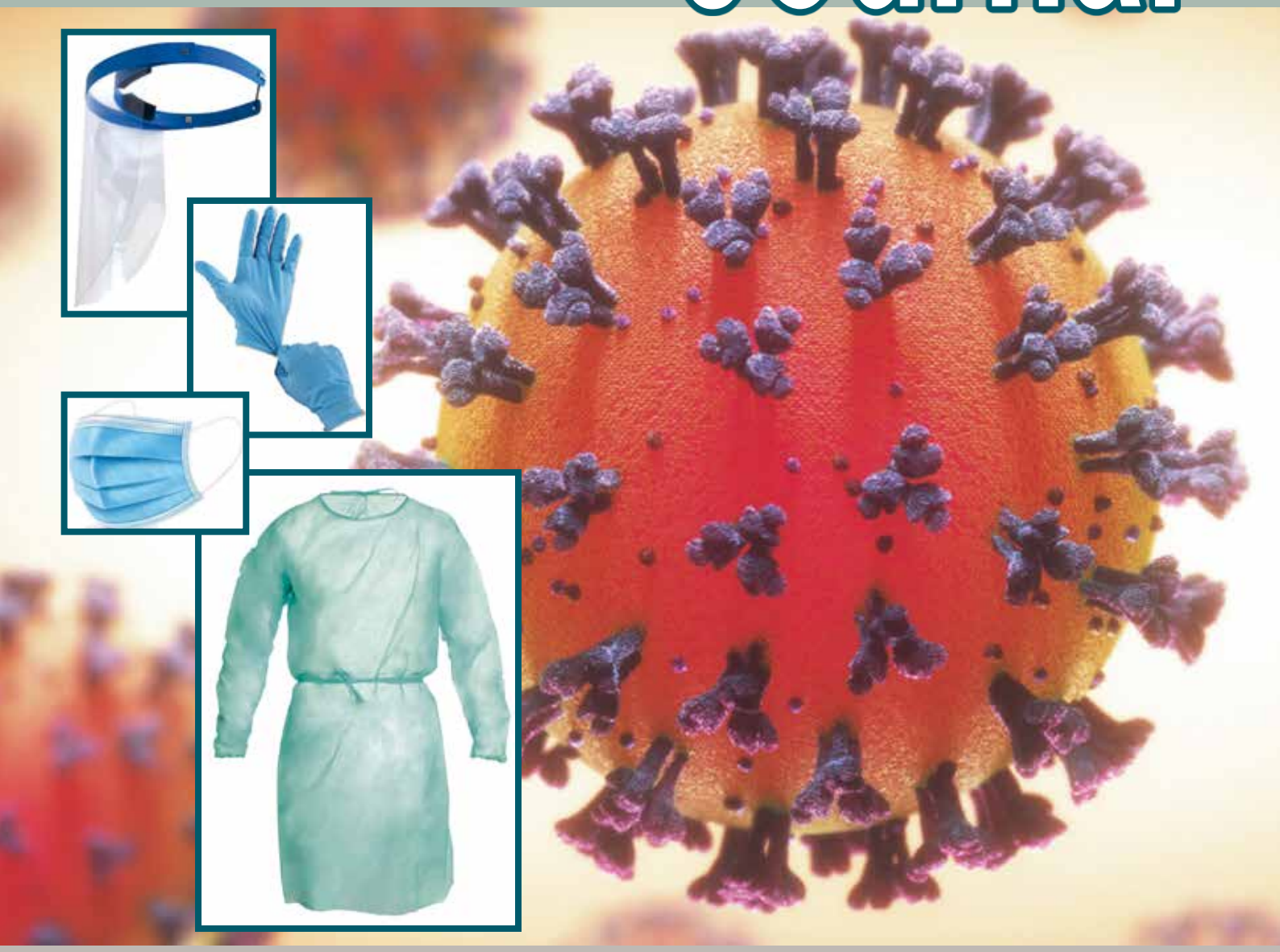
Malta Midwives' Journal



Malta Midwives Association

Issue 16

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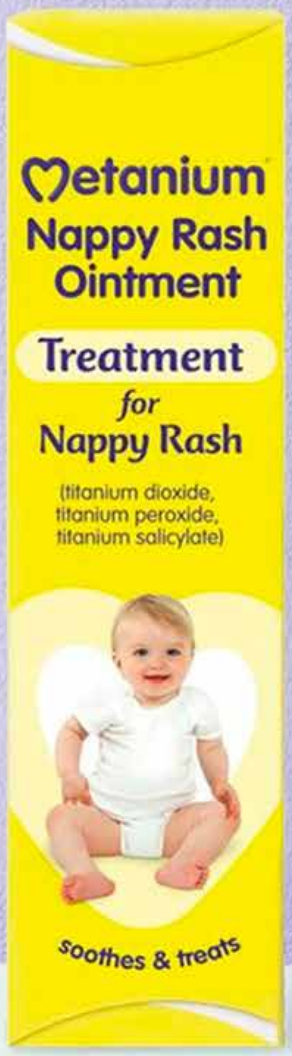

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Contents

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Correspondence should be addressed to the editor on MMA e-mail or to the above address.

Editorial

Dear Member,

Welcome to the second issue of 2020. The past months have been a great challenge for healthcare professionals and midwives, who have been caring for pregnant, labouring and postnatal mothers during the COVID-19 pandemic in Malta. Whilst all midwives have strived to give the best possible care, keeping up with changes in protocols and adapting to daily situations whilst taking care of themselves, has caused a certain degree of stress at our workplace.

I praise all midwives who successfully managed to deliver optimal care throughout such a difficult, stressful time our nation had to face, whilst still trying to enhance a positive childbearing experience for all mothers and families. This global issue has also given rise to local research interest about how the pandemic has affected childbearing mothers as well as healthcare students; which is featured in this publication. Additionally, to further contribute to educational development, master studies' abstracts by midwives are also published.

Like past issues, this issue brings you a diverse array of novel articles which aim to improve and enhance midwives' knowledge about mothers and new-born physiology; including evidence regarding gastric lavage and hypoglycaemia.

Moreover, articles about improving mothers' birth experience and enhancing the professional midwifery role at NPICU are also featured.

As beknown to many, the recent shift in management has affected the future of midwifery at NPICU. This intensive care unit has always been a midwifery entity; thus, great effort has to be made to expose students and junior midwives in the best possible positive way to keep the doors open to midwives who wish to work and specialise in this area.

On a final note, whilst I hope you find this publication interesting and useful to your practice, keep striving and remain motivated to deliver optimal care whilst staying safe, protecting yourself and your families during this difficult time.

Lauren Marie Grech
B.Sc. (Hons.) Midwifery
Co-editor

Message from the President

Dear Midwife,

The year 2020 was declared by the World Health Organisation (WHO) to be the 'Year of the Nurse and Midwife'. To commemorate this year, the Association was preparing a bigger celebration than previous years for its members, but the Corona Virus drastically contrasted the celebrative activities we had planned for midwives. Instead of celebrating, this virus is highlighting the critical role midwives and nurses play globally during a pandemic. This is reflected by the WHO decision to extend 'The year of the Nurse and Midwife' to 2021.

Global health systems are being put to the test as shortages of both staff and other resources place intense pressure on services. As health authorities struggle to get Covid-19 under control, health professionals are under increasing strain - and women-centred midwifery care is at risk more than ever. The International Confederation of Midwives (ICM) has received accounts from midwives working on the frontlines during this pandemic. Some anecdotes are harrowing. There is an increase in gender discrimination, domestic violence, human rights abuses, over-medicalisation of birth and fear and misinformation. All this culminates in growing distress among women and midwives. (ICM, 2020).

Protection of midwifery maternal care

Locally, we are in the midst of the second wave of a global health crisis from the Covid-19 pandemic. As midwives we are central to the health and protection of women and newborns, be it during pregnancy or childbirth as well as during those critical early days and weeks once a baby is born. As stated in the ICM document, Global Call to Action (ICM, 2020), midwives must be included in policy, decision-making, planning and response to Covid-19. Midwife involvement and leadership ensures in determining the appropriate and swift regulatory response to facilitate midwives to provide care within a regulatory framework that protects both the midwife and the public. The midwife is recognised as the most appropriate professional to inform governments about effective organisation of midwifery services and those of the women and newborns they care for.

ICM also highlights the need to uphold the right of pregnant women to a positive birth experience amidst the Covid-19 pandemic. Certain global restrictions imposed on health facilities such as, not allowing a birth companion where infection prevention and control measures are in place, separating mother and newborn baby after birth, not permitting breastfeeding, enforcing medical interventions such as unnecessary caesarean, or induction of labour, all are violations of women's and newborn's rights during pregnancy and birth. These actions also counter to the evidence on safe and effective care. ICM recommends a midwifery model of care to be the most appropriate model for childbearing women and their newborns. These can be provided outside of a hospital setting, thus reducing the burden of Covid-19 on the health system at the hospital level.

The pandemic has shown us the valuable benefits of providing community-based midwifery care. Some women are fearful of birthing in hospital where they risk infection. Women tend to be discharged from hospital earlier. This includes women who give birth by Caeserean sections. Midwives are stepping up to provide this care to women and their newborn but community services need to be appropriately supported with human resources and facilities. We are at a time where hospital services are decreasing and when women are increasingly opting for decentralised services. Allocating funds to community-based services will ensure that they have the resources and capacity to provide community-based services and enable midwife-led care to reach the most vulnerable women in our community. The pandemic is not likely to disappear very soon. Indeed with the seasonal influenza round the corner, the benefits of community care come further to the fore.

The pandemic has impacted significantly the lives of midwives as they continue to provide usual midwifery care but also take on all the new procedures related to prevention and treatment of Covid-19. These health-care professionals, like all their other colleagues,face overload, both emotional and practical. Midwifery managers need to ensure that there are systems and processes in place to maintain well-being, and reduce the risk of post-traumatic stress disorder and burnout among midwives. Pyschological support, social connectedness and physically and emotionally supporting one another are essential elements to minimise stress during a crisis.

Finally, we need to respond with sensitivity and compassion and not get swept up by disempowering fear. Rather than fear, the focus on providing accurate and factual information from reliable sources is paramount. Our focus needs to be on eliminating discrimination and the racial undertones that further isolate and increase risk for those most vulnerable. The fluid nature of this emergency is unprecedented in our time and requires us all to come together in solidarity.

On behalf of the Association, I would like to thank you for your hard work and dedication to provide our community with optimal midwifery services. Additionally,I urge everyone to take all the appropriate precautionary measures to stay safe.

Reference

ICM, 2020. Global Call For Action

Pauline Fenech

Treasurer's Message

Dear Collogues,

My first words as the treasurer are to express my gratitude and heartfelt thanks to Doris Grima who has been a treasurer for the last six years for her sterling job and commitment to the Malta Midwives Association and her continuous support and expert advice till this very day as the association's Assistant Treasurer. In my new role as the new treasurer, I promise to offer my commitment to the association by following my predecessor's footsteps by providing a transparent and meticulous service.

So far, my journey as the treasurer of the association has been a challenging and rewarding one. As a committee, our journey started with the various difficulties brought about by the Covid-19. Faced with these challenges, the committee as a team through their commitment and dedication turned these challenges encountered into opportunities. This brought about change and further upgrade to our services offered to midwives and couples.

This year brought about the introduction of the association's online session offered to midwives and couples. This was possible through the help and commitment of numerous midwives. Online sessions, discussions and workshops by local and international health care professionals were offered to midwives through an online platform. Couples were also given the opportunity to follow online childbirth courses, personalised sessions and bookings, Pilates and first aid sessions. In turn, this led to payments also being settled online through the website, via PayPal or BOV bank transfers. I highly encourage you to settle the Malta Midwives Association's membership which is also being conveniently settled online through our newly modernised website, PayPal or the bank's standing order service depending on the individual's preference and convenience. These online services further promoted transparency within the Malta Midwives Association.

Once again, I would like to conclude this message by showing my appreciation and thanking the association's committee members for their trust and continuous commitment, the midwives and healthcare professionals offering their services to the association for their support and cooperation and the members of the Malta Midwives Association.

Daniela Buttigieg

Malta Midwives Association Research Projects

The pandemic of Covid-19 brought many new and unexpected challenges that affected the usual provision of maternity services to women during pregnancy, birth and during the postnatal period. Health facilities, in Malta had to respond quickly to national public health policies and to strict infection control measures to guard against the transmission and spread of the virus. This situation prompted a group of researchers to initiate a research survey titled 'Women's experiences of pregnancy, birth and early postnatal period during the Covid-19 Pandemic'. The aim of the study is to explore how the COVID-19 pandemic is affecting women's pregnancy, labour, birth, and early postnatal experience in Malta. The study will help us gain a better understanding of women's experiences during this pandemic and will provide insights into how we could improve our help and support to other women during their pregnancy, childbirth, and postnatal period under similar circumstances. Ethical approval was sought and granted by FREC , University of Malta, ID 5608 01062020. Data collection is presently ongoing.

