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Willow Creek Women's Hospital Internship

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Abstract

While the use of midwifery is proven to improve outcomes for low-risk mothers and infants, many healthcare providers, nurses, and patients in Northwest Arkansas continue to be skeptical about utilizing midwifery care. During my internship, I worked directly with labor and delivery nurses, physicians, and a midwife at Willow Creek Women's Hospital and provided high-quality care to women during their birthing process. This hospital focuses entirely on women and infant care and provides gynecological, obstetric, and newborn services. Willow Creek Women's Hospital is also one of the few hospitals in Arkansas to implement a certified nurse-midwife (CNM) and has two low-intervention birth suites. Through my internship, I learned how to assist during the labor and birthing process, how to implement pharmacological and nonpharmacological interventions during labor, and how to approach each labor holistically and individually. My experiences during my internship have made me more comfortable communicating with healthcare staff and patients. It has also improved my understanding of the stigma that surrounds midwifery care compared to other traditional birthing practices in Northwest Arkansas. Lastly, my internship at Willow Creek Women's Hospital set a solid foundation for my future in labor and delivery and midwifery.

Willow Creek Women's Hospital Internship

Although research has shown that the utilization of midwives optimizes both maternal and fetal outcomes, Arkansas ranks lower than most states in midwife integration. According to The Birth Place Lab, Arkansas ranked number 30 out of 50 in midwife integration with 22 licensed midwives, while Washington ranked number one with 374 certified nurse-midwives (2018). States that included more midwives in maternal-fetal care experienced “significantly higher rates of spontaneous vaginal delivery, vaginal birth after cesarean (VBAC), and breastfeeding at birth and at six months; and significantly lower rates of cesarean section (CS), preterm (PTB), and low birth weight (LBW) infants” (Vedam et al., 2018). Midwives are also able to provide a more personal and holistic type of care to patients by providing shorter wait-times and longer appointments that are “comfortable, less clinical, hands-on, caring, respectful, and informative” (Darling et al., 2019). This model of care could potentially increase patient retention rates and improve the continuum of care. Midwives are also cost-effective. All three types of midwives work in a way that reduces costs by “prioritizing person-centered care; promoting...normal, physiologic birth; judicious evidence-based use of obstetric interventions and procedures; and collaborating with and/or referring to obstetric specialists when indicated” (Vedam et al., 2018). This reduces the rate of unnecessary, costly procedures such as cesarean sections and other unwarranted obstetric interventions. According the Midwives' Association of Washington State (2019), midwives saved the State of Washington \$1.9 million annually by reducing cesarean sections and other costly interventions. Lastly, midwifery care provides mothers with an increased sense of control during their birthing process, improves breastfeeding rates, and allows for births to take place in several different settings (American College of Nurse-

Midwives, 2012). All these positive outcomes address several of the maternal-newborn deficits in the United States such as infant mortality, low birth weight, and maternal complications.

While midwives significantly increase patient outcomes, there are still several barriers that affect access to midwifery care. Some of these barriers include misconceptions about midwifery care, lack of awareness about the presence of midwives, and lack of accessibility due to laws and regulations that govern midwives. Several patients end up “moving passively through the healthcare system which traditionally favors physician care” and do not realize that midwives are an option (Darling et al., 2019). Patients may also stray away from the use of midwives because they do not believe that they are as safe or as qualified as physicians. Furthermore, midwives often are deemed as inferior and receive “infrequent endorsement...by family physicians” (Darling et al., 2019). Although there are several social barriers that limit midwifery care, legislative barriers further decrease midwife accessibility. For example, in Arkansas, only certified professional midwives and certified nurse-midwives have a license to practice. All three types of midwives also have restrictions on where they can practice and do not have easy access to physician referrals (The Birth Place Lab, 2014). Patient outcomes have been shown to be improved when “midwives are regulated and have the legislative authority to practice to their full scope across birth settings, including collaborating with or referring to other health professionals” (Vedam et al., 2018). When there is limited collaboration between members of the healthcare team, patient outcomes decrease. Furthermore, when certified nurse-midwives have “greater professional autonomy (i.e. physician supervision not required), there [are] lower rates of surgical birth, preterm birth, and low birth weight [infants]” (Vedam et al., 2018). Restrictive laws not only inhibit midwives from practicing to the full potential of their

profession, but also deprives expecting mothers “who may not have easy access to obstetric care in a hospital of a safe and, for some, desirable method of delivery” (Ollove, 2016).

In order to address these barriers to midwifery care, it would be beneficial to spread awareness and knowledge about midwives and improve licensing and accreditation for all three types of midwives. By increasing awareness and knowledge of midwives in all patient populations, patients' misconceptions about midwives could be clarified. This increase in knowledge among patients and the improvement of licensing among midwives would aid in mitigating patients' apprehensions regarding the safety and qualifications of midwives. Educating physicians would also be beneficial so that a “change [in] physician referral behavior” could occur. Patients generally visit physicians first, and these providers could act as gateways to other healthcare options such as midwifery (Darling et al., 2019).

