An exploration of midwives' experiences and practice in relation to their assessment of maternal postnatal genital tract health

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ABSTRACT

Objective: to explore the experiences and practice of midwives in relation to the assessment of maternal postnatal genital tract health.
Design: a constructionist grounded theory methodology was employed to guide the research design and processes. Ethical approval was gained from the regional research ethics committee and the research and development committee at the data collection site. Sampling was purposeful and data were collected using narrative style in depth interviews involving 14 midwives. Observations of 15 postnatal assessments involving five midwives and 15 postnatal women were also undertaken.
Setting: a small maternity unit providing midwifery care to childbearing women in both the hospital and community setting in the North East of England.
Findings: three themes were identified from the data and form the framework of the constructed grounded theory: Methods, Motivators and Modifiers. Within each theme are a number of categories and focused codes. The Methods theme summarises a range of assessment methods used by the midwives, including risk assessment, questioning and clinical observations. The Motivators theme incorporates factors which motivated how, when and why the midwives undertook genital tract assessment and includes verification, personal preferences and sensitive care. The Modifiers theme consists of factors and contexts, which facilitated or inhibited the midwives' ability to negotiate an appropriate approach to assessment including therapeutic relationship, care in context and evolving midwifery knowledge.
Conclusions: the findings of this study suggest midwives are aware of a range of assessment methods; however there was less articulation or demonstration of methods pertaining to assessment of uterine health. The motivating and modifying factors highlight midwife, woman and contextual factors, which may enhance and inhibit the midwives clinical reasoning process. The complexity of contemporary midwifery practice is illuminated as these factors conflict and create practice tensions and contradictions for the midwives. Implications include the need to ensure midwives have the knowledge regarding uterine health and the skills, affective abilities, resources and opportunities to engage women in health assessments within the complexity of contemporary practice.

Introduction and background

Maternal health has improved over the preceding years in correlation with general public health improvements such as sanitation, reduction in overcrowding and poverty, improved diet and interventions such as infection control strategies, antibiotics and the availability of blood transfusion (De Costa, 2002; Marchant, 2006; Bick, 2010). These improvements in health have had a profound impact over the last century upon maternal mortality rates, which have seen significant reductions in developed countries such as the United Kingdom (WHO, 2010; CMACE, 2011). However findings from the triennial report into maternal deaths have highlighted a significant rise in maternal deaths due to genital tract sepsis (CMACE, 2011). Genital tract sepsis is now the major cause of direct maternal deaths in the United Kingdom, with 26 women dying as a result of genital tract sepsis, over the three years of 2006–2008 as compared to nine women in the period 1985–1987. The CMACE (2011) report considers for 12 of the women who died, substandard care contributed, specifically in relation to prompt diagnosis and treatment of infection.

In contrast to the relatively low rates of maternal mortality, postnatal maternal morbidity remains extensive, with poor identification and management a concern (Glazener et al., 1995; MacArthur et al., 2002; Webb et al., 2008). Morbidity associated with the genital tract includes perineal morbidity and complications of bleeding and uterine infection (Marchant et al., 2002; Bick et al., 2009; East et al., 2011). Early identification of postnatal
morbidity via accurate assessment processes may facilitate early intervention, potentially reducing the severity, duration and long-term impact of such health issues (Bick, 2008; Bastos and McCourt, 2010; CMACE, 2011). Therefore the assessment and prompt identification and treatment of postnatal genital tract health remains a maternal health-care priority (NMC, 2010; RCOG, 2012).

The uterus and vaginal loss (lochia) and the vulva, particularly the perineum, are aspects of the genital tract, which midwives frequently assess during postnatal care interactions (NICE, 2006; Baston and Hall, 2009; Marchant, 2009; Stables and Rankin, 2010). Up to the early 1990s midwives were directed by professional and educational guidance to complete set tasks to assess postnatal physical well-being, utilising traditional ‘hands-on’ midwifery assessment skills including palpation of the uterus and visualisation and smell of the women’s perineum and lochia (Marchant et al., 1999; Bick et al., 2009). Concern was expressed regarding the indiscriminate use of such clinical observations regardless of individual need or circumstance and at the effectiveness of routine genital tract assessment methods including uterine palpation, viewing the perineum and maternal temperature measurement (Cluett et al., 1995; Garcia and Marchant, 1996; Takahashi, 1998; Marchant, 2009).

