts. Abbreviating the topics as codes next to the appropriate segments of the text and observing the organisation of data to check if new codes emerge. • Finding the most descriptive wording for the topics and turning them into categories. Finding ways of grouping the topics that relate to each other and drawing lines between the themes to show their relationships. • Making a final decision on the specific abbreviation for each category and arranging the codes alphabetically. 	<p>The researcher's ideas and thoughts were written in the margin. This was an initial segmentation of Data and open coding.</p> <p>This process was repeated with all the transcripts, jotting down thoughts and listing the topics and clustering them.</p> <p>Codes were allocated to similar topics. These codes were written next to the appropriate segments of the text. This exercise was repeated with all the transcripts coding all the topics.</p> <p>The most descriptive wording of topics were identified and used as themes. Topics that related to each other were grouped together in order to reduce the list of themes. Identified themes were used to refine probing questions in further interviews and this allowed for the saturation of themes to occur.</p> <p>Appropriate abbreviations for each of the above were finalised. The data in each category were grouped together. The data was also checked to see if re-coding was necessary and the process of analysis was then finalised (Creswell 2009).</p>
<ul style="list-style-type: none"> • Assembling all the data material belonging to each category in one place and performing a preliminary analysis. 	<p>The researcher, together with his supervisors, both who are experienced researchers in qualitative data analysis, analysed data independently from each other, had a discussion and came to an</p>

	agreement on the themes and sub-themes identified.
<ul style="list-style-type: none"> • Discussing the themes and sub-themes 	The themes and sub-themes that emerged during data collection and analysis are discussed in the following section.

In reporting the research findings, some participants' verbatim responses have been included. Literature control was conducted in order to present results of similar studies, to relate the present study to the on-going dialogue in the literature, and to provide framework for comparing results of a study with other studies (Creswell 2003: 46).

As mentioned in previous chapter data was collected based on the Donabedian framework which presents data in three main components namely structure, process and outcome to reflect the whole production process for comprehension (Donabedian 2005: 700).

3.10. TRUSTWORTHINESS

According Lincon and Guba (1985 cited in Polit and Beck 2008: 539), there are four criteria that must be met to develop trustworthiness namely credibility, dependability, confirmability and transferability.

3.10.1. Credibility

This criterion refers to the confidence in the truth of the data and interpretations there of (Brink, Van der Walt and van Rensburg 2012: 172). This includes the enhancing of believability of the findings and taking steps to demonstrate credibility to external readers. For the purposes of this study all interviews were audio taped and field notes taken as back up. Data was interpreted verbatim by the researcher and handed over to the supervisors who checked that data was interpreted correctly.

3.10.2. Dependability

This refers to stability (reliability) of data over time and over various conditions (Brink, Van der Walt and van Rensburg 2012: 172). This criterion seeks to answer the question regarding whether the study would give the same findings again if it were to be repeated. During coding both supervisors served as co-coders so as to ensure that the coded data was dependable. Where opinions about coding emerged such was discussed until consensus was reached. This was done to ensure that the data was as accurate as possible.

3.10.3. Confirmability

Confirmability refers to the potential for congruency of data in terms of accuracy, relevance and meaning (Brink, Van der Walt and van Rensburg 2012: 173). This criterion seeks to establish that the data represent the information that the participants provided and that the interpretations of those findings are not figments of the inquirer's imagination. During the coding the both supervisors serviced as co-coders so as to ensure that the coded data was a true representation of the participants' data.

3.10.4. Transferability

This refers to the ability to transfer the findings to any other group or be applicable in any other setting (Brink, Van der Walt and van Rensburg 2012: 172). Pre-testing of the data collection tool was undertaken to ensure that the research tool was able to yield results that could be trusted and could give results that could be utilised to develop departmental policies either for the institution where study was conducted or other institutions..

3.11. ETHICAL CONSIDERATIONS

The research proposal was submitted to the DUT Ethics Committee for approval. After the proposal was approved by the committee, the researcher sought gate keeper permission from uThungulu Health District (Annexure 2) and the Department of Health (Annexure 4). Thereafter, a support letter was

sought from the Chief Executive Officer (CEO) of the selected hospital (Annexure 6). After permission was granted by the above mentioned gate keepers, the researcher approached participants. The information letter and consent form was given to participants (Annexure 7). To address the ethical issues related to participants, three fundamental ethical principles were respected throughout the research process: respect of persons, beneficence and justice (Brink, Van der Walt and van Rensburg 2012: 34).

3.11.1. Respect of persons

This principle includes the right of self-determination and full disclosure (Polit and Beck 2008: 171). Self-determination says that an individual participant is autonomous; the individual holds right to decide to or not to participate in the study without risking any untoward treatment (Polit and Beck 2008; Burns and Grove 2009; Schmidt and Brown 2009; Brink, Van der Walt and van Rensburg 2012). Full disclosure means that the researcher has fully described the nature of the study, the person's right to refuse participation, the researcher's responsibility and likely risks and benefits. Deception and concealment of information are to be avoided at all costs (Polit and Beck 2008: 172). The participants were all volunteers. Full information was given about the study for example the aims, benefits and risk associated with study. Participants had a right to withdraw anytime they felt it was necessary and no punishment was instituted because of such withdrawal.

3.11.2. Beneficence

The researcher had a duty to minimise harm and discomfort and maximise the benefits. Harm can either be physical, psychological, emotional, spiritual, economic, social or legal (Polit and Beck 2008: 170; Brink, Van der Walt and van Rensburg 2012: 35). The researcher had an obligation to minimise participants' burden and place as few demands as possible on them (Schmidt and Brown 2009: 154). The study had no physical discomforts for the participants and no financial burdens as the study was conducted in the participants free time and in their natural settings.

3.11.3. Justice

This refers to the participant's right of fair selection, fair treatment and privacy (Polit and Beck 2008; Brink, Van der Walt and van Rensburg 2012). Privacy is an individual's right to determine the time, extent and general circumstances under which personal information will be shared with or with-held from others (Burns and Grove 2009: 194). Participants who accepted to participate in the study had the right to expect that information collected from or about them would remain anonymous and confidential (Burns and Grove 2009; Brink, Van der Walt and van Rensburg 2012). All information shared by the participants was treated as confidential. In all transcripts the original name and registration number of participant do not appear. Code names and numbers were used as names for participants. All lists with true identities of participants whether in laptop, audio recorder or written list of participants will be kept privately by the researcher in a safe place.

3.11.4. Consent

Once the study was fully explained to the participant including the rights of the participant, the role of the participant, voluntary participation and the risk and benefit of the study, written consent was obtained from the participant(Annexure 7) (Polit and Beck 2008; Burns and Grove 2009; Brink, Van der Walt and van Rensburg 2012). The understanding of all this information was ensured by eliminating all technical terminology and professional jargon (Burns and Grove 2009; Brink, Van der Walt and van Rensburg 2012). A written consent was obtained in a language that the participant could understand (Annexure 4).

3.11.5. Confidentiality

Confidentiality was maintained through out the study. In transcribed data no where the names of the participants appears. Only codes appears in transcribed data so that there might be no way of linking transcribed data back to the participants. Burns and Grove 2009; Brink, Van der Walt and van Rensburg 2012) Even in audio tapes the participants are not called by their

names all to ensure confidentiality. The consent forms where the names of participants appears were kept by researcher in lockable cupboard

3.12. PRESENTATION OF RESULTS

In a qualitative study, findings are usually presented in terms of the themes that emerged from data. In order to substantiate and illustrate these themes examples of raw data are presented, for instance direct quotes from interview transcription or accounts of observations (Brink, Van der Walt and van Rensburg 2012: 201). Narrative patterns were used to present information.

3.13. DISTRIBUTION OF RESULTS

The data analysis, findings and recommendations will be sent to the public hospital concerned, to participants, to the Department of Health district (UThungulu) and provincial office (KZN) and will be published in medical/nursing related journals.

3.14. CONCLUSION

This chapter described the qualitative design and research methodology used in the study, specifically focusing on the assumed and actual target population and resulting sample. Ethical considerations are described as well as the collection and management of the data. The data analysis process is introduced. Data will be presented in Chapter 4.

CHAPTER 4: PRESENTATION OF THE RESULTS

4.1. INTRODUCTION

The previous chapter outlined the methodology adopted in conducting the study. As described in the previous chapter, a qualitative, exploratory and descriptive research design was used to explore and describe experiences of midwives regarding nursing practice breakdown in maternity units. Semi-structured interviews were used to collect data from consenting midwives. Within the current chapter the findings of the study are presented, analysed and interpreted within the context of the Donabedian framework. The objectives of the study were to:

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

Furthermore, the conceptual dimensions of care identified within Donabedian's framework as structure, process and outcome were referred to during the analysis process. As such, each of the emerging themes was grouped either in terms of whether they related to structure, process or outcome as per the theoretical framework. To allow for the development of new insights, issues that did not fall into each of these articulated dimensions were collated as stand-alone themes and were reported. The presentation of data is according to each of the participant themes and in the end a summative overview of overall observed themes is presented. Despite the differentiation between the different participants, the process for data collection with each midwife was identical and involved the identification of themes supported by relevant quotations.

