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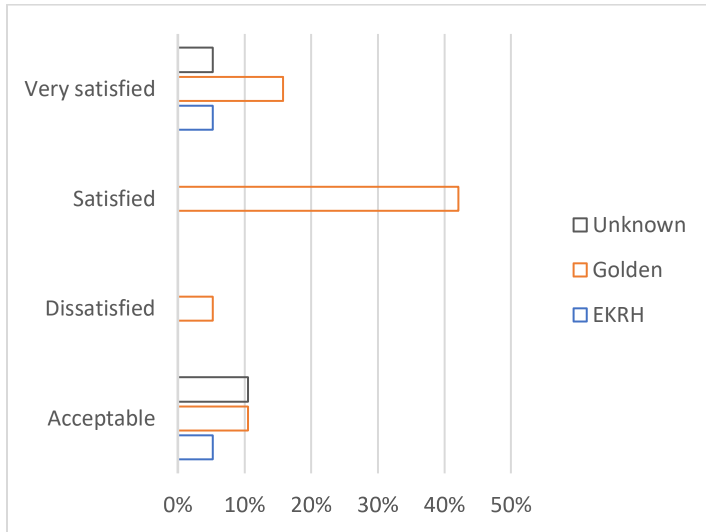
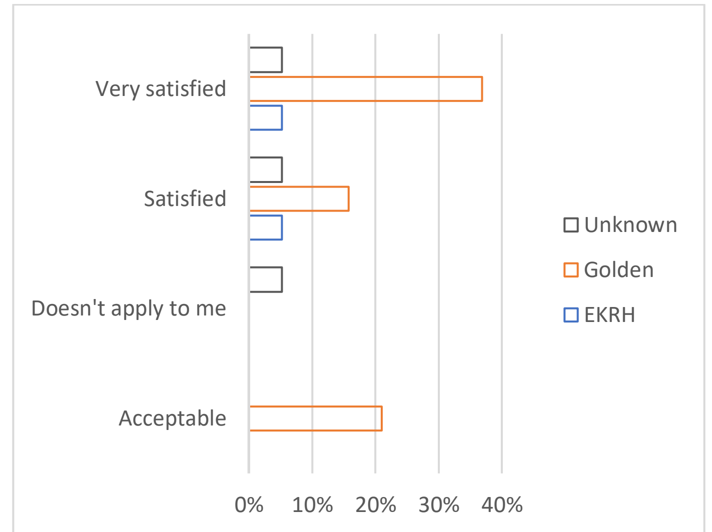
Survey Results

N=19, (4 Family Physicians, 10 Registered Nurses, 2 Mental Health Clinicians, 1. Pediatrician, 1 Obstetrician, 1 Unknown)

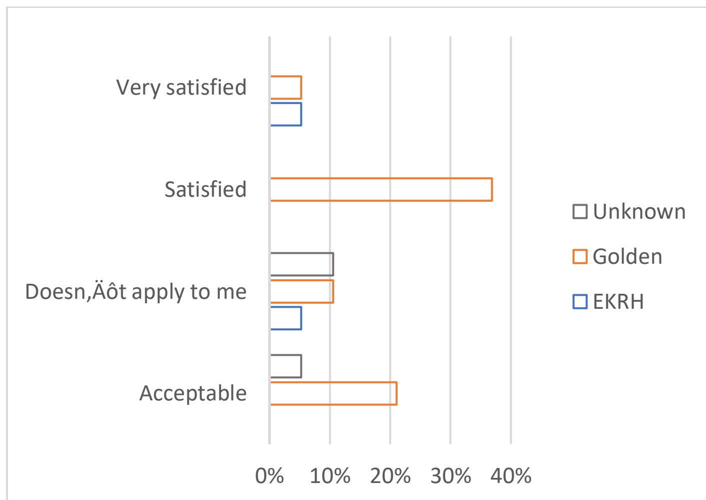
1. How satisfied are you with:
   a. Your community as a place to provide prenatal and postpartum care?



