Reflection on midwifery placement

Midwifery is a complex career, which in turn can cause mistakes especially for students who are on their first placement. In hindsight, I will be reflecting on my faults and successes based upon the auscultation of the fetal heart rate in two contrasting appointments. Although mistakes can be difficult to deal with and to acknowledge, it is vital for midwives to observe and reflect on past scenarios to improve. In order to achieve this, I'll be using Gibbs's Reflective Cycle (1998)[i]to observe my role as a student midwife pursuing and learning crucial antenatal skills. Besides the reflective cycle being a clear and effective model, it also allows you to maximize the opportunity for learning and prepares you for a later role as a registered midwife. As a result, it avoids committing the same mistakes and helps develop " professional competence and confidence" (The Code 2015, Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues).

Moreover, Gibbs's reflective essay follows several specific steps in order to be successful. These are broken down into six steps: description, feelings, evaluation, analysis, conclusion and action plans. To keep in line with regulations regarding theNMC code (2015, respect people's rights to privacy and confidentiality)I will be using a pseudonym for the first client " Jane", the second client " Rose", the midwife " Anne" and the Trust " Trust A". Therefore, respecting their right to privacy and meeting the requirements for confidentiality.

My first initial placement was at an Antenatal clinic at Trust A. During this placement I encountered Anne, one of the working midwives at Trust A. She explained to me that I would be working alongside her supervision. Adding to

this, Anne proceeded to show me how an antenatal appointment was structured and allowed me to undertake a thirty-eight-week appointment for a client called Jane (a healthy woman in her mid-twenties who was having her first baby). Due to her being an uncomplicated pregnancy she fell under the NICE (2008, uncomplicated pregnancy guidelines) in which, state that midwives should measure blood pressure, take a urine sample, measure fundal height and discuss any concerns the client may have. Soon after, I introduced myself to Jane and I explained who I was and why I was undergoing her antenatal appointment with reassurance that I was under the guidance of Anne as Jane seemed apprehensive to have a student. I proceeded to initiate the guidelines in her appointment in particularly making sure that blood pressure is measured accurately as it is a high-risk factor for serious maternal and fetal complications (NICE 2008). To undergo Jane's thirty-eight-week appointment I took her blood pressure and tested her urine sample with a dipstick. As exemplified Jane's pregnancy is healthy and as a result both her blood pressure (120/80 mmhg) and her urine sample was clear of leukocytes, protein, ketones and glucose. I explained her results to her and began to palpate Jane's stomach to measure the fundal height.

During this Jane had asked if she could hear her baby's heart rate aloud, something that I had only practiced using a pinard horn on a practice model. In accordance to NICE (2008, fetal growth and wellbeing) it states that *" it is not recommended to listen to the fetal heart rate as it is unlikely to have any predictive value but can be done to reassure the mother"* so Anne proceeded to instruct me that it was fine to do so and allowed for me to palpate Jane's stomach further to feel for the fetuses position. In order to hear the fetal

heart rate, you will need to firstly palpate the client's stomach to distinguish the position of the baby. Once this is distinguished you should listen to the baby's heart rate through their shoulder for a minute. As a student midwife you should listen to see if the heart rate is present and consistent and is within the healthy range of 120-160 beats per minute(Royal College of Midwives, 2008). This should be only done to pregnancies of over the gestation of 20 weeks to meet the guidelines of Trust A and also be recorded in her notes and explained to the client.

Despite Anne's help, I found it still very difficult to distinguish the difference between the fetus's head and anus. I found this was partially because the abdominal palpation models I used during practice were firm and didn't have the realistic features, such as amniotic fluid and different ranges of BMI. Additionally, the fetus was making lots of movements and changing their position. Therefore, it became difficult to position the pinard stethoscope over the baby's shoulder. Furthermore, I did not want to cause any discomfort to Jane when palpating, leading me to not placing enough pressure on the stomach to identify the differences between the head and anus. These factors combined led me to feel particularly embarrassed as I felt that I didn't know what I was doing. Additionally, I found myself constantly moving and changing my mind on the position of the fetus. As a result, I placed the pinard in the wrong position and when asked if I could hear the fetal heart rate in which I couldn't as I placed the pinard in an incorrect position. I proceeded to tell Anne that I heard the heart rate. This led to me placing the sonicaid in an incorrect position and picking up the placenta instead. Consequently, Anne decided that she should take over.