4.2. DEMOGRAPHIC DATA

After a brief explanation about the study and written consent obtained, a total of 13 participants who were all midwives employed at the selected hospital in maternity units which included labour ward, ANC clinics, NICU and postnatal care wards participated in data collection processes and as indicated above,

took part in a single face-to-face interview. Table 4.1 provides a descriptive overview of key characteristics of the participants including age, area of speciality and work experience.

Table 4.1: Summary of midwives who were participants in the study

Partici pant No.	Age	Nursing speciality	Department	Years of experience in maternity unit service-area
1	32	Midwife	Labour ward	8
2	40	Advanced midwife	Labour ward	16
3	50	Advanced midwife	Labour ward	28
4	33	Midwife	NICU	10
5	35	Midwife	Post natal ward	12
6	52	Advanced midwife	Post natal ward	17
7	53	Advanced midwife	High risk clinic	17
8	53	NICU trained	NICU	17
9	32	Midwife	High risk clinic	8
10	32	Midwife	High risk clinic	9
11	34	Midwife	Post natal ward	8
12	40	NICU trained	NICU	12
13	29	Midwife	Post natal ward	7

Table 4.1 shows that all 13 participants (100%) had experience in or continued working at the selected hospital in maternity units.

4.3. EMERGENT THEMES AND RESEARCH FINDINGS

‘Theme’ is a systemic method of managing data and aids the researcher to gain access to the data that was collected easily. Theme is also a method of breaking down data to smaller pieces and grouping similar content under one sub-heading. Theme is a recurring viewpoint that emerges from an analysis of qualitative data (Polit and Beck 2008: 509).

During data collection and analysis, a number of themes emerged and these themes and sub-themes are discussed with accompanying quotations from the data that was collected during each of the data collection phases.

4.4. THE DISCUSSION OF THEMES AND SUB THEMES

The researcher discusses each theme and key sub-themes elicited from each participant based on the Donabedian framework which focuses on structure, process and outcomes. The discussion is also structured according to the objectives.

4.4.1. Objective number 1: Explore factors leading to practice breakdown.

Relevant themes included:

4.4.1.1. Theme one: Administration

According to the framework this form part of the structure. The nurse administrators were viewed by participants as the main cause of practice breakdown. The main issues that were viewed to be caused by administrators were:

4.4.1.1.1. Subtheme one: Staffing of maternal units

4.4.1.1.2. Subtheme two: Support offered by nursing management

4.4.1.1.3. Subtheme three: Referral system

The midwives complained of severe shortage of midwives yet the hospital is busy hence it serves as a place of referral for three health districts. Shortage of midwives causes midwives that are on duty to overworked thus leading exhaustion and increase the rate of absenteeism which will further contribute to shortage of personnel. Midwives that are on duty are forced by the situation to multitask for example one midwife would be progressing into labour three to five pregnant women simultaneously, this makes it inevitable to prevent practice breakdown. There is even a greater shortage of advanced midwives. Assessments that have to be done by advanced midwives especially to high risk pregnant women are not done timeously at times not done at all because of shortage of advanced midwives. Midwives reported that they have raised the

issue many times with the nursing management but with no positive outcomes. Nurse managers were viewed to be offering little to no support to the midwives. The current referral system causes the influx of patients in the hospital with some patients having not been referred at all.

4.4.1.2. Theme two: Resources

This is part of the structure as well. Unavailability of quality working material causes midwives to be prone to practice breakdown. Sub themes that were identified include:

- 4.4.1.2.1. Subtheme one: Condition and availability of equipment
- 4.4.1.2.2. Subtheme two: Availability and proper allocation of funds
- 4.4.1.2.3. Subtheme three: Availability of working material

Unavailability of essential equipment was highlighted as the other main factor which predisposes midwives to practice breakdown. Some equipment breaks easily because it is of poor quality and because of high numbers of pregnant women it services. The repairing and replacement of equipment is one the problems experienced by midwives, for example if CTG machine breaks, in the hospital no one in maintenance department knows how to fix or service it, then the tender has to be issued for agents to come and service the equipment. All these process takes a long time and at times they don't happen at all because of shortage of funds. The participants reported that this shortage of equipment makes their working as midwives difficult and impossible. The participants were of the view that maternity units were not prioritised when budget was being allocated and they believed that if more budget could be allocated situation might improve. Participants reported that the units were very busy in such a way that some pregnant women would share beds. Some would be in labour only to find that there was no bed in labour ward. Some even delivered on the floor this was part of poor service delivery and it exposed pregnant women to infections that could later lead to deformity of newborn and later litigation

4.4.1.3. Theme three: Knowledge and skills

This is part of the structure as well. Lack of up to date knowledge and skills causes preventing practice breakdown impossible. Sub themes that were identified include:

4.4.1.3.1. Subtheme one: Guidelines and policies

4.4.1.3.2. Subtheme two: Training

4.4.1.3.3. Subtheme three: Scope of practice

The participants reported that hence they are a referral institution they have witnessed a number of cases where guidelines were not followed accordingly by midwives during ANC for example some pregnant women were not taken bloods, done ultra sounds as they should have been or even referred timeously. Such omissions makes it difficult to detect abnormalities early and added chances for midwifery practice breakdown. Upon further inquiry as to what were the reasons of not following guidelines it transpired that it was either because of lack of knowledge of such guidelines, policies or protocols. The need for consistent in service training was identified. Participants were of the opinion that due to difficulties that is encountered by midwives the senior midwives were resigning daily all over. This led to serious problems hence there were no midwives who would supervise the newly qualified midwives because the few senior ones left themselves were either busy or simply unavailable to assist this led to more midwifery practice breakdown cases. The other problem that was raised was the issue of shortage of Doctors and advanced midwives which forces midwives to practice things that are above their scope of practice. This led to some participants stating that they were attending legal proceedings because of these issues. These participants stated that for them this matter of practice breakdown was a serious matter and they wished something could be done fast to resolve this issue before all of them they are either arrested or resign. Practicing above ones scope of practice makes the occurrence of problems a possibility. Midwives have to undergo constant inservice education and be encouraged to go for advanced midwifery qualifications. These will help to relieve pressure in the maternity units.

4.4.2. Objective number 2: Describe the experiences of midwives regarding practice breakdown.

4.4.2.1. Theme one: Service delivery

In the research framework this is the process. In their practice midwives render maternity practice which must meet the expected standards. Failure to meet such standards equals poor service delivery. Subthemes identified included:

- 4.4.2.1.1. Subtheme one: Poor service delivery
- 4.4.2.1.2. Subtheme two: Service below expected standards
- 4.4.2.1.3. Subtheme three: Rise in levels of dissatisfactions and complaints
- 4.4.2.1.4. Subtheme four: Rise in litigation

The first experience of midwives is the service that the midwife would not feel proud about hence she knows that the service she rendered was poor. Although the midwife knows that in that given situation there was nothing she could have done, but knowledge that they were not performing according to the book and knowledge of possible consequences often lead to tension and to loss of interest in working. Services below expected standards did not lead to midwives feeling stressed only but it lead to rise in dissatisfaction and complaints against midwives. It also lead to negative out comes during delivery which will lead to rise in litigation.

4.4.2.2. Theme two: Influence on midwives

In the research framework, this is the outcome. In midwifery practice all the factors that impact midwives in their practice has negative influence. Subtheme identified included:

- 4.4.2.2.1. Subtheme one: Increase in stress levels
- 4.4.2.2.2. Subtheme two: Escalating levels of absenteeism
- 4.4.2.2.3. Subtheme three: Burn out
- 4.4.2.2.4. Subtheme four: Most staff members resigning

Most midwives reported an increase in work related stress. They reported that it was difficult for them to work being short staffed because it was like they are risking their careers and lives of the pregnant women. Practice breakdown was likely to occur because work conditions, however when such breakdown occurred work conditions were not looked as the contributory factors all the managers concentrated in was negligence of the midwife. Participants further reported that it was difficult for them to do what is 100% correct hence one midwife progressed between four and seven patients at the same time daily. This lead to serious problems for the midwives. They felt that they were risking their careers and they could be charged at any time hence breakdowns were the order of the day. Some midwives that pregnant women bled to death postpartum while the midwife that had previously assisted her was busy with other women. Fresh still births have become a norm because of the department being busy and with few midwives. Some midwives have been called to the hearing by SANC because of work related issues. Midwives reported that some of their colleagues have been suspended by SANC and they fear that the same is coming to them hence practice breakdown still occurs and in current situation there was little that could be done to change the outcomes. Some midwives even reported that they have a desire to resign but are bound by their personal economic factors. Most senior midwives are resigning this lead to serious problems hence there are very few midwives who would supervise newly qualified midwives.