Contemporary professional guidance does not direct midwives to undertake specific observational tasks but instead advocates a holistic approach to the assessment of maternal needs (Marchant, 2006; NICE, 2006; NMC, 2010). This necessitates the midwife deciding when assessing maternal postnatal health, if and what form of assessment and observation methods of the maternal genital tract she will employ. Previous action research in these areas had suggested there was a variation in practice regarding genital tract assessment with student midwives unsure how, when and why to undertake such assessments (Larkin and Sookhoo, 2002). This research addresses these issues and uncertainties, with the overall aim being to explore the experiences and practice of midwives’ in relation to the assessment of maternal postnatal genital tract health.

Research philosophy and methodology

This research is qualitative in nature as it explores not only what midwives do but also the rationale underpinning these actions, highlighting the subtleties and range of midwifery perceptions and meanings, to provide a deeper understanding. The literature review has not identified established theory regarding midwives’ approaches to maternal genital tract assessment, therefore it is more appropriate to focus upon theory construction (Layder, 1993). Strauss and Corbin (1998) suggest the use of grounded theory methodology helps to illuminate and interpret the details of individual perception and develop theory, which fits comfortably with the intentions of this study. As suggested by Bryar and Sinclair (2011) much of the theory development in midwifery intends to identify principal concepts and the relationships between these concepts to evolve a mid range theory.

This research employed constructionist grounded theory methodology, a flexible adaptation of grounded theory processes in which the researcher and participants develop and mutually construct a version of reality (Charmaz, 2003; Bryant and Charmaz, 2007; Corbin and Strauss, 2008). Such constructed meaning is specific and time and context bound, therefore constructionism does not claim to unearth the truth or generalisable theory but develop a mid range theory which is grounded in the data and may have some potential for transferability, rather than generalisation (Crotty, 1998; Charmaz, 2006; Jaccard and Jacoby, 2010; Bryar and Sinclair, 2011).

Recruitment and ethical considerations

Sixteen midwives and 15 postnatal women participated in this study. Recruitment to the study involved midwives and postnatal women from one Northern NHS Trust, which provides postnatal care in both the hospital setting and the client’s home. Recruitment involved the researcher attending team meetings, distributing information posters and leaflets and one to one information giving. Participants included midwives who currently provided postnatal care in either community or hospital setting, primiparous and multiparous women and postnatal assessment interactions occurring in the postnatal ward and the woman’s home.

Ethical permission was obtained for the study from the University ethics committee, regional research ethics committee and local research and development committee. Ethical principles and processes, such as confidentiality, consent, protecting the participants and acting with good faith and integrity, were reflected within all areas of the research including appropriate research intentions, methodology and methods (Department of Health, 2005). The potential research participants were provided with verbal and written information concerning the study including one to one discussion with the principal investigator and inclusion and exclusion criteria were identified (Appendix A). Consent was gained and reaffirmed throughout the research process both verbally and in writing conforming to national guidance (National Research Ethics Service, 2010; National Research Ethics Service, 2011).

Data collection methods

Data collection methods included interviews and observations in order to access not only what midwives did, but why, how and what influenced their approach to maternal genital tract assessment. This use of multiple methods and triangulation of the data aimed to provide greater detail and complexity to the data, adding depth and credibility (Denzin and Lincoln, 2008; Silverman and Marvasti, 2008).

Fourteen midwives were individually interviewed for up to one hour. The interviews were in-depth, semi-structured and narrative focused, using an interview guide where there was scope to probe with further questions (Appendix B). Czarniawska (2004) suggests narratives are used by people as a way of capturing and making sense of their experiences. The researcher encouraged the midwife participants to share narratives of their practice experiences concerning postnatal maternal genital tract assessment. They were asked to initially talk about a recent postnatal assessment they had undertaken. The resulting narratives consisted of a summary of midwives recollections of events. Through the midwives giving preference to certain aspects of their stories, it also provided insights as to how experiences had evolved within particular contexts as ‘cultural stories’ (Silverman, 2006, p. 137).

Observational data involved five midwives who were each observed interacting with a total of 15 different postnatal women. This helped to illuminate any differences in assessment method employed by the midwife depending upon individual maternal need, circumstance or context, which may not be expressed during interview and therefore provided a more holistic and trustworthy interpretation of the data (Bryans and McIntosh, 2000; Loftus and Smith, 2008). Brief field notes were made during
the observations, with details added as soon as practicable after the event.