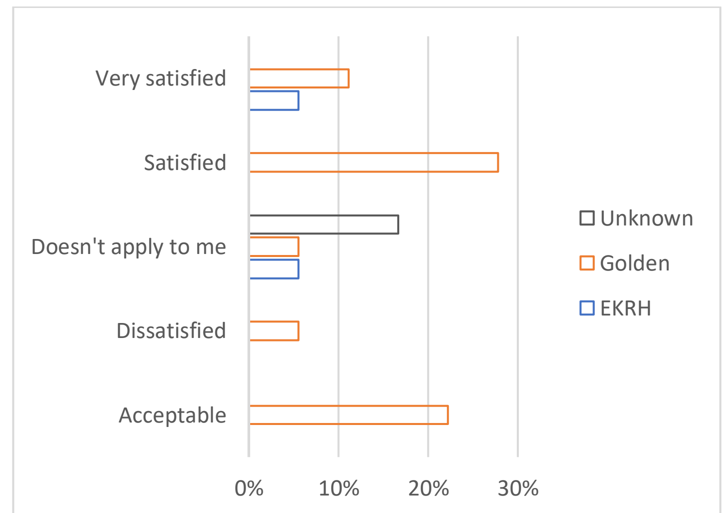
   b. The quality of prenatal and postpartum maternity care provided in your community?



   c. Your community as a place to provide intrapartum care?



   d. The quality of intrapartum care provided in your community?



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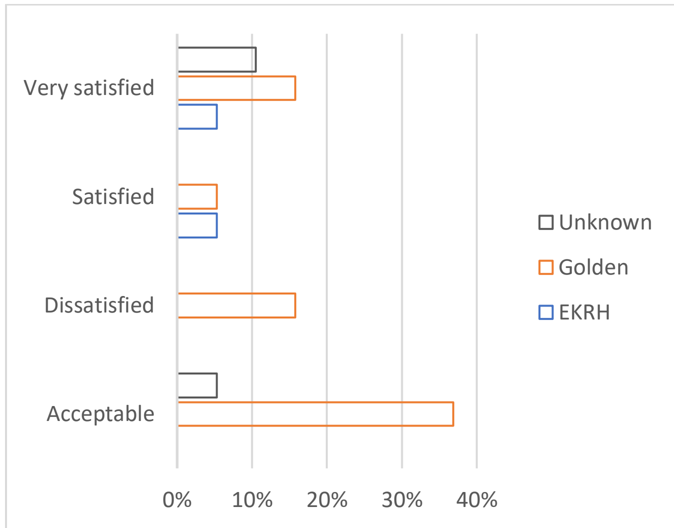
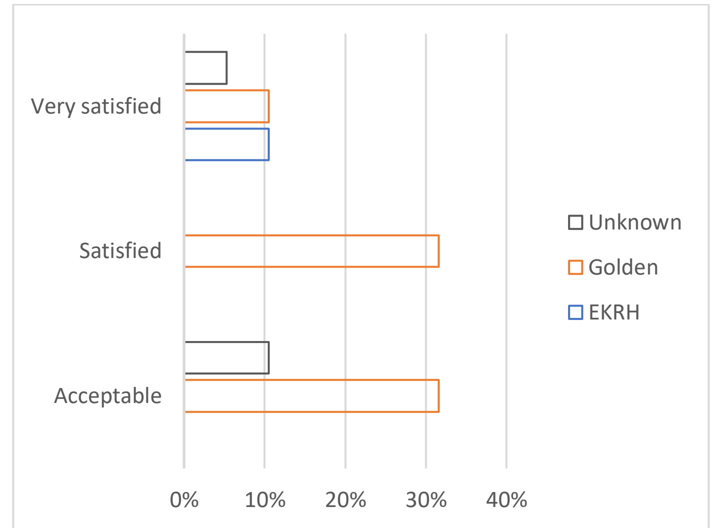
e. The balance between your personal and professional commitments?