4.4.2.3. Theme three: Impact on the pregnant women and the new-born

This also forms part of the outcome in the research framework. The practice breakdown is having a negative impact not only on the midwives practice only but on the life of both the pregnant women and the new-born child. Sub themes identified included:

4.4.2.3.1. Subtheme one: Disability of both pregnant mother and child

4.4.2.3.2. Subtheme two: Maternal or neonatal death

Mismanagement of the pregnant women during labour leads to rise in cases of disability or even death, either of the new-born or the mother or both. This leads to a rise in cases of litigation against the Department of Health. Though some deformity cases of the new-born cannot be avoided hence some develop in utero however most of the deformities happen due to mismanagement in labour. Because midwives are busy progressing many pregnant women who are in labour it makes it difficult to identify the occurrence of complications in other women. The other participant even reported that every time she thinks of the day she was busy progressing the women because of delayed second stage of labour the foetus was born flat. She stated that she does not doubt that the child would have a cerebral palsy. This occurred uThungulu district is one of the districts that is having high numbers when it comes to maternal and neonatal deaths. More has to be done to curb such deaths hence most of them are caused by preventable problems.

For ease of presentation, the themes, subthemes and verbatim statements from participants that emerged from this phase of data collection are summarised in Table 4.2.

Table 4.2: Summary of themes in relation to Donabedian framework

Theme identified	Sub-themes	Relationship to the Donabedian Framework	Exemplar verbatim statements from participants
Administration	<ul style="list-style-type: none"> • Staffing of maternal units • Support offered by nursing management • Referral system 	Structure	<p><i>The unit is understaffed. One midwife is expected to progress and deliver more than three patients at the same time.</i></p> <p><i>Our maternity unit is very busy since it is a referral to three districts and at times we end up looking after 70 patients in post-natal ward while its only three midwives.</i></p> <p><i>There are many more patients than nurses and as a result we get exhausted easily.</i></p> <p><i>The off duties that we currently use add to this problem of exhaustion and further increase rate of absenteeism.</i></p> <p><i>Something must be done to attract more midwives.</i></p> <p><i>The only time that the nursing manager will call us or come to have a meeting with us, is when there are litigations against us or when there is a crisis.</i></p> <p><i>Our concerns are not taken seriously by the management of the institution.</i></p> <p><i>Institutions don't refer patients early they refer only when they are at critical state and they die.</i></p> <p><i>Staffing should be in proportion to the number of patients referred.</i></p> <p><i>Some patients are self-referrals this creates overcrowding.</i></p> <p><i>If you are working in this institution, you are on your own, not even on a single day where you will receive a simple compliment from the management.</i></p>
Resources	<ul style="list-style-type: none"> • Condition and availability of equipment • Availability and proper allocation of funds • Availability of working material 	Structure	<p><i>Most of the equipment that we are using is old and not functioning well.</i></p> <p><i>If you send it for repairs you are told no funds available.</i></p> <p><i>Maternity units are not prioritised in terms of the budgets this is evidenced by the calibre of equipment we are using and availability of midwives.</i></p> <p><i>Equipment that we use break</i></p>

			<p>easily because of the large numbers of patients we see on daily basis</p> <p>Maternity units are one of the busiest units but our store department fail to understand why we order things in large quantities.</p>
Knowledge & skills	<ul style="list-style-type: none"> Guidelines and policies Training Scope of practice 	Structure	<p>Most midwives especially during ANC don't practice within maternal or prevention of mother to child transmission of HIV (PMTCT) guidelines for example patients are not initiated on ARTs or taken bloods as per guidelines, this causes complications during delivery.</p> <p>Newly qualified midwives must have a preceptor who will look after them and assist them where necessary.</p> <p>Shortage of midwives at times causes the newly qualified midwives to be allocated and left alone without anyone to supervise them which even leads to serious hazards</p> <p>Information that is taught during training is not enough, midwives need constant training and updating.</p> <p>In-service training has to be done always even about the guidelines and policies.</p> <p>Doctors when called to attend the patient don't come on time and refuse to take suggestion of the midwife.</p> <p>Because of shortage of doctor, midwives end up being forced to function above their scope of practice in an attempt to save a life, this put the lives of patient, child and midwife career at risk.</p> <p>Lack of knowledge on the side of midwife causes the midwife to be irritable and this has negative impact on service delivery.</p>
Service delivery	<ul style="list-style-type: none"> Poor service delivery Service below expected standard Rise in complaints Rise in 	Process	<p>The service that is rendered by state institutions is very poor.</p> <p>I do not wish that a relative of mine should deliver in government institution.</p> <p>At times what the community is complaining about we see and</p>

	litigation		<p><i>understand it, it's just that it's the situation above our control.</i></p> <p><i>Community complains about the service on daily basis and there is nothing we can do to help them since our advices are not considered.</i></p> <p><i>Since I started working in maternity units I don't know how much litigation have been brought.</i></p> <p><i>I have written a number of incidence reports I have lost count.</i></p> <p><i>Most of midwives working in the department are having final written warnings emanating from negative incidences that were above their control for example two midwives looking after 40 patients that are scattered over six cubicles and one patient absconds.</i></p> <p><i>Most midwives are not happy and they are irritable this has a negative impact on service delivery.</i></p>
Influence on midwives	<ul style="list-style-type: none"> • Increase in stress levels • Escalating levels of absenteeism • Burn out • Most staff members resigning 	Outcome	<p><i>I am one of the nurses who are severely stressed. As is today I am facing disciplinary action by SANC</i></p> <p><i>We are working under stressful and risky conditions a person can be charged at any time.</i></p> <p><i>I have even resorted into absenting myself and being off sick for no reason.</i></p> <p><i>I regret the day accepted an offer of going for advanced midwifery course.</i></p> <p><i>Most of us are burned out and we have no desire to work at all.</i></p> <p><i>I have lost passion for nursing because of what we face.</i></p> <p><i>If I was still young I was going consider change of career.</i></p> <p><i>I am no longer working for the love of it but we are now working so as just to earn a salary.</i></p> <p><i>We are being treated unfairly.</i></p> <p><i>Most midwives are resigning or relocating to other departments and I don't blame them at all.</i></p> <p><i>Most of us have developed negative attitude because of our working conditions.</i></p>

Impact on pregnant women and newborn	<ul style="list-style-type: none"> • Maternal or neonatal death • Disability of both mother and child 	Outcome	<p><i>It is sad really to see both mother and child dying because of wrong decisions taken during delivery.</i></p> <p><i>I have witnessed a 23 year old female patient having uterine rapture and she will never have children again.</i></p> <p><i>Patient was once transferred from one hospital which is about 200km away via ambulance, patient was uterine rapture she was not sutured by referring hospital the wound was just packed.</i></p> <p><i>The patient bled to death on the ambulance.</i></p> <p><i>Things we witness on daily basis are really sad.</i></p> <p><i>At times these disabilities emanate from the fact that patients refused to follow instructions.</i></p> <p><i>Some of the children are born low Apgar's and some are born having brain damage.</i></p> <p><i>The deaths and disabilities we see happening daily are sad reality because some of it are easily preventable.</i></p>
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4.5. SUGGESTION MADE TO IMPROVE SERVICE DELIVERY

At the end of each interview the participants were asked to state possible suggestions for improvement of midwifery practice. Participants then identified issues that they believed they ought to be changed. There was acknowledgement that some practice breakdown might originate from their inabilities as midwives. Notably, there were a number of midwives who specifically indicated that they differentiated between modifiable and non-modifiable factors that have to change for service delivery to improve.

4.5.1. Modifiable factors

Modifiable factors included equipping midwives with more skills. In support of this, some of the participants said:

“...More midwives must be trained and have advanced midwifery” Participant 01.

“...All midwives working in maternity units must have advanced midwifery and nursing managers must stop this trend of selecting people who are their friends to go for the training” Participant 02.

It is imperative that midwives have up to date knowledge and expertise, relevant training including in-service training and refresher courses where necessary should be implemented to improve service delivery. Some participants were of the opinion that having preceptors might help to improve situation hence they would do in-service education. The preceptors were viewed to be the solution in training newly qualified midwives because some midwives complained that they spend lots of their time focusing on newly qualified midwives.

The majority of the participants recommended that there was a need for support from the managers in order to improve the quality of care in maternity units. This is evidenced in the excerpts below:

“...We need support from our managers they must not sell us out. They often beg you to work even if you are alone and being junior but should anything wrong happen you are on your own they deny everything” Participant 02.