During this she went over the differences in sound and how to distinguish between placenta and heart rate. Furthermore, she placed my hands on the head and the anus of the fetus to help me feel the physical differences. Thus, meetingRCN Guidance for Mentors of Nursing and Midwifery Students (2017)as she gave me “ constructive feedback, with suggestions on how to make improvements to promote progress”.

Due to this, Anne wanted me to gain further experience and allowed me to partake in her second appointment with a client called Rose (gravida 3). Likewise, Rose was also healthy with a BMI of twenty-four and a normal blood pressure. Anne had explained to her that I’ll be undertaking the auscultation. I initially felt quite nervous but with Anne’s tutorial and guidance I managed to pick up the fetus heart rate rapidly using the sonicaid doppler. This made me feel more confident and more prepared to partake in more auscultations.

On evaluation, this experience has been beneficial in multiple ways. One is showing that as a student I will not always know the answer, but I should always make sure I use experiences like these for educational purposes and learn from my mistakes. Moreover, this experience has allowed me to learn what is deemed as normal during pregnancy. As a result, I can distinguish between what is healthy during pregnancy. For instance, in the case of Rose I was able to partake and listen to a healthy fetal heart rate, allowing me to learn that a healthy heart rate is between 120-160 beats per minute. Additionally, the fetus reacting to me palpating the stomach through movement in Jane’s case indicates that baby is aware and active. However, there are some negative elements. Firstly, I was quite disappointed in myself

that I wasn’t able to complete the appointment and personally fulfill Jane’s request to listen to the fetal heart rate. Additionally, I felt that I may have caused Jane to be stressed and more nervous as Anne had to step in and help me. This could have led her to believe as a first-time mother that there was something wrong with her baby.

My experiences have further taught me that in order to improve my skills as a student I will need to undertake more antenatal appointments to learn and gain a wider variety of skills. This is particularly important when learning what is expected at appointments. For instance, the NHS dedicates the breakdown of antenatal appointments fulfilling the NHS values of “ committing quality of care” (NHS England values) to their patients. Therefore, explaining to pregnant women and their families what care they’ll be receiving. Moreover, these experiences have showed me how important communication and teamwork skills are when providing care. This could be applicable by Anne working with me to teach me how to accurately perform auscultation. Furthermore, I could have used communication in the Jane scenario by informing her why Anne had to undergo the auscultation instead of me, alternatively I assumed she would realize that as a student, I may need help. This could have helped Jane feel reassured and cause less confusion.

After my research on auscultation I have found that it is not recommended by midwives to have home dopplers. This is because they may cause additional stress as they may not be able to find the fetus heart rate or mistake their own heart rate. This is due to them not being professionally trained to use them. Additionally, this may lead the client to believe they

don’t need medical intervention. However, in stories shared on *Kicks count* present mothers trusting dopplers as a method of assuming fetus’s wellbeing when normal movements aren’t felt. As a future registered midwife, I need to be prepared to educate clients to not use home sonicaid. In addition to this, I need to *“ practice in line with the best available evidence”* set by the Nursing and midwifery council (The code, 2015).

To conclude, If the same scenario was to arise, I believe I would have approached things differently. One part of this scenario I would change would be to make sure I fully explain to the client that if I would need any form of help that I would inform the midwife working with me. This partially could have been done by having a leaflet explaining the role of a student midwife as I felt that Jane felt pressure by both me and Anne to undergo her appointment with me as a student midwife. Additionally, I would have desired to have experience a longer appointment with Jane. This would have allowed me to go in depth with her pregnancy notes and gain further insight throughout her pregnancy. For instance, looking at Jane’s ethnic background as the highest proportion of preterm births at 10% occurred in the Black Caribbean ethnicity (national office of statistics, 2013). This would have allowed me to gain a wider insight of how midwives prepare for ladies like Jane who fall under these categories. For instance, discussing stages of labor and how the trust operates. Moreover, I have learnt that in the future antenatal appointments to be more confident and be prepared as patients will feel more at ease and re assure that I am aware of my duty as a student. Ultimately, fulfilling the Nursing and Midwifery council professional standards to act “ as a role model of professional behavior” (The Code, 2015).

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