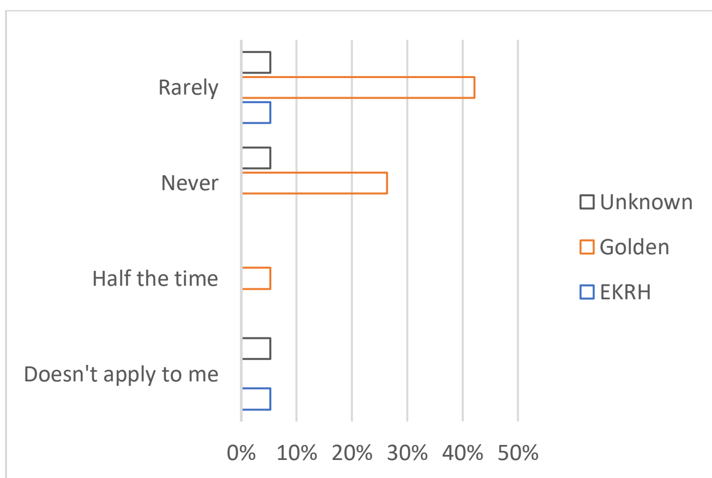


f. Your relationship with other maternity care providers in your community?

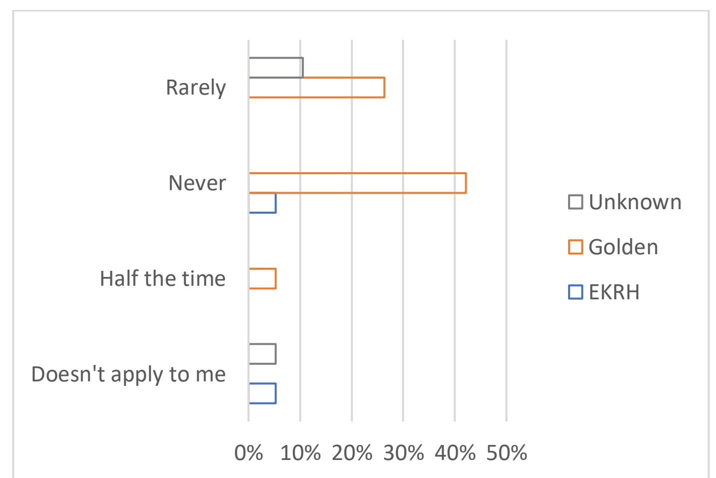


2. In the past six months, how often did you:

a. Delay care or turn away a maternity patient due to capacity concerns?



b. Feel unclear about which patients needed a consultation or transfer of care to another maternity care provider?



