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Bartholomew, Marcia (2018) Newborn and infant physical examination: motivating midwives after “training”. The Practising Midwife. ISSN 1461-3123

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Newborn and Infant Physical Examination: motivating midwives after 'training'

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1 May 2018



Newborn and Infant Physical Examination; motivating midwives after 'training'

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Increasingly, the call to incorporate the screening activities of Newborn and Infant Physical Examination (NIPE) as part of the professional remit and the public health role of the midwife has been heeded, illustrated by an increase in the inclusion of the training in both pre-registration and post-registration courses. However, the underutilisation of the skills attained upon completion of training remains evident. Issues that impact on perceptions of empowerment and autonomy in the role may be contributors to the problem. Clear professional boundaries with a focus on low-risk newborns; an increase in the value placed on the extended role, by both midwives and paediatricians; investment in resources that support continuous professional development – could all be an answer to the problem.



Introduction

The NHS Newborn and Infant Physical Examination (NIPE) programme is a screening activity usually completed within 72 hours of birth. The detailed examination is primarily performed to confirm that the newborn is healthy, and to identify and refer babies born with congenital abnormalities (Public Health England [PHE] 2018), extending beyond the usual checks made by midwives at birth (Davies 2008; Carr and Foster 2014). By supporting midwives to develop the required clinical competency and knowledge in NIPE, among other benefits, it was seen as a way of empowering midwives and increasing their autonomy (Lomax 2001). However, although a significant number of midwives have undertaken a course to conduct the detailed examination of the newborn, there are some who hesitate to, or have not had sufficient opportunities to effectively utilise and develop their skills post-qualification (Hayes et al 2003; Rogers et al 2015). This is worrying for a number of reasons: for not only is there a poor return for the investment of time and financial resources (Simms et al 2012), but also midwives are missing vital opportunities to contribute to a public health activity that can hugely impact on the lives of women and their families.



Drivers for placing NIPE in midwifery practice

The bulk of the published work on the midwife's role and involvement in NIPE traversed the developmental pathway from the early 1990s to present day.

Documented are the drivers for extending their duties, one of which was the need to improve services to women and their babies by delegating some of the responsibilities of paediatric Senior House Officers (SHOs) to midwives (Department of Health [DH] 1993); reducing doctors' longer working hours to enable compliance with the, then new, European Union Working Time directives.

PRACTICE CHALLENGE 1



After completing the training, periodically assess what knowledge and experience you need to enable you to enhance and maintain your competence in performing NIPE skills. Initially it could be at three- or six-monthly intervals, then annually, as you gain experience.

Seemingly reluctant at first, midwives eventually viewed the change as opportunistic, being a means of acquiring new skills and enhancing their range of competencies; and, as implied by MacKeith (1995), fully articulating the lead professional role in the care of women with low-risk pregnancies and birth. Working as part of a multi-disciplinary team in NIPE, it was seen as a way of enabling midwives to further provide health information for women and contribute to the making of policies and protocols which impact on the newborn (Mitchell 2002).

PRACTICE CHALLENGE 2



Think about what would be useful to support you and other NIPE colleagues in developing relevant skills in your local setting. Consider how you can get your ideas moving forward, encouraging peers to join you.

Acceptance of midwives' practice of NIPE

In scoping the literature, it would appear that the demands over the years for the skill to be made part of the midwife's role has been heard and acted upon. There is a current increase in the inclusion of NIPE training in pre-registration programmes (Yearley et al 2017). Most of the early studies on the topic – like the seminal report by Townsend et al (2004), often referred to as the EMREN study – were mainly evaluative in their approach. The findings of the work by Townsend et al (2004) have provided a much-needed platform to validate the idea that midwives, when trained, are able to demonstrate competence in undertaking the skill. In one part of this evaluative research, consultant paediatricians rated midwives highly on their performance of NIPE (Bloomfield et al 2003). However, the experienced midwife practitioners who were also observers in this study seemed less satisfied with the accomplishment of their peers.

What women think about midwives performing an examination previously conducted by doctors is important, as it may have implications for the level of respect afforded to their relationship and the perceived value women have of the midwifery profession. However, how fellow paediatricians and midwifery colleagues feel is equally important.

Taking into consideration the findings of the study by Bloomfield et al (2003), it is possible that midwifery

NIPE AT A GLANCE

NIPE IS A PUBLIC HEALTH ACTIVITY



NEWBORN SCREENING WITHIN 72 HRS OF BIRTH



AIMS TO IDENTIFY AND REFER CONGENITAL ANOMALIES




PART OF THE ENHANCED MIDWIFERY ROLE



practitioners may have unrealistically high expectations of what is necessary during the examination. This could be the consequence of an inherent need to prove themselves in the professional arena, having a need for affirmation of their worthiness, which some may think can only be conferred by them over-performing. If this is so and midwives are too self-critical, it may impact on their belief in themselves and resultant satisfaction in the role, factors which would influence whether they practise NIPE or not.



PRACTICE CHALLENGE 3



Consider what learning resources are readily available to you. They should be easy to use and enjoyable to revisit regularly. For example, your favourite midwifery textbook or short, online video clips.

Empowering NIPE midwives and increasing their autonomy

In organisations where leadership is empowering, it means that there is a release of resources for learning and development to facilitate experience, so that employees become more competent, enabling them to gain the ability to self-lead and self-manage in practice (Amundsen and Martinsen 2014). Though difficult to define at times, empowerment is closely linked to autonomy and if midwives are to be truly self-governing, effective practitioners, they must feel that they can take, rather than be given, that power to make decisions about their role and their needs for personal development.

However, there has been further research into issues impacting on the expansion of the midwife's duties to include NIPE, exposing recurring themes: a lack of managerial support; non-allocation of resources or protected time for development; feelings of being undervalued; role conflict and crossing over of boundaries, beyond the remit of low-risk pregnancy – have all been cited by midwives as compounding elements (Lumsden 2005; Steele 2007; Simms et al 2012).

Certainly, these are essential to improving that sense of motivation, which should occur when empowerment exists. In particular, feelings of appreciation have been looked upon as one of the rudimentary features for motivation, to enable individuals to be more productive and achieve their highest potential (Maslow 1943). As healthcare professionals, Maslow's Hierarchy of needs (Maslow 1943) is often used to inform how basic care is planned for clients to promote their health. It is equally important to turn the theoretical mirror around, to reflect on how fundamental elements such as respect and acceptance are addressed for NIPE midwives.

**PRACTICE
CHALLENGE 4**



Continuously reflect on your qualities as a midwife, remembering that a significant portion of the knowledge and skills required in your NIPE role starts with what you already know and do well as a competent midwife.

Conclusion

It seems that the analogy of a train running full steam ahead is apt here. Over the last two decades, midwives have been invited to take a journey, with a promise of professional rewards such as increased autonomy, empowerment, an improved service for women and their babies. However, there needs to be a continuous focus on the experiences of midwives as passengers on this journey or what will happen to the new travellers that come on board; particularly those qualifying through pre-registration midwifery programmes. Midwives appear not to be fully satisfied with the ride, with some disembarking as soon as they board and not wanting to get back on. Lacking feelings of fulfilment and perception of support, for many correlate to a number of factors, including clearer demarcation of roles and responsibilities. Working as part of the multidisciplinary team is pivotal to the effectiveness of service, but the remit of midwives as experts in low-risk pregnancy and birth must not be forgotten. Factors that influence how contented NIPE midwives feel, such as the resources available for continuous professional development, may be one of the answers to provide encouragement for them to use their valuable NIPE skills. **TPM**



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