Researchers: Prof. R. Borg Xuereb, Ms. P. Fenech, Ms. J. Zammit, Ms. L. M. Grech, Dr. N. Riva.

Babies Born Better – an international survey

The Babies Born Better survey is an international survey run by international academics, activists and practitioners. The survey was started as part of an EU funded project and is now managed by the University of Central Lancashire (UCLan) in the UK, supported by a steering committee of people from many countries.

The purpose of the Babies Born Better study is to explore women's views and experiences relating to care during labour and birth across the world so that we can compare the experiences of women in different countries and birth settings. The ultimate aim of our research is to improve care for women by learning from good care and practise. In the last 2 versions of the survey we collected the experience of 80,000 women.

The BBB survey version 3 was reviewed this year. Ethical approval was sought and was granted by UClan. We have also sought and obtained FREC permission, University of Malta, ID 5601 01062020. We are now in position to subsequently publish and compare the local data coming out of this research with similar international data. Data is being presently collected in Malta and overseas, whereby mothers who have had a baby in the previous 3 years are being invited to participate in this study online via collaboration with MMA. The survey is currently available in 15 languages: https://www.babiesbornbetter.org

Local collaborators are Prof. R. Borg Xuereb, Prof. J. Calleja Agius, Dr A. Agius, Ms. P. Fenech f' The Malta Midwives Association (MMA).

Letter sent to Midwives during the Covid-19 Pandemic

22nd March 2020

Dear Midwife,

On behalf of the Malta Midwives Association, I am sending this message with one thought in mind, to thank you in the warmest way for your continuous commitment and dedication towards the women and their families under your care during the Covid-19 pandemic. Indeed, this is a time of great stress, not only for the loved ones, colleagues and friends around you, but also for your personal health.

I am very thankful for the amazing commitment, hard work and dedication that midwives are undertaking in order to provide the best possible midwifery care to our community. I am touched everyday by women's narratives on how they were supported, cared for and looked after by capable and compassionate midwives.

Babies continue to be born every day, irrespective of the Coronavirus pandemic. Birth is taking place amidst stringent infection control measures aimed at safeguarding the health and well-being of mothers and babies. Hospital guidelines are continuously being revised and updated, staff training is ongoing, and preparations and drills undertaken, all with the aim to give the best care whilst minimising the potential spread of the virus.

We are all in this together. Therefore, it is essential to remember that all of us are reaching for the same goals: to stop the spread of Covid-19 transmission, provide mothers with safe midwifery care as well as giving mothers the opportunity to have a positive birth experience, even in these unprecedented times. Eventually, this period will also pass and as we move forward, we must all remember to support each other, to listen to one another and to remain keenly aware of our shared humanity.

I conclude by urging every midwife to keep up the excellent work and take every necessary measure to stay safe and healthy. What you do matters greatly to so many women. My sincerest thanks and appreciation goes to all of you, for the expertise, passion and dedication which collectively makes midwifery care.

Pauline Fenech

Letter sent to the Minister of Health & to the Superintendent of Public Health

25 April 2020

Re: Department of Obstetrics & Gynaecology – The Birthing Partner in Delivery Suite

Hon Christopher Fearne
Prof Charmaine Gauci

I am writing on behalf of the Malta Midwives Association (MMA) in order to express our views in relation to the set of directives issued on 7 April by the Department of Obstetrics and Gynaecology, regarding the presence of the birthing partner in the delivery suite.

I would like first of all to congratulate you on the tireless and continuous work that you are doing in order to mitigate the effects of COVID-19 and to ensure the health and safety of everyone. The Malta Midwives Association has advised and encouraged its members to follow all the measures issued by the Maltese government in this regard.

It is being suggested that there might be an '*ease of restrictions'* if the current pandemic situation remains stable and the numbers of local transmissions remain low. In the eventuality that the current restrictions are eased, the Malta Midwives Association suggests the early lifting of the set of directives issued on the 7th April 2020 by the Department of Obstetrics and Gynaecology.

The set of directives state that for Normal Vaginal Deliveries: *'The Birthing Partner:*

To enter the Central Delivery Suite delivery room ***only during the second stage of labour,***

To remain in ***a corner of the room*** *as indicated,*

To leave the delivery room ***after holding the baby for 5 minutes.***

The Malta Midwives Association observes that the lack of the birth partner's support during labour is having a negative effect on the couple's decision to come to hospital for birth. There have been several instances where couples are coming to the hospital at the last minute. You will agree that this is not ideal. Moreover, we have observed that the demand for ambulance service to attend labouring women at home has increased. Not only such a situation is not advisable, but it is also creating pressure on resources given that two midwives or, a midwife and a nurse, would need to accompany the ambulance during these calls.

Birth may be a highly stressful and traumatic event for the expectant couple. The Association is concerned that the restrictions imposed on the birth partner to support his partner during labour, together with the shortened hospital stay, the reduced midwifery community service and the lack of support from the extended families, the couple is at an increased risk of anxiety and mental ill-health associated conditions. The physical and psychological vulnerability of parents is also.

The Malta Midwives Association suggests for the:

- *The birthing partner to stay with the woman during the 1st stage of labour and to leave the delivery suite when the woman is transfered to the obstetric ward.*
- *Birthing partner to wear a mask.*

The Association would like you to kindly reconsider this decision in the best interest and well-being of the childbearing couples.

Yours,

Pauline Fenech
President
Cc Prof Yves Muscat Baron

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News: Faculty of Health Sciences – University of Malta

The Midwifery Department Research Unit During the Covid-19 Pandemic

The coronavirus crisis has challenged higher education institutions in many new and unexpected ways. As universities must take radical measures and make major efforts to slow the contagion and to better understand the virus, they are forging new paths in crisis management. This brings both challenges and opportunities in particular in relation to digitalisation and digitally enhanced learning and teaching and research.

The department of midwifery responded to these challenges and sought the opportunity to set up the foundation for collaborative research through the development of its own research unit. The research unit is pursuing this initiative by exploring three research projects focusing on Covid-19 from different perspectives namely; pregnancy, childbirth and the postpartum, neonatal care and students' experiences.

All three research projects have been granted ethical approval from the Faculty of Health Sciences Research Ethics Committee. Data is currently being collected. Details of each of the studies are included in the abstracts below.

Study 1:

Pregnancy, birth and the postpartum: Couples' experiences during the COVID-19 pandemic in Malta

Lead researcher: Dr Georgette Spiteri

This research study will explore couples' experiences of pregnancy, birth and the postpartum during the COVID-19 pandemic in Malta. The objectives of this study are 1) To understand the coupled experiences of pregnancy, birth and the postpartum period during the COVID-19 pandemic. 2) To explore the meanings couples place on these experiences. 3) To explore the ways in which couples can be better supported in future complex situations. Hence, the research question reads: What are couples' experiences of pregnancy, birth and the postpartum during the COVID-19 pandemic in Malta?

A qualitative research design will be adopted to conduct this study and a semi-structured one-time interview schedule will be used to generate the data from adult consenting individuals. A coupled interview will be conducted with a researcher from the department of midwifery which will take approximately 1 hour. This interview will occur at a time and place of the participants' choice.

The interviews will be audio-recorded with the participants' consent. Participants may choose to speak in either the Maltese or English languages as questions have been prepared in both languages. Approximately 10 couples will be recruited for the purpose of this study. Participants are being invited to participate in this study through social media.

All participants will be consenting adults aged 18 years or older who can speak in either the Maltese or English languages. Eligible couples need to have been pregnant and given birth during the COVID-19 pandemic in Malta (onset March 7th 2020). To be considered eligible for participation, the couples' infants needed to be born healthy without needing admission to the neonatal and paediatric intensive care unit.

Interpretative phenomenological analysis will be used to analyse the generated data. It is hoped that the information gathered may help to better support parents during similar complex situations and/or pandemics in the future.

Study 2:

Mothers' experiences of having their newborn on NICU during the COVID-19 pandemic

Lead researcher: Dr Rita Pace Parascandalo

The aim of this research study is to explore mothers' experiences of having their newborn on the local neonatal care unit (NICU) during the COVID-19 pandemic in Malta. The objectives of the study include: to understand the impact of mothers' experiences of having their newborn cared for on the local neonatal unit during the global pandemic of COVID-19, to explore the meanings mothers attribute to such experiences and to identify ways how mothers of NICU infants can be better supported during similar complex situations in the future.

A qualitative research design using one-time, semi-structured interviews will be used to generate data from study participants who will be adult consenting mothers of NICU infants. Each interview will be conducted with the lead researcher and will take about 45 minutes to one hour. The interviews will be audio-recorded with the participants' consent. An interview schedule is prepared in both Maltese and English languages and the participants may choose the language they prefer for the interview to be held in. The study will recruit approximately ten mothers who had their newborns cared for on the local neonatal unit during the COVID-19 pandemic in Malta, since its local onset in March 2020. Participation is voluntary and participants must be 18 years of age or over and need to be able to communicate in either the Maltese or the English language. Additionally, mothers whose newborns have been discharged home from the local neonatal unit will be eligible to participate. Participants are being invited to participate in this study through social media.

This study will help to generate new knowledge based on the unique experiences of participating mothers when their newborn was cared for on the local neonatal unit during the COVID-19 pandemic when specific infection

control measures were taken on the unit. Findings can help to better support mothers of NICU infants and their families during similar complex situations in the future.

Study 3:

Healthcare University students' stress and coping experiences during the COVID-19 pandemic

Lead researcher: Dr Josephine Attard

The research study will explore the experiences of stress and coping in healthcare university students during the COVID-19 pandemic in Malta. The objectives of the study are to gain an understanding of students' experiences of stress and coping during this pandemic and to provide insights into how different Faculties/ Departments can find ways how to support students to cope with stress more efficiently and improve their academic experience particularly in the 'new normal' Hence, the research question reads: 'What are healthcare university students' experiences of stress and coping during the COVID - 19 pandemic'?

Using quantitative research, a descriptive cross-sectional survey utilising a one-time anonymous online questionnaire using google forms will be adopted. The questionnaire will be made available in the English language and data from closed-ended questions will be statistically analysed. Some open-ended questions are also included in the questionnaire to better capture the students' feelings and concerns and how they tried to cope. Content analysis of this data will also help to inform the study's conclusions. Such research approach will help to capture the students' experiences of stress and coping particularly in meeting the study program demands during COVID-19 pandemic. Findings will provide information that may help the Faculty/Department to find ways to support students to cope with stress more efficiently particularly during complex situations in the future.

In conclusion, research is the driving force of new knowledge and practice in midwifery education, healthcare systems and particularly maternity care of this and future generations. We are excited about the development of the research unit and these three projects. We look forward to disseminating our findings as a contribution of our work while we encourage and support your participation in our local midwifery research for the benefit of midwives, students, mothers and the babies whom we care for.

Dr Josephine Attard, Dr Rita Pace Paracandalo & Dr Georgette Spiteri
Department of Midwifery, Faculty of Health Sciences
University of Malta

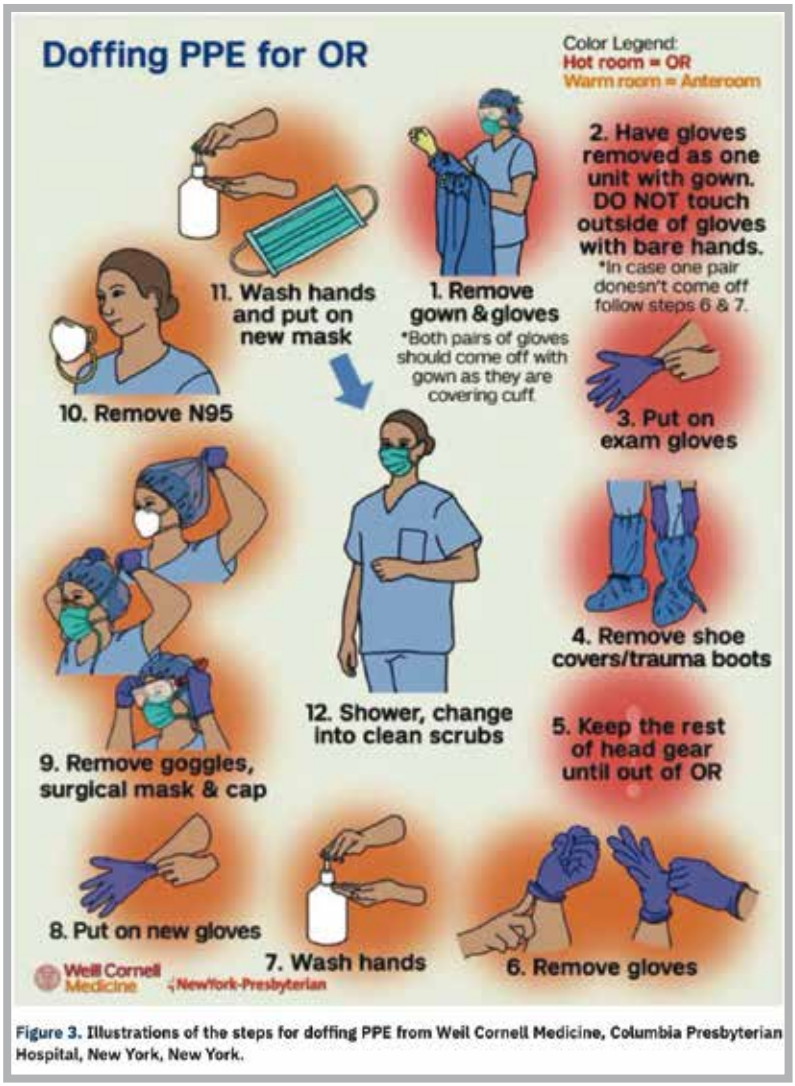

Figure 3. Illustrations of the steps for doffing PPE from Weil Cornell Medicine, Columbia Presbyterian Hospital, New York, New York.

