EUR/ICP/HSR342 (2)
7197B
ENGLISH ONLY
UNEDITED

WHO

REGIONAL OFFICE FOR EUROPE

BIBLIOTHÈQUE OMS
07 JAN. 1992
WHO LIBRARY

MIDWIFERY QUALITY ASSURANCE

Report on a WHO Workshop

Brussels
17–20 June 1991

SCHERFIGSVEJ 8
DK-2100 COPENHAGEN Ø
DENMARK

TEL.: (45) 39 17 17 17
TELEFAX: (45) 31 18 11 20
TELEX: 15348

1991

EUR/HFA TARGET 31

This activity was organized by the WHO Regional Office for Europe to promote work aimed at achieving the following target in the health for all strategy.*

TARGET 31

ENSURING THE QUALITY OF SERVICES

Index terms

MIDWIFERY
QUALITY ASSURANCE, HEALTH CARE
BELGIUM
CZECHOSLOVAKIA
DENMARK
HUNGARY
NETHERLANDS
POLAND
UNITED KINGDOM
USSR

All rights in this document are reserved by the WHO Regional Office for Europe. The document may nevertheless be freely reviewed, abstracted, reproduced or translated, but not for sale in conjunction with commercial purposes. Any views expressed by named authors are solely the responsibility of those authors. The Regional Office would appreciate receiving one copy of any translation.

* *Targets for health for all.* Copenhagen, WHO Regional Office Europe, 1985 (European Health for All Series, No. 1).

38115

CONTENTS

Introduction

Target 31 of the WHO health for all strategy for the European Region states that, by 1990, all Member States should have built effective mechanisms for ensuring quality of patient care within their health care systems. The European Conference on Nursing, held in Vienna in 1988, focused on the "assurance of the quality of care and the appropriate use of technology".

Until 1991, quality assurance work in midwifery was not well coordinated. Existing work had focused on the setting of standards of care and the processes for monitoring those standards.

A meeting on quality assurance in midwifery was therefore held in Brussels, Belgium, 10-17 June 1991, by the WHO Regional Office for Europe with the support of the Government of Belgium. It was attended by 16 participants (midwives, nurses and obstetricians) from eight European countries. There were three facilitators from Denmark, Sweden and the United Kingdom and five midwife observers from Belgium. Madame Simoens DeSmet welcomed the participants on behalf of the Belgium Government. Ms Elisabeth Stussi opened the meeting on behalf of the WHO Regional Director for Europe. A list of participants is given in Annex 4.

The aims of the Workshop were:

- to create a quality assurance programme for use by midwives in Europe;
- to prepare a caucus of midwives who will act as consultants in quality assurance techniques for midwifery;
- to define a programme for quality assurance activity, facilitated by consultant midwives in appropriate countries.

A questionnaire was sent in advance to midwifery organizations and government departments in all countries covered by the WHO Regional Office for Europe. It was intended to obtain information on quality assurance work in midwifery, and the availability of published standards which could assist in such programmes. A summary of the findings is given in Annex 1. Apart from some limited work, standards of practice in most of the respondent countries were linked only with the requirements for midwifery training programmes.

Additional objectives were therefore defined for the Workshop:

- to increase the participants' knowledge of the application of quality assurance techniques;
- to share information about current work in midwifery standard-setting;
- to review a quality assurance model for midwifery practice.

The Workshop was designed around plenary sessions, where participants were introduced to a quality assurance concept, and group work, where they used exercises based on midwifery practice to consolidate their understanding of the concepts. All participants had received background papers as listed in Annex 2.

Country reports

Participants started by reporting any relevant activity in their country - a useful addition to the information gathered by the questionnaire.

Belgium

Belgium has a system of local and national statistical returns relating to maternity care. Belgian midwives are trying to increase their opportunity to practise autonomously, particularly in intrapartum care.

Czechoslovakia

Midwives are all registered and their continued registration depends on working to an acceptable standard. Their registration can be revoked if their standard of practice falls.

Denmark

There is a national system of registration. This has helped the work of a perinatal mortality audit group consisting of five medical staff and four midwives. It looks retrospectively at all perinatal deaths and attributes each of these to one of three categories: avoidable, potentially avoidable or unavoidable. Some hospitals are devising systems which give midwives feedback about their practice, for example the episiotomy rate for each midwife.