Data were collected between April and October 2010. Initial sampling was purposeful and self-selected (Appleton and King, 2002; Silverman and Marvasti, 2008). As the research process developed, theoretical sampling was employed to allow the principles of grounded theory methodology to emerge, in which the data determine the direction of the inquiry (Cutcliffe, 2000; Silverman and Marvasti, 2008). Initial participants identified other midwives who had particular perspectives and experiences and most of those approached did subsequently agree to participate, enhancing the diversity of the recruitment and resulting data, for example midwives with specialist caseloads such as young mothers. All interview and observational transcripts were returned to the midwives for comment and ‘respondent validation’ (Silverman, 2006, p. 291).

Data analysis

The data from interviews and observational field notes were sorted, shortened and summarised into codes and then discussed with the researcher’s supervisors. These were initially descriptive and abundant but through further coding, categorising and data collection they became fewer and increasingly conceptual until groups of concepts described as categories were developed.

Within this study there was simultaneous collection and analysis of data to facilitate a constant comparison of data, which enhanced the refining, and verification of the concepts generated (Charmaz, 2003). As issues emerged from the data, they were incorporated into future data collection, in the form of new questions or observations within the data collection guides, and via theoretical sampling seeking those participants who may provide these insights (Glaser and Strauss, 1967; Charmaz, 2006). This enabled the researcher to confirm or disconfirm aspects of the emerging theory and provided conceptual detail (Silverman and Marvasti, 2008).

Possible relationships between the categories were identified, moving the data from analytical to theoretical. All of these processes were undertaken simultaneously using the constant comparative method, comparing codes, incidents and categories to themselves and other sources of data leading to theory generation, a theory of midwifery assessment of maternal postnatal genital tract health (Glaser and Strauss, 1967; Charmaz, 2006; Bryant and Charmaz, 2007). This paper presents some of the research findings and in keeping with constructionist grounded theory methodology, findings will be presented and simultaneously discussed and compared with contemporary literature and research (Charmaz, 2006; Kelle, 2007).

Research findings and discussion

In this grounded theory study the relationships between the categories are expressed as three themes: Methods, Motivators and Modifiers. The Methods theme represents the potential range and use of maternal genital tract assessment methods midwives may action. However the Methods of assessment are influenced by the other two themes. The Motivators theme reflects categories from the research data, which indicated how midwives’ actions, and assessment methods, were prompted by their particular beliefs, knowledge and experiences. The final theme, Modifiers, consists of factors and contexts that facilitated or inhibited the midwives’ ability to negotiate an appropriate approach to genital tract assessment and impacted upon both the motivators and methods categories. However, the concepts within the constructed theory are dynamic. They interact, relate and simultaneously apply to the midwives’ reasoning as they undertake postnatal genital tract assessment.

For each midwife, woman and context there are different connections, resulting in differing midwifery practice responses and actions. Therefore the themes and categories should not be seen as linear or reductionist but as an integrated system in which the categories simultaneously connect and impact upon the midwives practice experiences and practice actions. The diagrammatic representation of the data (Fig. 1) reflects this layering and integration of methods, motivators and modifiers to highlight how these processes or systems interrelate and interact with each other (Jaccard and Jacoby, 2010).

Methods

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<th>Theme</th>
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<th>Focused codes</th>
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<td>METHODS of genital tract</td>
<td>Risk assessment</td>
<td>• Childbirth events</td>
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<tr>
<td>assessment</td>
<td>Questioning</td>
<td>• General symptoms</td>
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<td></td>
<td>Clinical observation</td>
<td>• Self-assessment</td>
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The midwives in this study recognised the need to assess maternal genital tract health postnatally and employed a range of assessment methods including, risk assessment, questioning and clinical observations. These methods are similar to those advocated within the professional literature and national guidance and confirm the midwives application of procedural knowledge during their assessment of maternal genital tract health. For example identifying childbirth events as potential risk of perineal morbidity, questioning women about the amount, colour and smell of their lochia, undertaking clinical observations selectively and integrating findings from uterine palpation with observations of the woman’s lochia (Marchant et al., 1999; Alexander, 2001; Marchant et al., 2006; NICE, 2006; Williams et al., 2007; CMACE, 2011):

What colour it [lochia] is, does it have an offensive smell, is it particularly heavy, how many pads do they use, are they changing their pads regularly... any clots? Midwife E

However differences were also identified, between the responses and practice of the midwives and contemporary evidence and guidance. The midwives tended to identify and associate risk factors and questioning with the health of the woman’s perineum. They were less likely to make explicit reference to risk factors or employ questions that pertained to uterine morbidity such as postpartum haemorrhage or genital tract sepsis. Only one-third of the participating midwives made an explicit reference to questioning the woman regarding uterine or abdominal pain, in comparison with all midwives identifying perineal pain, and none identified asking about diarrhoea. Uterine pain, particularly tenderness and diarrhoea, may be indicative of uterine morbidity such as genital tract sepsis (NICE, 2006; Bick et al., 2009; CMACE, 2011). Midwives tended not to ask whether women worked with or had young children with recent sore throats, which would be symptomatic of Group A streptococcal infection (CMACE, 2011). In addition none of the midwives identified noting the woman’s respiratory rate as a clinical
observation method for genital tract sepsis. As highlighted by CMACE (2011, p. 92) ‘tachypnoea (respiratory rate higher than 20 breaths per minute) is sepsis until proven otherwise.’