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SURVEY

WHAT DO MIDWIVES THINK OF THE MALTA MIDWIVES ASSOCIATION?

PAULINE BORG MS (MELIT) RM

Midwifery Associations are one of the three pillars that strengthen the midwifery profession (Education, Regulation & Association), as stated by the International Confederation of Midwives (Castro et al. 2016). As part of an ongoing process of reflection and improvement, the Malta Midwives Association [MMA] sought to implement a survey among local midwives to obtain essential feedback and explore their views about a number of relevant issues.

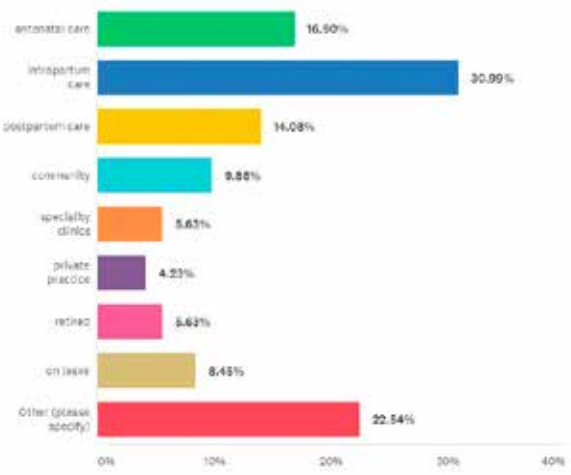
AIMS & OBJECTIVES OF THE SURVEY:

To obtain essential feedback regarding organisational performance from members

To enhance member to organisation relation by providing a channel for communication

To discover midwives' interest to participate in innovation at the MMA

Figure 1:



DESIGN

The survey design was in the form of an anonymous, online questionnaire. The questionnaire included open-ended questions, to provide in-depth qualitative data, together with likert scale and quantitative questions for statistical and objective data. The questionnaire was piloted with a small group of midwives prior. A covering letter and request for consent was included in the survey.

PARTICIPANTS

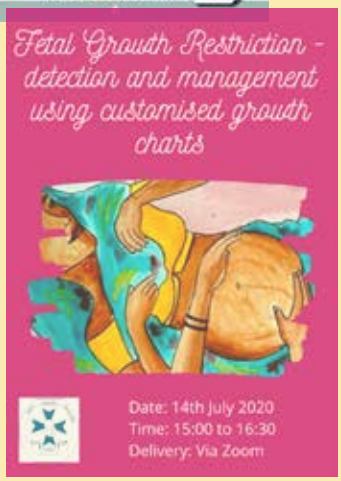
The response rate was above 90%. There was a good mix of midwives who have been in the profession for a different amount of years, and the age groups were also well varied. The participants came from different practice areas thus there was good representation from all fields of midwifery practice (Figure 1).

FEEDBACK ON ORGANISATIONAL PERFORMANCE

Services for clients

"All educational antenatal & postpartum classes provided are a positive element of midwifery outreach to the community"

Services for Midwives



"The perseverance towards education"

"To continue learning about our profession"

Strenghtening the profession

"The Malta Midwives Association unites the Midwives in Malta, thus there is strength within an association"

Thematic analysis of the qualitative data generated from the survey, indicated that midwives felt that certain aspects of the association were positive and should be continued. This included the fact that the association provides **services for childbearing couples**. The mission statement of the association is to **'advance the art and science of midwifery'**, hence this work falls well within the association's aims. In order to advance the science of midwifery, the MMA organises several **educational activities** and these are well appreciated by the midwives and there is a demand to increase their frequency. **Social activities** were also deemed very important; *"Social activities bring the midwives together."* The association was perceived by the midwives as being of particular significance for their **professional identity** as midwives,and for the midwifery profession as a whole in Malta. Having an association gives **strength, recognition** and **authority** to the profession.

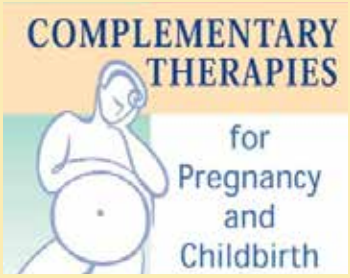
FUTURE ASPIRATIONS

For our clients

"Smaller groups & following the same group throughout the course- continuity."

"Environment can be improved by adding colour. We want to project the place as comfortable and homey. A place where parents feel comfortable to speak up ... More warm colours can help parents feel more comfortable."

For midwives



"More frequent educational/updates in midwifery"

<u>Suggested topics:</u>
Meditation & Mindfulness
Pre-conception Care
Midwifery Specialisations
Women's empowerment for adolescents
Workshops on promoting physiological birth
Management of labour
Human Factors
Management
Communication

For the profession

"Make everyone know about the midwife"

"Be a positive voice for midwives and childbearing families and be seen in media issues with a face and a name"

"Act as a pressure group to stakeholders and policy makers to promote natural birth"

"...promoting positive attitudes and relationships amongst midwives."

For the future, midwives feel that the services provided for clients should be continued but also improved. Suggestions were in line with core principles of midwifery, such as providing **individudalised attention** by having small-groups in childbirth education, and entrusting one or two midwives to provide a complete course for more **continuity**. Midwives also suggested improving the **ambience** of the premises. This was also clearly grounded in the midwifery philosophy of care of providing comfort and relaxation for couples, which is best achieved through a homely environment (Hodnett et al. 2005).

Education is a top priority for midwives. It seems key for midwives to continue their professional advancement, which is a strength for the profession. Midwives also asked the MMA to be **visible and vocal,** with stakeholders and in the public, to raise awareness about the value of midwifery care and the needs of childbearing couples. Another role identified for the association, was that of promoting **positive interpersonal relationships** among midwives, which ties to their belief that the association acts as a unifying factor for midwives .

INNOVATION AND PROFESSIONAL ADVANCEMENT

"Push for more community antenatal midwifery for low risk mothers."

"Ideally we should have a consultant midwife."

"Midwifery led antenatal visits or do house visits."

"Work on introducing Antenatal Midwifery-Led Care."

(Sandal et al. 2016)

The midwifery profession in Malta has a very solid educational background. However, there is a disparity between what should be an integral part of midwifery practice; such as antenatal care for low-risk women, and what midwives have the opportunity to practice in the clinical area. Midwives look up to the association to tackle this disparity. Midwives recommended lobbying, and taking the lead as an association to show that these models of care can function. Midwives expressed an interest to work in all areas of maternity care (Figure 2) and explained that midwives need to be recognised as lead caregivers.

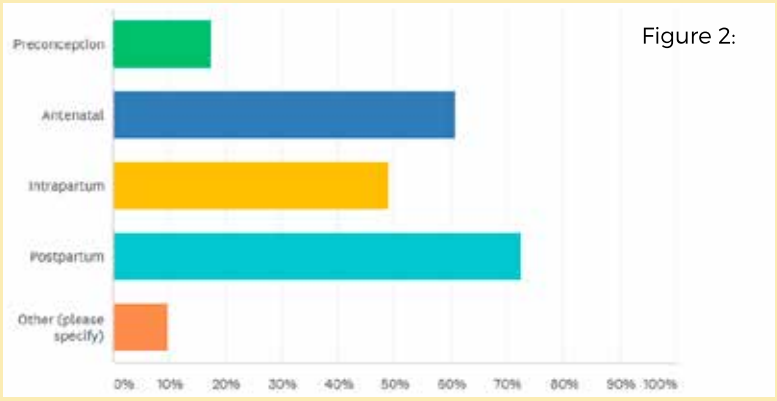


Figure 2:

CONCLUSION

This survey showed that midwives hold a set of values, goals and ideals, derived from their underpinning philosophy of midwifery care. This closely relates to what they expect from their association. Midwives emphasized the need to work on the principles of care, holism, advocacy, relationship, compassion, education and evidence-based practice. It is also clear that midwives want the profession to advance and they look to the association to be part of this change,

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Pauline Borg

Nathalie Zammit's Nursing and Midwifery Career

Nathalie Zammit nee' Guillaumier started her long Nursing and Midwifery Career in February 1973. She and her close friend Miriam Beck nee' Muscat, went to the United Kingdom and took up the State Registered Nursing Course at Grantham & Kesteven General Hospital in Lincolnshire and at the Leicester Royal Infirmary, U.K. They qualified as State Registered Nurses in 1976.

Later, in 1976, both Nathalie and Miriam proceeded to Chertsey, Surrey where they took up Midwifery training at St. Peter's Hospital. Midwifery training included three months working in the community. The Domino System of Care was practiced. Continuity of Care was given to mothers by the district midwife at the mother's own home. The same midwife cared for the mothers antenatally, intrapartum and postnatally, starting with the booking visit at the mother's residence. Subsequent antenatal visits were also carried out in the mother's home.

The community midwives used to also run a ward in the general hospital. They brought in mothers in labour, delivered them at the labour ward, transferred them to the community ward, cared for them for the first six hours in that ward and then discharged them home where they continued looking after the mother and baby for up to 10 days or, for a longer period, if the need arose.

Each student was assigned to a community midwife who shadowed her throughout the three months placement. When mothers went into labour, the midwife and her student used to go to the mother's home and cared for her there. When labour progressed, the mother was taken to hospital and cared for her as explained above. This system was both client and midwife friendly.

Both Nathalie and Miriam qualified State Certified Midwives in 1977 and both were employed as Midwives at St. Peter's Hospital. Nathalie was assigned duties at the Labour Ward. Besides assisting mothers in labour, she helped in setting up epidurals. She obtained a certificate in assisting during the Setting Up of Epidurals and in the Topping Up Procedure of Epidural Analgesia. She also carried out scrubbing duties during cesarean sections. Midwives completely ran the labour ward theatre. There were no nurses employed there.

Nathalie returned to Malta in January 1978 and immediately started working at the Maternity Unit of the Blue Sisters' Hospital. This was a 15 bedded Private Maternity Hospital which also comprised 20 cots, one incubator, a cesarean section theatre and two delivery rooms. In this unit, holistic care used to be given to mothers and babies.

Rooming in was practiced most of the time during the day and night. Care was given antenatally, in labour and postnatally, including complications during pregnancy, in labour and postnatally. Care of preterm babies was also provided. However, when there was a complicated case, the baby used to be transferred to the Special Care Baby Unit at Karin Grech Hospital. Nathalie continued working at the Blue Sisters' Hospital until January 1981 when the hospital closed down.

Between February 1981 and July 1983 Nathalie worked as a Private Practice Midwife in collaboration with an obstetrician doing Home Deliveries. During this time, she cared for mothers during labour, delivery and postpartum. Antenatal Care was given by the Obstetrician at his clinic. Nathalie got to know the couple when the Obstetrician referred them to contact her and book them for the Home Delivery. She only met them again when the mother went into labour. Care was also given to the newborn in the couple's home.

In July 1983 she started practicing the Art of Midwifery at the Labour Ward, Karin Grech Hospital as a Shift Midwife and in 1987 she became Head of Shift.

In 1989 she was promoted to Deputy Midwifery Officer and in 1991 to Midwifery Officer in charge of the Labour Ward. She carried out Midwifery Officer's duties until July 1996 when she was appointed Departmental Midwifery Manager. In this post, she helped the Manager Midwifery Services to run the Midwifery Services of the Obstetrics & Gynaecology Department and the Special Care Baby Unit.

On the 1st January 2001, Nathalie was promoted to Manager Midwifery Services, taking on the responsibility of the whole department, whilst collaborating with the Head of Obstetrics & Gynaecology. She also worked closely with the Chief Executive Officer, the Director Nursing Services and the Medical Administrator. On the 28th February 2013, Nathalie was appointed the first Chief Midwifery Manager of Mater Dei Hospital and worked in this capacity up to her retirement on the 24th December 2015.