Netherlands

A new national obstetric audit has been introduced in the Netherlands, and individual midwives and obstetricians submit coded summaries for each case they manage. It is at present voluntary; there is an 80% participation rate among independent midwives, and a 60% participation rate among doctors and midwives in the hospital system.

Poland

Midwives in Poland are currently seeking to achieve greater continuity of care. They have no input into antenatal care - both issues are important to Polish midwives.

United Kingdom

National statistics are collected and collated in reports which are fed back to health authorities. There are published standards of care under the title "Maternity Care in Action". Each local service should have a maternity services liaison committee, which can examine local standards, but the operation of these is patchy. Audit programmes in health care are now being encouraged and in part funded by government health departments. Well organized consumer groups also publish criteria for care. Midwives have available two information databases, MIDIRS and MIRIAD, which give easy reference to current research. The National Perinatal Epidemiology Unit at Oxford conducts research and has recently published a detailed meta-analysis of maternity randomized control trials (1).

USSR

There are great differences in the provision of maternity care between each Soviet republic. This is reflected in different outcomes of care. There is still a worrying level of maternal mortality in Asian republics. The role of the midwife also varies greatly, from an almost completely hospital-based service to a community-based service.

The background to quality

Participants were then given background information on quality assurance, in health care and in industry. Sources of information that midwives could use to formulate their standard of care were also identified (see Resources).

The work of Donabedian (2) was discussed and his framework for quality - structure, process and outcome - was reviewed. Maxwell's six dimensions were outlined: access, acceptability, efficiency, effectiveness, relevance to need and equity (3). The use of these ideas in quality assurance for nursing, with particular reference to Kitson's work, was described - including the Royal College of Nursing's Dynamic Standard-Setting System (DySSSy), with its emphasis on continuous setting and monitoring of standards by clinical staff (4).

Questions were then raised about some health professionals' approaches to quality programmes.

- The strong emphasis on the role of professionals in determining standards of care, with little evidence of any real involvement by women receiving the service.

- The tendency of health professionals to aim for "perfect" standards, rather than take into account the available resources. Vuori (5) makes the distinction between absolute quality (aiming for the best) and optimal quality (aiming for the achievable best), suggesting that the latter approach should be adopted by the health care system. He recognizes, however, that this may create a tension between the providers of a service and the recipients, throwing into even sharper focus the need to involve service users in any decisions on quality.

- Health professionals often use a problem-solving approach, which means they respond retrospectively to problems, rather than attempting to prevent the problem in the first place.

To resolve some of these conflicts, participants examined quality assurance techniques developed by industry. Originally industry, not unlike health care today, used quality control measures, first responding to customers' complaints about faulty goods, then setting up internal systems for finding and discarding faulty goods at the end of the production line (a retrospective approach). This was first rejected in the USA in favour of quality assurance and total quality management to minimize the production of faulty goods and thereby save money. Instead of rejecting faulty goods, systems would be designed so that faulty goods would not be produced. The idea was adopted enthusiastically by Japanese industry, and the success of Japanese manufacturing has been largely attributed to the adoption of quality assurance techniques.

In a brief examination of the British Standard Institute approach to quality (BSI 5750, now adopted as an international standard, ISO 9000) a definition of quality was identified (6). It can be summarized as: "Goods or services which are fit for the purpose and safe in use and which are designed and constructed to satisfy customers' needs". Using this definition, but with the concept that optimum rather than absolute quality should be the aim, participants examined a model for quality assurance in midwifery developed by the Royal College of Midwives of the United Kingdom, entitled QAMID.

Using QAMID

The QAMID approach to quality assurance for maternity services is shown in Annex 3. The components of this model are described in detail in a working paper (ICP/HSR 342/4), but are outlined briefly below.

- The first step of any quality assurance programme in maternity services should be the identification of customer needs - what are women's expressed needs, or what could they reasonably be assumed to want or need? A standard based on current research, market research and reasonable assumption should be stated.

- This standard should than be subjected to a review that takes into account current clinical research. Where such research demonstrates that the written standard would be "unsafe", it should be modified. There should then be a review of the resources available to meet the stated customer need. Again, where adequate resources are not available, the original standard can be modified. (Every attempt should be made, however, to modify the available resource first, rather than the standard to be achieved.) This statement, modified or as originally framed, will then become the "service specification", the standard to be achieved.

- A plan for implementation of the specification and the process of evaluation should be expressly set out.

- Implementation and evaluation will follow. If it proves difficult to achieve the standard, the first three stages should be re-examined and where necessary modified.

