## Competency Programme and Evaluation Framework for Senior Midwife

### 4.1 Midwifery Worked Examples

Nursing Services Directorate

The selected practice examples are provided to assist in the completion of the competency framework. They must not be copied in your framework.

<table>
<thead>
<tr>
<th>Name &amp; Surname</th>
<th>Joanna Borg</th>
</tr>
</thead>
<tbody>
<tr>
<td>ID Card:</td>
<td>100015M</td>
</tr>
<tr>
<td>Address:</td>
<td>2 Triq il kbira Mosta</td>
</tr>
<tr>
<td>Government Email Address:</td>
<td><a href="mailto:Joanna.borg@gov.mt">Joanna.borg@gov.mt</a></td>
</tr>
<tr>
<td>Mobile Number:</td>
<td>79797979</td>
</tr>
<tr>
<td>Entity:</td>
<td>MDH</td>
</tr>
<tr>
<td>Title:</td>
<td>Midwife</td>
</tr>
</tbody>
</table>

*personal details are fictitious*
Scope of Document

This document Competency Framework- Sample Worked Examples has been developed as a sample of how a filled self-assessment booklet should resemble prior to its submission.
## Domain 1: Professional and Ethical Practice

<table>
<thead>
<tr>
<th>Competencies</th>
<th>Evidence</th>
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<tbody>
<tr>
<td>Competency 1.1: Demonstrates adherence with standards of the professional practice, scope of practice, and code of ethics(^1).</td>
<td>Evidence 1 pg 8</td>
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<tr>
<td>Competency 1.2: Demonstrates ability to lead, supervise and monitor care provided by junior registered midwives, students and support workers in accordance with Scope of Practice.</td>
<td>Evidence 2 pg 9</td>
</tr>
<tr>
<td>Competency 1.3: Promotes an environment that enables clients’ health, quality of life, independence, comfort and safety.</td>
<td>Evidence 3 pg 10</td>
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\(^1\) Available from:

## Domain 2- Provision of Midwifery Care

<table>
<thead>
<tr>
<th>Competencies</th>
<th>Insert the reference and page number where evidence is provided.</th>
</tr>
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<tbody>
<tr>
<td>Competency 2.1: Undertakes a holistic and detailed assessment of clients through history taking, observation, interview and examination in a variety of settings.</td>
<td>Evidence 5 – Competency 2.1 13</td>
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<tr>
<td>Competency 2.2: Ensures that the client has been provided with the necessary information to make informed decisions and remains in control of their health.</td>
<td>Evidence 6 pg 14</td>
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<td>Competency 2.3: Carries out midwifery care in a responsible, safe and accountable manner.</td>
<td>Evidence 7 pg 15</td>
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<td>Competency 2.4: Facilitates the discharge process and adaptation to parenthood in the community.</td>
<td>Evidence 8 pg 16</td>
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<td>Competency 2.5: Demonstrates the ability to tackle complaints and queries independently and professionally.</td>
<td>Evidence 9 pg 17</td>
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<tr>
<td>Competency 2.6: Takes charge of ward/section/unit, in the absence of Charge Midwife, and / or Deputy Charge Midwife (if applicable).</td>
<td>Evidence 10 pg 19</td>
</tr>
<tr>
<td>Competency 2.7: Demonstrates ability to respond effectively to unexpected or rapidly changing circumstances.</td>
<td>Evidence 11 pg 20</td>
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## Domain 3: Interpersonal and Therapeutic Relationships

<table>
<thead>
<tr>
<th>Competencies</th>
<th>Insert the reference and page number where evidence is provided.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competency 3.1: Demonstrates the ability to establish, maintain, and conclude therapeutic relationships with clients and their significant others.</td>
<td>Evidence 12 pg 21</td>
</tr>
<tr>
<td>Competency 3.2: Communicates effectively with clients, significant others, and members of the interdisciplinary team using verbal, non-verbal and written communication as needed.</td>
<td>Evidence 13 pg 22</td>
</tr>
<tr>
<td>Competency 3.3: Always provides and requests handover from colleagues and other health care professionals to ensure continuity of care.</td>
<td>Evidence 14 pg 23</td>
</tr>
<tr>
<td>Competency 3.4: Demonstrates respect and sensitivity for diversity in beliefs, values, and cultural practices.</td>
<td>Evidence 15 pg 23</td>
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## Domain 4: Interprofessional Collaboration and Quality Management