A few of her responsibilities included liaising with Mater Dei Hospital's Directors, especially the Director Human Resources, cooperating closely with the Midwifery Department of Gozo General Hospital, Chairing Selection and Disciplinary Boards and Assessing Students during Clinical Examinations.

Highlights in Nathalie Zammit's Career

Post Qualification Diploma – Health Science: Between 1993 and 1995 Nathalie read and obtained the Post Qualification Diploma from the University of Malta. Her dissertation focused on Initiating and Managing Change in the Delivery of Midwifery Care.

Master of Science Degree – Health Services Management: She continued her studies at the University of Malta and acquired this degree in 1997. Her thesis was entitled Evaluating Clinical Outcomes on Implementing and Managing Team Midwifery in Malta.

Team Midwifery System of Care

The purpose of this system of care was to change the fragmented care provided in Traditional Systems, into a Team Midwifery approach. Team Midwives recruited

mothers during the booking visits. They were followed throughout pregnancy and delivered by team midwives. Team Midwives also visited the mothers on the antenatal and postnatal wards. This system provided clients with Continuity of Care by Known Carers throughout the three phases of childbirth. This system provided a 100% maternal satisfaction rate.

The mothers were so satisfied with the Team Midwifery System of Care that they suggested that this system was to be extended and made known to all women. It also resulted in an increase in job satisfaction for midwives. Team midwives were very enthusiastic on this concept of care and all agreed that every midwife was to be given the opportunity to permanently belong to a team. These satisfaction rates meant that a more efficient and dynamic system of care was provided with the Team Midwifery System. This system became a service for the mothers and ran for five years. Unfortunately, it was abruptly stopped by the Head of Obstetrics and Gynaecology for no apparent reason.

Breastfeeding Walk-in Clinic

In her capacity of Manager Midwifery Services, Nathalie Zammit was the catalyst in the setting-up and opening of the Breastfeeding Walk-In Clinic. She assigned Helen Borg, Midwife qualified on the topic, to work towards the opening of this clinic on the Postnatal Ward at Karin Grech Hospital. The service of this clinic was to welcome mothers with breastfeeding problems who could call in from home and be helped with their problems. The service started on a small scale and grew as the years went by until it became the service offered today.

Leonardo Da Vinci E.U. Projects

Nathalie Zammit, together with Mary Buttigieg Said, Specialist Midwife, worked and obtained Leonardo Da Vinci European Union projects as follows:

Normalizing Childbirth and Breastfeeding Baby Friendly Initiative Project

23 Midwives were sent to Midwifery Led Units and Birth Centres in the U.K. to obtain an insight on how these units were run by Midwives. Each Midwife spent two weeks in these units. This project took place between 2009 and 2011 and funding for this project amounted to 34,000 Euro. Nathalie Zammit and Mary Buttigieg Said themselves travelled to the U.K. to visit these units to undertake the necessary arrangements for the Midwives prior to the latter going there.

Promoting Normality in Pregnancy & Childbirth Project

68 Midwives travelled to the U.K. for an intensive one week study period. This study was in collaboration with the University of West England in Bristol. Besides the one week study in Bristol, the Midwives had to also show evidence of 92 hours of learning. This project consisted of seven modules and for the finalization of this project a conference was organized here in Malta. Nathalie Zammit opened the conference. E.U. Funding for this project amounted to 63,300 Euro.

Nathalie Zammit enrolled as member of the Malta Midwives' Association as soon as she returned to Malta in 1978. She was an active committee member of this association for many years. She performed duties of Secretary, Treasurer between 1995 and 2008 and President. She participated in annual general meetings of the European Midwives Association. She presented papers and opened conferences locally on regular basis.

Reflections and Recommendations

Nathalie Zammit stated that the most job satisfaction she achieved during her midwifery experience was when she worked in the Domino System of Care in the U.K. She said that this system offered one of the best continuity of care systems one could achieve when compared to the fragmented care offered today.

She explained that this system could easily be introduced in Malta by setting up groups of three to four midwives per group, working in collaboration with each other, in hospital and community. Mothers would receive care within their own community throughout pregnancy, taken to hospital to be delivered and continue being taken care off in the mothers' homes postnatally.

She suggested for one of the Obstetrics Wards to be dedicated to the midwives working within this system of care, whereby midwives would exclusively care for the mothers under their care, for the first six hours post delivery. While collaborating with obstetricians, this system would give midwives more autonomy. It would also minimize undue travel by women and their partners. Midwives would give all care in the women's homes and in health centres in towns and villages.

Before embarking on such a system of care, one needs to plan the system in great detail. Constructive discussions with obstetricians need to take place. One needs to investigate the midwives' interest in working in such a system since it definitely involves great responsibility and commitment. One also needs to evaluate the financial aspects of such a system by cost analysis and comparison with the traditional systems of care being used at present at Mater Dei Hospital.

Nathalie went on to elaborate that certain Midwifery Skills would resurface with this system. The fact that midwives would be looking after mothers in their homes would largely diminish the use of fetal heart monitors being continually used today. Midwives would make use of the traditional fetal stethoscope instead of using monitors.

They would also revert to palpating the women's abdomen instead of sending the mothers for multiple ultrasounds. Care would be more women-centred since midwives would be caring for mothers and giving them personalized attention rather than continually looking at monitors. The level of communication between midwives and mothers would be much higher.

In conclusion Nathalie stated that it had always been her dream to offer the Maltese Mothers a continuity of care system. She emphasized that the mothers would be highly satisfied with the service offered to them and that the midwives would have an optimal level of job satisfaction. They would also be highly appreciated by their clients.

Pregnant during Pandemic-Snippets into Mothers' Worldview

COVID-19 is a worldwide public health emergency with outbreaks being documented in every continent (Vasconcellos Freitas-Jesus, Rodrigues, & Garanhani Surita, 2020). The clinical outcomes associated with COVID-19 in pregnant women and babies are still uncertain (Vasconcellos Freitas-Jesus, Rodrigues, & Garanhani Surita, 2020). Particularly some studies suggest the risk factors for respiratory complications are similar to that of the general population (Breslin, et al., 2020; Knight, et al., 2020) whilst some studies show that maternal respiratory morbidity related to covid-19 is notably higher than that of the general population in particular women who already suffer from certain comorbidities such as obesity, diabetes, hypertension and advanced age (Kayem, et al., 2020). Moreover some studies suggest a higher risk of premature labour (Kayem et al., 2020).

Pandemics like this are a source of anxiety, sadness, and fear. In addition to pregnancy and the uncertain scenario related to the disease, pregnant women may be experiencing intense psychological suffering, which can cause serious consequences in terms of mental health (Vasconcellos Freitas-Jesus, Rodrigues, & Garanhani Surita, 2020). Additionally the imposed restrictions, although crucial, may take a considerable toll on mental health (Matvienko-Sikar, Meedya, & Ravaldi, 2020; Rivaldi, Wilson, Ricca, Homer, & Vannacci, 2020).

The COVID-19 pandemic has taken us all by storm. Thorough and intensive research must take place if we are to truly understand the phenomenon which is unfolding before us. In the local context, it is both interesting and necessary to document local mothers' experiences during this pandemic. Since we have no research in this moment, I feel that it is important to draw upon foreign research in hopes of shedding light on the local scenario. During this pandemic, as midwives, we have become accustomed to the new gear and procedures: the mask, the gloves, the apron, the visor, the alcohol, the restricted visitation hours and so on. However, I cannot help wonder how do mothers feel to be engulfed by the stresses of a pandemic during such a unique and vulnerable time in their lives? As stress, anxiety, depressive symptoms, insomnia, denial and anger in pregnant women continue to spiral (Matvienko-Sikar, Meedya, & Ravaldi, 2020), what is traditionally a happy and exciting time has been overshadowed by worry and anxiety (Ashworth, 2020). As midwives we bear witness to how this pandemic has left the mothers we care for consumed by fear and in isolation.

In a study done in Italy (Rivaldi et al., 2020) researching 1787 women using a COVID-ASSESS survey, open text responses were analyzed examining expectations and concerns before and after the onset of the pandemic. What was alarming in this study is that with regards to basic emotions, 'joy' was the most prevalent emotion expressed before COVID-19, with fear being the most prevalent after covid-19 (Rivaldi et al., 2020). In addition whereas fear was the most common word used by women to describe their birth expectations both before and after covid-19, looking further into the responses show 'fear' differed across the two time points (Rivaldi et al., 2020). Before COVID-19, fear was associated with an emotion that would ultimately bring joy, happiness and sharing, and serenity, whilst after covid-19 it was associated with restriction, sadness, loneliness, pain, anxiety and inability (Rivaldi et al., 2020).

In a recent AIMS journal 20 women shared their experience about their pregnancy and/or birth experience in the UK during the Covid-19 pandemic (Ashworth, 2020). It was clear that women are experiencing profound fear. Fear for their safety, their unborn babies and loved ones (West, 2020). Moreover, they are experiencing a fear of hospitals and they seem to feel that the longer they spend in hospital, the more they are at risk (West, 2020). Additionally in the UK, some areas have completely discontinued homebirth and water birth services and thus women feel that their choices have been greatly reduced (Miller, 2020). A woman explained " I am keen to stay away from hospital as much as possible, so the thought of having no choice but to go to hospital to give birth, during a pandemic is very frightening" (Miller, 2020 p.20). What may be more apparent now, now more than ever, is that healthy women, women who have no risk factors benefit greatly from an out-of-hospital birth experience.

Furthermore, as social media continues to flood the feeds with covid-19 related news, society continues to be plagued by a climate of fear, uncertainty and anxiety, regarding the present and future (Vasconcellos Freitas-Jesus, Rodrigues, & Garanhani Surita, 2020). This situation is increasingly burdening for pregnant women whom even in the absence of the pandemic commonly experience feelings of uncertainty and anxiety related to labour, childbirth and the arrival and care of a newborn (Rivaldi, Wilson, Ricca, Homer, & Vannacci, 2020). One woman recalls how she found herself "awake during the night on Google looking for answers on how the virus could affect unborn babies, pregnancy, giving birth and newborns" (Noble, 2020, p.13). However, in the absence of social contact with the outside world, social media has proven to be vital for interaction. Women described how online pregnancy groups, video chatting with their personal midwives and online antenatal classes have been essential for their mental wellbeing and to ease the fear associated with covid-19.

In some UK hospitals, women were forced to labour

without their partners as hospitals implemented further restrictive measures which heighted emotions of sadness and distress (Rivaldi, et al. 2020). For some women, even antenatal visits without partners may be distressing, let alone laboring without their partners (West, 2020). The situation is worse when mothers undergo birth complications. Under these pandemic restrictions, one woman described her birth experience as being a 'nightmare'; "cheated out of a day that should have been amazing" (Castelino, 2020, p.25). This woman explains how having to endure an emergency caesarean section without having her partner to support her during such a distressing and emotional time made her feel helpless and alone (Castelino, 2020). To make matters worse her newborn twins had to be transferred to the neonatal intensive care unit. Thus, she felt she had to push herself more than she physically and mentally could to travel alone to the neonatal intensive care unit which only allowed one hour of visiting hour (Castelino, 2020).

To conclude, even though these are stressful times for us midwives as well, I do feel we need to do our utmost to make pregnant women feel as at ease at possible especially during these difficult times. Despite these times of hardship our efforts do not fall unnoticed. One woman quotes

> *"everything was done with a smile… you may not be able to see them behind the masks but you could see it in their eyes and hear it in their voices" (Colquhoun, 2020, p.9).*

And although all the masks and gloves can be unnerving to certain women, women recall how the compassionate care of midwives was of paramount importance of offsetting this great challenge we are facing; "…the fear of the virus can not be taken away, but my midwives have certainly soothed them" (Powell, 2020, p.31). It is these testimonials which show us how we can be of solace even in the darkest of times.

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Claudine Grech
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Optimising her birthing experience: What matters to *her*?

I need

I need kindness because I praise my baby every day but scold myself.
Because its wrinkled little features are beautiful, but my stretched, dark, skin is ugly.
Because it's crying because it needs something, but I'm crying because I'm not good enough.

I need compassion because I am a person, not a bump
Because I am in the middle of my whole life, not just Week 36
Because I am hopes and fears, not just a blood sugar level

I need respect because…I am growing a baby inside me!
Because I'm currently more than one human being but not yet two,
Because I'm becoming a mother, because the life inside me is becoming a new member of our world, because we are evolution in action.

Catherine Grosvenor
(As cited in "The Roar behind the Silence")

The midwife has a unique role to play in optimising a woman's birthing experience: we can make the difference between a traumatic birth experience and a positive, empowering and fulfilling experience for the new mother. In the year 2020, parents-to-be face even more fear, stress, and uncertainty in the shadow of the Covid-19 global pandemic and hence it is timely that we reflect on our role as midwives and our priorities during this precious time in a couple's life. We are there for women, to be 'with women', but what does that look like in practice during labour? What should it look like? Does reality match with the ideal?

