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ORIGINAL ARTICLE

Midwives autonomy in discharge women after physiological childbirth

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ABSTRACT

BACKGROUND: International literature identifies the midwife as the professional figure deals with women and newborns in the context of childbirth; it is however found to be still difficult to ensure this continuity of care. In Italy both the national laws and the indications of Emilia Romagna region promote this practice, ensuring the midwives management of the low risk women immediately after childbirth.
The aim of the study is to investigate and describe the midwives autonomy as regards the post-partum discharge.
METHODS: The computerised medical records were consulted to identify the mothers after childbirth who can be discharged independently by the obstetrician following the guidelines of the Emilia-Romagna region.
RESULTS: A retrospective analysis of 1371 medical records related to the period January- June 2017 showed that 41% of discharges were managed handled by the midwives, while the remaining 59% by obstetricians. Fifty-seven percent of the women followed by the family counselling service were discharged by the obstetricians and 43% independently by the midwives. Considering the women followed by a private physician 62% were discharged by the obstetricians and 38% by the midwives.
CONCLUSIONS: The study shows that, in a short time from the beginning of the project, the results as regards midwives autonomy were excellent. Indeed the midwives discharges does not differed significantly from the medical ones, and care continuity between the hospital and territory is strengthened. Further studies must include questionnaires concerning satisfaction of the mother not administered in this sample of women.

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KEY WORDS: Nurse midwives; Patient discharge; Continuity of patient care.

The midwives professional figure has seen significant changes in the last ten years, from the legislative as well as from the care point of view, acknowledging the midwife as the person who assists and advises the woman during the pregnancy, delivery and in the postpartum period.[1]

At the same time the national and regional services regarding care during pregnancy, delivery and after childbirth developed new strategies following the World Health Organisation (WHO) recommendations.[2, 3]

The Italian ministerial project at 2000 identifies a central role of the Family Counselling Services managed by midwives in the offer active management of the woman after childbirth at several levels.[4] Moreover eight years later the Emilia Romagna region guidelines recognised the pivotal role of midwives in the management of the low risk pregnant woman highlighting the midwives autonomy.[5]

In the last 20 years it has been observed a significant progress in the conquest of midwives

autonomy and in the final frontier concerns discharge from hospital of the mother after childbirth by using common protocols, shared and continuously modified in compliance with the evolution of medicine based on efficacy tests.[6]

The healthcare criteria for appropriate discharge of the mother and the new-born before 48/72 hours must be satisfied the following conditions: vaginal delivery, absence of intra-partum complications requiring ongoing medical treatment or an observation, women informed about routine care (*e.g.* changing diapers, umbilical cord, and breast-feeding methods) and about hospital and territorial support resources.[7] Indeed, as established by the Italian rules to promote humanization of the childbirth pathway, it is necessary to provide information on the hospital-territorial service and social healthcare network for the return home of the mother and the new-born in order to favour protected discharges and support breast-feeding.[8] Moreover also the National Institute for Health and Care Excellence recommendations concerning childbirth and the newborn care encourage the use of proved efficacy interventions promoting abandoning futile and harmful care methods.[9]

The study, conducted in 2017 in the context of the Master "Ostetrica di Comunità – Health Community Care", aims to describe autonomous midwife discharge of the mother after physiological childbirth at the Mother-Infant Department of the University of Modena and Reggio Emilia.

Materials and methods

A retrospective observational study was conducted by consulting 1371 computerized medical records of the women discharged in the period January-June 2017. To identify the women who can be discharged autonomously by midwives it has been applied a check list approved by the region Emilia Romagna identifying mothers which could be discharged by midwives or shared with obstetricians[10-14] (Table I). The following data were considered for the analysis: age, nationality, instruction and profession, mode of delivery (vaginal delivery or caesarean section), care service during pregnancy and type of discharge.

Statistical analysis

The Microsoft Excel system was applied for the statistical analysis: the data were analysed as the mean±standard values (M±SD) and a P value less than 0.05 was considered as significant.

Results

As far as the socio-demographic features are concerned more than half precisely 57%, are aged between 30 and 40 years, 33% between 20 and 30 years, 9% less than 20 years and just 4% of the women are older than 40 years.

Thirty-eight women take a degree while 42% take a high school and just 20% of the women a lower secondary school education. Sixty-seven are employed while 33% are housewives or unemployed. Seventy percent of the women came from Italy and the remnants from Europe or Africa.