“...If you are in work place the supervisor must be like your parent. The supervisor must be the one who will understand what you are going through as a midwife, when you tell him your challenges he must make sure that your concerns are well taken care of and that does not happen we feel all left alone” Participant 11.

Nurse managers should device strategies of showing support to midwives. Midwives should be encouraged and motivated so that they regain confidence.

Some midwives raised the fact that counselling and debriefing sessions were important with a suitably qualified person such as a psychologist to help to relieve stress as seen in the following excerpts:

“...I have now become an alcoholic because of work related stress” Participant 12.

“...I cannot function any more in my personal capacity as a wife and I need counselling” Participant 13.

“...No one in this world can face what we face daily and still be psychologically stable without relevant assistance” Participant 03.

It is important that midwives have a forum where they would table their challenges and be discussed. This might prove to be useful to the midwives psychologically.

4.5.2. Non-modifiable factors

Non-modifiable factors include the hospital structure to include waiting rooms for pregnant women to avoid complications especially if the women stay far away from the hospital. This should not only happen in hospitals only but in even in clinics hence some patients are transferred from the clinic having the complication already happened. The emergency services has to be improved as well. All clinics should have ambulances stationed in them who only deal with pregnant mothers.

4.6. CONCLUSION

The current chapter dealt with management of field data. The data was generated from midwives working in maternal units. During the management of data, quality was retained and managed through an integrative process using Tesch's method of data analysis. The chapter discussed participants' observations and presented a brief description of qualitative data to complement personal accounts. The narratives were subsequently integrated into themes that spoke to the domains identified by Donabedian in his work on human systems.

CHAPTER 5: DISCUSSION OF THE RESULTS

5.1. INTRODUCTION

The intention of this chapter is to discuss the most important findings in relation to the research questions and the theoretical framework discussed in Chapter 2. Literature is used where necessary to further clarify findings that emerged from data analysis.

5.2. RESEARCH OBJECTIVES AND THEORETICAL MODEL

In Chapter 1, research objectives were set that gave direction to the study. The objectives of the study were to:

- Explore factors that influence practice breakdown in maternity units at a public hospital in KZN.
- Describe the experiences of midwives regarding practice breakdown in maternity units at a public hospital in KZN.

Data collection and analysis was guided by Donabedian's theoretical framework.

5.3. SUMMARY OF DATA COLLECTION

A qualitative, exploratory, descriptive and phenomenological research design was used to explore and describe experiences of midwives regarding nursing practice breakdown in maternity wards. Semi-structured interviews were conducted with midwives employed at the selected hospital in maternity units. As mentioned in the previous chapter, a total of 13 interviews were conducted. Interviews were conducted in the participants' work place. Data saturation was reached at the end of the eighth interview but the researcher proceeded to conduct five more interviews to confirm data saturation. All interviews were voice recorded. The researcher transcribed the interview content verbatim, both the transcribed material and original tapes were handed over to

supervisors who examined them and ensured that they coded correctly so as to exclude bias.

5.4. FINDINGS OF THE STUDY

The findings of the study revealed that midwives faced practice breakdown almost daily. Most of the findings of this study were consistent with the findings of other studies that were relevant to this study. Midwives felt that the practice breakdown they experienced happened not because of their fault but because of contributory factors that were often beyond their control. The contributory factors are described below. Findings below are discussed based on the objectives of the study

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 in referral

Midwives who were participants to the study felt that pregnant women were not transferred into the hospital timeously because of a number of reasons which might include the distance an individual had to travel, the non-availability of doctors to refer or non-availability of ambulances to take pregnant women to the next level hospital. These factors delay pregnant women getting help and when the pregnant women arrive at the next institution there is very little the institution can do to prevent maternal or neonatal complications or even death. Participants were of the opinion that such delays put the midwives who received the patient at risk of being blamed, investigated or even charged. They said that chances for the pregnant women to end up in complications were great if the women referral was delayed. This confirmed the findings of the study conducted by Ndlovu(2011: 104) which revealed that delay in seeking ANC, ignoring danger signs and delay in seeking medical care can lead to

deaths that could be avoided. According to the RSA Department of Health (2014: 1), the delay in referring a pregnant women can lead to complications which might result in death of pregnant women or new-born, which could have been avoided by early referral.

b. Poor management during ANC

Midwives felt that most cases that ended in complications during delivery were cases that were poorly managed during ANC. Participants explained that poor management of a pregnant women during ANC was when the midwife failed to nurse the pregnant women according to set protocols and guidelines. During interviews the participants emphasised that if the pregnant women had been managed and referred accordingly during ANC, the chances that the complications might occur during delivery were very slim since the risk factors were identified during pregnancy. One participant even reported that she has seen patients complicating because of raised blood pressure some were pregnancy induced hypertension some were chronic cases that were poorly managed during ANC. The participant told a recent experience of a pregnant women who was brought in by relatives in a van and they gave history that she was having seizures on examination patient was fully dilated and was having eclampsia. What was even more shocking was that the pregnant women attended ANC at the local clinic few days before seizure and had an elevated blood pressure and there was no history of pregnant women ever having blood pressure but the mother was not referred accordingly. Unfortunately the child of that women demised. What was shocking for the midwife was that the blame came to her. She was blamed for not calling the Doctor or advanced midwife since she was a junior midwife. Though the midwife insisted that she did but because it was not recorded it was taken that she did not and was taken to disciplinary hearing. ANC is very important. ANC visits gave midwives a chance and an opportunity to detect abnormality early and to refer pregnant women accordingly (Ndlovu 2011: 104). The findings of this study were consistent with the findings of the study conducted by Gcawu (2012: 49) which revealed that most midwives who attended to pregnant women during ANC did not follow set policies or guidelines during their midwifery practice, which led to poor

management of pregnant women. Examples of neglect of policies or guidelines include not taking blood tests, no urinalysis, no ultrasounds or not initiated on ARTs as per guidelines. Results also concurred with those of Hoque, Hoque and Kader (2008: 66) who found that ANC conducted in KZN were below required levels.

The majority of pregnant women attended ANC but midwives omitted to do the tests that should have been done which included haemoglobin levels and syphilis testing as per guidelines (Hoque, Hoque and Kader 2008: 66). As stated in ANC guidelines by the RSA Department of Health (2007: 20), the general appearance of the pregnant woman during ANC must be assessed as far as it points to good or poor health. A general examination must be done including weight, height, and 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. Where no midwife in the antenatal clinic is trained to perform the heart and lung examination, this may be omitted provided the pregnant woman has no history or symptoms of heart or lung disease. It is common practice to refer pregnant women with dental problems to a dentist or dental therapist. A gynaecological examination should be undertaken, including an inspection of the pregnant uterus, a measurement of the symphysis-fundal height in centimetres and listening to the foetal heartbeat after 26 weeks (RSA Department of Health 2007: 20).

Ndlovu(2011: 113) indicated that if there was inadequate prenatal care, there were increased risks of neonatal death when pregnancies are complicated by anaemia, cardiac diseases, lung diseases, chronic hypertension, diabetes and other conditions all of which can be avoided by following guidelines during ANC. Dlamini (2012: 150) concluded by revealing that the results of study he conducted showed significantly poor midwifery practice rendered during postnatal the period, which included neglecting to take vital signs like temperature, pulse, respiration and blood pressure as well as neglecting to ensure uptake of prophylaxis during labour and such omissions contributed to the increase of maternal and neonatal deaths.

c. Transport related matters

The study revealed that most pregnant women who were transferred to the selected hospital were from other rural hospitals. These pregnant women lived in deep rural areas which were many kilometres away from hospital and transport to and from these areas was a challenge. Because of the distance and cost implications involved when an ANC was to be attended or any problem has arisen some did not come to hospital and some delivered at home and because of this many complications and deaths occurred. Empangeni is surrounded by many rural areas and most people living in these areas are of low socio-economic status especially pregnant women and it becomes difficult for them to have money for transport to go to a health facility (Hoque, Hoque and Kader 2008: 66c).