Motivators

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<th>Theme</th>
<th>Categories</th>
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| MOTIVATORS of genital tract assessment | Verification | • Sufficient information  
| | | • Accurate information |
| | Personal preference | • Maternal preference  
| | | • Midwife preference |
| | Sensitive care | • Recognising individual needs  
| | | • Providing appropriate care  
| | | • Care with dignity |

On my first visit, I would always palpate the uterus… so I can assess where the uterus is at that stage, and if then they would say to me in subsequent visits, if the lochia was normal, if they have no pain or problem passing urine, then I wouldn't necessarily touch the woman again, it would all be done verbally but I always think you need a starting point for me. Midwife N

Following the initial baseline assessment the midwives employed a sliding scale technique commencing with the least intrusive method of maternal genital tract assessment, such as identifying risk factors, and proceeding along the scale until they had sufficient information:

Sometimes you can come out of a visit and then think I didn't actually put my hands on that woman. But you've got the information you need from the woman herself. Midwife A

However at any time along the sliding scale the midwives suggested they might reach a pivotal point, a concern, necessitating her to ‘jump’ along the sliding scale, usually to request clinical observation:

Depending on her answers obviously, that would lead me on to further investigation really. Midwife M

Such a midwifery response reflects national guidance (NICE, 2006; Bick et al., 2009). However these findings contrast to those by Bick et al. (2011) in which over three-quarters of the midwives reported that at most postnatal contacts they undertook routine clinical observations.

The midwives also attempted to verify if the information about maternal genital tract health was accurate, as most genital tract assessment involved maternal self-assessment. All of the midwives considered most women could provide them with accurate...
information on which to base their decisions regarding maternal genital tract well-being:

A lot of the older ladies who have deliberately waited till they’re older to have a family, do lots and lots of reading. Midwife D

However the midwives suggested that not all women had an accurate understanding of genital tract anatomy and physiology or knew what to expect in relation to their genital tract, following childbirth and the physiological changes during the postnatal period:

You tend to assume that women will now be much more informed than they’ve ever been. And the majority of women are but you will still get women who will not have any knowledge of how their own body functions and how you can expect to be after you’ve had the baby. Midwife A

The midwives suggested some women were unsure if their self-assessment findings were accurate and within normal physiological parameters and would request the midwife to clinically observe particularly their perineum to provide reassurance:

“Oh, it doesn’t feel right, will you have a look?” I’ll say. “Yeah, no problem, I’ll have a look at it” and you can say. “Really, there’s not much to see. It looks great, it’s nice and clean, you’re doing everything right.” Midwife I

Self-reporting of morbidity is recognised in the literature as problematic, as some women may not know what constitutes ‘normal’ physiological parameters following childbirth, lack the confidence or motivation if they feel unwell to articulate their concerns or feel their concerns are trivialised by midwives (Marchant et al., 1999; Cattrell et al., 2005; Dugdale and Hill, 2005; Williams et al., 2007; Bhavnani and Newburn, 2010; Beake et al., 2010). Midwifery skills involve being both responsive and led by the woman but also when the need arises to ‘seize the woman’ being more directive (Downe et al., 2007, p. 134).

Sensitive care

The midwives also suggested the need for reassurance was finely balanced with ensuring the woman’s dignity needs were sensitively met. All of the midwives in this study expressed concern regarding women ‘losing dignity’ during childbirth. Most of the midwives suggested events during labour such as repeated vaginal examinations and exposing the genitalia during the birth process contributed significantly to this maternal loss of dignity:

All the doctors being there and having loads of VEs and I just think when you get them postnatal that that’s enough, you know… I think the last thing you want to be doing is lying legs akimbo and somebody doing that again… I think it’s awful, especially postnatally when you’re trying to get a little bit of dignity back. Midwife I

Losing dignity appears to occur prior to the postnatal period. However the repercussions of this lost dignity, surfaced and impacted upon postnatal care, particularly the approach to maternal genital tract assessment.