<table>
<thead>
<tr>
<th>Competencies</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competency 4.1: Collaborates effectively with different members of the interdisciplinary team to promote teamwork and to facilitate and coordinate care.</td>
<td>Evidence 16 pg 24</td>
</tr>
<tr>
<td>Competency 4.2: Recognises and respects the different roles and skills of all members of the health care team and support services.</td>
<td>Evidence 17 pg 25</td>
</tr>
<tr>
<td>Competency 4.3: Participates in the planning and/or implementation of quality improvement initiatives such as evaluation and improvement of practice, clinical audits, and development of policies/standards.</td>
<td>Evidence 18 pg 26</td>
</tr>
<tr>
<td>Competency 4.4: Contributes to the professional development of peers and other healthcare professionals and promotes a culture of learning.</td>
<td>Evidence 19 pg 27</td>
</tr>
</tbody>
</table>
Applicant’s Declaration

1. I declare that I have assessed myself against the Competency Framework for Senior Midwives and that I meet the required standards of competence.
2. I declare that any documentation and evidence presented is entirely my own work, or whenever the work was part of a team due reference is made.
3. I certify that the documents referenced and submitted for evidence are authentic.
4. I understand that I will be called for an interview to verify evidence submitted and to demonstrate the competencies achieved.
5. I understand that the board may ask for additional material or evaluation of evidence.

By signing I declare that the information I have given is true and correct.

Applicant Signature

[Signature]

20/10/17
Evidence 1 – Competency 1.1

This evidence discusses a case of patient identification upon which a hospital policy exists.

On November 1st, we had two mothers in our ward with the same name, surname and locality. It is the hospital policy that each patient/client should wear identification (id) bracelet during her stay. In this situation, it was essential that the ID bracelet had 2 identifiers such as the name and national identification number which is the same as the medical record number. The ID bracelet has to be checked every time before any treatment and procedures carried out and/or any specimen taken. This is essential to ensure that a correct match is made between the patient and the interventions; be it drug administration, surgical intervention, phlebotomy, and blood transfusion amongst others. The id bracelet proved useful to ensure a correct identifier for the above mentioned interventions and therefore minimised errors.

This scenario was given its due importance. The whole team took on the challenge to ensure that it was handed over at every change of shift. The respective medical teams especially the on call doctors were also made aware in particular when carrying out any documentation to ensure that the appropriate file was chosen. The consequences that can result are detrimental if one is not careful. This case also shows the importance of handing over and effective communication between the whole multidisciplinary team to ensure that preventable errors do not occur.
Evidence 2 – Competency 1.2

Delegated Task: PCA Charting by a 2nd year BSc Midwifery Student.

I was a mentor for a 2nd year student who had been working with me on the obstetric ward for the last 2 weeks. Throughout these two weeks, we had several mothers who had PCA infusions post-caesarean section. The reason for the usage of the PCA after caesarean section, the advantages and disadvantages of this form of pain relief, caring for mothers with PCA and the correct way how to control the machine were discussed with the student. In addition, it was ensured that the student understood and was able to accurately record the vital signs in accordance with recommended frequencies.

On her third week of the placement, I delegated the PCA charting to the student during my lunch break. I advised her that if she is in doubt to seek the help of the midwife whom had been allocated the care of my clients whilst I was on break. I also advised the midwife to supervise the student whilst she is doing PCA charting and discuss the results of the parameters taken.

Following my break, I went through the documentation with the student and ensured that this had been done correctly. We also developed some scenarios and discussed the necessary actions needed to be taken accordingly. This enhanced further the student’s knowledge and was a reflective exercise also for myself.

Affirmation of Evidence by CN: As Charge Midwife of Mrs. Borg I would like to state that she ensures that effective delegation is carried out with her colleagues as well as students. She follows up on the delegated task and ensures that the person being delegated to is competent in carrying out the task. She also ensures that the task is within the scope of practice of the delegatee.