Like several other states, there is a stigma surrounding midwifery care in Arkansas due to lack of information and accessibility. Like other advanced practice nurses, certified nurse-midwives are unable to practice independently of a physician in Arkansas. Providing patients with accurate information about midwifery would allow them to make more informed decisions regarding their care and could possibly remove the stigma that surrounds midwives. Increasing the use of midwives in Arkansas would significantly improve maternal-fetal outcomes because much of Arkansas is rural and a large portion of the population lives in poverty. According to a study completed by the University of Arkansas' Division of Agriculture called the Rural Profile of Arkansas, 41 percent of Arkansas live in rural counties while only 14 percent of the United States' population live in rural counties (2019). It was also found that the poverty rate for all populations in Arkansas were significantly higher than the rest of the United States. Lastly, this study also found that the United States' seven-year infant mortality rate was 5.6 deaths per 1,000

births while Arkansas' infant mortality rate was 7.1 deaths. After reviewing a study about midwifery completed by Saraswathi Vedam, Neel Shah, an assistant professor at Harvard Medical School, stated that "licensed midwives could be used to solve shortages of maternity care that disproportionately affect rural and low-income mothers, many of them women of color" (Martin, 2019). The increased use of midwives in Arkansas could bridge the gap for the rural and impoverished populations in this area and provide high-quality, safe care for those in need.

During my internship at Willow Creek Women's Hospital, I had the privilege of shadowing labor and delivery nurses and aiding patients throughout their birthing process. I learned a great amount about all the factors that go into preparing and completing a delivery, and I was able to observe several different roles that must collaborate to ensure a safe and optimal birth. I also developed communication skills with healthcare staff and patients, expanded my critical thinking skills regarding the birthing process, and practiced technical skills common in a labor and delivery setting. I was also able to witness midwifery practice in Northwest Arkansas and understand the views that patients and other healthcare staff had regarding midwifery care. Although this internship was under a year, I attended more births than the average person will witness in their lifetime and was able to better understand all the specialties and factors that go into delivering a baby. It was incredible to be able to observe the miracle of birth and to be a part of something so sacred.

While working with a labor and delivery nurse, I prepared rooms and assisted the nurse throughout each labor and delivery. Before a patient was admitted, the rooms had to be "labor and delivery ready," delivery tables needed to be made, and supply carts needed to be restocked. I would prepare the rooms with all the necessary equipment needed such as the infant warmer and crib, suction and oxygenation equipment, IV pole, and several sensors needed to monitor

mother and baby. I also made delivery tables that included all the sterile instruments, drapes, gauze, and towels that the physician required during delivery. Lastly, I ensured that the supply carts had sutures, vacuums, suction bulbs, lab vials, and other miscellaneous items. When a mother was ready to deliver, I would place the delivery table and supply cart in their room. Once a room was prepared, the nurse and I would bring the patient to their room, have them change into a hospital gown, and connect them to all the necessary sensors. These sensors included the cardiotocography cords to measure uterine contractions and fetal heart rate, pulse oximeter to measure the mother's oxygen saturation, electrocardiogram cords, if necessary, to monitor the mother's heart rhythm, and blood pressure cuff to monitor the mother's blood pressure. While all these monitors are external, sometimes an intrauterine fetal monitor would be placed in the uterus to monitor the baby's heart rate more accurately if the external monitor was not performing well. During this time, the nurse and I would perform an assessment on the mother to establish an admission baseline by assessing heart and lung sounds, capillary refill, edema, vital signs, and fetal position. The nurse would also perform a vaginal exam to determine dilation and effacement of the cervix, which measured how stretched and thin it was. However, I learned that nurses tend to avoid performing cervical exams except for upon admission and during changes in the patient's status because it can increase the risk for infection.

After the initial preparation of the patient, we would start an intravenous (IV) line and begin any necessary medications. Even if a patient was not receiving any medications, we had to have IV access in case of an emergency. While most medications were required to be administered via IV, IV medications were also preferred because several patients experienced nausea and vomiting and were unable to take medication by mouth. If a patient came in for an induction of labor (IOL), Pitocin, or Oxytocin, would generally be used and started IV to induce