Our role as healthcare professionals is to ensure the health and safety of the mother and child, but is this enough? Is this the **only** thing that matters? Complaints of maltreatment on social media pages, movements such as '#metoo in the birth room' and organisations like 'Birthrights' would suggest otherwise- it is often words spoken or perceived attitudes of staff members that seem to hurt the most (Birthrights 2017). Whilst it is perhaps human nature for us to react defensively with a whole plethora of excuses such as "we were very busy" or "she had unrealistic expectations" and the classic "she has a healthy baby, what more does she want?", it is more constructive to reflect on our actions and seek ways to improve every woman's experience of birth and initiation into motherhood. A healthy baby is not all that matters - it may be the most important thing; however, it is not the only thing that matters. Women matter, their wishes, their fears, their experience matters too (Hill 2019).

Central to this reflection should be the needs of the women, who come to Central Delivery Suite and are expected to blindly trust and 'obey' the healthcare professionals caring for them. The natural process of labour is often treated as a high-risk event as we fear adverse birth outcomes, leading to over-medicalisation and unnecessary interventions. The focus on a "healthy baby" at all costs can over-ride women's own preferences and instil a sense of fear in what should be a normal, physiological event. Globally, women are reporting high levels of disrespect and abusive care in maternity services, robbing them from what should be a positive pivotal moment in a family's life (Simelela 2018). It is time to move away from this overly archaic patriarchal culture and put the woman and her rights central to the care we provide. A "good" birth goes beyond having a healthy baby. The focus of the global agenda has gradually expanded beyond the survival of women and their babies, to the more holistic approach in ensuring that they thrive and achieve their full potential for health and well-being. International guidelines such as those by the World Health Organisation (WHO 2018) and the National Institute for Health and Care Excellence (NICE 2017) have been updated to promote the delivery of a woman-centred package of care which ensures that giving birth is not only safe but also a positive experience, through a holistic, human-rights based approach.

International law protects all childbearing women's Universal Rights. The 'Respectful Maternity Care Charter: The universal rights of childbearing women' (2011) highlights maternal health rights particularly within the broader human rights context. This document

outlines the specific international laws which protect childbearing women's universal rights. In Europe, these rights are also protected by the European Convention on Human rights. These fundamental human rights including dignity, autonomy and equality are relevant to the way a woman is treated during pregnancy and birth. Examples such as the failure to provide adequate maternity care, lack of respect for women's dignity, invasions of privacy, procedures carried out without consent, the failure to provide adequate pain relief without medical contraindication, administering pain relief when it is not requested, unnecessary and unexplained medical interventions, as well as a lack of respect for women's choices about where and how a birth takes place, may all violate human rights and can lead to women feeling degraded and dehumanised (Birthrights 2017).

The guideline 'WHO recommendations: Intrapartum care for a positive childbirth experience' (2018) highlights respectful maternity care which maintains dignity, privacy, and confidentiality, ensures freedom from harm or mistreatment and enables informed choice and continuous support during labour. Effective communication, a birth companion of choice throughout labour and birth as well as continuity of care (ideally in midwife-led continuity of care models) are the recommendations with which this guideline opens. WHO then delves into the specifics of communication to include practices such as:

- "Introducing themselves to the woman and her companion and addressing the woman by her name
- Respecting and responding to the woman's needs, preferences, and questions with a positive attitude
- Supporting the woman's emotional needs with empathy and compassion, through encouragement, praise, reassurance, and active listening
- Supporting the woman to understand that she has a choice, and ensuring that her choices are supported
- Ensuring that procedures are explained to the woman, and that verbal and, when appropriate, written informed consent for pelvic examinations and other procedures is obtained from the woman" (WHO 2018)

The NICE Intrapartum Care Guideline has also been adapted over the years with previous guidelines focused almost exclusively on clinical actions, the most recent version (2017) emphasises the importance of good intrapartum communication and respect for women's autonomy. A direction is now made to senior staff to "demonstrate, through their own words and behaviour, appropriate ways of relating to and talking about women and their birth companion(s), and of talking about birth and the choices to be made when giving birth." The authors emphasis that **HOW** the birth is conducted is just as important as **WHAT** we do. Instructions are given such as "Ensure that the woman is in control of and involved in what is happening to her and recognise that the way in which care is given is key to this". Similarly to WHO (2018), NICE (2017) also goes on to specify how we should communicate with women, addressing also the importance of maintaining a calm and confident approach so that our demeanour reassures the woman that all is going well.

The issue of gaining informed consent is a central issue. When women are discussing their birthing experiences phrases such as "I was not allowed to…" or "They wouldn't let me…" are unacceptable in a woman-centred model of care. We need to treat women as persons worthy of respect, who are indeed capable of making their own autonomous decisions about their child's birth. Our duty as midwives is to inform women of unbiased evidence-based information so that they can make their own decisions, and then respecting their decision even if we do not agree with them. Performing any procedure, such as vaginal examinations or instrumental deliveries without the explicit informed consent of the woman is deemed as obstetric violence and is something that can leave lasting psychological trauma for the new mother.

It is not only the words that we choose to use however also the way in which we communicate which makes a difference. We can encourage, praise, and boost a woman's self-perception and belief in her ability to birth her baby, or we can degrade and erode a woman's self-confidence. The table below highlights some examples of alternative phrases which may have a more positive effect (Mobbs et al 2018). (Table 1)

The midwives' demeanour and communication with the woman as well as with colleagues in her presence will impact her levels of fear and stress. Consideration to the birthing environment, such as dim lighting, soft voices, protecting the couples' privacy and limiting interruptions can all contribute to a positive environment, and help the mother feel safe and calm. Discussing the woman's wishes and preferences, whether verbally expressed or in the form of a birth plan, will empower her to birth her baby the way she wants to (Dahlberg et al 2016). Evidence suggests not only humanistic and emotional benefits to reducing stress and fear in labour however many physical benefits also such as the reduced need for analgesia in labour, reduced risk of medical intervention including instrumental and emergency caesarean births (Buckley 2015). This not only has a cost implication however reduces the workload on the midwives and healthcare team, with shorter lengths of stay, less complications, and less complaints.

These are simple things that we can do to promote positivity. The Dalai Lama said, "A simple smile. That's the start of opening your heart and being compassionate to others." Smiles have the ability to change one's whole day,

"you are **only** 3cm dilated"	"your cervix is 3cm dilated- you are doing great!"
"big baby"	"healthy baby"
"delivered"	"gave birth"
"failure to dilate/progress"	"delay in the 1st stage of labour"
"poor maternal effort"	"delay in the 2nd stage of labour"
"good girl"	"you're doing really well"
"you are not allowed to get out of bed with an epidural"	"I would recommend that you stay in bed as an epidural may numb your legs and you might fall if you try to stand up"
"you must have a caesarean section"	"I would recommend a caesarean section because... (giving benefits, risks, alternatives)"
"she refused"	"she declined"

Table 1

and not only to the one that's smiling, but also to those who see a smile. It is just a simple expression, and yet it may be the most powerful, as it is the most positive one. Even when wearing a surgical-mask or protective personal equipment, those around you can still tell if you are smiling. Boosting positivity in the birth room will not only have profound effects on the parents-to-be and their birthing experience, but also on the midwife and the healthcare team.

In attempting to reduce the fear and stress that may be experienced by a mother in labour, it is useful to reflect on our own feelings and fears towards labour and birth. What are we afraid of? Is this impacting the care that we give, the aura that we ooze in the labour room? Are we filled with a positive confidence in woman's ability to birth her baby safely, or are we fearful of all the potential complications that may arise? In identifying our own innermost assumptions, we can then reflect on the effect this has on our demeanour, our information giving and our care-plan decisions. In turn, our body language and undertone in communication will determine whether the woman in our care is able to trust us, have confidence in us and feel safe and secure.

To help us with these reflections, we can tap into resources such as books like "The Roar Behind the Silence" by Shiela Byrom and Soo Downe, "Birth Crisis" by Shiela Kitzinger and "The Positive Birth Book" or "Give Birth like a feminist" both by Milli Hill. We can make use of similar resources online, watching 'youtube' videos or listening to podcasts on the subjects of birth rights and positive birth. Locally our 'Positive Birth Movement' is a great source of inspiration, and hearing uplifting positive birth stories can inform and influence our behaviours, so that we may continue to develop and enhance our midwifery practice.

We can take measures to reduce our own fear and stress and that of our team. In the same way that the expectant parents need to feel safe and cared for, so do we in our workplace. Only when we feel cared for ourselves are we truly able to have care and compassion towards mothers in labour. The system and management are responsible for certain elements in our workplace culture, however, there is a lot that we can do for ourselves and our colleagues every single day. Make self-care a priority; get enough sleep, balance family-life, exercise, eat nourishing healthy food, practise mindfulness or whatever relaxation techniques work for you. When at work, care for your team. Do we always support and help each-other? Are we consistently complaining and criticising, or are we complimenting and boosting one another? Do we promote a positive work environment? It is amazing the ripple effect a kind-gesture or kind word can have on a mother-to-be, on your colleague, on your team. Let me challenge you to be more mindful of your words and your actions and take notice of the impact you can have on the people around you.

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Roxanne Galton
B.Sc (Hons) Midwifery, MA Advanced Practice

LA ROCHE POSAY
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Skin irritations in children and babies
Protect against daily aggressions

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solar erythema

Rubbing
nappy rash,
chafing

Insects
bites

Cold
chapped skin, dry patches

Saliva
irritative dermatitis
angular cheilitis

Bacteria
impetigo

Falls
minor wounds, cuts &
grazes

Eruptive diseases
chickenpox

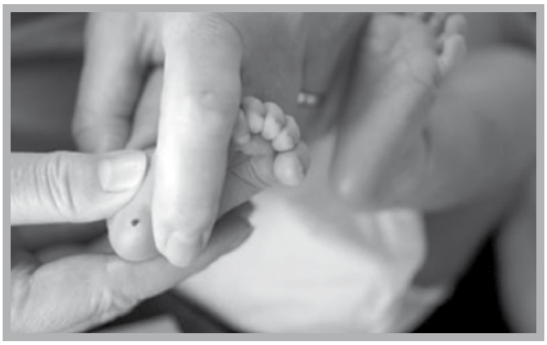
Heat
minor burns,
minor scalds

CICAPLAST
BAUME B5
SOOTHES REPAIRS PROTECTS

Hypoglycaemia of the Newborn

Introduction

Medicalisation of childbirth is trending rapidly into the postnatal period. Babies are no longer considered to be term and healthy, care seems to focus on risk factors and is becoming more and more modelled on treating these whether or not the condition has occurred. Every new mother fears caring for her baby in the early days, it is a role where confidence develops as she learns to understand her newborns needs. Unfortunately medicalised models of care increase a mother's anxiety giving her worries that she feels little control over and which in some women can continue for a prolonged period of time (Wray, 2006).



Hypoglycaemia has become the lastest trend in normal neonatal care within Mater Dei Hospital. Large numbers of babies are being labelled as 'at risk' and commence blood glucose monitoring. This tends to continue for extended periods of time and of course at some point one reading is low and interventions start.

Metabolic Adaptation at Birth

Blood glucose is the body's source for energy so when levels are low body function is affected. During the transition to extrauterine life blood glucose levels in nearly all newborns fall during the first 1- 2 hours. This drop can go as low as 2.2mmol/l and then rises over the next 12 hours (Adamkin & Polin, 2016). Unhurried, uninterrupted skin to skin contact between mother and baby for at least the first hour following birth help the baby to maintain a normal body temperature and reduce energy expenditure. The first breastfeed should be initiated during this period of skin to skin as early breastfeeding has been found to lower the incidence of hypoglycaemia (Lowmaster et al 2014).

For the next 24 – 48 hours it is common for the neonate to feed infrequently. This does not cause problems in healthy, term infants who will respond to with a process called counter-regulation, the production of endogenous fuel production through gluconeogenesis, glycogenolysis and ketogenesis. The newborn brain has an enhanced ability to utilise ketones providing it with glucose and protecting neurological function. As the infant recovers from birth the demand to feed should naturally increase so that by 72 hours the baby will feed betwen 8 – 12 times in 24 hours. In fact, during the first 24 hours intervals of 8 hours between feeds have been shown NOT to be linked to hypoglycaemia with term, healthy neonates. However, it is important during the first 48 hours to distinguish babies who are naturally not bothered to feed with babies who are excessively sleepy and reluctant to feed (Adamkin, 2016). Observant, bedside midwifery care differentiates these babies. Formula fed babies do not have such an effecient counter-regulation so feeding should be more frequent with the use of breastmilk substitutes (Lowmaster et al 2014).

The risk of hypoglycamia becomes a concern when there is excess utilisation of glucose including hyperinsulinemic states or the infant is unable to produce an adequate counter-regulation These babies are identified by maternal history and clincal observation and examination of the newborn and involve implementation of a plan of care that includes blood glucose monitoring and feeding management (Thompson-Branch & Havranek, 2017).