Signature: [signature]

Sharon Camilleri
Charge Midwife
Obstetric Ward 4

Joanna Borg
Midwife
Obstetric Ward 4
Evidence 3 – Competency 1.3

During the midwifery assessment, a pregnant mother who was admitted in hospital for uncontrolled blood sugar levels outlined that although she had a blood glucose machine at home she was scared to use it. I advised her to tell her relatives to bring the machine to the ward so that we could look at it together and I would teach her how to use it appropriately. Once the mother received her glucose machine, I showed her several times how to use it. Following this I dedicated time to listen actively to ensure that she understood fully how to monitor her glucose with the machine and offered reassurance with her concerns. I dedicated some time to discuss her diet as well as the symptoms and management of hypo and hyperglycaemia. Within two days, the mother felt more confident, started performing the test herself and was able to be discharged. I ensured that she had the ward’s direct telephone number and encouraged her to phone if at any time she was not sure about the result obtained. I have also contacted the diabetic clinic and organised a follow up appointment to serve as refresher and to ensure the latest information with regards to diabetic care has been provided to the mother. The diabetic clinic also carried out an in-patient visit to meet with the mother and explain more about the service offered by the clinic.

This case study demonstrates the importance of involving the mother in her own care. We should not assume that a young relatively healthy mother will automatically know how and would be willing to use a simple medical device. Yet through the establishment of a therapeutic relationship based on trust, one can empower the mother to be independent in monitoring her glucose level and report accordingly.
Evidence 4.4 – Competency 1.4

Include a list of CPD – certificates to be presented during the interviews.

2016 – Safe Practices within the Clinical Environment

Short summary on ‘Safe Practices within the Clinical Environment’

I had the opportunity to attend a one day Conference on Safe Practices within the clinical environment. A brief introduction to patient safety issues including the physical, social, emotional and economic costs was presented. This was followed by a description of the PASQIT project currently being implemented in Mater Dei Hospital. A number of initiatives associated with this project were also presented including thermoregulation of the newborn, pressure sores, and the importance of discharge planning to reduce potential safety issues.

Most of the topics on patient safety were not new however I was not aware of some of the initiatives that were taking place. Also the importance of the reporting and its positive impact at organisational level was presented. This facilitated my understanding of the whole concept. The lack of reporting by all professionals was also debated. During the presentation I could relate to a number of incidents including near misses that I could have reported but did not.

The importance of reporting is an issue that I will be working more upon. Reporting provides a means for the organisation to analyse the processes and improve upon them. It has also widened my perspective on other areas which are considered as part of the patient safety alert. These areas will aid as a reminder in my every day practice.
Evidence 55 – Competency 2.1

Midwifery Report

NB: All the names used are fictitious to maintain anonymity

<table>
<thead>
<tr>
<th>Name</th>
<th>Chantelle Borg</th>
</tr>
</thead>
<tbody>
<tr>
<td>ID</td>
<td>4444(M)</td>
</tr>
<tr>
<td>Father’s Name</td>
<td>Michael Borg</td>
</tr>
<tr>
<td>Occupation</td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td>Government Clerk</td>
</tr>
<tr>
<td>Father</td>
<td>Accountant</td>
</tr>
<tr>
<td>Telephone No</td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td>999999999999</td>
</tr>
<tr>
<td>Father</td>
<td>77777777777</td>
</tr>
<tr>
<td>Reason for Admission</td>
<td>Intra Uterine Growth Restriction</td>
</tr>
<tr>
<td>Medical History</td>
<td>Nil of note</td>
</tr>
<tr>
<td>Allergies</td>
<td>Allergic to Penicillin</td>
</tr>
<tr>
<td>Blood Group</td>
<td>A Neg</td>
</tr>
<tr>
<td>Obstetric History</td>
<td>2012 Normal Vaginal Delivery of female infant following a healthy pregnancy, Alive &amp; Well</td>
</tr>
<tr>
<td>LMP</td>
<td>5th June 2015</td>
</tr>
<tr>
<td>EDD</td>
<td>11th March 2016</td>
</tr>
<tr>
<td>Stage of Pregnancy</td>
<td>35 weeks</td>
</tr>
<tr>
<td>History of Complaint</td>
<td>Normal fetal growth until 32 weeks</td>
</tr>
<tr>
<td></td>
<td>By 35 weeks growth was marking as 32 weeks</td>
</tr>
<tr>
<td>Plan of Care</td>
<td>Monitoring include:</td>
</tr>
<tr>
<td></td>
<td>• Cardiotocography twice daily</td>
</tr>
</tbody>
</table>
- Biophysical profile
- Doppler ultrasound