Some patients report that they called an ambulance but because of either the unavailability of ambulances or the state of the roads it was difficult to reach them quickly. The Saving Mothers Report on Confidential Enquiries into Maternal Deaths suggests that transport problems from home to the health facility resulted in 1.4% of maternal deaths and from institutions to institutions resulted in 8.8% deaths and delay in accessing medical help resulted in 28.8% deaths (RSA Department of Health 2012c: 20).

d. Pregnant women and compliance related matters

Midwives felt that some pregnant women choose not to comply with treatment regimens and advice given by midwives during ANC for various reasons which included culture, religion and finances especially if the pregnant women had to travel for ANC or was referred by a local clinic to the hospital. The study revealed that some pregnant women were advised on dietary changes but did not do it, some were given return dates but did not come back, some tested HIV positive but did not come back for reviews and follow up. All these factors contributed to the negative outcomes experienced during labour. According to Ndlovu (2011: 131), each person should attend at least four ANC visits and pregnant 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 (RSA Department of health 2012c: xii). Almost four out of five pregnant women who died in pregnancy, childbirth or the puerperium were tested for HIV infection. throughout South Africa. Of those tested, 70% were HIV infected. All HIV positive women are to be initiated on ARTs as per guidelines and compliance is very important to ensure prevention of mother-to-child transmission (PMTCT) or unnecessary maternal or neonatal deaths (RSA Department of Health 2012c: 12).

e. Staffing of the units

The study also revealed that there was a shortage of midwives. Participants reported that the shortage is so bad that they do not take lunches and that pattern has become a norm for them. The participants reported that they were overloaded with work. The maternity units of the institution is very busy since the institution specialises in obstetrics and serves as a referral destination for three health districts however the midwives are of the view that it is not staffed as it should be staffed. A number of reasons were raised for personnel shortage, some of which include high stress levels, absenteeism, poor working conditions and slow process of training of midwives. According to the participants the Unfortunate part was that such poor staffing had adverse consequences for the all that is the pregnant women and foetus, the midwife, the institution and Department of Health. Midwives are of the view that if the staffing is sorted care that is provided to pregnant women and newborn would also improve. Staffing includes the staffing of advanced midwives and Doctors as well other nursing categories and support staff so that the midwives would focus on pregnant women only and at least the maximum of two pregnant women at a time.

These findings confirmed the findings of the WHO, which stated that a shortage of midwives has been noted worldwide (WHO 2013: 29). According to the RSA Department of Health, there is 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 (RSA Department of Health 2013b: 31). A study conducted by Quinn (2013: 128) revealed that hospitals with higher pregnant women turnover were not well staffed to accommodate frequent pregnant women transfers. Staffing should be based on pregnant women turnover. Bradshaw (2011: 39) suggested that heavy workloads as a result of shortage of midwives causes midwives to fail to offer high quality midwifery practice. According to ICN (2009: 3), the ratio of 1:5 has to be maintained in the ante/postnatal units. Where such ratio is maintained the environment is safe and midwives are satisfied (ICN 2009: 3).

f. Working material matters

Findings of this study also revealed the midwives find it difficult to perform their duties because of either faulty or non-availability equipment and material. Some participants felt that working material was sufficient and available but most did not agree with that point of view. Some participants reported that it has become a norm that when material or equipment is ordered at the stores department the term 'out of stock' is written on the order form and no one will say when stock will be available and what is to be done in the absence of the stock. Some participants reported that if equipment was broken and it needed 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. If the equipment had to be replaced the study revealed that midwives were told to fill and place the order as a non-stock item which takes up to six months or more it to be available because of the lengthy supply chain procedure. The findings of this study confirm the findings of the study by Gladys (2014: 105), which revealed that equipment that is essential for midwifery practice 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 midwifery practice. Some equipment that was reported to be unavailable at times included basic material such as case books, photocopying machines, CTG machines and CTG paper and urine testing strips.

g. Nursing management support mechanism

The study also revealed that most participants were of the opinion that their supervisors including the RSA Department of Health did not understand and did not care about their needs. The participants of this study reported that they felt that their management was very autocratic hence they did not discuss things which pertain to the service being rendered by the midwives. The issue of the recent change in 'off duties' was raised as an example. The participants reported that the current off duty pattern was very tiring and these were forced to them by management in spite of them rejecting the pattern. The study revealed that there were no general meetings being held between management and midwives unless there was a crisis. Midwives reported that the day the new pattern of off duties commenced the management had to call the South African Police Services (SAPS) the way situation was tense. Urgent meetings had to be called by management to try and do damage control.

Some participants raised the fact that disciplinary processes were not followed properly. For example, if a pregnant women absconds especially in postnatal ward, during your shift one is then called to a disciplinary hearing but the respondent would only be notified few hours before the hearing started and this made it impossible for the participant to have a representative. In the hearings, the participant reported that they were made to sign final written warnings even though they had never even received a single warning before. As result most midwives working in maternal units have final written warnings. The issue of written warnings on its own made situation even worse hence very few were willing to in work in maternal departments.

Some midwives during the interviews stated that the nurse managers and Department of Health often turned a blind eye when it concerned the midwives needs and the only time they came to midwives was when negative incidents has occurred. Most participants were of the opinion that they were not supported as they should have been by the SANC, Department of Health and management of institution they worked in.

These findings confirmed the findings of the study conducted by Nkosi (2014: 66) which revealed that most midwives felt that the managers did not care about their needs. Ngwenya (2009: 201) states that nursing services managers use bullying tactics instead of providing support to nurses/midwives. Dorse (2008: 87) argues that no nurse feels comfortable working where they feel unsupported because this leads to feelings of discomfort at work. A nurse working under those conditions is likely to leave. It is the responsibility of the managers to ensure that the working environment is conducive for the midwives. Gcawu (2012: 47) concurs by stating that if the nurse/midwife is not receiving appropriate support from supervisors that nurse is likely to develop burnout.

The study also revealed that the supervisors were perceived by the participants as having poor management skills. The findings of this study are consistent with the conclusions reached by the RSA Department of Health (2011: 5) which stated that poor nursing care standards could be attributed to poor management skills. If nursing care standards are to improve a collective effort from all managers is needed. According to the RSA Department of Health (2007: 10), poor management was identified as a major weakness of health services in developing countries. Proper financial planning and optimal management of staff and resources were keystones to a fully functional district or provincial health system.

h. 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 adequately, because when a new midwife comes in they have to start from the scratch in training her/him. Midwives were of the opinion that the newly qualified midwives should not be allowed to practice independently hence in midwifery competency is very important and this is acquired through experience. However due to shortage of senior midwives and advanced midwives the junior midwives end up being independent which makes them prone to practice breakdown and legal actions taken against them. Lack of

knowledge made it impossible for a new midwife to note the possibility of complications and the proper way of preventing such. This is consistent with findings of the study conducted by Gcawu (2012: 61) which revealed that midwives felt that during training their curriculum had not exposed them sufficiently to the requisite skills in clinical areas. The newly qualified midwives then lacked confidence in performance since they felt that they were incompetent so were fearful of complications that could lead to litigation. In maternity, it is important to be knowledgeable, highly skilled and competent. This is confirmed by the findings of Fentainah (2012: 220) which revealed that competence is associated with a midwife's knowledge, skills, and attitudes in performing assigned jobs efficiently and safely. Competency is the ability of midwife to present knowledge, demonstrate skills, and display attitudes appropriately for specific activities in specific situations. The absence of midwifery competency, assessment of knowledge, skills, and attitudes may lead to poor decisions, serious malpractice, midwifery practice errors, and negative outcomes during delivery.

The study also revealed that most midwives had not done refresher courses, workshops or even in service education in a long time this made the researcher be of the opinion that they have information that is out-dated. Midwives were of the opinion that there was favouritism when midwives were chosen to go for post basic studies like advanced midwifery. Some participants even stated that when it was their turn to go for studies their applications were turned down and shortage of midwives was cited as the reason for declining the applications and some have lost interest in furthering their studies in midwifery. According to participants many reasons for this were identified for not organising refresher courses for midwives, the main reason being constant complaints of lack of funds from the Department of Health. According to RSA Department of Health (2012c: 4) 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

Objective number 2: Describe the experiences of midwives regarding practice breakdown in maternity units at a public hospital in KZN.

The grand tour question that was used for this section was: describe the experiences of midwives concerning practice breakdown.

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 risky units. Stress they experienced was high to such an extent that most participants are either burnt out or no longer wanted to practice 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 originates in their working conditions. During the interviews, participants reported that absenteeism levels were very high amongst 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 shortage of midwives and leads to an increase in the number of midwifery practice breakdown cases.

Study revealed that some midwives were undergoing disciplinary processes by SANC. These processes were often taking long time to finish up, with some cases dragging up to two years to complete while midwife on the other hand is in a suspense not knowing what the outcome of the hearing would be. Midwives reported that they are emotionally some even financially drained hence once the hearing was on the legal advice was needed. One midwife reported that they she cannot sleep at night and she is attending a clinical psychologist because of work related problem. She said this emanated from the fact that she was progressing four pregnant women to labour the other day. While she was busy delivering the women the other one became fully dilated she delivered with no one to assist unfortunately it was cord around the neck the newborn died and mother bled to death. By the time she finished resuscitating the newborn of the other women who she was busy delivering,

this other women was gasping for air with the child having no signs of life the mother eventually died. The midwife was charged with negligence and is awaiting to be called for hearing by SANC. The institution gave her final written warning. The midwife stated that the picture of that seen is not going away from her mind. She is one of the midwives who were planning to leave midwifery practice.