Local Audit

In 2019 a small audit was performed at Mater Dei Hospital to observe managment of hypoglycaemia and how this relates with evidence based practice. Babies were followed through their hospital stay to note reason for monioring, length of time monitored and management of hypoglycaemia. During the audit period staff were advised not to supplement breastfed babies unless a venous blood glucose was below 2.6mmol/l one hour post feeding or the babie was symptomatic.

It was evident that formula fed infants have low-key management whilst breastfed infants have immediate and often aggressive management. Interventions for formula fed infants mostly occurred when levels dropped below 2.4mmol/l whilst breastfed infants normally had supplements introduced when levels were 2.8mmol/l which is not even considered as hypoglycaemia. Management then varied hugely, and the majority of the time there was no evidence base behind the plan of care.

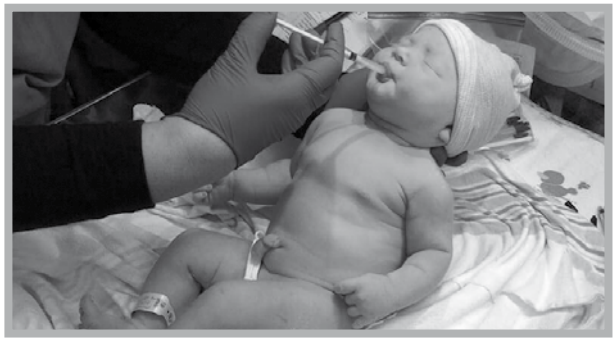
- Many breastfed babies were supplemented from birth because they were considered at risk of hypoglycaemia.
- Paediatricians were immediately informed when a blood glucose is low despite standard care being to feed the baby and recheck blood glucose after one hour. Thus midwifery/nursing care was unable to provide simple intervention and observation without guidance from the medical team.
- A number of breastfed babies where considered as hypoglycaemic with blood glucose less than 3.0mmol/l with immediate introduction of formula milk. No action was taken with formula fed infants with similar readings.
- Supplements were rarely supplements, more often than not they were complete feeds.
- Some cases were managed by giving larger feeds, either the baby was offered a large bottle and encouraged to drink as much as possible or feed was calculated at 80ml/kg/24 hours rather than at 60ml.
- Continuing supplements with increased daily amounts until discharge
- Formula milk supplement given first followed by breastfeeding.
- Blood glucose monitoring often continued until

discharge despite no episodes of hypoglycaemia. The worst example was a small for gestational age baby who had 12 consecutive good readings who was only not discharged because the mother needed an extended stay.

- Formula fed infants mostly had increased feed volumes although this often caused vomiting and did not always cause an immediate rise of blood glucose.
- Questioning of whether venous samples were the standard thus intervening anyway because capillary sample gave a low result although venous sample was within a normal range.

Some good management plans were seen but these were the exception rather than the rule

- A venous sample taken and with action only being implemented if result showed hypoglycaemia.
- Increased feeding frequency to 2 hours until blood glucose increases.
- Supplementing with expressed colostrum whatever quantity was harvested. This actually worked well along with 2 hourly feeds.
- Supplementing breastfeeding with a small amount of formula 10-15 mls. This also worked well.



Evidence Based Practice

A team of paediatricians have analysed this audit and are in the process of producing a hypoglycaemia policy. Hopefully this will result in more standardised management that is evidence based and stops undermining breastfeeding. The rapid introduction of formula supplements given by bottle with no attempt to express colostrum has an extremely negative effect on both breastfeeding and milk production. Women feel they did not feed their baby properly and lose all confidence at being able to return to exclusive breastfeeding and very often stopped completely (Chantry, Dewey & Peerson, 2014). Feeding plans need to correct low blood glucose but this can be done alongside supporting effective breastfeeding. Formula fed infants also deserve evidence based practice. Giving large feeds might solve the problem of hypoglycaemia but there should be consideration to what effect this may have on the child's long term health. Babies prime their appetite and metabolism in the first few weeks of life, overfeeding during this time can lead to lifelong obesity (Patel & Srinivasan, 2011).

Oral glucose gel to reverse hypoglycaemia was one important recommendation to come out of this exercise. An aqueous gel which is massaged into the oral mucosa of the cheek following a feed causes rapid absorption of glucose. This non-invasive, inexpensive treatment standardises the management of hypoglycaemia and does not undermine the mother's choice to breastfeed (Harris et al, 2013). Availability of oral glucose gel is expected in the near future.

Single episodes of low blood glucose are not associated with neurological damage so mothers must not be scared into compliance with this. Hypoglycaemic encephalopathy is associated with persistent or repeated episodes of severe hypoglycaemia and it would be highly unlikely that this would occur with asymptomatic hypoglycaemia.

Recommendations

An updated and evidence based hospital policy for screening and treatment of hypoglycaemia in the neonate should support standardised care preventing, hypoglycaemia whilst supporting breastfeeding and Baby-Friendly standards. It is important that on the launch of this policy all disciplines are aware of it and adhere to it.

Conclusion

An updated and evidence-based national guideline for screening and treatment of neonatal hypoglycaemia will support standardised regimes, which may prevent hypoglycaemia and the risk for hypoglycaemia-related long-term sequelae.

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Busting 5 myths about *modern cloth nappies*

Cloth nappies are increasing in popularity and many parents are now becoming interested in using the cloth nappy option with their babies. We meet lots of parents who would like to try cloth nappies but are still afraid or confused because of certain myths that surround cloth nappies.We've been there! And we're here to tell you: it's not true. Here are five myths and the truth about modern cloth nappies.

1. We do not put poop in our washing machine

Many people think that when using cloth nappies you place poopy nappies inside the washing machine. The truth however is that put poop goes where it belongs i.e. in the toilet. Some people also use biodegradable liners which hold poop and are disposed of in the garbage to make it easier to deal with poop. As for the rest of the nappy, let the washing machine do its' brilliant work.

2. Cloth nappies do not need to be boiled

With a simple cold quick wash and another intense 40-60°C wash in the washing machine, nappies will come out smelling fresh and ready to reuse.

3. Cloth nappies no longer involve pins and needles

Pins and needles are no longer needed with modern cloth nappies. The velcro, snaps and prefold fasteners are the new fastening systems that make cloth diapers as easy as disposables.

4. Washing modern cloth nappies is simple

A lot of parents are concerned that cloth diapering will involve a lot of time and effort especially due to the washing routine. Whilst it will involve some time and effort, it's not as bad as it might seem. With around 15 to 20 nappies you will wash twice a week and have enough cloth nappies to use with your baby full time.

5. Cloth nappies are not smelly

Used cloth nappies can be placed in waterproof and reusable wet bags that keep odours from coming out. At home, a bucket with a lid can be used until it's time for laundry.

We understand that because cloth nappies are relatively new to the scene, there are lots of questions and misconceptions about them. Before we started using cloth diapers, we too were almost discouraged from trying them out, but now we are so glad that we didn't. Our experience has showed us that cloth diapers are practical and easy to use and we are happy to share this experience with as many parents as we can.

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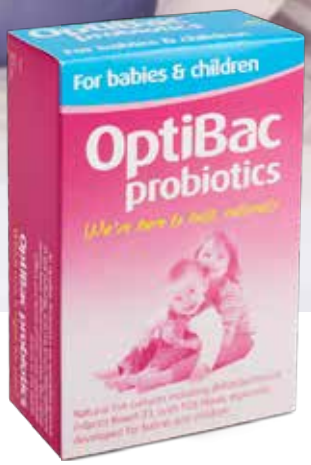

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Exploring Evidence for Gastric Lavage in Babies - Altered Vomiting. Why does it happen? What are the recommendations for Rusty Duct Syndrome?

Exploring the evidence for gastric lavage in babies

Performing early gastric washout in babies soon after birth in all neonates with meconium-stained amniotic fluid (MSAF) is still practiced in many hospitals. The incidence of MSAF ranges from 5-12% of all live births per annum (Wiswell, 2001; Nangia, 2014). A portion of infants born with MSAF may swallow meconium and although unsubstantiated, it is hypothesized that the presence of meconium in the stomach act as a chemical irritant, interfering with gastric function and causing feeding problems. The routine use of gastric lavage in MSAF babies has been advocated for a long time as part of the conventional treatment and surprisingly this recommendation is also made in some textbooks, without supporting evidence. This recommended practice is not without risks – it can cause complications like bradycardia; apnoea; vomiting; trauma; aspiration and esophageal or gastric perforations; increase in mean arterial blood pressure; increased wretching and disrupted sequence of pre-feeding behaviour (Desmond, Rudolph & Phitaksphraiwan, 1966; Niermeyer & Keenan, 2001; Bonnard, Carricaburu & Sapin, 1997; Widstorm et al. 1987; Garg, Masand & Tomar, 2014).

Narchi and Kulaylat (1999) had found that those babies that did not undergo elective gastric lavage, the incidence of secondary respiratory owing to pulmonary aspiration as well as feeding problems was nil – identical to the group where gastric lavage was routinely performed. In addition, it was suggested that gastric washout is not necessary in most babies born with MSAF, regardless of the thickness of the meconium-stained fluid. Anand (2004) found that gastric suction undertaken at birth, is also associated with a long term risk of a functional intestinal disorder. The majority of the babies with MSAF (95%) do not have feeding problems and their natural history seems to be devoid of the theoretical complications feared from meconium remaining in the stomach and hence there is no role of routine prophylactic gastric lavage. Moreover, the reduction in the number of lavages result in savings on resources including nursing time, medical equipment and clinical attention, as well as, preventing procedure-related complications, without an increase in morbidity and allows a quicker establishment of early breastfeeding and maternal infant bonding (Narchi & Kulaylat, 1999; Sharma et al., 2013). As stated by Widstorm et al. (1987), although the physiological side effects induced by gastric washouts are minor, it seems to be unpleasant for the newborns. The aspiration of gastric contents through a catheter in newborns can be a noxious stimulus. Such stimuli, especially if repeated, can increase functional disorders in adulthood (Anand, 2004).

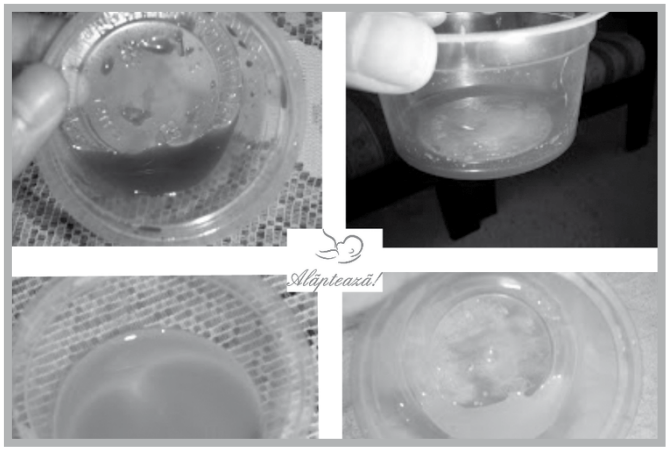
Thus, it may be suggested that gastric lavage should be reserved for treating the rather rare occurrence of feed intolerance in neonates born with meconium-stained liquor, rather than being performed on a routine prophylaxis basis.

The rusty duct syndrome

The presence of bloody discharge in a lactating mother can elicit anxiety and concern among the mother and medical staff and also opens the door for many benign and malignant differentials for certain conditions. Bloody nipple discharge during lactation can occur as a result of several common factors such as trauma, cracked nipples, mastitis, abscess or other more serious conditions such as intraductal papilloma and fibrocystic disease (Deboni, Moldenhauer & Do-Nascimento, 2018; Gueye et al. 2013). The timing of blood stained breast milk is important to rule out the causing factor.

Cause of rusty pipe syndrome

An uncommon physiological condition known as “rusty pipe syndrome” can cause painless bloody discharge in both pregnant and postpartum women. Rusty pipe syndrome is a breastfeeding condition in which the colour of the breast milk looks either pink, orange, brown or rust-coloured, similar to dirty water coming out of an old rusty pipe (hence the name of the syndrome). The rusty colour is a combination of colostrum with a small amount of blood. This rusty-coloured milk usually appears during the first few days of breastfeeding, where in most cases, this syndrome is spontaneously cured within 2-7 days after the onset of lactation (Cintesun, Gul, Akar, Ezveci & Celik, 2017; Virdi, Goraya & Khadwal, 2001).