Provide further information to both parents by the obstetric team.

| Considerations and Actions | Separation from 3 year old child- I have discussed with the couple regarding potential family help and support and how they can schedule a timetable so that mother feels more reassured. Parental/Maternal Anxiety related to any potential adverse effects for the baby in view of the growth retardation- I have given the couple initial information and then requested that the mother’s obstetric team come to discuss the case further and ensure that information and care is planned together with the couple.

Father – quite withdrawn and reserved and is not currently active in discussion about the baby. – The plan is to ensure that he is included in all discussions, encouraged to participate and voice any concern, and also to provide the necessary information and support as needed. |
Evidence 6 – Competency 2.2

Two years into my practice I was assisting a woman who was about 3 hours into the first stage of labour. The woman was asking for something stronger than Entonox for pain relief. The options of Pethidine injection and of the epidural infusion were given but both the woman and her partner seemed to have no idea what either of these entails. I tried to provide information about the pros and cons of both but I realized that she was getting more confused and stressed out. Therefore, I encouraged her to go for an epidural, after taking into considering how she had been reacting to pain during these last few hours, and that it looked like the delivery will be a prolonged one. By then, the woman was in quite some pain and it was difficult for her to focus her attention on what I was explaining. The woman decided to go for an epidural and coped very well throughout the rest of labour.

Despite the fact that everything went well, I had questioned my assessment and actions several times. First of all, I realized that the timing of information giving was not adequate and both she and her partner were too stressed out to understand the information given so as to make an informed choice. Secondly I had focused on pharmacological pain relief and did not mention any other options for managing contractions such as mobilization and use of different positions, the use of Swiss ball, massage, relaxation techniques, and reassurance. Evidence based practice suggest that these are crucial component of intrapartum midwifery management as they support the physiology of birth. Following this case I had changed my practice and whenever possible I make it a point to discuss pain relief management in the very early stages of labour. At this stage the mother would more coherent to decide on the appropriate pain relief methods to be adopted throughout labour.
Evidence 7 – Competency 2.3

3 skills:

1. **Intravenous Drug Administration** – successfully achieved the certificate in Intravenous Drug administration – July 2016 and is valid for 5 years. (Certificate to be presented during the interview)

2. **Basic Life Support** – successfully completed the Certificate of basic life support for Health Care Professionals – November 2016. (Certificate to be presented during the interview)

3. **Removal of Redivac Drain:**

   This is to certify that I have witnessed Ms. Borg in carrying out Removal of redivac drain. The following were all demonstrated:
   - Procedure explained to patient to gain consent and ensure cooperation. Ensured that patient is placed in a comfortable position.
   - Followed and adhered to infection control principles – in terms of hand hygiene and use of hand rub, sterile techniques in opening of packs.
   - Equipment to be used checked for sterility, expiry and placed on previously cleaned trolley.
   - Dressing removed and discarded in yellow bag. Site observed for any signs of infection or inflammation.
   - Drain site cleansed and dried to visualise suture knot. Suture removed and checked it was complete.
   - Swab placed under tubing. Patient advised to inhale and exhale slowly during removal of drain. Drain slowly pulled then applied pressure to drain site until bleeding stopped. Drain site covered with sterile dressing. Patient informed that procedure was ready.
   - Correct disposal of sharps and equipment carried out.
   - Ensured proper documentation of procedure, site and output in drain charted on output chart and nursing report.

