Effective Communication Between Nurses and Midwives

Created from Article: Special Delivery
Vol. 2, Issue 1 Spring/Summer 2010
Reviewed and updated: April 2017

Effective communication is a constant challenge for all of us. What I have learned from our experience with cases reported to both the Health Care Protection Program and the Midwives Protection Program is that certain communication patterns or problems seem to repeat themselves in obstetrical settings.

In this article I will try to set out a few of those examples to illustrate how effective communication and preparation can assist both nurses and midwives. Of course the same principles and considerations will apply to relations with other health care providers but the focus of this article is on the dynamics between nurses and midwives in a hospital setting.

One of my frequent observations is that for nurses and midwives who have practiced in other jurisdictions, or for midwives who have recently acquired privileges in a new hospital, it is imperative that the nurse or midwife familiarize him/herself with the procedures and guidelines of the new setting(s). It is unsafe to assume that the rules of engagement are the same between one country or province and another and in many respects the same consideration must apply as between hospitals, particularly between health authorities but also for different hospitals within the same health authority.

Both nurses and midwives frequently acknowledge in investigations that they have not taken the time or effort to familiarize themselves with a new work environment. In some instances nursing orientations have been lacking. In other instances policies and procedures that differ as between health authorities, or are inconsistent or unevenly applied in different hospitals within the same health authority, have made the health care providers' lives more difficult than need be.

Midwives must pay particular attention when they are serving clients who may end up in an unfamiliar hospital due to lack of choice, urgency or timing. Clearly not all planned homebirths will remain at home and once they move to hospital, often at short notice,

there is little time to learn the environment, meet staff or read critical policy or procedure. Prepare for these contingencies ahead of time, where reasonably possible, and give nursing staff sufficient information to assist you so that they too can provide the best care possible.

An essential part of the midwife's client preparation and birth plan is to ensure that the client's transfer and transition to hospital care is as seamless as possible. This includes knowing the culture of the facility and being as familiar as possible with the expectations, the guidelines and local policies and procedures: some of which may differ from practice in other facilities.

Conflict or misunderstanding over local policies can lead to significant problems for all care givers and leave clients and families wondering if they are in safe hands: especially so where tension or dispute arises in their midst.

Knowing local procedures and, where possible, the expertise, expectations and limitations of nursing and other health care providers ahead of time can make a sudden change in condition or transfer of an at-home client to hospital less stressful for all concerned. For the registered midwife this may mean taking the time to visit the facility ahead of time and introducing yourself to the staff. For the registered nurse on duty when a midwife is providing care this may mean stepping forward and stating your level of experience and/or ability to provide care given other patient demands and/or staffing levels.

It is important to try to know and understand each other's skills and limitations. Equally, if not more, important is to know your own skills and limitations and to be able to state those clearly. This is especially important between the primary care giver and the second attendant, be that second another midwife or a nurse. I am aware of many examples where nursing staff did not fully understand the midwife's role or did not agree with a particular assessment. Conversely the midwife may have had a different expectation of the nursing staff or second attendant's role(s) in a particular delivery or a different assessment of the urgency or condition of a client or infant. Where arrangements are with a second attendant at another practice or at some distance consider whether that distance or means of transport will, given changing weather conditions, be appropriate for your client's needs.

Obviously not all nurses and not all midwives working in an obstetrical setting will have the same level of experience, confidence, expertise or specialized training. Uncertainty about who can, or who is willing and/or able to do <u>what</u> has led or contributed to some unfortunate outcomes or close calls for clients and their families and for the nurses and midwives providing care. By knowing strengths AND your own limitations, which can change from one birth to another or even during the course of a difficult labour and delivery, you are better serving your client, your profession and your relationship with other health care providers.

There should be no shame for a midwife in asking an available obstetrician to take over suturing a client if the midwife is too tired or too adrenaline rushed to hold the needle steady, or if the tear is of questionable severity. A registered nurse should not hesitate to ask: “Do you need any help?” or “Do you need me to call the obstetrician or paediatrician or other back up?”

There should also be no hesitation in the midwife asking a nurse or her supervisor to ensure the midwife, as the most responsible health care provider, is given the same level of assistance and cooperation that a doctor delivering the infant would be able to count on. Registered nurses for their part need to understand what a midwife’s expectations are and not, as has happened in some unfortunate cases, leave the midwife without the support or cooperation a doctor would receive.

Communication is not only the direct discussion, orders or casual banter that may occur during delivery, it includes how the record is recorded. It should be clear in any delivery who will be responsible for what observations or measures or actions are to be taken by whom. Effective communication includes who charts what, and where and when. Ideally all of this is clear to the relevant caregivers well ahead of time. If APGARS are going to be altered (a frequent problem) or if there are differences in interpretation of foetal monitoring (another frequent challenge) or if there is disagreement in any assessment, it is imperative that there either be some effort at accommodation or a common understanding, or, at a minimum, an explanation must be given in the record.

Where a client's care has been transferred to an obstetrician the continuing role of the registered midwife as support-only, if that is the case, must be made clear to everyone concerned. If care has been transferred back to the midwife, nursing staff need to be aware of that transfer, as does the client and her family. There have been several instances where confusion about who is responsible for providing care have left families feeling abandoned or wondering who is responsible for what and when.

Confusion of all kinds is to be avoided if nurses and midwives are to communicate effectively and ensure the kinds of positive outcomes we all want to enjoy for our clients, patients, families and ourselves as caring human beings.

Grant Warrington RPN LLB MA CRM

It should be clearly understood that this document and the information contained within is not legal advice and is provided for guidance from a risk management perspective only. It is not intended as a comprehensive or exhaustive review of the law and readers are advised to seek independent legal advice where appropriate. If you have any questions about the content of this article please contact the Midwives Protection Program to discuss.