AIMS For a better birth...

One-to-one care

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Lulu Stacey shares her experience of supportive midwifery in a case-loading practice

This personal reflection draws on my experience of caseholding as a student midwife providing a woman with midwifery continuity of care.

There is strong evidence that the inter twined concepts of midwifery continuity of care and woman-centred care should be established for all women.[1,2,3] Woman-centred care is defined by Nicky Leap[4] as focused on the woman's individual, unique needs, expectations and aspirations, encompassing the needs of her baby, family and community, and holistically addresses the woman's social, emotional, physical, psychological, spiritual and cultural needs and expectations.

Working closely with my community midwifery mentor, we approached Anna (I've changed names in accordance with guidance from the Nursing and Midwifery Council).[5] Anna was a mother of three, pregnant with twins; sadly she miscarried, at 12 weeks' gestation, on Boxing Day 2013, but on becoming pregnant again with triplets (monochorionic twins and a singleton) she enquired whether I was still available for caseholding.

Unfortunately, the twins showed signs of acute twin-totwin transfusion syndrome and died in utero at 18 weeks' gestation. Anna's pregnancy continued without further physical complication, but inevitably with uncertainty and emotional discord: the remaining 20 weeks of her pregnancy and the postnatal period were extremely challenging to both Anna and her husband Nick as they grieved the loss of their much-wanted twins at the same time as celebrating the healthy development of the surviving triplet.

Anna was booked to have an elective caesarean section at 38 weeks following three previous sections. This had been an issue in previous pregnancies as Anna desperately wanted to experience a vaginal birth and was disappointed not to do so, however, she was accepting that this baby would be born by caesarean section. The anticipation of the birth was difficult on many levels: Anna did not believe she would reach full term and set milestones to reach 24, 28 and 36 weeks, each time adjusting her mental preparation for the baby she was to birth.

Anna found it difficult to look forward to the birth of her daughter, as she knew she had to say goodbye to her twins at the same time; furthermore, it was difficult to anticipate what would remain of the twins at the time of birth. Anna's consultant had indicated that twins at 18 weeks' gestation would be very small and may have been reabsorbed. Anna and Nick discussed whether they would like to see the babies, or hold them, without knowing whether there would be anything to see or hold. Their personal preferences

differed, with Nick feeling he didn't want to see them but rather hold a memory of them from their scan images, whilst Anna was unsure and unable to make a decision until the time came.

The fetal-maternal medicine consultant and midwife, their community midwife and specialist bereavement midwife all gave the family considerable support. I observed the highest-quality parent-led care in which both parents were given time and freedom in which to discuss their options and preferences with healthcare professionals. Their now trusted consultant provided continuity of care, performing the caesarean section, providing postnatal care and support, and significantly enhancing the birth experience.

Anna and Nick were concerned that the day of delivery must be focused on the celebration of their daughter's birth and made arrangements to say goodbye to their twins the following day. The antenatal input of the bereavement midwife was invaluable for helping Anna and Nick prepare for the imminent birth, validating their mixed emotions, and eliminating as much formality as possible. Consent forms for histological investigations, and post-mortem examination and funeral arrangements were discussed without fully knowing what remains would be available for investigation. We discussed and prepared memory boxes for which Anna's mother knitted blankets: two boxes were prepared in advance with two teddies in each and the blankets, one kept at home and one taken to hospital ready to receive the twin babies. I collected the necessary documentation for Anna's notes, which was left in the baby room on labour suite where I would lay the babies to rest in their box until they were ready to be taken to the mortuary.

As the lead midwife under supervision, I liaised with Anna's consultant and introduced myself to the theatre team when signing in. Anna and Nick, understandably anxious on the morning of the operation, disclosed to us how calming it was to have us leading their care. As Huber and Sandall[6] have demonstrated, women and their birth partners aspire to a calm childbearing experience, linked to the establishment of relational continuity, and this relationship built up overtime instilled confidence and mutual understanding between Anna and Nick, their consultant obstetrician and myself as their midwife. We were able to form a picture of the couple, which helped us to advocate for them, as Huber and Sandall6 and McCourt[7] have shown. For example, I informed the theatre staff that, encouraged by Anna's consultant, we were planning skin-to-skin contact so I would stand next to Anna to help her position her baby at the breast instead of receiving and taking the baby to the resuscitaire as is normally done.

I found that the enhanced relationship and mutual respect resulting from collaborative working provide team members with enriched social relationships and greater reward at work[8] It also helps midwives to share knowledge and expertise with obstetric colleagues, presenting alternative methods of realising positive outcomes for vulnerable women. Together midwives and obstetricians can be innovative, combining their skills to think laterally and provide flexible, responsive continuity of care to women with increased social, emotional or physical need. Anna reported afterwards that holding her baby in a skin-to-skin embrace while the placentas and her twins were being delivered made all the difference to her

ability to cope with the situation emotionally. All Anna and Nick's attention was on their new baby; the focus was on Anna's needs, not the clinical situation. Anna and Nick did not wish to see the twins on the day of birth and some comfort was offered by knowing they were wrapped in a blanket made by their grandmother, which had been in the family home until that day. We did not discuss further what remained of them until the following day, as arranged. I kept the healthy placenta of the surviving singleton safely on labour suite too as I knew that Anna might wish to see this when she was ready. From recovery I accompanied Anna and her newborn to the postnatal ward and remained with them providing their post-operative care. I returned to the postnatal ward the following day and worked the full shift as Anna's caseholding midwife.

Providing continuous, sensitive care demands knowledgeable practice and commitment from the midwife, ensuring appropriate and timely interventions responding to women's individual needs.[9] Before a special service of blessing for the twins carried out by the Chaplain from the family's church, Anna was moved into a side room overnight in order to have the necessary privacy. I brought the remains of her babies to the ward for her before Nick arrived, as he did not wish to see them. It is a prerequisite of the midwifery profession to assess women's needs and provide advocacy on an individual basis[5] Caseloading provides an excellent level of service for those with complex needs where the midwife's advocacy helps the woman to access the best available care and increases satisfaction for both midwives and women.

I was extremely fortunate to have the opportunity to care for Anna and her family through this emotional childbearing experience that was most likely to be her last. I felt privileged to be able to focus my attention entirely on the needs of Anna and her family without being torn away by the usual pressures of mounting workload.

Anna benefited from having a known and trusted caseloading midwife. In the emotional tension that had reached a climax on the day of birth, Anna and Nick knew that the consultant obstetrician and I would make sure that the day would start as we had discussed and planned. I was aware of their hopes and fears and was able to advocate, intervene or avert deviation from the intended plan of care. Equally they knew they could say anything to me to change the plan at any time if they wished to. They didn't need to explain to anyone that their daughter's birthday was to be a day of celebration and that their demised twins were to be kept safe until the following day when they would bless them, see them if they wished to and say goodbye, because I was there to discreetly explain their preferences.

AIMS note: we will continue to campaign for caseloading so that this kind of care can be provided for all women.

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