Sharon Camilleri  
Charge Midwife  
Obstetric Ward 4

Joanna Borg  
Midwife  
Obstetric Ward 4
Evidence 8 – Competency 2.4

I was the Discharge Liaison Midwife that visited Heidi the day following discharge after an emergency caesarean for her first baby. Clinically she and the baby were both well but I was not happy with her general demeanour and her lack of interest towards her baby. I decided to stay a bit longer. I started asking some open-ended questions to prompt her to start a conversation. Very shortly she began to cry which gave me the opportunity to explore how she was feeling emotionally. I realised she had been traumatised with the outcome of her birth and felt let-down by her body. These feelings were affecting her response to the baby and she described that she was so afraid of not caring for him properly that she was finding it difficult to respond to him. I asked her if we could bring her husband into the room as it is important that he understands how she is feeling and how he can help her. After a while she agreed and we spent some time discussing her birth and I helped her to understand why she needed an operative birth and reassured her that this was necessary. I encouraged her to change and feed the baby whilst I was there and praised her during this and pointed out how the baby responded to her voice and calmed in her arms. I offered referral for emotional support but she declined. This did concern me but I could neither persuade her to change her mind nor could I force her to accept. I gave her the direct number of the Discharge Liaison Midwives and encouraged her to call if she had any queries or felt sad. I asked her about her appointment with the Breastfeeding Clinic and was reassured that she was planning to attend this. I assured her that I would try and ensure that I would be allocated for her follow-on visits.

Following the visit I informed the Charge Midwife who agreed that we should follow her with daily phone calls for the rest of the week. I also called the Breastfeeding Clinic and discussed my concerns so that they would be aware of any possible problems. They would also offer some form of reassurance with breastfeeding. I also asked if they could give me a hand over regarding the visit as I would be following her for a while longer.

I also ensured that all my concerns and actions were well documented just in case I will not be following the case.
Evidence 9 - Competency 2.5

One of our visiting mothers at the Breastfeeding clinic was quiet upset. Rachel (mother) told me her disappointment with the care she was provided during hospitalisation. The below is a brief account of what happened to the mother.

Rachel was due for discharge following a normal vaginal delivery but had to stay overnight as the baby had a weight loss of 10.4%. Rachel said she had been complaining with the midwives that she is having trouble feeding the baby but she felt she was not given the appropriate attention. In addition on the extra day Rachel had tried to seek help but was told off by a midwife that she is very busy and needs to allocate her time to those mothers who have just given birth as by the 3rd day she should be able to manage alone. On the third day the baby had lost weight but Rachel was adamant not to remain in hospital. She argued that if she is to be kept here because there is an issue with feeding at least she should receive some help and as this was not the case she could do better at home with the support she would receive from her partner and family.

The paediatrician was quite concerned and was not comfortable with discharging the baby at all. Rachel insisted that she will exercise the right to discharge herself. The paediatrician called the Breastfeeding Clinic and asked if she could be followed closely. Rachel visited before discharge and was given a 24 hour feeding plan with an appointment for weighing the following morning.

During her morning visit Rachel's baby had gained 100g and feeding was becoming easier. Rachel was still very upset and angry. She felt that the solution had been simple, the clinic had just helped to position the baby better, and that she had been put through a stressful experience which could have been avoided if she had received this help when she first asked for it. At the clinic she was asking for names as she wanted to put a complaint in writing and wanted to make sure that this arrived at the right place.

I discussed with Rachel regarding the fact that the Midwifery Officer must be aware of this so together we agreed to call the ward involved and asked if she would like to come and speak to her. She agreed and sat down and listened to Rachel's complaint. She was very apologetic and explained that the ward been very busy and that there had been a low staff quota that week. She continued that this is not a good excuse especially in view of the fact that discharge had been delayed because of weight loss which clearly indicated that there was a feeding problem. Rachel explained that she had been so worried about her baby that she automatically became very upset at feeding time and that it would have been more reassuring for her if the midwife had spent some time with her at feeds. The Midwifery
Officer agreed with her and reassured Rachel that she will be speaking to the midwives involved and will make sure that such an incident is not repeated in the future. She pointed out that this will not take away the stress that she encountered but it will prevent any other new mothers from having such a negative experience. Rachel stated that the reason she had wanted to complain was to prevent anyone else going through such a bad time, she thanked the midwifery officer for listening and said she felt much better now that she had spoken to someone. Rachel was not interested in sending a formal written complaint however stressed the fact that she wished that the promised actions are taken for the benefit of other mothers.