The midwives differentiated areas of the woman’s body into public and private areas, suggesting women were more amenable to clinical observations of public areas. The findings of this research suggest this notion of public and private areas affected not only the women (as reported by the midwife participants) but also the midwives, as they were more likely to use clinical observations of a wound located in a woman’s abdomen then they were concerning a perineal wound. Twigg et al. (2011) also suggest health-care professionals attempt to distance and sanitise their actions in relation to the body to protect the dignity not only of the clients but also for themselves.

Two midwives provided narratives of using genital tract assessment as a subterfuge strategy, as a means to conceal other concerns from a woman’s partner and enable access to the woman without her partner present:

I just felt she’d been very controlled so I used that [genital tract observation] to get her away from him and into the bedroom so we could have a chat about, you know, had he been domineering, had he pressured her? Midwife G

Midwives are expected to play a pivotal role in the identification of domestic violence and provide appropriate information and referral to agencies (CMACE, 2011; DH, 2011). The midwife may wish to have access to the woman without her partner where there was a suspicion that the woman may be a victim of domestic violence. In this study some midwives utilised genital tract assessment to provide this opportunity.

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<th>Theme</th>
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<tr>
<td>MODIFIERS of genital tract assessment</td>
<td>A therapeutic relationship</td>
<td>• Rapport</td>
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<td>• Meaning making</td>
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<td>Care in context</td>
<td>Evolving midwifery practice</td>
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<td>• Competing priorities</td>
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<td>• Personal theory</td>
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A therapeutic relationship

The midwives in this study suggested a therapeutic relationship consisted of developing a rapport with the woman and helping her to construct meaning from her experiences. Rapport was felt by most of the midwives to consist of interpersonal skills, which helped to form a connection, a sense of reciprocity and trust, which promoted effective woman and midwife communication. The relationship features and qualities raised in this study, such as effective communication, trust and reciprocity are also identified as important for effective midwifery care in a number of other midwifery research studies (Hunter, 2006; Deery, 2009; Edwards, 2009; McCourt and Stevens, 2009; Beake et al., 2010; Frei and Mander, 2010). The findings of this study suggest reciprocity and trust are important during postnatal interactions due to the intimate nature of postnatal genital tract assessment. A therapeutic relationship helped to facilitate maternal disclosure and acceptance of midwifery care and advice and enhanced the midwives receptiveness to maternal needs and preferences:

If you build up that rapport, you know you have trust. People will tell you things. Midwife B

To develop a rapport with women the midwives specified that the sequencing and structuring of the interaction was important and should be a ‘chat’ or a ‘conversation.’ This acted as a bridge between general conversations used in most social interactions and more focused questioning which may be more intimate, probing and associated with interactions with a health-care professional;

Your having a bit chat about what they’ve been doing and have they been alright… tends to build up a bit of a rapport. Midwife A
This conversational approach involved using open questions and following the woman’s lead. However, if closed questions were noted to predominate early in the interaction the development of a conversational approach and subsequent rapport appeared less likely. This was noted during observational data collection in which a midwife commenced the interaction with a closed, probing question. ‘So you had a normal delivery and no stitches, have you got any grazes?’ This elicited a monosyllabic response, ‘yes’. As the interaction continued it became increasingly midwife led. The closed question led to a closed response and quickly the midwife and woman became locked in a question and answer cycle, which the midwife found difficult to break.

The need to balance between engagement and detachment, avoiding formulaic interactions that exclude personal elements if care is to be sensitive and responsive to individual need, has been raised within several studies (Deery and Hunter, 2010; Edwards, 2010). This study highlights how these ‘soft’ processes become significant for safe and effective health assessments (Kirkham, 2010).

Accessible language

The midwives also identified negotiating with women words they could both comfortably use to identify aspects of genital tract anatomy and physiology:

Again, you have to pitch it to whoever you’re dealing with because some of the girls, you know, you say, ‘How’s your perineum?’ and they know exactly what you’re talking about. But a lot of girls will say, ‘My what? What do you mean? What’s one of them?’ Even though it’s probably been referred to before during their pregnancy or in delivery. So sometimes, you just have to say, ‘Well, your bottom. How does your bottom feel, when you sit down or when you have a wee?’ Midwife G

The midwives suggested some women were not aware of the anatomical names for their genital tract, therefore to aid understanding they frequently used lay terms.