- Representation of the users of the service should be equal to that of the professionals at each stage.

- Finally, at intervals of approximately two years, there should be a reappraisal of the original customer needs statement. If necessary, this should be changed and the ensuing stages revisited.

The model can be used for "macro" and "micro" aspects of the service: on broad areas of care, such as the provision of community-based antenatal care, or on specific clinical issues such as episiotomy.

Participants in the Workshop were given a detailed description of each of these stages. They then divided into groups to discuss how each could be implemented in their own practice or in the practice of midwives in their country. A brief summary follows of the main points.

Can QAMID be used in other countries?

All countries represented expressed an interest in using the model. The United Kingdom and Sweden did not envisage any difficulties in implementing a project. Poland reported that quality assurance was being used in some aspects of coronary care and care of the elderly, and it should be possible to use it in the maternity services. Hungary and Czechoslovakia reported that their countries were undergoing major change in the provision of health care, and that using the model to assist in these changes presented an exciting opportunity. Belgium saw some difficulty as midwives were controlled by obstetricians, but they were beginning to increase their responsibilities, particularly in antenatal care.

Can quality be driven by the needs of women?

This approach can be facilitated by:

- the availability of research into women's needs and wants for maternity care;
- the greater assertiveness of women, particularly in western European countries;
- the existence of consumer groups;
- a growing awareness among professionals that the needs of their clients must be met;
- maternity care systems which achieve continuity of care, so that the woman's needs are explicitly stated in a trusting relationship with her carer.

Difficulties can be encountered because:

- women are still not fully empowered to state what they want;
- strong medical domination may hinder midwives' attempts to change their practice;
- midwives' attitudes need to change if they are to work in partnership with clients;
- changes in attitude of managers and policy-makers are also needed.

Can a customer needs statement become a "service specification"?

The groups worked through some hypothetical customer needs statements, discussed their clinical and resource implications, and worked towards developing a service specification. Some difficulty was encountered in establishing a common base for discussion within the groups, owing to wide variations in knowledge and practice. However, it was generally felt that the principles of this aspect of the model were understood and were workable.

How will implementation and evaluation work?

The groups returned to the topics they had worked on when developing a service specification, and considered possible processes for implementation and indicators for evaluation.

Summary

The Workshop helped the participants to understand the components of a quality assurance programme, and to apply a programme specifically designed for midwifery either to their own practice or to the practice of midwifery in their own country. All felt confident that they would be able to set up a project or activity on their return. The final sessions of the workshop comprised a sharing of planned future work.

All participants were asked to complete an evaluation questionnaire. Responses were marked against a four-point scale: excellent, good, fair and poor. Most responses fell within the excellent/good categories. Adverse comments were as follows:

the openmindedness of the organizer	fair - one comment
time for individual and group discussion	fair - two comments
adequacy of resource materials/literature	fair - two comments poor - one comment
comparison with other international meetings	fair - one comment.

One participant requested more background material.

Action plans

Belgium

A first priority for midwives in Belgium was to discuss with the Secretary General for Health the future identity of midwives in the health care system. To strengthen the midwifery voice, the four midwifery associations in Belgium will begin to work together. A small pilot project would be carried out using QAMID applied to an aspect of antenatal care.

Czechoslovakia

Czechoslovakia has a commitment to changing the status of the midwife through improving education. Consideration would be given to including quality assurance methods in training, with a focus on QAMID, and the possibility of holding a national conference would be explored. Contact would be made with the Ministry of Health in the Slovak Republic to arrange programmes to promote quality assurance. English-speaking midwives would be identified so they could participate in any future workshops.

Denmark

A report would be published in a midwifery journal. Groups would be set up to disseminate the model, and work with the Midwives Institute to hold a workshop in 1991/1992 would be explored. Topics for implementation of QAMID would be chosen, possibly continuity of care or episiotomy.

Hungary

A small group is preparing a book on quality assurance for nurses and midwives. The QAMID model will be introduced to the group.

Netherlands

The midwives would test QAMID in their own practice, possibly applying it to continuity of care after postpartum haemorrhage, starting in January 1992. An article about the workshop would be published and a paper on QAMID given at the midwives' annual conference.

Poland

A report would be published on the workshop. Discussions would take place with the Midwives Association to disseminate information on quality assurance. A midwifery group would be set up to take forward a programme of quality assurance. A QAMID exercise would be carried out on an aspect of delivery care.