After Rachel had left, I felt that this was not right and discussed it with my superior. Apart from the emotional distress, there are also added costs on the system including the extra hospital day stay. My superior and I discussed the possibility of carrying out some refresher lectures on proper breastfeeding techniques and current practices to ensure that the ward staff are kept updated and hopefully prevent similar future incidents.
Evidence 10 10 – Competency 2.6

To whom it may concern,

Ms Joanna Borg has formed part of this unit since its initial phases and thus was one of the members who participated in the setting up of the unit as well as training and mentoring of new staff during its expansion. Ms Borg was one of the senior qualified midwives and has also been acting in my absence as a Deputy Midwife for the last 3 years. She has systematically demonstrated the ability to be flexible, knows how to prioritise work and willing to share her knowledge and expertise with patients, families and other members of staff. She is a very responsible, organised and accountable person. She is able to work independently, out of own initiative and/or within a team. Ms Borg has strong communication and interpersonal skills and is a valued team member.

Yours Sincerely

Sharon Camilleri  Joanna Borg
Charge Midwife  Midwife
Obstetric Ward 4  Obstetric Ward 4
Evidence 11 11 – Competency 2.7

Sarah, a junior midwife on my shift informed me that she is going to send a mother allocated to her care to the Breastfeeding Clinic. I enquired why and offered my help before resorting to sending the mother to the clinic. It had been 5 hours since the baby last fed and Sarah was unable to arouse the baby and initiate a feed. Sarah had checked the blood glucose one hour previously which was 3.2mmol/l. This was good and led Sarah to leave the baby for another hour.

I went with Sarah to the mother’s bedside and attempted to wake the baby and put to the breast. After a short while, I noticed the baby became cyanosed around the mouth as I was pushing him to breathe. I stopped attempting to feed and held the baby still and within a short time the baby looked pink again. Patricia, the mother started to become a little anxious when she saw me closely observing the baby; she was already worried because the baby did not want to feed. Sarah stressed that we must feed the baby and implied that was the only issue. She did not seem to realise what I was observing. I tried another attempt at feeding but again the baby became cyanosed around the mouth so this time I did point this out to Patricia and Sarah and suggested we take full parameters and call the paediatrician. Parameters were within the expected range but the SaO2 was only 87% which was well below the acceptable range.

The baby was transferred to NPICU for observation and further tests. Later that day a diagnosis of a cardiac defect was made which meant that the baby needed to go abroad for surgery in the next few days. Sarah was quite upset that she had not been able to pick this up so I made an effort to sit with her and reflect on the case. We concluded that this was a good learning experience and that in the future when she is caring for a baby who is reluctant to feed she will consider other reasons for this and try to move away from the mentality that the most important thing is making the baby feed. We also discussed the importance of seeking help from other colleagues especially from senior staff when in doubt.
Evidence 12 12 – Competency 3.1

One of our clients sent me a friend request on Facebook whilst still hospitalised at the obstetric ward. I had a very good rapport with this mother having taking care of her during frequent admissions during her pregnancy. She trusted me and discussed various matters regarding her pregnancy and other personal issues even when I was not allocated with her. I had started noticing that she would only share concerns with me rather than with the allocated midwives. If I was not on duty she would wait until I’m back to work to ask major issues.

I was taken back when I saw a friend request sent by her on Facebook as I had never encountered such circumstances before. I did not feel it was right to accept her as this would compromise our relationship. I saw the friend request on my off day. When I returned to work on my first day, the mother came by and asked if I saw her friend request. I told her that I had not seen it yet since I don’t use it that often. I took the opportunity to go through some literature and foreign policies with regards to social media so as to make sure that I was taking the right decisions. It took a lot of courage to talk to her and explain the reason why I was not accepting her friend request. I tried to reassure her that this will not change our relationship in any way whilst she is in hospital. At first the client did not talk to me at all, however I made sure that I would continue as if she never sent the request. I knew that she felt awkward with my presence in the beginning but the fact that I showed her my support all along minimised this uneasiness. I wanted to ensure that the professional boundaries were respected. Following this episode I discussed the case with my Charge Midwife and other colleagues to check if the client had sent them Facebook requests as well. As a unit we realised that this is not the first time that this situation presented itself and together we are discussing the best way to tackle it. We are referring to the Policy on the Use of Social Media in the Public Services so as to establish guidelines for future reference.
Evidence 13 13 – Competency 3.2 (Ventouse/BFC/CDS)

I was allocated a mother who had been transferred from Central Delivery Suite 3 hours beforehand following a ventouse birth. I gave her priority based on the fact that the mother had just had a higher-risk instrumental birth just a few hours ago. I sat with the mother and actively listened to her experience and tried to answer her concerns. I focused first on discussing pain management and whether she was able to assume a comfortable position for sitting and feeding. I helped her to the bathroom and noted that she was not moving easily and did portray reactions to pain when moving. She had not had any pain relief and I had already noted that she did not have any treatment prescribed. I explained to her the options of pain relief and their benefits. I also reassured her that any medication prescribed would be safe to take during breastfeeding. As the baby was sleeping I took the opportunity to settle the mother before the baby woke for a feed to ensure more comfort and easiness.