Seventy-two percent of the sample experimented vaginal delivery while 28% caesarean section. Following the physiological eligibility criteria to establish the discharge[12, 13] among the women experiencing a spontaneous delivery 41% of the women were discharged by midwives, while the remaining 59% by obstetricians.

The mode of discharge was similar between women followed by family counselling centre vs private physician: by midwives (43% vs 38%) or by obstetrician (57% vs 62%).

Conclusions

The study shows that in a short time from the beginning of the project the number of midwives discharges do not differed from the obstetrics discharges leading to a better care continuity, indeed the women followed during pregnancy by the public counselling centre were discharged by the midwives and reconnected to the territorial services.

The positive results obtained by this project depends to the midwives cooperation by following the procedures, by making the language and the actions uniform for the users. For an improvement of the care continuity all the people must be willing to accept the change, the re-distribution

TABLE I.—*Reference parameters.*

Reference parameters	Obstetric discharge	Shared discharge	Medical discharge
Vaginal birth: spontaneous, induced, assisted or in analgesia	X		
Operative delivery with kristeller manoeuvre		X	
Operative delivery with vacuum suction cup		X	
Grade i or grade ii laceration	X		
Grade iii or grade iv laceration			X
Episiotomy		X	
Trachelloraphy			X
Haematoma emptying			X
Manual removal of the afterbirth			X
Caesarean section			X
Blood loss after birth ≤500 mL	X		
Blood loss after birth >500 mL		X	
Hb values at the time of discharge ≥ 8 g/dL	X		
Hb values at the time of discharge < 8 g/dL		X	
Changes in blood tests during hospitalisation (*)		X	
Positive swabs at removal of afterbirth and eco with negative outcome	X		
Positive swabs at removal of afterbirth and eco with positive outcome			X
Dilation and curettage (D&C)			X
Dura mater puncture			X
Transfusion during hospitalisation (*)		X	
Gestational diabetes in dietotherapy	X		
Gestational diabetes in insulinotherapy, or pre-existent diabetes		X	
Pressure increases at end of pregnancy or during labour not during labour	X		
Pz with chronic high bp under treatment		X	
Thyroid diseases	X		
Pz positive for HBSAG, HCV, LUE treated in pregnancy		X	
Pz HIV positive			X
Preterm delivery	X		
Vaginal twin birth	X		
Pre-TC spontaneous birth	X		
Minor patient (*)	X		
Problem patient (*)		X	
Drug addict patient		X	
Patient with thermal curve open without antibiotic TP		X	
Patient with antibiotic TP during hospitalisation		X	
Sepsis protocols			X
Psychological disorders		X	
Psychiatric disorders			X
Autoimmune diseases		X	
Cardiac or coagulative diseases		X	
Multiple sclerosis		X	
Return of new mother owing to breast-feeding disorders		X	
Urinary/gas/fecal incontinence			X
Execution of 2 or more extemporary catheterisations during the hospitalisation		X	
Untreated condylomatosis			X
Infibulated pz			X
Pz with vaginism			X
Maternal fetal isoimmunisation	X		
Allergic reaction			X
Thrombophlebitis or varices		X	

of responsibilities and the network between all the components of the team managing the pregnant woman, after childbirth and the new-born.

The results of this study, accordingly to the guidelines of the pilot project proposed by the region,[12] highlighted a cultural change at the level of maternal and neonatal care system with advantages for the mother and the new-borns.

Moreover, the post birth gap is avoided ensuring that discharge is done in appropriate manner for the triad (mother, new-born and father). Such integration ensure active support and care for the mother after childbirth and for the new-born. following the best practices based on evidence as required by WHO.[2, 3]

The Italian guidelines of physiological pregnancy states that the care provided by obstetricians in low risk pregnancies lead to better health outcomes and greater satisfaction of users. Moreover the subject of care continuity and obstetric discharge shows a strong clinical significance and further represents a fundamental element in the definition of midwives autonomy. Nevertheless few studies take into account this topic.

A recent Cochrane review about care continuity confirm its beneficial effects even if remain to be clarified the role played by care continuity or by the presence of midwives.[14] A further study demonstrated that the low risk women showed a greater degree of satisfaction of the childbirth pathway when they are managed by the midwives[15] and also that the midwifery continuity care should be implemented and supported by local protocols.[16]

The present study reports a preliminary experience of midwives discharge, the results encourage to continue the experience. A further analysis must include questionnaires to investigate the degree of satisfaction correlated to the path of autonomous discharge by and the relative follow-up programs, which were not administered in this study.

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Conflicts of interest.—The authors certify that there is no conflict of interest with any financial organization regarding the material discussed in the manuscript.

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