The syndrome is a benign and self-limiting physiological condition that should be included in the differential diagnosis in women who present with painless bloody nipple discharge during gestation and lactation. This condition may go unnoticed unless the mother is expressing the milk or the infant vomits out blood, which tests positive for adult haemoglobin (Faridi, Dewan & Batra, 2013). The etiopathogenesis of this syndrome occurs due to elevated vascularization of rapidly developing alveoli in breasts during later half of the pregnancy. These delicate

and overgrown capillaries rupture easily and result in blood staining secretion. The syndrome is commonly seen in primagravida mothers, as stated by Melob et al. (1990), mainly happens in bilateral breasts and sometimes induced or exacerbated with Hoffman's procedure, which is frequently recommended for flat or inverted nipples (Clark, Rudert & Mangasaryan, 2011). Lafreniere (1990) estimated that 15% of lactating women have blood in their early secretions.

Safety of blood-stained milk

Initial diagnosis of rusty pipe syndrome is based on medical history and routine physical examination. Specialized investigations including cytological analysis of the bloody discharge, to exclude the presence of any malignant cells, as well as breast ultrasound, which help rule out other pathological conditions (Deboni, Moldenhauer & Do-Nascimento, 2018; Gueye et al. 2013).

Nursing mothers are often concerned regarding blood-stained breast milk – whether it is safe to be consumed by their infants. Such concerns are made worse when some online advices vary from discarding the breast milk and discontinuing breastfeeding to continuing breastfeeding. The decision is also mixed amongst health care professionals, between discarding the milk or to be given to the infant. The main concern raised is that blood-stained breast milk may result in gastrointestinal disturbances such as vomiting or regurgitation and any unnecessary investigation to be carried out especially in premature babies, where necrotizing enterocolitis is a common complication. In fact, this is highlighted by Phelps et al. (2009), where only 22% of the neonatal nurse practitioners, recommended feeding moderately blood milk. Faridi, Dewan & Batra (2013) and Barco et al. (2014), found that the infant was able to tolerate the blood-stained milk without any complications. Hence, this shows that it is considered harmless to feed an infant with a blood stained milk and there is no need to substitute with artificial milk during this period, if the infant is able to tolerate the blood-stained breast milk.

Recommendations

In rusty pipe syndrome cases, nipple manipulation should be strongly discouraged and if the infant tolerates milk, then breastfeeding should be continued and encouraged to strengthen exclusive breastfeeding. The mother should be evaluated further, if the bleeding persists for more than a week. It is important to create awareness among the medical healthcare professionals regarding proper counselling and management of this condition, so as to avoid causing anxiety and unnecessary investigations to the mothers. Hence, proper counselling is crucial to encourage these mothers to successfully breastfeed their infants in such challenging situations.

In addition, human milk can offer advantages to NICU infants (AAP, 2005; Schanler et al., 2005; Meier et al., 2004; Edmond et al., 2006; Lambert et al., 2007; Updegrove, 2004; Street et al., 2006). The unique aspects of colostrum's composition includes more than twice the concentration of protein of mature milk with four to eight times of B12 and vitamin E concentration (Lawrence & Lawrence, 1999) plus the cells of maternal origin (Chirico et al., 2008). Thus, deciding that an NICU mother's colostrum should be discarded on the basis of blood contamination, can be of medical relevance. When expressed breast milk is discarded by professionals, an unintended message of inadequacy can be conveyed to the mother, who might already be dealing with guilt from delivering a preterm or otherwise ill neonate. Certainly, if significant risks to the well-being of the neonate can occur consequent to consuming blood-tinged milk, parents and healthcare professionals alike, would wish blood tinged milk to be investigated and if need be discarding. Hence, evidence is continuously needed to facilitate risk/benefit analyses in such situation, thereby enabling informed decisions.

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Working through Change with Focus on Adequate Exposure in NPICU

Change may be difficult, but it is also necessary for organisations to grow and develop as plenty of literature will show. Unfortunately, there will always be some resistance to change, but with authentic leadership, the change has the potential to reap benefits on many levels [1,2]. It is up to all involved to ensure that this will remain the continued direction for the organisation.

NPICU was inaugurated and developed by Midwives in Malta and had always remained up to this day as a midwifery entity. Midwives have always been at the forefront of the NPICU workforce as it is inherent in midwifery training. As midwives, we are trained in optimum care in the postpartum period, neonatology, recognition of the sick neonate and very importantly, the psychological support that these new families require.

Despite any management changes, Midwifery will still always have a place in NPICU. NPICU was always a collaboration of Midwives, Nurses and Doctors towards a common goal, and with a mission unchanged, this collaboration is intended to stick. As midwives working at NPICU, we have always worked for recognition of the midwives' role here through the support of the family unit and the neonate. Although circumstances might be different, we will still do that, possibly more so than before.

Midwives have, in recent years, not had as pleasant an experience as rotators as would be desired. As an intensive care unit, often full to capacity, the workload is substantial, and staffing always a problem. This has always created problems for adequate teaching and learning opportunities. Hopefully, with the plan to implement a 6-month rotation period with appropriate support, we will be able to provide them with a better rotation period to better expose them to the role of Midwifery in the NPICU and all its facets.

Clinical education and mentorship have long been discussed as methods of teaching in the healthcare professions, although having become more prominent only recently. While there are many different terminologies, each with their slight differences in the description, they are a learning relationship between an experienced educator and a student for a specific placement or course usually associated to the clinical setting[3]. The clinical educator can facilitate the transition from theory to practice by filling the gap between both areas of healthcare professionals' education[4].

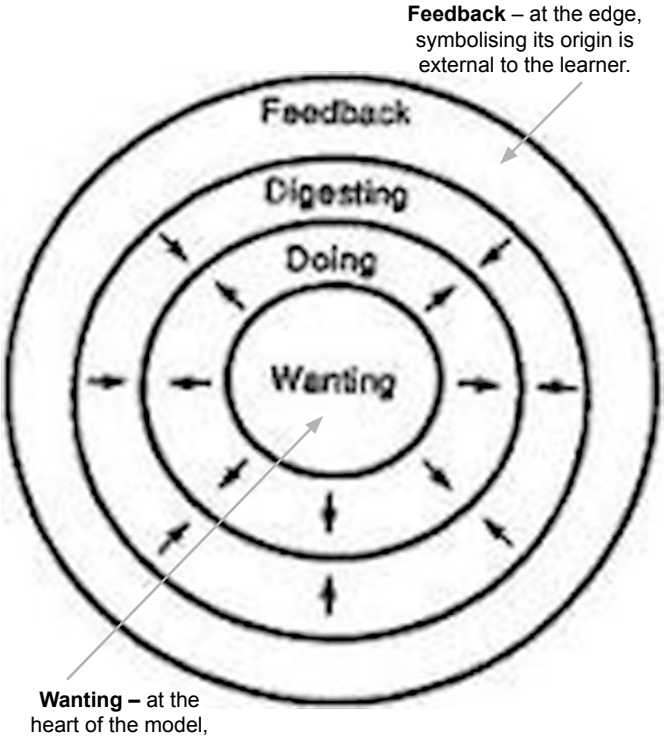
Through the possession of certain qualities, a mentor can be central to the success of the learner by providing sound knowledge, practice skills and feedback through a teaching and assessment continuum. Such qualities should include, amongst others; trust, openness, listening skills, patience, teaching skills, clinical knowledge, approachability, and critical reflection[5].

According to the Five-Stage Dreyfus Model[6], clinical education can lead our midwifery graduates from *'Novice'* to *'Expert'* through skills acquisition with adequate learning opportunities. This model can be summarised as:

Novice:	*Needs instruction, monitoring and first achievements. Follows instructions closely.*
Advanced Beginner:	*Needs simple, controlled situations. Has limited situational perception and treats aspects individually.*
Competent:	*Needs real experiences. Shows deliberate planning and improved coping strategies.*
Proficient:	*Needs abundant practice and the overall picture. Has holistic understanding, perceptive and is an active decision-maker.*
Expert:	*Needs to expand knowledge and experience. Intuitive with tacit knowledge and analytical with vision.*

Clinical education should place the learner at the centre of their own learning by making them an active participant in the learning process. Giving the learner the chance to do something alone gives them more practical knowledge and greater confidence, for there is a difference between simply supervision and clinical education, as the latter requires guiding the student towards their own learning[7].

Another model is that of Phil Race[8] (1993), based on Kolb's Learning Cycle[9] (1984), in that learning is truly most effective by *doing* and requires *feedback* for the learning process to progress, and this is assimilated



Phil Race's Ripple on a Pond Model of Learning (1993)

together during a process he termed as *digesting*. Race's theory compares the interaction between each process like those of ripples in a pond, starting from the middle, the start of the entire process of learning, which is *wanting*, or need to learn something more.

In summary, Race's Ripple Model for successful learning is as follows:

- *Needing/Wanting* – Motivation
- *Doing* – Trial and Error or Practice
- *Feedback* – Results, or response received
- *Digesting* – process of understanding or making sense of it

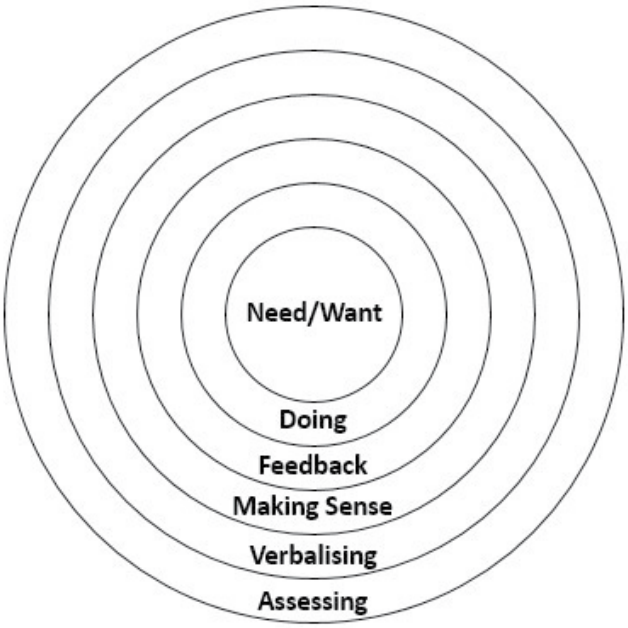
According to this model, our inherent need or want to learn sends ripples out that encourages us to do something and actively seek feedback on it. Feedback, on the other hand, send ripples back in, which, after reflection and consideration will affect how we do things and create a new desire to learn more or to learn how to do it better. While the doing and the digesting are usually overlapping, all rings in the model send 'ripples' to the others affecting them in some way, and this influence is continually ongoing both from within and from the feedback received (Race, 1993).

According to Race[10] (2015), through the education of others, we are enhancing our learning. Phil Race explains this by adding another two rings to his model to include *verbalising* and *assessing* as he believes that verbalising through teaching helps us to learn more ourselves as clinical educators. Then this is in turn further enhanced when assessing how much of what we have taught has been absorbed. This can easily be linked with the expectations of learning at the '*Expert'* level on the Dreyfus Model.

Prospective students need to be better involved in NPICU placements. The best time to be exposed to the NPICU is as a mentored student. It provides adequate, supported exposure to a setting that has much from which to learn. Students who have already had a mentored placement are more likely to be confident in their rotational period and more likely to reach greater expertise. According to the Scope of Professional Practice, the education and instruction of students is part of the role of the midwife in all healthcare settings[11].

Considering the possible limitations within the course outline for adequate placements at NPICU, a supported rotation period will then serve as a secondary opportunity for midwives to get their footing on a role critical to neonatal care relevant to their other places of work too. Recognising the sick neonate through working at NPICU will aid midwives to recognise neonates at risk in all of the maternity setting, and be able to support them as best as possible to try and minimise chances of morbidity for the neonate and the disruption of the new family unit.

As a midwifery entity, keeping open doors for midwives should be the focus, now and always. Enabling a fitting exposure during rotation and offering a fair chance for midwives to choose NPICU will keep the link open as it always was. Furthermore, enhancing ties with the institute, to better expose students to all departments, is key to keeping the full diversity of midwifery. Students should be involved in all aspects of midwifery, not only its core focus, as it opens many more opportunities while keeping the true midwifery spirit alive.



Race's 2015 Ripples Model of Learning

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Smart Staff, Smart Phones, Smart Bugs?: Infection risk of using hand held devices.

Today's society is fully immersed in the digital age and technology is part and parcel of almost every facet of our daily lives with the supposed purpose to make it easier and more manageable. It is therefore no surprise that handheld devices such as smart phones and tablets are also used in the healthcare field.

Smartphone devices carry out the conventional functions of a mobile phone allowing for instant social and professional communication along with more advanced computing capabilities which allow users to access software applications commonly termed as "apps". There are various applications designed especially to assist healthcare professionals in clinical practice at the point-of-care such as medical calculators, reference tools, medical guidelines such as resuscitation algorithms and drug guidelines with the aim to improve patient outcomes (Koehler et al 2013, Manning et al 2013, Mickan et al 2014, Nick 2020). Indeed various apps on my personal smartphone include up-to-date, induction, NeoMate and other pediatric resuscitation apps which offer various benefits, be it for quick access to real time reliable data, telephone extension numbers, using the calculator to calculate daily fluid balances or just simply checking the time.