Midwives intentions to leave the organisation stems from their job dissatisfaction. Job dissatisfaction encompasses feelings and emotions that employees attribute to their poor working conditions (Horwitz and Pundit 2008: 27). Prolonged exposure to stress can result in burnout and poor health amongst personnel. Burnout is described as a psychological syndrome resulting from prolonged workplace interpersonal stressors (Babenka-Mould and Laschinger 2014: 148). Working under stressful conditions can result in practice breakdown (Makhanya 2012). Therefore, it is imperative that health care institutions should focus on improving working conditions by promoting healthy workplace environments.

b. Attitude related matters

According to Louw and Edward (2011: 746 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, they also have developed the "I do not care attitude". Some have stated that they only feel pity for the pregnant women and their newborns who will suffer in all this mess. According to the midwives they cannot help to control their attitudes any more it is more than what they can bear. Elevated stress levels has led to midwives developing negative attitude towards management and unfortunately to pregnant women (Ndaba 2013: 59). Such attitude can lead to serious omissions and negligent behaviour. The negative attitude of a midwife can lead to pregnant women ill-treatment, poor midwifery practice and ultimately the occurrence of complications (Ndaba 2013: 59).

5.5. CONCLUSION

This chapter dealt with reporting of the findings of the study. The study revealed that midwives were not satisfied with their working conditions and such dissatisfactions led to serious practice breakdown. The next chapter will present the recommendations emanated from the study.

CHAPTER SIX: CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

6.1. INTRODUCTION

The intention of this chapter is to discuss the most important findings in relation to the research question and the theoretical framework discussed in Chapter 2. Literature is used where necessary to further clarify findings that emerged from data analysis.

6.2. CONCLUSION

Midwifery practice is a caring profession. All midwives in the profession have been trained to care and to render safe and efficient midwifery practice. It is important to note that if midwifery practice breakdown is to be stopped in maternity units the government/ Department of Health, midwives and pregnant women must all co-operate. Only then will the health care system improve. The working conditions of the midwives must be improved so that they can render the necessary care to pregnant women. The pregnant women on the other hand must take advice given by midwives.

6.3. STUDY LIMITATIONS

Qualitative research design was used in this study. Conducting the study utilising the other research design might yield other results. The study was conducted at a public hospital, which is a Level II hospital situated in a semi urban town of uThungulu District. The study can also be performed in a deep rural area where the hospital is a Level I hospital. The study was conducted in one district which was uThungulu district therefore the findings obtained cannot be generalised to other district hospitals, as they may have different infrastructure, development and geographical features.

6.4. RECOMMENDATIONS

The following recommendations were made based on the findings of the study:

6.4.1. Administrators

At the national and provincial levels the administrators must formulate strategies, guidelines and policies that talk about the wellbeing of midwives. This would assist in attracting and retaining midwives. In all programmes that are formulated midwives must be made a priority. A compensation model for midwives who work especially in rural areas must be developed since the current rural allowance and occupation specific dispensation models seem to be ineffective. An appraisal for midwives who specialised in any of the speciality areas relevant to maternity which might include specialised midwifery and NICU must be considered.

At the district and institutional levels nurse administrators must ensure a working environment that is conducive for midwives to work in. Nurse administrators must offer emotional and physical support for midwives (Dorse 2008, Gcawu 2012). They must consider issues such as midwives' appreciation days where they will sit with midwives and share motivational talks and show empathy to them. By doing this it might aid in making midwives feel important. The administrators must organise a debriefing sessions with midwives, nurse administrators and psychologists. The implementation of a proper support system for midwives will be beneficial to the work environment.

Formulation of support groups to support midwives may alleviate the pressure of the challenges they are faced with. Formulation of a forum for midwives in the institution where midwives sit and discuss issues that pertain to their service might be beneficial to the midwives and the institution. Consistent monthly or trimester meetings between the midwives and nursing management might help the midwives by offering them a platform to air their

grievances. Implementation of the employee assistance programme may be effective in this regard.

Procurement procedures must be improved to ensure that equipment and other working material is available and in good working order. Maternity units should be prioritised during allocation of funds. All equipment must be serviced timeously (Gladys 2014: 105). The midwives must be trained as to how to utilise any new equipment. Maintenance department must do the rounds in all maternity wards to check if all equipment is in good working order.

A properly arranged and written referral method must be established in the health district. All high risk pregnant women must be referred timeously with all investigations done as per guidelines (Hoque, Hoque and Kader 2008: 66c). The RSA Department of Health must see to it that more ambulances are added and ambulance personnel be thoroughly trained as to how to conduct a delivery, how to see a complication and what to do should a complication occur.

6.4.2. Education

Midwifery training period should be extended from one year to 18 months for those who are doing post basic diploma in midwifery and those who specialise in midwifery and from six months to one year for those who are doing the four year course. The researcher believes that the current method of learning midwifery is too congested and limits the time available for practical exposure of the learners (Gcawu 2012: 61). The researcher believes that whilst looking at the midwifery curriculum the intakes to the midwifery courses should be increased. The researcher also is of opinion the Enrolled midwives be revived so as to help reduce pressure on registered midwives. Policies regarding selecting midwives for post basic courses should be amended and midwives must be encouraged to do maternity related post basic courses. The midwives must not wait for a period of four years before midwives are placed at the speciality post. The midwives should continuously be taken for

refresher courses and workshops. The institution has to constantly liaise with uThungulu Health District midwifery specialist regarding in-service education for the midwives so that they are up to date. Constant skills assessment by the district management must be conducted in the institutions under their jurisdiction to ensure quality of knowledge and skills of midwives. Quality assurance practitioners must constantly assess the quality of work done in maternity units.

All midwives must acquaint themselves with new guidelines and policies. It remains the duty of nurse administrators to ensure that the midwives are aware of new policies and guidelines.

6.4.3. Staffing

Flexi-hours and overtime should be relooked at and implemented in such a way that it does not become a burden to the midwives and overtime money should be paid timeously (Dorse 2008: 83). Career development should be considered as another option to attract and maintain more personnel. Off duties should be designed in such a way that they do not exhaust the midwife. All vacant posts must be filled timeously. The midwives must be relieved from all non-nursing duties. Support staff must be employed including ward clerks, store controllers and general orderlies who will make sure that everything that the midwives need from cleaning the ward to stationery to working material is always available. This will assist the midwives by relieving them of unnecessary burdens and allowing them to only focus on the patients. Staffing nursing agencies is the other option that can assist in alleviating shortage of midwives (WHO 2013; Quinn 2013).

6.4.4. Further research

Further studies on the impact of the administrator on midwives duties, influence of the current training midwifery model on current midwifery practice and the influence of midwives' attitude regarding outcomes during labour are recommended.

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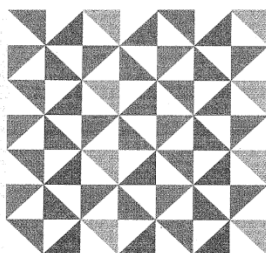
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Annexures

Annexure 1: University ethics clearance certificate



Institutional Research Ethics Committee
Faculty of Health Sciences
Room MS 49, Mansfield School Site
Gate 8, Ritson Campus
Durban University of Technology

P O Box 1334, Durban, South Africa, 4001

Tel: 031 373 2900

Fax: 031 373 2407

Email: lavishad@dut.ac.za

http://www.dut.ac.za/research/institutional_research_ethics

www.dut.ac.za

4 February 2016

IREC Reference Number: **REC 124/15**

Mr N M Mhlongo
P O Box 802
Eshowe
3815

Dear Mr Mhlongo

Experiences of midwives regarding practice breakdown in maternity units at a public hospital in KwaZulu-Natal

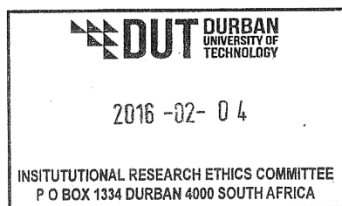
The Institutional Research Ethics Committee acknowledges receipt of your gatekeeper permission letter.

Please note that **FULL APPROVAL** is granted to your research proposal. You may proceed with data collection.

Yours Sincerely,



Professor J K Adam
Chairperson: IREC



Annexure 2a: Permission request letter to uThungulu District Manager

P.O. Box 802

Eshowe

3815

District Manager

UThungulu Health District

Empangeni

3880

Dear Sir

REQUEST FOR PERMISSION TO CONDUCT A STUDY

I am hereby requesting permission to conduct a study on **‘Experiences of midwives regarding practice breakdown in maternity units at a public hospital in KwaZulu-Natal’**.

The study shall be conducted at XXXX Hospital. The researcher aims to explore and describe the lived experiences of midwives regarding practice breakdown in maternity units in a public hospital at KwaZulu-Natal. A qualitative research study that was exploratory, descriptive and contextual in nature was conducted to explore the experiences of midwives regarding practice breakdown in maternity units. Data will be collected in purposively sampled midwives who will participate in semi-structured interviews. Data collection will be conducted during tea and lunch breaks so as not to disrupt the services. A copy of the summary of the proposal is enclosed for your perusal.

