

The problems confronting core midwives in DHBs –having an effective voice



This edition of **Midwifery News** is focusing on the **working environment**

of core midwives, especially those working in our tertiary and secondary hospitals. Here, Bernard McIlhone, General Manager and Caroline Conroy, Organiser for the Midwifery Employee Representation & Advisory service (MERAS), the main union for midwives in New Zealand explain the issues confronting core midwives and suggest how they might be addressed.

Improving the pay and conditions for midwives employed by DHBs remains the single biggest challenge for MERAS. The reality is that MERAS and employed midwives are subject to the complex interplay of factors with no simple, quick solutions. What is required is to have an effective voice in the workplace.

How are we doing?

MERAS has a clear consistent voice about what it stands for articulated in the MERAS Midwifery Staffing Standards.

1. All women, regardless of where or how they are labouring and birthing, require at least one to one midwifery care.
2. Midwifery staffing must be set at levels to support 24 hour seven day care.
3. The birthing suite and/or maternity service in a secondary/tertiary maternity hospital provide an acute service operating 24 hours a day seven days a week. The midwife coordinating this service shall be supernumerary and in a recognised, named leadership midwifery position.
4. Maternity facilities are staffed by core midwives who provide support for the care of women in collaboration with the woman's Lead Maternity Carer.
5. Midwives are not employed to undertake administrative and hotel support staff tasks. All maternity units should employ sufficient ancillary staff to support the work of midwives.
6. Employed midwife caseloads reflect urban (1 midwife: 45-50 women) and rural (1:35-40) environments, and complex needs (max 40 women)
7. Maternity units have mechanisms in place to support midwives to progress through the Quality and Leadership Programme (QLP)
8. Midwifery professional leadership roles are established and supported in District Health Boards.

Importantly, in addition to this MERAS strongly advocates for higher pay for midwives relative to nursing. That separates us from our colleagues in the New Zealand Nurses Organisation (NZNO) which is the nurses' union so it is understandable that they don't agree that midwives should be paid more than nurses. MERAS represents most midwives and we are not conflicted because we only represent midwives and we believe that your midwifery specific training underpins this argument.

Realistically until either both unions argue together for higher rates of pay or the clear majority of midwives belong to MERAS and support an argument for higher pay then this can't be achieved.

Support for the MERAS Midwifery Staffing Standards is broadly supported by NZNO and many midwifery leaders. Achieving them is another matter particularly where the voice of midwifery leadership has diminished. Structural changes mean that these roles have disappeared or report to nursing leadership.

If we are to meet the standard that "all women, regardless of where or how they are labouring and birthing, require at least one to one midwifery care" we need to look at the baseline staffing established by DHBs. It is not clear how these were historically set but midwives, particularly in tertiary settings know that even on the rare occasions that recruitment and retention has meant that a DHB is operating at their budgeted FTE that they are still short staffed.

The reality is that the MERAS standard that "midwifery staffing must be set at levels to support 24 hour seven day care" is not being met.

For a number of years MERAS has worked with DHBs, the New Zealand College of Midwives and NZNO to develop Trendcare into a validated acuity tool that can underpin arguments for more midwives. MERAS acknowledges the frustration of midwives with Trendcare but with the latest refinements we think it is time to use it as part of a concerted effort to prove what we know, that more staff are required.

More staff means more midwives not nurses. Increasingly DHBs are running an argument that there are not enough midwives and so by necessity they need to employ nurses. MERAS stands firmly behind the Staffing Standard that, "maternity facilities are staffed by core midwives who provide support for the

care of women in collaboration with the woman's Lead Maternity Carer." Overall, there are enough midwives if we consider the available workforce to include those who work as self-employed midwives and the majority of midwives who choose to only work part time.

The challenge is making DHBs an attractive place to work. Despite the increased training of new midwives over several years DHBs still struggle with midwifery vacancies. There are different factors behind this reflecting different locations, the nature of the community they serve, the population size and the culture of the workplace.