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<th>Uterus</th>
<th>Perineum</th>
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<td>Stitches</td>
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<tr>
<td>Womb</td>
<td>Down below</td>
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<tr>
<td></td>
<td>Delicate/lady/girl/bits</td>
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<td></td>
<td>Bottom</td>
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<td>Downstairs</td>
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Some of the midwives articulated the use of words such as ‘littles’, ‘quick’ and ‘peek’. These words appeared to be used by the midwife to coax women into agreeing to examinations and also to demonstrate some sensitivity that the women may have contradictory feelings regarding examinations of the genital tract. By using minimising words the midwives appear to be attempting to express they would attempt to minimise the procedure:

I would cajole them…. I would say, “Oh, come on, it’s really important. Honestly, it’ll be dead quick. Just let us have a little look.” Midwife K

Meaning making

The majority of the midwives also discussed meaning making by storytelling as a means of enabling the postnatal women to make sense of and come to terms with childbirth events associated with their genital tract health. This included women telling stories of their experiences and on occasions the midwives used narratives to help the women to develop realistic expectations of what to expect and what the future may hold in relation to their genital tract and postnatal recovery and health in an attempt to bridge the gap between ideals associated with childbirth and the reality of the postnatal period:

‘Is it only me who looks like this? Is everybody else walking round and everything is absolutely fine?’ So it’s trying to say to them, ‘this [the woman’s perineum] is probably normal. This looks normal considering you’ve had a baby.’ Midwife F

The midwives recognised women had concerns regarding their genital tract function and appearance. Olsson et al. (2005) identified that women wanted professional guidance regarding sexual life following childbirth and reassurance that their body was ‘normal’. However only one midwife in this study suggested she explicitly used this opportunity to discuss sexual functioning and health.

Care in context

Several of the community midwives discussed difficulties in ensuring the home environment was conducive to effective mother and midwife interaction with noise levels frequently cited as a problem.

You can’t hear yourself speak for the telly or the Playstation. You know, their partner’s sat killing somebody on the Playstation. Midwife N

During interview data collection none of the hospital postnatal ward based midwives identified ambient noise levels as an issue. However during observational data collection I noted in over half of the observations that the environment was very noisy, busy and distracting. High levels of noise and simultaneous activity can be distracting for both woman and midwife, making interaction difficult and potentially affecting the woman’s ability to comprehend and assimilate the high level of new information being provided at the time of postnatal assessments.

The majority of the midwives also cited privacy as a location concern. Other people in the location was the most common concern for midwives. The midwives suggested both they and the women might be uncomfortable discussing personal issues such as genital tract trauma and exposing their bodies for clinical observations when visitors are on the other side of curtains:

I wouldn’t even contemplate doing a postnatal check during visiting time because it’s just not very nice when you could have three or four people round each bed and you’re behind a curtain. Midwife L

For some community based midwives access to a private location may also be modified by the woman’s home circumstances, particularly overcrowding. This appeared to be particularly the case for younger mothers who may live in the family home. In one account the midwife considered overcrowding was instrumental in a woman declining genital tract clinical observations and therefore preventing appropriate and timely intervention to prevent wound breakdown:

She’s actually sharing a bedroom with her two younger sisters and the baby, so there’s nowhere to go. There’s nowhere to go to examine her. There was no privacy, ... and that was why she didn’t want to be examined and didn’t want anybody going into the bedroom. Midwife G

A range of contemporary literature reflecting the views of women and midwives also highlights the negative impact of high
noise levels, particularly within the hospital postnatal ward (McLachlan et al., 2008; Bhavnani and Newburn, 2010), Beake et al. (2010, p. 7) discuss how many women feel ‘on view’ during their time on the postnatal ward, with limited privacy and the women reported valuing visitor free rest periods. Other studies highlight the tension between women wanting flexibility regarding visiting arrangement for their own visitors and wishing to restrict the visitors of other women, as this reduced rest, privacy and opportunities to receive midwifery information and support (Wray, 2006; McLachlan et al., 2008).

**Competing priorities**

Competing priorities involving simultaneous demands for the woman or midwife were also identified as context factors which could modify postnatal genital tract assessment and create conflicts and tensions for the midwife. These included the diversity and volume of midwives practice activities, which were exacerbated by too little time and too few staff. For the staff on the postnatal ward this also involved covering delivery suite staff shortages. Several of the midwives suggested this limited time reflected an increased midwifery workload with greater diversity of activity and administrative duties:

Well, I haven’t got time for that now [social chat with mothers] because there’s so much pressure on your time because we do so many more things now than we used to do years ago. Midwife E

Staff shortages and lack of staff time is a dominant theme in much of the research concerning postnatal care, with an Australian survey suggesting 57% of women received no more than 10 minutes uninterrupted time with the midwife (Forster et al., 2006; Rudman and Waldenstrom, 2007; McLachlan et al., 2008; Dykes, 2009; Schmied et al., 2009; Ellberg et al., 2010). It is exacerbated by a high bed occupancy rate, diverse and extended tasks and roles, administration tasks and staff relocation to the delivery suite (Wray, 2006; Lavender, 2007; Frei and Mander, 2010).