Your support and permission to conduct the study in your facility will be appreciated.

Sincerely

.....

Mr NM Mhlongo (Student)

Telephone: 072 759 7352

Email: ndumiso.mhlongo01@gmail.com

.....

Prof MN Sibiya (Supervisor)

Telephone: 031-373 2606

Email: nokuthulas@dut.ac.za

Annexure 2b: Approval letter from uThungulu District Manager



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

Physical Address: No. 2 Corner Lood Avenue & Chrome Crescent, Empangeni, 3880
Physical Address: Private Bag X20034, Empangeni, 3880
Tel: 035 787 0631 Fax: 035 787 0644 Email: sindisiwe.mabaso@kznhealth.gov.za
www.kznhealth.gov.za

DIRECTORATE:
District Manager

INTERNAL MEMO

Date: 05 January 2016
Enquiries: Ms. SCC Mabaso
Ref: 25/1

To: Ndumiso Mhlongo
ndumiso.mhlongo01@gmail.com

Cc: Mrs. CNN Mkhwanazi
CEO LUWM

and
Dr. Elizabeth Lutge
Manager Research Unit KZN DOH

RE: PERMISSION TO CONDUCT RESEARCH ON "EXPERIENCE OF MIDWIVES REGARDING PRACTICE BREAKDOWN IN MATERNITY UNITS AT A PUBLIC HOSPITAL IN KWAZULU NATAL"

1. I have pleasure in informing you that permission has been granted to you by Uthungulu District to conduct research at Lower Umfolozi War Memorial Regional Hospital "Experience Of Midwives Regarding Practice Breakdown In Maternity Units At A Public Hospital In KwaZulu Natal".
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure this office is informed in writing before you commence your research.
4. This office will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to this office.

Thanking you

Yours Sincerely

Ms. Sindisiwe CC Mabaso
District Manager
uThungulu District

Fighting Disease, Fighting Poverty, Giving Hope

Annexure 3a: Permission request letter to Research Director Department of Health

P.O. Box 802
Eshowe
3815

Dr Elizabeth Lutge
Health KwaZulu-Natal Department of Health
Health Research and Knowledge Management Secretariat
330 Langalibalele Street
Natalia Building
Pietermaritzburg
3200

Dear Sir/ Madam

REQUEST FOR PERMISSION TO CONDUCT A STUDY

I am hereby requesting permission to conduct a study on '**Experiences of midwives regarding practice breakdown in maternity units at a public hospital in KwaZulu-Natal**'.

The study shall be conducted at XXXX Hospital. The researcher aims to explore and describe the lived experiences of midwives regarding practice breakdown in maternity units in a public hospital. A qualitative research study that was exploratory, descriptive and contextual in nature was conducted to explore the experiences of midwives regarding practice breakdown in maternity units. Data will be collected on purposively sampled midwives who will participate in semi-structured interviews. Data collection will be conducted during tea and lunch breaks so as not to disrupt the services. A copy of the summary of the proposal is enclosed for your perusal.

Your support and permission to conduct the study in your facility will be appreciated.

Sincerely

.....

Mr NM Mhlongo (Student)

Telephone: 072 759 7352

Email: ndumiso.mhlongo01@gmail.com

.....

Prof MN Sibiya (Supervisor)

Telephone: 031-373 2606

Email: nokuthulas@dut.ac.za

Annexure 3b: Approval letter from the KZN Department of Health Research Director



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

330 Langalibalele street,
Private Bag X905, PMB 3200
Tel: 033 395 2605/3189/3123 Fax: 033 394 5762
Email: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

DIRECTORATE:

Health Research & Knowledge
Management (HKRM)

Reference: HRKM345/15
KZ_2015RP26_91

06 December 2015

Dear Mr N M Mhlongo
(Durban University of Technology)

Subject: Approval of a Research Proposal

1. The research proposal titled 'Experiences of midwives regarding practice breakdown in maternity units at a public hospital in KwaZulu-Natal' was reviewed by the KwaZulu-Natal Department of Health (KZN-DoH).

The proposal is hereby **approved** for research to be undertaken at Lower Umfolozi War Memorial Hospital.

2. You are requested to take note of the following:
 - a. Make the necessary arrangement with the identified facility before commencing with your research project.
 - b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.
3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Ms G Khumalo on 033-395 3189.

Yours Sincerely

Dr E Lutge
Chairperson, Health Research Committee

Date: 08/12/15

Fighting Disease. Fighting Poverty. Giving Hope

Annexure 4a: Permission request letter to the CEO of the hospital

P.O. Box 802
Eshowe
3815

The Chief Executive Officer
XXXX Hospital
Private Bag XXXX
Empangeni
3880

Dear Sir/ Madam

REQUEST FOR PERMISSION TO CONDUCT A STUDY

I am hereby requesting permission to conduct a study on **‘Experiences of midwives regarding practice breakdown in maternity units at a public hospital in KwaZulu-Natal’**.

The study shall be conducted at your health facility. The researcher aims to explore and describe the lived experiences of midwives regarding practice breakdown in maternity units in a public hospital. A qualitative research study that was exploratory, descriptive and contextual in nature was conducted to explore the experiences of midwives regarding practice breakdown in maternity units. Data will be collected on midwives who will be purposively sampled to participate in semi-structured interviews. Data collection will be conducted during tea and lunch breaks so as not to disrupt the services. A copy of the summary of the proposal is enclosed for your perusal.

Your support and permission to conduct the study in your facility will be appreciated.

Sincerely

.....

Mr NM Mhlongo (Student)

Telephone: 072 759 7352

Email: ndumiso.mhlongo01@gmail.com

.....

Prof MN Sibiya (Supervisor)

Telephone: 031-373 2606

Email: nokuthulas@dut.ac.za

Annexure 4b: Approval letter from the CEO of the hospital



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

Lower Umfolozi War Memorial Regional Hospital
29 Union Street, EMPANGENI, 3880
Private Bag X 20005
EMPANGENI 3880
Tel: 035 907 7139 Fax: 086 629 2075

DIRECTORATE:

ETHICS COMMITTEE

14 December 2015

To: Mr. MN Mhlongo
P.O. Box 802
Eshowe
3815
Email: ndumiso.mhlongo01@gmail.com

Dear Mr Mhlongo

PROTOCOL: EXPERIENCE OF MIDWIVES REGARDING PRACTICE BREAKDOWN IN MATERNITY UNITS AT A PUBLIC HOSPITAL KWAZULU - NATAL

The LUDWMH Ethics committee has considered your research proposal at a meeting held on 23 November 2015.

You were granted Provisional institutional approval pending submission of a consent form for the study.

Having received this consent form on 14/12/2015 and two members reviewed it on the day, we are in a position to give consent for your study.

On completion of the study, the results must be made known to our hospital Management.

Yours Sincerely,

Dr Andrew J Grant (Ethics committee Chair)

Dr I Popa (Medical Manager)

CEO (MHS N Ikhwalizi)

Fighting Disease, Fighting Poverty, Giving Hope

Annexure 5a: Letter of Information



Thank you for agreeing to participate in this study.

Title of the Research study: Experiences of midwives regarding practice breakdown in maternity units at a public hospital in KwaZulu-Natal.

Principal investigator/s/researcher: Mr N.M. Mhlongo, B Cur.

Supervisor/s: Prof M.N. Sibiya, D Tech: Nursing and Dr R.M. Miya, PhD.

Brief introduction and purpose of the study: Nursing is known as a caring profession that is founded in strong ethical background. It is the duty of the nurse to care, protect against infection and ensure safety of the patient. In maternity wards we are not concerned about the well-being of the mother only but the well-being of the child she is carrying. In maternity wards there is an increase in complains (some accompanied by litigations) due to substandard or unprofessional or unethical nursing practice. This study is aimed at exploring and describing in-details the experiences of midwives regarding practice breakdown in maternity units.

Outline of the procedure: You are kindly requested to participate in the interview to discuss nursing practice breakdown in maternity units. Interview will take 30-45 minutes. Interviews will be conducted at the time that will suit your schedule.

Risks or discomforts to the participant: There is no expected risk or discomfort during the discussion.

Benefits: Recommendations from this study can be used to improve the care you receive in the ward.

Reasons why the participant may be withdrawn from the study: You can withdraw from the study at any point in time if you wish to do so. There will be no penalty for withdrawing from the study.

Remuneration: You will not receive any money for participating in this study.

Costs of the Study: You will not be expected to pay money to be involved in the study.

Confidentiality: There will be no mention of your name on the questionnaire that will be used for the study. The consent form with your name will be kept separately from the questionnaire by the researcher.

Research-related Injury: The nature of the study does not have the risk of you being injured.