These factors can include:

A shortage of midwives

Not enough 'spare' midwives in the community to easily fill any vacancies that occur. There may also be a shortage or only just enough self-employed midwives. In these situations any midwife considering moving to this community often needs to also consider if there are jobs available for her partner, the impact of housing costs, loss of local support networks (especially for child care), changing schools for children. In the view of MERAS this is a reason for several maternity units currently experiencing vacancies, especially where midwives in the community have retired.

In other areas there may be lots of self-employed midwives but a reluctance to work in the DHB. That may even result in midwives living in that community but choosing to work in a neighbouring DHB. In these situations, there are often factors within the workplace that need to change in order to attract midwives.

Also, as was highlighted in our recent survey results a DHB may have a good number of midwives employed but a high percentage only working very part-time and then choosing to work additional shifts as it suits. This is likely to be a consequence of concerns over rostering or other workplace factors.

The ability to attract and or retain midwives in employment can also be affected by housing and living costs. While this has featured as a concern for some Auckland midwives there is no clear pattern albeit that housing is becoming unaffordable in areas beyond Auckland.

Workload

Factors that have increased midwives' workloads on maternity wards include the rising number of caesarean sections,

increasing complexities associated with obesity and diabetes and increased surveillance of babies as a result of GROW charts. DHBs fail to recognise the baby as a patient in its own right and consequently most bed spaces in postnatal wards have two patients rather than the one seen elsewhere in the hospital. This means that when a midwife is allocated five patients she is generally actually caring for 10 women and babies and this becomes an unachievable workload.

MERAS works closely with individual DHBs to ensure that midwifery staffing problems are a priority for the DHB to address.

What should midwives do who are concerned about midwifery staffing in their DHB?

The MERAS Multi Employer Collective Agreement (MECA) provides some guidance on this:

8.1 Safe Staffing

When a midwife considers they have reached the limits of safe practice they will be supported to resolve the situation as follows:

- the midwife manager or duty manager will be immediately informed of the situation by the midwife

-the midwife will not be required to take additional workload until strategies have been implemented to address the immediate workload issues (ie redeployment of staff or patients) not withstanding any duty of care requirements.

If the process outlined above does not resolve the situation, steps will be taken immediately to elevate the issue to that level of midwifery service management authorized to resolve the immediate problem and

take steps to reduce the likelihood or a recurrence of similar problems

The most senior midwife in the DHB, at the time of the event, will report the event to the most senior manager in the DHB as soon as reasonably possible. Direct assistance will be given from this level of the organisation and the event reported to the CEO by the senior manager as soon as is reasonably possible.

What is your role as a midwife?

You may find that you are the 'senior midwife in the DHB' at the time of a staffing situation if you are the Charge Midwife, shift coordinator or even the most senior staff midwife on a shift after-hours. It is critical to complete an incident report (or Riskpro) if the above situation arises as this will highlight the situation and the frequency at which these situations occur.

What happens with an incident report (or Riskpro)?

All incident reports are sent to the line manager to provide an outcome report and are then collated by department and 'type' (eg staffing deficits, falls etc) and presented in regular reports to the senior management team of the hospital. If a trend starts to emerge in one department then the senior management team will want to investigate what's happening and have a responsibility to address the issue.

The union can also ask for these reports

and be involved in the investigation and corrective action.

Unfortunately incident reports are often not completed frequently enough to highlight an issue in the workplace. Completing an incident report is often the last thing a midwife wants to do when she is already feeling overworked and she may worry that doing this might get her Charge Midwife into trouble.

The incident report does not need to be very detailed, it can simply have the date and shift and state comments such as:

'one midwife off sick not replaced. 3 midwives for PM shift with full ward. Staffing levels inadequate for acuity-duty manager notified'

'3 midwives on duty. Very busy ward. 2 women requiring secondary care in labour, 2 new LSCS, 8 other postnatal women and babies requiring lots of support. Staffing inadequate for workload. Unable to find additional casual or part-time midwives to come in to help on this shift. Service manager notified'.