The midwives in this study suggested insufficient time led to activities being undertaken quickly, trying to ‘contain’ the content and focus of their activity and keep to time, which impacted upon their ability to establish a rapport with the woman. Similar findings are identified by Olsson et al. (2011), in which midwives distance themselves from the postnatal women, using a more task orientated approach. In turn women recognise that staff are busy and are reluctant to ask for help (Dykes, 2009; Beake et al., 2010).

Despite a reduction of contact with women postnatally, the midwives identified how the content and remit of postnatal care had increased. It still included traditional aspects such as maternal genital tract assessment, but also included emphasis upon emotional and social issues and health promotion, particularly neonatal advice and screening.

At times the women in this study appeared to be exposed to information overload. This allowed midwives to tick the midwifery documentation that information had been given; however I, as did several of the midwives, wondered if the information was comprehended or assimilated by the women, a finding similar to that made by Stapleton et al. (2002) when evaluating midwives providing antenatal information. Fenwick et al. (2010, p. 19) suggest lack of time results in a standardised approach to information giving not sensitive to individual women’s needs and frequently leaving the postnatal women to ‘sift through and discern for herself what is most appropriate’. On occasions this was evident in this study, with postnatal women left with a bundle of leaflets and booklets.

**Conclusion**

There are limitations to this study that must be acknowledged. The constructionist research paradigm from which this study originates recognises that representation is inherently time and context bound. Temporal and situational influences are reflected in the midwives’ actions, the data collection methods and my own interpretation and presentation of the findings. For example the participant sample involves only one practice location and was self-selecting. The data collection methods such as interview may be influenced by characteristics of the interviewer and interviewee. The way in which I have conceptualised, analysed and presented the data must also be understood within these contexts. Generalisation of the research findings may therefore be limited. However as I have ensured the research processes are explicit and have been attentive to maintaining quality principles such as trustworthiness, through a reflexive approach, there may be transferable aspects (Graneheim and Lundman, 2004).

The findings of this study suggest midwives are aware of a range of maternal genital tract assessment methods but they appear less sensitive to factors pertaining to uterine health and genital tract sepsis. The rationale for this decreased sensitivity to uterine morbidity is not clear from this study; however it must be acknowledged the research data were collected just prior to the publication of the most recent CMACE (2011) report which highlighted the rise of genital tract sepsis. Several reports and practice evaluations recommend a return to ‘back to basics’ regarding identifying and responding to puerperal sepsis (CMACE, 2011; Dawson and Robson, 2012; RCOG, 2012). The findings from this study add support to such recommendations and have implications for midwifery education.

The assessment approach adopted by the midwives was motivated by a desire to verify the information they had was sufficient and accurate but also reflected personal preferences and was sensitive to individual needs. At times this created practice tensions for the midwives as they simultaneously needed to facilitate disclosure and intimate assessments whilst being sensitive to the perceived dignity needs and recognising women may have varying insights of their genital tract health. This process occurred in a practice context in which a range of factors including lack of time, staff and competing priorities modified the midwives actions. Such factors could inhibit the midwives ability to communicate effectively with the woman and impact upon the validity and range of assessment methods available to the woman and midwife. These practice tensions and contradictions must be acknowledged within the professional literature and midwifery education to provide midwives and student midwives the opportunity to consider and rehearse for the reality of contemporary midwifery practice.

This study has highlighted potential areas for future research including:

1. To explore postnatal women’s thoughts and preferences regarding self-assessing their genital tract and their involvement in determining the assessment approach.
2. To explore the concept of public and private areas of a woman’s body and the impact this has for women and midwives in determining postnatal genital tract assessment approaches.
3. To explore women’s thoughts and preferences regarding information they require about their postnatal genital tract health and providing postnatal information in a timely and effective manner.

The grounded theory of midwifery assessment of maternal postnatal genital tract assessment constructed from this research provides insights into the experiences and practice of midwives. The theory details the individual attributes, which contribute to
genital tract assessment, providing illumination of how and why midwives decide upon their assessment approach. In addition the theory acknowledges the dynamic and unique nature of such care interactions and the resulting multiplicity of potential assessment responses and actions.