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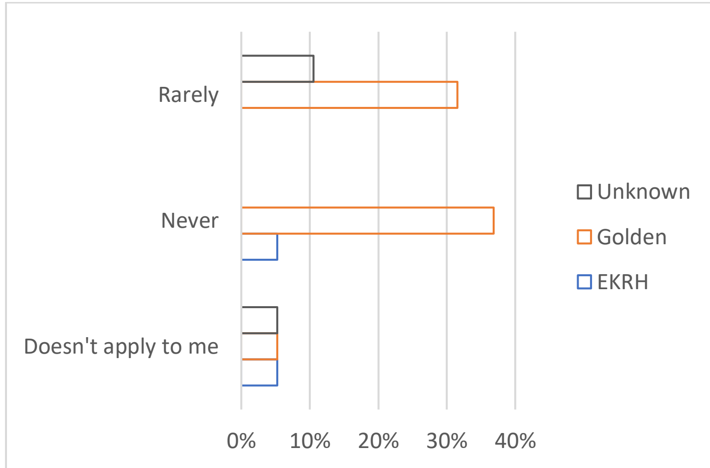
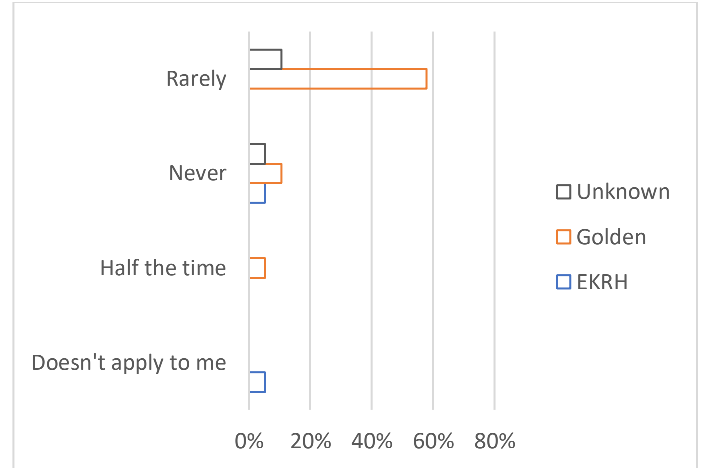
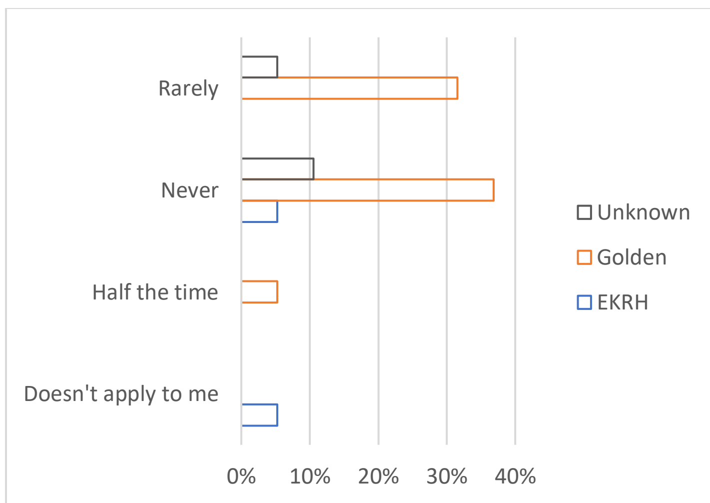
c. Feel unclear about which patients needed a consultation or transfer of care to other care providers (e.g. Endocrinology, Internal Medicine, Anaesthesia, Psychiatry, etc.)?



d. Provide care to a patient who experienced problems due to suboptimal care coordination?



e. Provide care to a patient who was unable to access care from another provider in a timely manner



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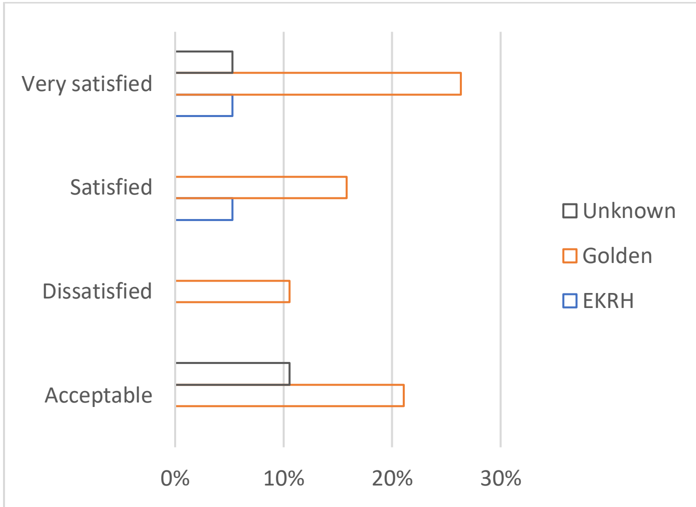
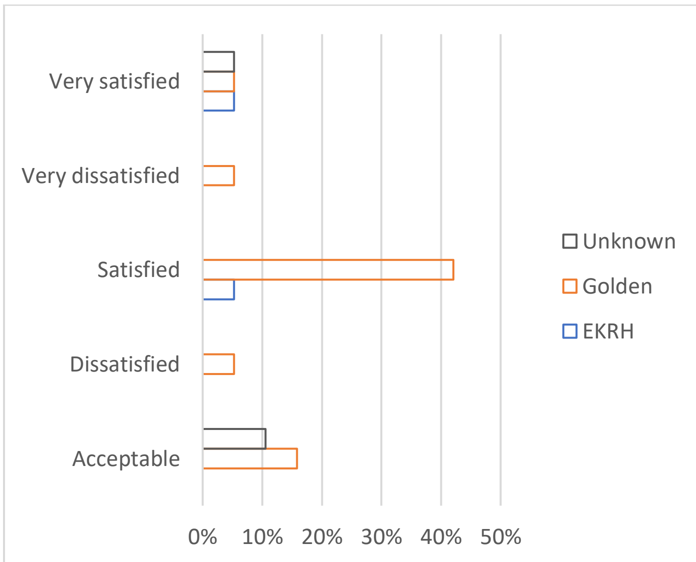
3. For prenatal and postpartum care, please indicate how satisfied you are with the following:

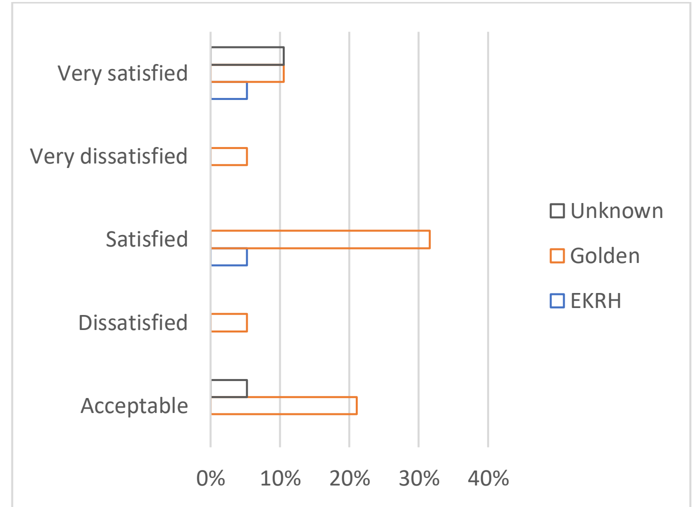
a. How colleagues understand each other's roles and scopes of practice?



b. How colleagues communicate with one another?

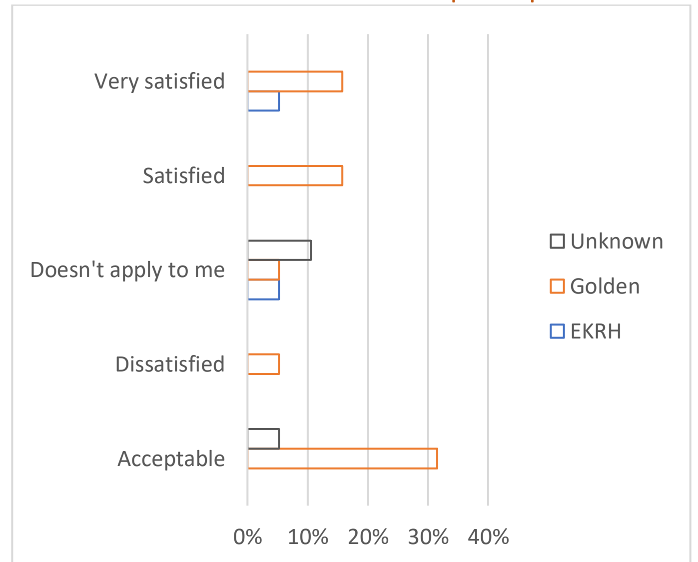


c. How colleagues respect and support each other?



4. For intrapartum care, please indicate how satisfied you are with the following:

a. How colleagues understand each other's roles and scopes of practice?