Every woman must have at least one to one care



Core midwives provide care in collaboration with the woman's LMC



Employed caseloads reflect urban, rural and complex needs

Trendcare

For those units with Trendcare it is also helpful if this is completed when busy as the reports from this should also highlight that the staffing was inadequate for the workload. However, when midwives are already over worked this is again something that often does not get completed comprehensively.

It is useful to raise your concerns about the ward or unit staffing levels at a staff meeting and with your MERAS workplace rep (who will then advise Bernard or Caroline) so that further discussions can be had with senior managers within the service.

Role of MERAS

MERAS works with individual maternity units to look at the factors influencing their recruitment and retention of midwives and to address factors that may be deterring midwives from working in their Unit. MERAS also has the MERAS staffing standards for maternity facilities to provide some guidance around the staffing levels that a maternity service should be aiming for.

MERAS remains committed to helping to achieve workplaces where midwives are not over stressed because of workload and where they are fairly



Secondary and tertiary maternity units provide an acute service, 24 hours a day, seven days a week



Maternity units should employ sufficient ancillary staff to support the work of midwives

rewarded. The solution is building support for the MERAS Midwifery Staffing Standards and improved pay and conditions for midwives. If you are not already a member of MERAS then you are encouraged to join and help to make a difference.



For MERAS Membership e-mail merasmembership@meras.co.nz or call 03 372 9738

Voices from the core

Maria Scott

So what is working life like for midwives in New Zealand's secondary and tertiary maternity units? This time last year *Midwifery News* asked this of core midwives working in a variety of roles, managerial and otherwise in units around the country for a feature themed 'a day in the life of a core midwife'. Midwives who spoke to us did so on the basis that they would remain anonymous and there was a strong thread of concern in their stories about staffing levels and increasing workloads. "I worry about the mental health of midwives because of the mounting pressures of the job," said one. And from another: "There are always staff shortfalls and we have increasing acuity in the women we are looking after and this increases with the workload."

A year on and not much has changed. If anything the situation around the country has deteriorated. We spoke to a range of core midwives again this year and their comments suggested continued concern overworking conditions. This matches the anecdotal evidence reaching the College not least in the number of queries to midwifery advisors about tensions

over hand-over responsibilities between LMCs and core staff. Again, for this year's interviews midwives did not want to be identified fearing repercussions from doing so. Here is a selection of feedback :

"Sometimes it feels as though staffing is unsafe, especially on night shifts. Staff regularly receive texts on days off asking if they will come in because there is a shortage of midwives and staff are not happy about rosters. For the nightshift we have a midwife on call but the pay for being on call is too low. Sometimes nurses fill in on post natal wards."

"I think the staffing situation is the worst it has been on the unit I am working on."

"Acuity is increasing. We are getting a lot more unwell women. More women are having caesareans and there are more older women needing to be induced."

"Our unit manager listens but she has trouble getting it to the next level."

"The root of the problem appears to be lack of money."

"Some colleagues are willing to stand up but some go with the status quo."

"People know there's no money (because of) the budget the National government

has given the health sector and that we are not going to get far with National."

"A lot of midwives are over tired and goodwill is wearing thin."

"We need more staff. Midwives need better compensation for being on call or taking higher roles."

"The pleasure of your work is taken away because you are putting out fires."

"There is a concern that (if you speak up) you will be seen as a trouble maker."

"There are so many steps to take before money is devolved (to maternity)."

Managers have to jump through so many hoops. I think management is overwhelmed with bureaucracy."

"Over the last five years our workload has increased markedly."

"A big part of my role is supporting women to breastfeed. If you can get breastfeeding right at the beginning then ultimately you can save the country money (because of the long term health benefits to the baby). But (often) you are the ambulance at the bottom of the cliff."

"We need recognition for what midwives do and their value."