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Appendix A

Midwife participants

The inclusion criteria for midwife participants included:

- Midwives who currently provided postnatal care in either community or hospital setting.
- Midwives who had entered midwifery via either three year or shortened (post nursing) entry routes and had a range of practice experiences, including the length of practice experience and location of practice.

Exclusion criteria included:

- Any practitioner undertaking a period of supervised practice, or phased return to work following a period of sickness/absence, in which any additional pressure of interview or observation may be deemed inappropriate.

The inclusion requirements relating to the postnatal women

The inclusion requirements relating to the postnatal women whose midwifery care was observed included:

- Both first time mothers and mothers with previous births.
- Postnatal assessment interaction occurring in the postnatal ward and woman’s home.

The exclusion requirements included:

- Any complications of the intrapartum or postnatal period which would make such observations insensitive or inappropriate, such as stillbirth, neonatal morbidity or neonatal death.
- As part of the focus of the observation is to observe how the midwife interacts with the client, it would be unhelpful to data collection to observe an interaction in which an interpreter was required.

Appendix B. Interview guide

Introduction

- Self
- Intentions of interview (establish no right or wrong answers)
- Time
- Clarification of terms (genital tract)

- Ethical issues—reiterate and ensure consent, confidentiality and data issues, including need to ensure client confidentiality in narrative telling.

Beginning the interview

- Personal facts—age, gender
- Professional biography—years in practice, range of locations and experiences, entry route (direct or post nursing)
- Present practice—since when, location and range of activity.

Provoke narrative (story) telling

- From your practice experiences during the last three months can you tell me about a typical practice interaction involving an assessment of maternal genital tract well-being?
- From your practice experiences during the last three months can you tell me about an unusual practice interaction involving an assessment of maternal genital tract well-being?
- Facilitation/probing
- (as/if required by interviewer), including non-verbal and verbal.

Verbal probes, if appropriate to include ‘can they provide an example from their practice that provides an illustration’ to maintain the development of narratives.

- General probes (content mapping—sensitising concepts)—headings

To open up a range of issues, develop breadth.

- What they did/happened next

Location
Contextual factors
Key characters
Motives
Actions
Consequences
Specific probes (content mining)—subheadings
To elaborate and explore detail and develop depth, move from description to action orientation, evaluative/attitudinal.

Procedural reasoning

- What potential means of observing and assessing genital tract well-being
  - Use of maternal questioning
  - Use of visual cues
  - Use of clinical observations

- How do they identify the most pertinent/need identification potential cues such as:
  - Visual cues (e.g. pain)
  - Risk factors relating to client known health status/obstetric history
  - Questioning
  - Response cues—colour, amount, smell of lochia, pain, malaise.

- Why do they observe for these cues (hypotheses generation, cue interpretation and knowledge sources)?
- What influences their choice of information sources/observation method?
• What practice action would a particular cue necessitate (hypotheses evaluation)?
• Impact of experience on future practice actions.

Interactive reasoning

• What potential means of facilitating/interacting do they use to uncover women individual needs?
• How/do they attempt to integrate women’s individual needs into the reasoning process?
• Why do they attempt to integrate women’s individual needs?
• What practice knowledge informs this?
• How does it reflect their values and beliefs about practice and have these changed and if so why?

Conditional reasoning

• What conditions facilitate or minimise their practice response when assessing maternal genital tract well-being?
• What problems do they encounter and what are the sources of these problems?
• What contextual factors influence their practice reasoning and actions?
  - Location of practice
  - Organisational/resource concerns
  - Practice traditions/values
• How does it influence their present and future practice reasoning and actions?

Narrative reasoning

• Do they use practice examples and stories with women about their postnatal genital tract well-being?
• How do they do this—can they provide examples?
• Why do they/do they not use stories with women?

Specific probes (content mining)

• What make them say that?
• Why did they think that?
• How did they feel?
• What effect did that have on them?
• Did they consider other practice actions?
• What conditions facilitate or minimise their response?
• What effect did that have on their practice actions?

Ending the interview

• Summarising discussion
• Any concluding remarks midwives would like to contribute
• Is there anything else they think I should know to understand their reasoning processes better?
• Thoughts for the future
• Verification
• Is there anything they would like to ask me?
• Potential follow up interview/observation
• Reassurance regarding confidentially/ongoing consent
• Thanks

References