I paged the doctor on call and informed him about the client’s situation in detail and my concerns with regard to pain management. I explained that the mother was moving very slowly and guarded and that I believed she could benefit from some pain relief. We went together to see the mother and the doctor agreed. This was immediately prescribed and administered throughout the day resulting in the mother coping quite well and feeling much better by the end of my shift. I have documented all in the report to ensure continuity of care. When the mother was feeling better, I sat again with her and involved her husband to make sure that she felt confident with feeding and caring for their baby. Moreover, I have provided them with contact numbers of Breastfeeding Clinic and Discharge liaison Midwives and empowered them to ask for assistance and support should they have any other queries once discharged.
Evidence 14 – Competency 3.3

During one of my day shifts I had been struggling with helping Sandra with breastfeeding and after several attempts I decided to send her to the Breastfeeding Clinic for help before resorting to giving infant formula. I contacted the team at the Breast Feeding Clinic and explained that the baby did not have feeding cues and that I was having difficulty to rouse him for feeding. On the telephone I gave a brief description of the birth and a more detailed description of the baby’s feeding history. I sent the nursery notes to the Breastfeeding Clinic to enable written documentation of how they managed feeding and a plan of care for the day. The mother was accompanied to the clinic by a nursing aide who held the notes and handed these directly to the midwife at the Breastfeeding Clinic. Following the consultation, I was given a detailed handover via telephone as well as written documentation explaining the way forward which I have shared and discussed with Charge Midwife as well as the Medical Team.

Evidence 15 – Competency 3.4

During one of the admission assessments, a foreign client who was very fluent in English speaking and understanding expressed the wish that all information is provided solely to the husband. The mother revealed that she held Islam belief and wished that all information about her is provided to the husband and that the consent form is signed by him as well. Since our first duty is to inform the client and she herself needs to provide informed consent, the multidisciplinary team met to discuss how to go about this especially as the Elective Caesarean Section was planned due to other medical issues. The team spoke to the couple and discussed the ethical and legal implications and explained that in Malta, it is the client who has to sign for the operation. Together with the husband, we agreed that the information is discussed with both of them together. We gave the couple time to decide on the treatment options, and as a team we met and agreed upon a plan of action which was documented in detail to ensure continuity of care. We gained both husband and wife’s trust as they felt that their concerns were being taken care of. The client happily signed the consent and the husband was also encouraged to attend for the birth of the baby in theatre. He expressed gratitude as he felt fully involved in the experience which allowed him to support his wife throughout.
Evidence 16 – Competency 4.1

Reflective Account: Teamwork

Reflection on one’s own practice is essential for personal and professional growth. Today I encountered a scenario which struck me whilst doing the Discharge Liaison Assessment in the Obstetric ward. The mother whom I was doing the assessment looked very upset and distressed and on probing she was not disclosing any information apart that she felt tearful for no specific reason. She was crying all the time during the assessment even though she seemed to be coping well with the baby. Baby was breastfeeding on demand and looked settled. I sat with her and tried to empower her to open up whilst I offered my help but it was in vain. I informed her about the psychologist and psychiatric services that are available and that I could refer her myself but the mother preferred to wait at that time. I gave detailed hand over to the ward nurse/midwife and informed her regarding my concern on the mother’s emotional wellbeing so that they could keep a close eye on her. I informed them that I was going to revisit her the following day.

The next day, I noticed that the mother was not planned to be discharged though she was 48 hours due and physically stable. Upon arrival on the ward, I was notified by the ward Charge midwife that following my expressed concerns the obstetrician was notified and called a meeting between the ward staff and DLM. The mother’s case was discussed and it was agreed to speak again to mother so as to refer her to the psychiatrist for review.