Purpose for using mobile phone during clinical practice	*n*
Access emails	22
Access medically related internet sites	19
Access medically related mobile phone apps	14
Make and/or receive phone calls from healthcare colleagues	27
Make and/or receive phone calls from patients	16
Send and/or receive patient related information such as photographs (e.g., rashes/lesions) or results (e.g., ECGs)	6
Send and/or receive text messages from healthcare colleagues	22
Send and/or receive text messages from patients	6
Record patient appointments	4
Record patients' clinical data (e.g., medical notes/results etc)	0
Take photographs of clinical cases (e.g., wounds, rashes)	13

Source: Koehler, N., Vujovic. O., McMenamin, C., 2013. Healthcare professionals' use of mobile phones and the internet in clinical practice Journal of Mobile Technology in Medicine 2:1:3-13 DOI:10.7309/jmtm.76

A concern regarding the use of smart phones within clinical practice pertains to cross-infection. As portable devices, mobile phones come into close contact with heavily contaminated human body areas with a subsequent cross-infection risk should healthcare professions not carry out adequate hand hygiene. A study by Ulger et al (2009) showed 94.5% of healthcare workers mobile phones to be contaminated with various types of microorganisms. 49 % of theatre and Intensive care staff phones grew one bacterial species, 34 % two different species and 11.5% grew three or more different species with MRSA isolated from 52% of the phones. Similar studies by Borer et al (2005), Brady et al (2005) and Kirkby & Biggs (2016) also found a significant percentage of phones and hands to be contaminated with multi-drug-resistant organisms (MDRO's) such as *A. baumannii*. After a systematic review of the literature regarding smart phone usage and neonates in the NICU, Curtis et al (2018) report a pathogenic rate of 40% to 100% with the majority of presenting bacteria being nosocomial pathogens and some MDRO's. Daoudi et al (2017) discovered a 100% bacterial contamination rate of all mobile phones studied in a Moroccan NICU, of which 35% were also contaminated with MDRO's. Modern touch screen devices have been associated with a lower rate of bacterial contamination than traditional keypad alternatives and wiping with disinfection wipes found to reduce bacterial contamination, however studies still overwhelmingly recommend rigorous adherence to hand hygiene as the most effective means of preventing the transmission of pathogens to patients (Brady et al 2005, Osborne et al 2012, Kirkby & Biggs 2016, Daoudi et al 2017).

Kirkby and Biggs (2016) and Wentz & Bowles (2018) advocate the use of a phone cleaning station and disinfection by rubbing with 70% isopropyl alcohol for 15 seconds to remove potential bioburden. Other strategies mention placing the phone in a transparent zip-lock bag prior to entering the clinical area (Manning et al 2013, Pyrek 2017) and ultra violet radiation devices are also available on the market for phone decontamination. It has to be emphasized however that only with strict hand hygiene compliance within the clinical environment is it possible to view smart phone devices as safe and invaluable tools of daily practice (Osborne et al 2012, Kinsey 2019).

Considering the risks and benefits, the answer seems to lie not in barring technology from clinical areas but in being aware of the advantages and disadvantages it affords whilst at the same time using a disciplined approach to assure patient priority and safety at all times. A strategy to reduce the risk of health care-associated infections transmitted by mobile device cross-contamination would be to ensure infection control training for all clinical staff stressing the vital importance of compliance with hand-hygiene policies and the need for environmental and routine device disinfection. Pertinent information also needs to be provided for visitors and the patients themselves on the importance of appropriate hand hygiene and technique (Beckstrom et al 2013). Having a clear policy with specific recommendations for the appropriate and safe use of mobile devices in the health care setting is also necessary, including detailed instructions for the cleaning and disinfection of phones, tablets, and cases (Borer et al 2005, Kinsey 2019).

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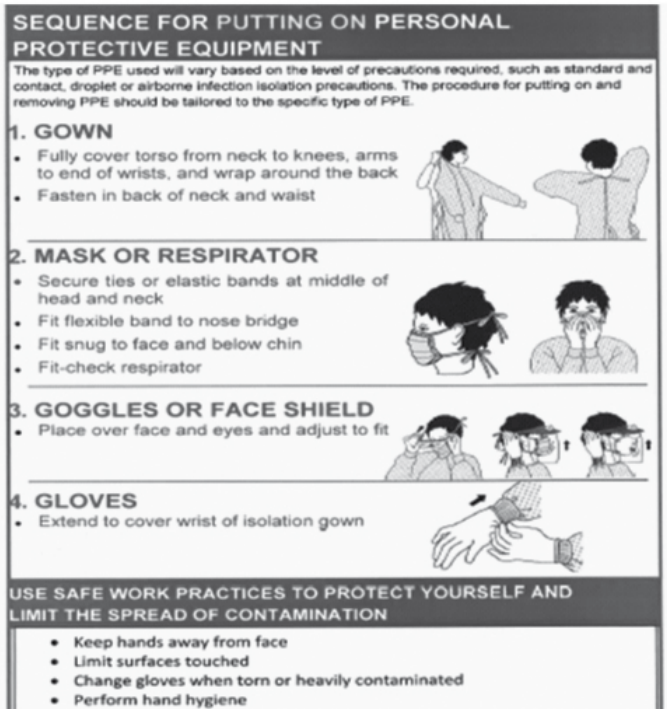
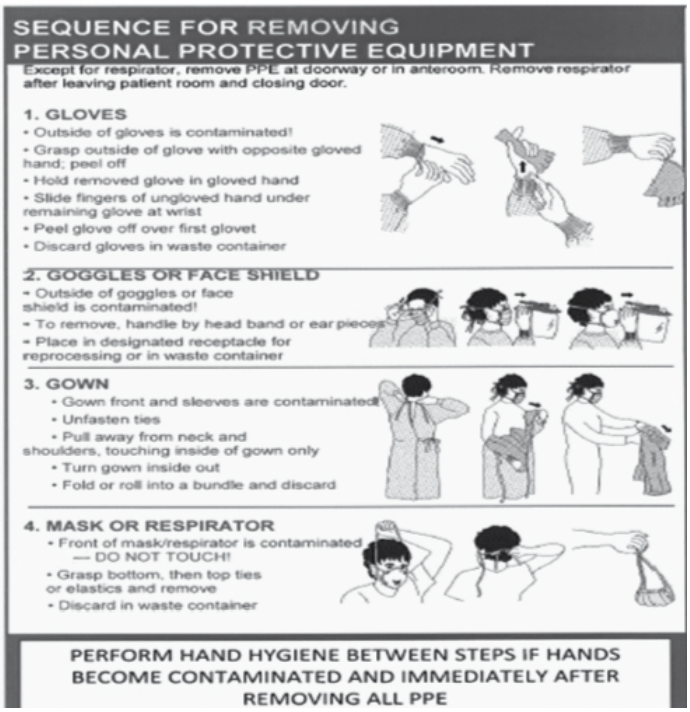
Sequence of Putting On and Removing PPE





M.Sc Abstracts

Maintaining a Balancing Act: A Research Project Investigating Satisfaction with Work-Life Balance & Its Impact on Nurses and Midwives in the Local Public Hospital

With the pace of work increasing in the last decade, the demand to achieve work-life balance (WLB) has been on the increase (Pandey, Shukla & Nanda, 2018). Studies show that employees within the healthcare industry have high work-life conflicts due to their schedule, work relationships, burnout, and job-related stress, which has resulted in a global shortage of HCPs (Drazi & Evans, 2016; Leineweber et al., 2016; Neumann et al., 2017). Little is known about the current satisfaction with WLB of HCPs in the local setting.

The aim of the study was thus to investigate satisfaction rates with WLB of HCPs, to explore the employees' work characteristics and WLB initiatives offered at the workplace, as well as their impact on WLB and employee outcomes. The effects of social demographics on WLB were also explored. Lastly, the impact of satisfaction with WLB on employee outcomes was also analysed. A quantitative research design using one-time questionnaires was adopted to fulfil the proposed aims and objectives of the study. A census was carried out through the distribution of 200 questionnaires to midwives and nurses working within the maternity department of the local public hospital. A response rate of 95% (190) was achieved. The collected data was analysed using IBM SPSS.

The findings demonstrated that the majority of HCPs were not satisfied with their WLB. Findings also showed that WLB was affected by the work environment, WLB initiatives, and the individual's demographics. Results further showed that some areas of work offered WLB initiatives to the employee, while other areas did not. Barriers to using initiatives also featured. Additionally, the study demonstrated that employee outcomes were affected by the level of satisfaction with WLB, the work environment, and incentives used.

These findings were compared with previous studies, and recommendations for practice were proposed. The study suggests improving working conditions, increasing staffing levels, improving policies to make use of leave, having flexible rosters, and receiving support from the management as ways to enhance WLB of employees. Lastly, the author provided recommendations for further research, mainly through exploring the effects of personality on WLB.

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Charlie Gard and Alfie Evans: State-Sanctioned Euthanasia?

The cases of Charlie Gard and Alfie Evans, although similar, were taken to court for different reasons. Charlie's parents applied to Court intending to get permission to allow the child to travel abroad for experimental treatment whilst, Alfie's parents sought permission to allow the child to travel abroad for comfort of care.

The main purpose of this small-scale research study is to examine in-depth the cases of Charlie Gard and Alfie Evans and analyse the rights of the different individuals involved in these cases. The objectives of such a study, aimed at achieving more knowledge on the Best Interests Standard and the different rights of the health professionals and the parents in cases of conflict on the plan of treatment for a child. A semi-structured interview schedule, designed by the researcher of the study, was used as a research tool, to conduct interviews with four paediatricians working in a private sector or at the local general hospital. Interviews were recorded and transcribed using thematic data analysis as explained by Richard and Morse.[1] Three themes emerged from the qualitative data including, The cases, The Rights of the Health Professionals, and The Rights of the Parents. Results showed that all health professionals emphasized the importance of good communication with the families of the children involved, while also claiming that parents should be the ultimate decision-makers in their child's plan of care. All paediatricians participating in this study, believed that the sentences were just as treatment was, in fact, futile and these children were suffering as also stated by the Best Interests Standard. Furthermore, all participants believed that referring to the media, was not ideal as these cases were sensitive and ought to have remained private.

Given these findings, the author believes that with better communication between the parents and the health professionals, a better outcome could have resulted. In cases where a decision cannot be reached, the health professionals and the parents should meet with an external mediator to decide upon a better plan of care for the child. The court should always be left as a last resort.

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Appropriate Hospital Staffing Levels for a Healthy Work Environment: Health Care Professionals' Views on Staffing Levels and its Effects.

Having appropriate staffing levels is crucial in the health care sector, and it is widely acknowledged that appropriate staffing levels are needed to be able to deliver safe and effective care. Despite this, the problem of staffing levels continues to persist, stubbornly resisting solutions. A substantial amount of research has shown that there is a significant relationship between staffing levels and both patient and employee outcomes. However, such findings seem to be "ignored". Moreover, locally, this topic is at risk of stagnation.

Therefore, the aim of this research study was to explore health care professionals' (HCPs) views on the local staffing situation, focusing on the maternity sector of the local public hospital. To fulfil the study's aims and objectives, a quantitative approach was adopted, and a self-designed questionnaire was distributed to be able to gather data. The researcher distributed 185 questionnaires to midwives and nurses who work within the maternity setting. Data was then analysed using SPSS.

Overall, findings of this study indicate that locally HCPs perceived their staffing levels as inadequate, suggesting that shifts are quite often understaffed. HCPs argued that low staffing levels were leading to a decrease in the quality of care provided, putting patients at risk. In fact, low staffing levels were strongly linked with a higher risk for complications, morbidity and mortality amongst patients.

Furthermore, inappropriate staffing levels were also negatively affecting employees leading them to feel over-worked and over-stretched. Due to low staffing levels, employee's felt burnt out and exhausted which was negatively affecting both their physical and mental well-being. Such burnout also increased the rate of absenteeism, sick leave and turnover amongst HCPs. This was therefore creating a viscous cycle where one problem exacerbates the other, reinforcing each other.

Finally, it was also concluded that locally, guidelines related to staffing ratios are lacking with the majority of the participants stating that guidelines are either unavailable or not implemented. Moreover, HCPs reported a strong desire to be included in decisions related to staffing numbers which were mainly taken by people in a managerial position.

On the basis of the results, the researcher came up with a number of recommendations for practice and further research. One of the most important recommendations was the need for the development of appropriate nurse staffing ratios to safeguard both patients and employees. Moreover, the researcher also suggests the introduction of an E-rostering system which would help managers make use of all the available resources to implement safe and efficient staffing. Furthermore, the researcher suggests that a large-scale quantitative research would help broaden our knowledge about the topic. Finally, the researcher urges health care organisations, policy makers, managers and HCPs to fulfil their obligation and ensure a healthy work environment where safety is the norm and care of optimal quality is the goal.

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