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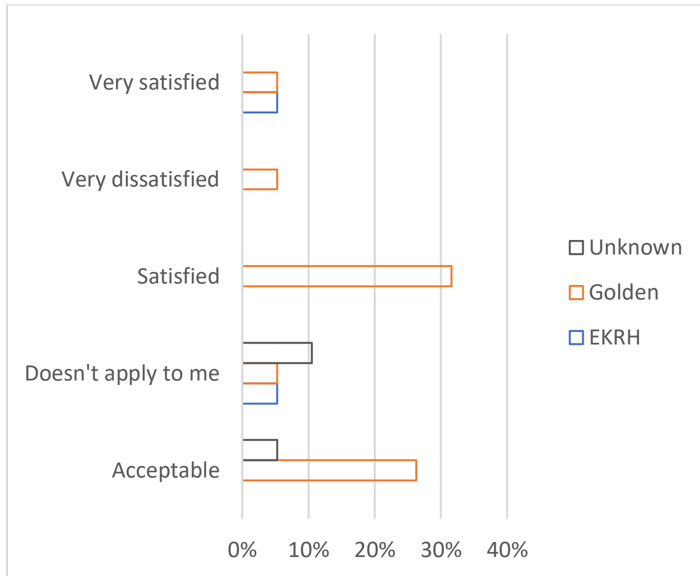
b. How colleagues communicate with one another?



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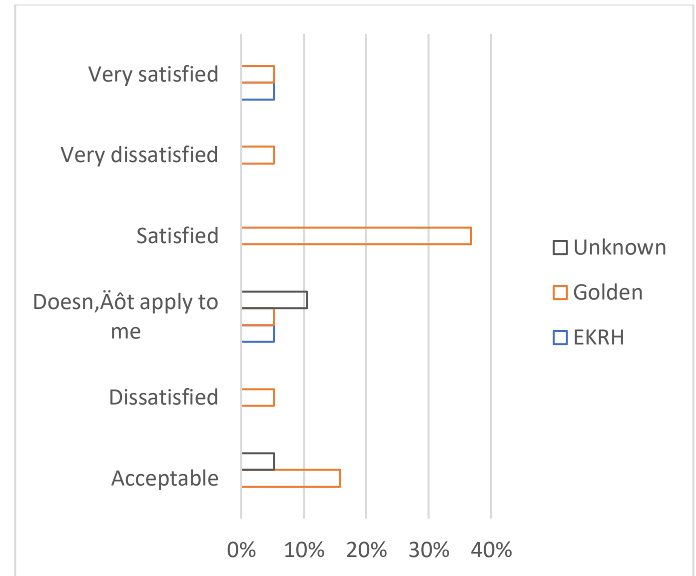


Qualitative Summary:

1. Please describe the relationships between obstetricians, family physicians, registered midwives, nurse practitioners, and nurses in your community.

Responses to this question were mixed. The majority of respondents believed that relationships between staff were generally positive, stating the following:

- "I believe it's open, educational and respectable"
- "Excellent"
- "It's a rotating shift between our doctors and midwife as to who sees obstetrical patients over a week. Nurses coordinate with the labour MD, public health nurses, and the midwife when discharging patients."
- "As an observer I think the relationship is fairly good with a respectful working relationship between all of these group. There is a desire to learn (Ob rounds) and improve on things."
- "Obstetricians are consulted by phone and come to the community periodically to see referrals -our family physicians who provide obstetrical services do not seem to hesitate to consult OBGYN as needed -the midwife is a part of the obstetrical group providing maternity care -nurses have a working relationship with the physicians through other departments, which helps with easier communication, mutual respect, and knowing scopes/skill sets"
- "Family physicians do not provide obstetrical in our community, we have a group of GP's with obstetrical privilege's (and one midwife) that provide prenatal care through a clinic in our community. Prenatal records are then brought to the hospital and kept on file with nursing to access, should a patient present. The midwife is the only provider to support home births in our community, with a back-up OB provider on call. Nursing staff is made aware of home births before-hand and as they are happening with frequent updates. Our midwife and public health provide postpartum care in the community, the extent of this is well known to the OB providers but not to hospital nursing staff. There is a liaison record faxed to public health nursing and our midwife on discharge. We have 24 h surgical coverage for emergency c/s, if this service is not available, as a site, we only consider low risk deliveries"