United Kingdom

QAMID would be used in Glasgow and London with projects already in progress. These will be modified to allow for the setting of service specifications and techniques for evaluation. Topics chosen will enable short, medium and long-term evaluation of the model. The outcome will be fed back to workshop participants. Funding will be sought to instigate a major survey of women's views, using the manual entitled Women's experience of maternity care - a survey manual (7). Rosemary Jenkins, the workshop facilitator, also agreed to act as the central point of a network of midwives interested in quality assurance.

USSR

Information about the Workshop will be shared with health departments in the republics, and an expert committee at ministerial level will be established to develop quality assurance in midwifery. A national workshop on quality assurance in midwifery will be planned, possibly linked with conferences on family planning and perinatal technology.

Future exchange of information

Members of the group agreed to exchange short summaries of the progress on projects and activities at the end of 1991.

Mrs Jenkins would request a formal report of the achievements to date from each participant in April 1992. These will be collated into a report for publication and distribution in Europe.

REFERENCES

1. Enkin, M. et al. A guide to effective care in pregnancy and childbirth. Oxford, Oxford University Press, 1989.
2. Donabedian, A. The definition of quality assurance and approaches to its measurement. Ann Arbor, MI, Health Administration Press, 1980.
3. Maxwell, R. Quality assessment in health. British medical journal. 288: 1470-1472 (1984).
4. Kitson, A. A framework for quality: a patient-centred approach to quality assurance in health care. London, Scutari Press, 1989.
5. Vuori, H. Quality assurance of health services. Copenhagen, WHO Regional Office for Europe, 1982 (Public Health in Europe, No. 16).
6. A positive contribution to better business. British Standards Institute, London, 1987 (BS 5750/TSO 9000).
7. Mason. V. Women's experience of maternity care - a survey manual. London, H.M. Stationery Office, 1989.

RESOURCES

DySSSy (Dynamic Standard Setting System). Royal College of Nursing Standards of Care Project, Institute of Nursing, Radcliffe Infirmary, Woodstock Road, Oxford OX2 6HE, United Kingdom

MIDIRS (Midwives Information and Resource Service). Institute of Child Health, Royal Hospital for Sick Children, St Michael's Hill, Bristol, United Kingdom

MIRIAD (Midwifery Research Database). National Perinatal Epidemiology Unit, Radcliffe Infirmary, Woodstock Road, Oxford OX2 6HE, United Kingdom

Annex 1

SUMMARY OF QUESTIONNAIRE SENT TO EUROPEAN COUNTRIES TO IDENTIFY CURRENT QUALITY ASSURANCE WORK

1. The following questions were asked:

(a) Who holds the address(es) given on the attached annex for information on vital statistics, manpower information, official national surveys and the provision of health care facilities such as family planning services in your country?
Are you aware of any other official agencies that would supply this or similar information? If there are, could you give the addresses?

(b) Do you have midwifery databases/information services in your country? YES/NO
If yes, could you list them with the addresses where they are held?

(c) Are there any published midwifery standards tools available in your country? YES/NO
If yes, from what address can they be obtained?

(d) Are there any published standards or monitoring tools available in your country? YES/NO
If so, from which addresses can they be obtained?

(e) Are there any consumer groups in your country which produce information on consumer needs in maternity services? YES/NO
If so, could you list them and give their addresses?

(f) Does your country have current legislation controlling the practice and education of midwives? YES/NO
If so, could you attach a copy (or summary) of the current legislative position (preferably in English)?

2. Replies were received from the following 18 countries: Austria, Czechoslovakia, Denmark, France, Germany, Greece, Hungary, Italy, Luxembourg, Netherlands, Norway, Portugal, United Kingdom (Scotland), Spain, Sweden, Switzerland, USSR, Yugoslavia.

3. The results:

(a) All countries confirmed that national statistics on births were held centrally, through birth registration systems.

(b) Very few gave a positive reply to this question, and 5 referred back only to the national statistics. One (Scotland) identified 2 available midwifery databases available in the United Kingdom.

(c) Five countries had no published standards. Seven stated that the only standards were those required nationally for midwifery training. Four gave information (addresses) on possible standards of care. One gave full details of published clinical standards (Scotland). The remainder did not answer.

(d) Only Scotland gave details of available monitoring tools.

(e) Only six countries confirmed the existence of consumer organizations which produce information on women's needs.