The mother was feeling more tearful that she was the day before. Together with the ward charge midwife I spoke to the mother and explained that she was not just having ‘postnatal blues’ and needed assistance. She admitted that she felt strange and too sad and therefore agreed to be referred. The psychiatrist came to review mother on the same day and on handover, the psychiatric stated that he will refer her to a psychologist as the mother had some childhood pending issues that needed to be discussed with the right health professional to help her cope with her adaptation to parenthood.

On reflection, I was very pleased that I managed to notice that the mother needed help and that in collaboration with the interdisciplinary team we have supported the mother for a better wellbeing and health and safety for the baby. Effective teamwork is essential for the delivery of high quality, safe patient care. The different skills and abilities that complemented the team ensured that a holistic approach was provided and all the bio-psychosocial and spiritual needs were addressed.
**Evidence 17 – Competency 4.2**

The care provided in Obstetric wards is centred on the management of normal and complicated pregnancies and postpartum care. The service is part of the free National Health Service although there are instances where care is paid for by some non-EU/non-Maltese national clients.

The Obstetric wards have a permanent staff of midwives, nurses, nursing aides and cleaners. Midwives and nurses are responsible for the general care of mothers and babies with midwives having the additional responsibility of antenatal care, fetal monitoring, assessment of women in early labour and to attend any unexpected births. Nursing aides and cleaners are also valuable members of our team.

The medical team including Obstetricians, Paediatricians and Anaesthetists are also key members of the interdisciplinary team who are specialized and responsible for treatment and discharge of mothers and babies. There are a number of other services that complement our own service. The Phlebotomist for blood testing, the Obstetric and Paediatric Physiotherapist and specialist midwifery services of the Discharge Liaison Midwives, Bereavement Support Midwife and the Infant Feeding Practice Midwife.

Upon reflection, during my course of work I came to realize that it is crucial to respect and be knowledgeable of all the different roles and responsibilities of all the staff working with mothers and babies from prenatal till discharge. Working as a team, communication and collaborating together is the key to provide quality holistic care to all our clients.
Evidence 18 – Competency 4.3

As a unit, we have noticed that there were a number of babies with suboptimal body temperature following transfer from Central Delivery Suite. We decided to analyse this occurrence and to identify the causing factor/s. In accordance with the WHO recommendations, the room where birth occurs must be warm (25C). Newborns without complications should be kept in skin-to-skin contact with their mothers during the first hour after birth to prevent hypothermia and promote breastfeeding. Bathing should be delayed until after 24 hours of birth. If this is not possible due to cultural reasons, bathing should be delayed for at least six hours. Appropriate clothing of the baby for ambient temperature is recommended. This means one to two layers of clothes more than adults, and use of hats/caps. Upon evaluation we realised that skin to skin with mother to avoid cold stress was not always appropriately performed and not all the recommendations were adhered to. We have discussed these findings with the charge midwife as well as the midwifery management and decided to provide better guidance. Education was provided to staff so that babies are dried well before being placed skin to skin and that no clothing comes between the mother and baby so that they are actually skin to skin. A system was also devised where mothers coming out of theatre were warmed-up before the baby is placed skin to skin.
Evidence 19 – Competency 4.4

During the course of our work, I was noticing that our care workers were not performing appropriate lifting and handling techniques with our clients. I was concerned about the safety of the clients and themselves and asked them if they ever received any training. Whilst 2 had received training 4 admitted that they had forgotten the techniques learned. I discussed this with the Charge midwife who is always very supporting in learning initiatives and we asked the physiotherapist in our ward if they could help us out with this. Together we organised 2 sessions in our ward where the physiotherapists have demonstrated the correct lifting and handling techniques. They also dedicated sometime after 2 weeks to evaluate if the carers were implementing the techniques in practice. These sessions also served as a refresher for myself and other ward nurses and midwives who also attended the session.

Affirmation of Evidence

As Charge Midwife I affirm that Ms Borg discussed with me her concerns with regards to the carer’s handling techniques and took the initiative to provide training and assist her colleagues in achieving the needed competency in moving and handling.

Sharon Camilleri
Charge Midwife
Obstetric Ward 4

Joanna Borg
Midwife
Obstetric Ward 4