Others believed that, though relationships are generally positive, there are areas for improvement. These responses included the following:

- "I think it is very good. I do feel find our obstetrical colleagues tend to err on the side of caution and often recommend more conservative measures than are suggested in the SOGC's guidelines. However they are usually very supportive of us as a low-risk obstetrical group. I do think our nursing staff would benefit from the return of the More OB programs to improve their confidence in dealing with OB patients."
- "Overall good. There are still some instances of nursing staff treating our midwife colleague differently from the physicians. Sometimes locums are also treated differently by nursing staff, in that they are doubted and questioned more."
- "Generally respectful but some providers are unaware of how their comments impact others."
- "Variable depending on the individuals. Improved when our last GPA left who was providing maternity care as well. I really enjoy working with Joyce and feel she is a huge asset to the team as a midwife providing more hands on care then the physicians do during labour."

2. What do you need to improve collaboration for maternity care in your community?

Respondents most often spoke about facilitators of building relationships between providers such as communication, respect and understanding. These responses included the following:

- "Mutual respect, a defined care path, clear understanding of each other's roles, and communication"
- "Meetings about performance improvement or practice changes that includes ALL RNs"
- "Information sharing on roles and scope"
- "Easier communication between providers would be nice- referring physicians/midwifes to mental health. It doesn't come up often but can sometimes be hard to get a hold of a provider given differing and busy schedules"
- "Interventions to create a more respectful environment. Allow members to disagree but in a safe, unthreatening manner"
- "Ongoing communication with all members of the team, through informal debriefs, and conversations about care (decision-making) with the patients."
- "Maintain good communication between OB providers and nursing staff around case management and any cases that didn't go well"
- "Ongoing communication/education"
- "I think a maternity clinic with a hard call GP group would improve care and communication between all the care providers."

Others spoke about technology such as:

- "Online prenatal health records would be nice"
- "It would be great if we could upgrade to electronic charting. Some antenatal records are difficult to read."

3. What is working well for maternity care in your community/the area where you provide maternity care? The main themes included:

Collaboration and support:
- "FP/Midwife working together"
- "Improved collaboration with our regional consultants. Good teamwork among the maternity doctors and midwife. Good support from locum physicians for c-section coverage
- "Everyone works together
- "Presence and availability of the providers and their willingness to come in whenever need to support RN"
- Docs/MW are hands on, it's great having a Midwife
- I feel our low-risk OB group is cohesive and communicates well. We are supportive of each other and collaborate well to provide good care."

Referrals/Handover:
- "Easy referral processes, lots of services available."
- "Weekly handover meetings where we can stay on top of issues, ensure next provider is aware of inductions, any potential issues. Group prenatal classes."

Training:
- "Training all nurses to provide labour & delivery care so there is not a lack of skilled providers -the group care model for physicians seems to enable them to strike a better work/life balance and each patient is often able to meet all members of the team at the different prenatal visits -midwife able to provide home birth services"
- Small group of dedicated physicians and excellent maternity nurses who are expanding their scope by getting nursery training

4. What is needed to improve maternity care in your community/the area where you provide maternity care?

Respondents reported needing the following to improve maternity care:

Education and resources:
- "I feel like we do an incredible disservice to many of our families by moving too quickly to c-sections. I understand that there are many factors that contribute to this decision and we have a very small margin for flexibility because of our resources. I feel like if our nursing care was stronger and we were more empowered to coach mothers through there delivery we would have far better success rates. Many nurses are generally uncomfortable with maternity because we are involved so infrequently which I think then creates a hesitancy to coach and guide families through their experiences (i.e., encouraging walking, yoga, showers, baths, massage, music, breathing techniques etc.). Maternity nursing in Golden is very passive and shouldn't necessarily be, especially for primes."
- "Paid, continuing education for RNs"
- "Ongoing educational/sim support, we hardly do any sims on Vaginal deliveries, most are on C-sections"
- "Consistent surgical coverage so we don't have to send away higher risk women"
- "Larger birthing room where the patient can labor, deliver and have post-partum care provided without having to be moved around the facility. With ample space for the partner to room in and for equipment to be stored out of the way"
- "More volume"
- "Appropriate neonatal unit"