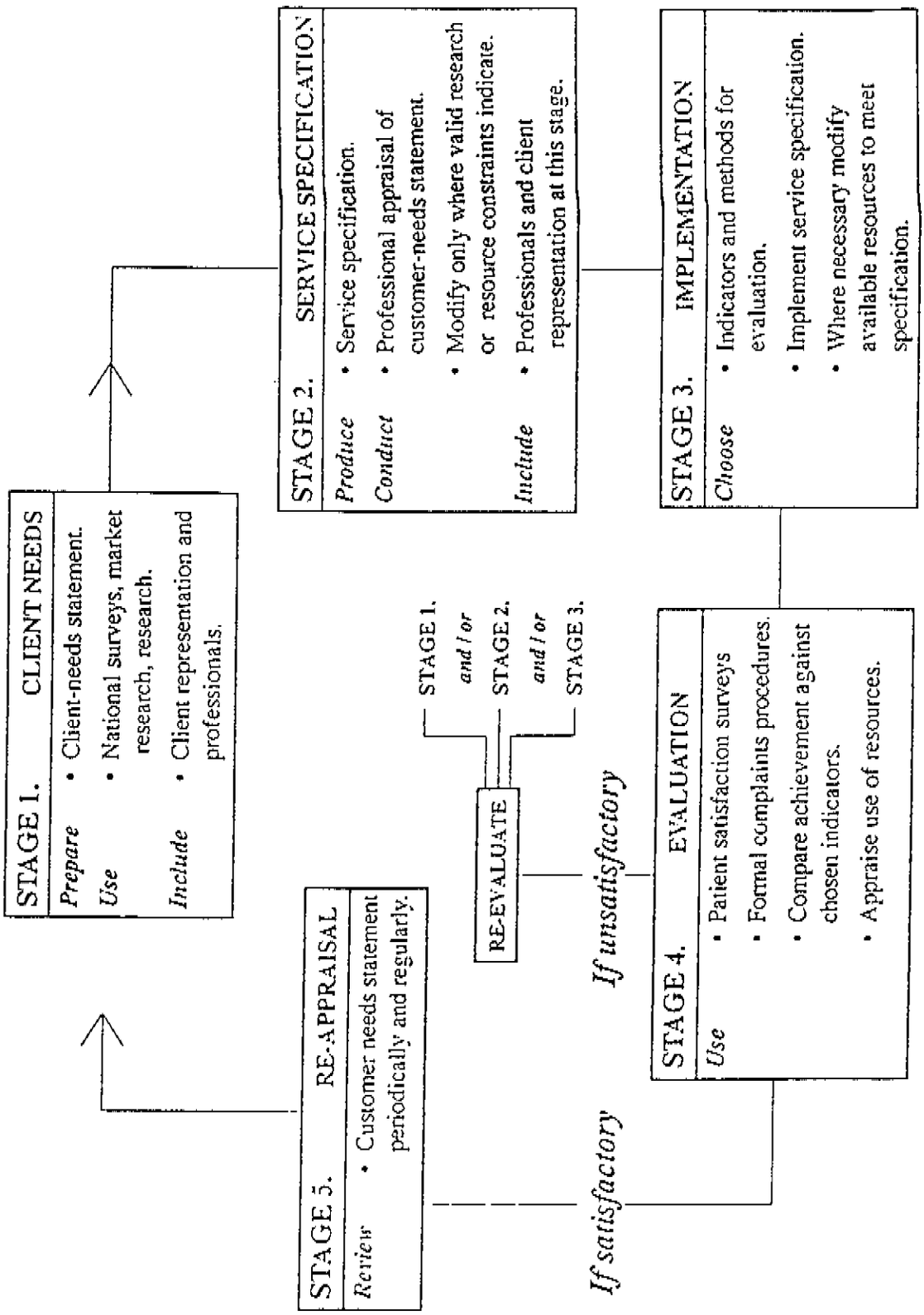
Annex 2

WORKING PAPERS AND BACKGROUND DOCUMENTS

ICP/HSR 342/1	Quality Assurance - previous work in nursing and midwifery.
ICP/HSR 342/2	Quality Assurance - industrial modelling.
ICP/HSR 342/3	Quality Assurance - professional utopia versus the resource imperative.
ICP/HSR 342/4	Quality Assurance - a model for midwifery practice.
ICP/HSR 342/5	A summary of information from the questionnaire to European midwifery organizations.
	Nursing standards: toward better care. Copenhagen, WHO Regional Office for Europe, 1985 (unpublished document).
	Nursing standards: toward better care. Guidelines for standards of nursing practice. Copenhagen, WHO Regional Office for Europe, 1985 (unpublished document).
EUR/ICP/HSR 324	The consultant's role in quality assurance in nursing practice: report on a WHO Meeting. Copenhagen, WHO Regional Office for Europe, 1988 (unpublished document).
EUR/RCP/HSR 336	The consultant's role in quality assurance in nursing practice: report on the Second Meeting. Copenhagen, WHO Regional Office for Europe, 1989 (unpublished document).