Persons to Contact in the Event of Any Problems or Queries: Should be there any problems or queries please feel free to notify the researcher Mr N.M. Mhlongo at 072 759 7352, my supervisor Prof M.N. Sibiya at 031-373 2606, my co-supervisor Dr R.M. Miya at 033-373 9017 or the Institutional Research Administrator on 031-373 2900. Complaints can be reported to the DVC: TIP, Prof F. Otieno on 031-373 2382 or dvctip@dut.ac.za.

Annexure 5b: Consent



Statement of agreement to participate in the research study:

- I----- (participant full name), hereby confirm that I have been informed by the researcher Mr Ndumiso Mbonisi Mhlongo about the nature, conduct, benefits and risks of this study – Research Ethics Clearance Number-----.
- I have also received, read and understood the above written information (Participant Letter of Information) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerised system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

Full Name of Participant
Thumbprint

Date

Time

Signature/ Right

I, _____ (name of researcher) herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

Full Name of Researcher

Date

Signature

Full Name of Witness (If applicable)

Date

Signature

Full Name of Legal Guardian (If applicable)

Date

Signature

Annexure 6: Interview guide

Date-----

Participant no.

- *Grand tour question number 1:* What are the factors that influence practice breakdown in maternity units?
 - *Probing questions used:*
 - In your experience as a midwife, what are the factors that contribute to practice breakdown?
 - What could be done in future to prevent such occurrence?
 - What impact do these have in your practice as a midwife?

- *Grand tour question number 2:* What are your experiences regarding practice breakdown in maternity units?
 - *Probing questions used:*
 - In your experience as a midwife, have you ever been involved in any act that suggests practice breakdown?
 - What was the practice breakdown that you were involved in?
 - What was the factor(s) leading to practice breakdown?
 - What was your emotional, psychological or physical state after the event had happened?
 - In your views, what can be done to revive the nursing profession?

Annexure 7: Example of an interview transcript

Interviewer: Good morning

Interviewee: morning

Interviewer: I am here to conduct a study about midwifery practice breakdown, the causes of it and emotional bearing of such breakdown. Is there anything you understand about the phrase “Midwifery practice breakdown”?

Interviewee: I am not sure whether I understand it fully. Can you please give me more clarity on the phrase.

Interviewer: ok, midwifery practice breakdown involves midwifery related situations where some aspects of essential midwifery practice expectations are not met. This includes failure of the midwives to care for pregnant women whether during antenatal or labour or postpartum periods, according to set guidelines and protocols as they are expected too.

Interviewee: ok now I fully understand we can begin.

Interviewer: What are the factors that influence practice breakdown?

Interviewee: there are many factors that influence this problem they include late presentation of the pregnant women to the health facility. At times due to the distance people travel to the health facility they cannot report timeously should any problem occurs. At times even the transport including the ambulances are not available. Which makes even matters worse, because the women can come timeously to the health facility but if there is no ambulance to transfer the women to the next institution than a problem occurs. The other factor is non-attendance of ANC by pregnant women and non-compliance with treatment regimen given during ANC. Shortage of midwives makes matters worse because it demands that as a manager you allow a newly qualified midwife to practice on her own with very little supervision, if any. This makes practice breakdown inevitable.

Interviewer: what could be done to prevent this?

Interviewee: this is not the problem of the Department of Health only other departments must be brought in for example Department of Transport, it must be brought in to look into the conditions of the roads. It takes ambulances a long time to reach pregnant women because of the condition of the road. If roads can be sorted out it might reduce transport problems in a way. I think if the Department can introduce the midwifery roving team, that will go in deep rural areas might be of assistance. Obviously this idea challenges employment of more midwives. Other than this idea we need more staff and specialised midwives for that matter so means of motivating midwives to join the units must be put in place.

Interviewer: what impact do these challenges have on the midwives and their practice?

Interviewee: in my own observations the status quo demoralises midwives. Most midwives are demotivated, there is nothing that excites them about coming to work anymore. They come because of financial burdens other than that the passion for midwifery practice is gone. This leads to the very practice breakdown we are talking about. Midwives are absenting themselves and are resigning almost daily it is all because of the way things are in the units.

Interviewer: What are your experiences regarding practice breakdown?

Interviewee: Shortage of staff leading to lots of mistakes for example there many patients in maternity units and few midwives this cause a midwife to fail to assess patients as she should. By the time the midwife gets a chance to assess the patient complication has already occurred. The other problem is the problem of the Doctors. You report the matter to the Dr which according to your assessment will lead to the complications and the Dr will simply ignore what you are saying and delay assisting the pregnant women or transferring the patient to next person who can assist. As a result complications occur. At times you call the Dr in an emergency and the Dr will not come. He/she will come very late when either the

complication has occurred or you have found a way of assisting the patient.

The other challenge is equipment. The other main problem we face is shortage of equipment. If equipment can be made available our nursing care would improve. We spend a lot of time running around looking for working material this leads lots of problems because we waste time that we should be assisting the patient.

The other problem is the patients themselves especially the teenagers who do not co-operate with us as midwives.

Interviewer: Have you ever had cases here in the postnatal ward where complications occurred for example Post-Partum Haemorrhage (PPH) or death? If you have how did you deal with such cases?

Interviewee: It is very rare for such occurrence to occur hence we have protocols and guidelines that tells exactly what is to be done. Usually patients who complicate are those patients who did not attend ANC or were late bookers.

Interviewer: How long have you worked in maternity unit

Interviewee: More than ten years.

Interviewer: you do not wish to change to other unit?

Interviewee: I am flexible.

Interviewer: What impact do all these challenges have on your emotional and psychological well-being?

Interviewee: As we face such shortage of midwives we sleep at night very much exhausted. You end up losing passion for work and just work just because you need money to buy food for the children.

Interviewer: Are you saying, the work we do as nurses is too much?

Interviewee: That is true our work it is too much at times I contemplate on just resigning and go and sell cabbages on the street. This shortage makes it highly likely that hazards take place.

Interviewer: In your own experience and thoughts working in private and in public setting is it the same in terms of the challenges?

Interviewee: I have not worked for private hospital I usually get admitted there but I can tell that it is not the same.

Interviewer: What can the government do correct all this mess?

Interviewee: The government must hire more midwives. Get more equipment so as to be able to save time (that I will spend looking for equipment in an emergency) and the patient's life. Establishment of co-operation among us as health care team. This includes support from our managers and stop becoming so much trouble on us.

Interviewer: Your managers don't support you at all?

Interviewee: Yes they do not. As a midwife, you will be busy in another cubicle and you cannot see what is happening in another cubicle and the patient absconds. Once the patient absconds in your shift you as a midwife you are in serious trouble. One of my colleagues was ordered to literally leave everything she was doing and go out of the hospital on her own to look the patient that had absconded. Just imagine the risk she is putting her life in what if she was injured looking for the patient and using her own transport. Our managers simply do not support and protect us; they act as if you had sent the patient to abscond.

Interviewer: On average how many patients do you have in your ward?

Interviewee: It is about 70 patients.

Interviewer: How many midwives do you usually have per shift?

Interviewee: Before these new off duties were started, we usually had about six midwives but now because of this new type of off duties which fails to maintain balance of midwives at the end of the shift you will end up having only two midwives out of 70 patients.

Interviewer: Thank you for your time like I said earlier I will compile all my findings and submit to DUT and Department of Health and you will receive feedback via your institution.

Interviewee: We can be very happy if things can change so that we can work freely and do what we are supposed to do. In maternal units we deal with two lives the life of the mother and life of the child.

Annexure 8: Certificate from the professional editor

DR RICHARD STEELE

BA, HDE, MTech(Hom)
HOMEOPATH and EDUCATOR
Registration No. A07309 HM
Practice No. 0807524
Freelance academic editor

110 Cato Road
Glenwood, Durban 4001
031-201-6508/082-928-6208
Fax 031-201-4989
Postal: P.O. Box 30043, Mayville 4058
Email: rsteele@telkomsa.net

EDITING CERTIFICATE

Re: Ndumiso Mbonisi Mhlongo

MTech Nursing: **EXPERIENCES OF MIDWIVES REGARDING PRACTICE
BREAKDOWN IN MATERNITY UNITS AT A PUBLIC HOSPITAL IN KWAZULU-
NATAL**

I confirm that I have edited this dissertation and the references for clarity, language and layout. I am a freelance editor specialising in proofreading and editing academic documents. My original tertiary degree which I obtained at UCT was a B.A. with English as a major and I went on to complete an H.D.E. (P.G.) Sec. with English as my teaching subject. I obtained a distinction for my M.Tech. dissertation in the Department of Homeopathy at Technikon Natal in 1999 (now the Durban University of Technology). During my 13 years as a part-time lecturer in the Department of Homoeopathy I supervised numerous Master's degree dissertations.

Dr Richard Steele
18 February 2016
electronic