Communication and relationship building:

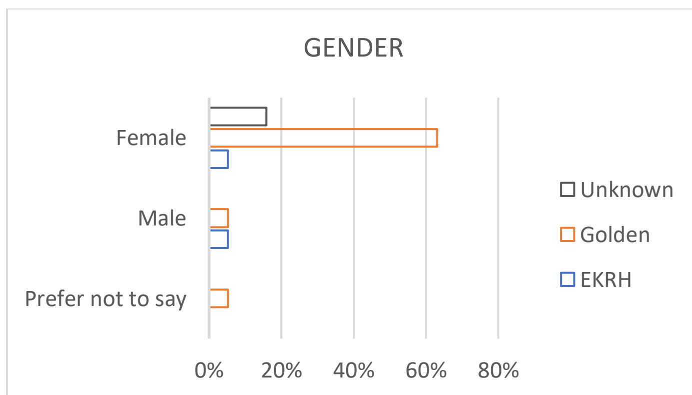
- “Midwife/OB working together FD/OB working together”
- “Sense that when an opinion is offered it is respected even if not in agreement.”
- “Improved nursing confidence with L&D patients. Continue to work on establishing trust and relationships with our Obstetrician colleagues in Cranbrook”
- “As previous, a maternity clinic with GP hard call group to minimize handovers, increase number of Physicians willing to provide maternity care and prevent physician burnout”

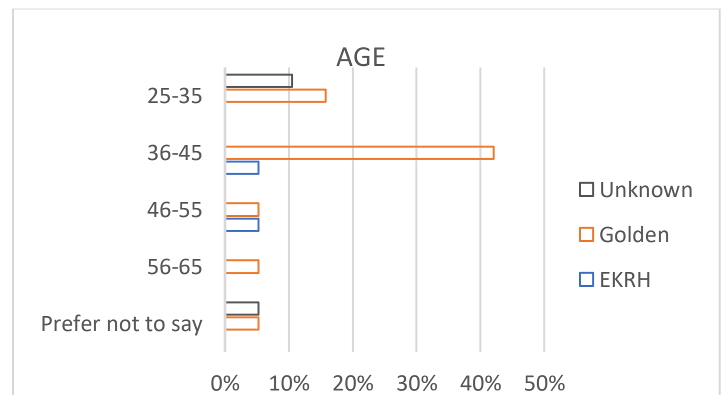
5. What would an “ideal state” of maternity care in your community/the area where you provide maternity care look like?

Responses for this question referred to collaboration, central service locations, increased resources, and patient involved. These responses included:

- “Each and every provider feels comfortable and safe offering opinions, asking questions, sharing any sub-optimal experiences”
- “Person comes into care and all providers located in central location where person can choose services if needed, evidenced based postpartum care (i.e. frequent visits in the first week at home) , many coming together options (groups in person and/or virtual) for support after loss, PPD/A, breastfeeding, etc”
- “frequent education and practice as we infrequently do deliveries”
- “100% staffing for 1:1 nursing in labour and delivery, nurses and physicians for C/S coverage 100% of the time, and everyone on the care team communicating well and supporting each other to provide evidence-based standard of care.”
- “A little higher volume so both OB providers and nursing staff are more comfortable with L&D. A better working relationship with our Obstetrician colleagues in Cranbrook, it would be nice if they would consider surgical outreaches.”
- “We would have a level 2 NICU”
- “OR in maternity Neonatal unit appropriate level”
- “the patient would present for labour support, deliver a healthy baby, and feel supported throughout her postpartum care in hospital and at home”

Respondent Demographics





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