Annex 3

A QUALITY ASSURANCE MODEL FOR MIDWIFERY



Annex 4

LIST OF PARTICIPANTS

BELGIUM

Mrs Lammers
Hôpital ERASME, Université libre de Bruxelles, rue Emile Pouilliot 29, 1060 Brussels

Dr Anes Roelens
Directrice de l'Ecole d'infirmières Sainte Geertruid, Sint Geertruid, Kortryksesteenweg 1024, B9000 Gent

Mr Luc Verhaegen
Accoucheur en chef, Katholieke Universiteit Leuven, Malendriesstraat 13, 3370 Kerkom Boutersem

CZECHOSLOVAKIA

Mrs Blanka Misconiova
Chief Nursing Officer, Ministry of Health, Palackeho Nam. 4, 12008 Prague

Dr Marta Stankova
Director, Department of Education and Science, Ministry of Health, Palackeho Nam. 4, 12008 Prague

DENMARK

Ms Eva Kongsgaard
State University Hospital (Rigshospitalet), Blegdamsvej 9, Copenhagen

HUNGARY

Ms Mariann Varfalvi Bognarne
Ministry of Welfare, Arany Jaanos U. 6-8, H 1361 Budapest

Mrs Klara Sovenyi
Chief Nurse, Department of Preventive and Curative Care, Ministry of Welfare, Arany Jaanos U. 6-8, H 1361 Budapest

NETHERLANDS

Ms Kathy Cecile Herschderfer
Heuvel 5, 5528 NH Hoogeloon

Mrs H.A.A. Wijnen[a]
Andromeda 15, 5505 RM Veldhoven

[a] Expenses not paid by WHO.

POLAND

Miss Katarzyna Koronka
Chief, Nursing Section, Ministry of Health and Social Welfare, Miodowa 15, Warsaw

Mrs Joanne Wojtowicz
Ul Monte Casina lm 22, Warsaw

USSR

Dr N.G. Baklaenko
Deputy Chief, Board of Maternal and Child Care, Ministry of Health of the USSR, Rahmanovskij pereulok 3, 101431 GSP Moscow K51

Dr G.M. Perfiljeva
Chief, Central Methodological Cabinet of Nursing Education, Ministry of Health of the USSR, Rahmanovskij pereulok 3, 101431 GSP Moscow K51

UNITED KINGDOM

Ms Mary C. McGinley
Senior Midwife, Glasgow Royal Maternity Hospital, Rottenrow, Glasgow, United Kingdom

Miss Anne Rider
Maternity Services Manager/Director of Nursing Services, University College Hospital, Gower Street, WC1E 6AU London

OBSERVERS

Mrs Delalieux
39, rue du Parucq, 1080 Brussels, Belgium

Mrs L. Mannaert
Nieuw Straat 2, 1745 Opwijck, Belgium

Mrs Meylemans
Petrus Bogaertslaan 15, 2970 Schilde, Belgium

Mrs Porrot
615, chaussée d'Alsemberg, 1180 Brussels, Belgium

Mrs Anne Van Hove
Oversneslaan 37, 2610 Wilrijck, Belgium

TEMPORARY ADVISERS

Ms Hanne Kjaergaard Nielsen
Chief Midwife, Glostrup Amtssygehus, 2600 Glostrup Denmark

Professor Vivian Wahlberg
Nordic School of Public Health, Box 12133, S 402 42 Gothenburg, Sweden

Mrs Rosemary Jenkins[a]
Royal College of Midwives, Brandy Cove Suite, Microlink House, Queensway, Fforestfach, Swansea, United Kingdom

WHO REGIONAL OFFICE FOR EUROPE

Ms Elisabeth Stussi
Regional Adviser for Nursing, Midwifery and Social Work

[a] Expenses not paid by WHO.