contractions and begin the labor process. Pitocin was titrated based upon the physician's orders and the intensity, duration, and frequency of the patient's contractions. If the contractions were occurring too often, the Pitocin would be titrated down, but if the fetus and mother were tolerating the medication well and contractions were stable, the Pitocin would be titrated up. I learned that it was important to monitor contraction duration and frequency because if the contractions were occurring too frequently, it could cause a decrease in fetal oxygenation and circulation. If a patient had pre-eclampsia, an intravenous infusion of Magnesium Sulfate would be started. Pre-eclampsia is characterized by hypertension and can lead to a seizure disorder called eclampsia. Because Magnesium Sulfate acts like a sedative, it was used to prevent potential seizures from occurring. When a patient was on Magnesium Sulfate, the nurse and I would always have Calcium Gluconate at the bedside as an antidote if toxicity occurred. We would also assess the patient's deep tendon reflexes, respirations, heart rate, and level of consciousness to ensure that toxicity was not occurring. If a patient requested to have an epidural, a bolus of normal saline IV solution would be started in order to increase their fluid volume to prevent a blood pressure drop during the epidural. The potential hypotension from an epidural is caused by arterial and venous vasodilation which causes fluid to shift from the intracellular space to the intravascular space. Once the bolus was complete, the anesthesiologist would be notified, and they would place the epidural and begin the infusion. Once a patient received an epidural, I would insert a Foley catheter under the nurse's supervision. This was done because the patient would be unable to get out of bed due to the numbing of the lower body caused by the epidural. We would also educate the patient that they needed to lay on their backs so the numbing effect would be even since epidurals work by gravity. However, I learned that mothers are not encouraged to lay on their backs during pregnancy because this compresses

several major arteries and decreases oxygenation and circulation to the fetus. Based on this information, I learned that turning and repositioning mothers are primary nursing interventions that are used if the fetal heart rate exhibits decelerations, or prolonged, abrupt drops in heart rate.

Once a patient had been prepared for delivery, most of the work included monitoring the mother and baby and intervening accordingly until the mother was ready to deliver. While there were universal interventions implemented for each mother (like turning and repositioning), each labor was unique and treated as so. I learned that different interventions, like guided breathing, were ineffective for some mothers while applying a full face of makeup, for example, proved to be more successful in relaxing the patient. This personalization of care was also apparent when we respected patient's wishes regarding their birthing plan. Unlike other areas of nursing, labor and delivery provides patients with a lot more opportunities to participate in their care. For example, a patient of the midwife had a detailed list of her birthing wishes that the nurses were expected to follow during her care if medically safe and appropriate. While not all patients were as informed and educated about their care, I enjoyed witnessing patients wanting to be engaged in their care. While several patients have advanced directives that are generally created outside of a hospital stay to specify which medical interventions they are to receive or not receive, the labor and delivery setting actively encourages patients to participate in their care throughout their stay. After experiencing active participation first-hand, it was obvious that it improved patient outcomes and communication between the patient and healthcare staff. While all healthcare providers should respect each patient's desires, I enjoyed being able to be a part of creating a special experience for each mother by carrying out their wishes.

While monitoring patients, I learned how to read cardiotocography patterns and measure contraction intensity, duration, and fetal heart rate pattern in relation to the contractions. I

learned that variability and accelerations generally meant that the fetus was doing well because their bodies were responding appropriately to changes in their environment, while decelerations were not reassuring because this potentially meant that hypoxia or other complications may have been occurring. The nurse also informed me that it was important to take into consideration the medications that the mother was taking and whether the fetus was asleep or not because these factors could affect fetal heart rate. If the fetal heart rate was not reassuring, some interventions that the nurse and I performed included starting a fluid bolus in order to raise the mother's fluid volume to increase circulation, assisting the mother in changing positions, and applying an oxygen mask on the mother to, in turn, increase the baby's oxygen.

Although several interventions focused on protecting the fetus, there were also several nonpharmacological interventions that could be performed to assist the mother during her labor. I was able to give mothers essential oils such as ginger and peppermint to assist with nausea and lavender to assist with relaxation. We were also able to perform guided breathing exercises with mothers, implement peanut balls and exercise balls to open their hips, and teach significant others to perform acupressure massages to distract the mother from her labor pains. Although several of the nursing interventions performed in labor and delivery were simple, they had a great impact on maternal-fetal outcomes. By helping a patient relax, we were able to help their labor progress more smoothly and quickly. Relaxation prevents the release of catecholamines such as epinephrine and norepinephrine that are produced by the sympathetic nervous system during periods of stress. These catecholamines cause vasoconstriction which can reduce blood flow to the fetus and reduce the natural production of oxytocin which can increase the length of labor. Therefore, helping patients relax as much as possible was vital.

Once a patient was ready to deliver, most mothers tended to state that they had “extreme pressure” and the “urge to push.” Before the physician or midwife was called, we prepared the patient for delivery. We would take out the bottom part of the bed so that the physician would have better access to deliver the baby, position the mother’s legs into the stirrups of the bed, and cleanse the patient’s perineal area with an iodine solution. We then would instruct the patient on how to breathe by informing her to take large cleansing breaths before and in between contractions. We would then instruct the patient to take a big breath in, hold, and “bear down” with their chin to their chest during a contraction. Patients often found it helpful when we performed guided breathing exercises with them. We also taught mothers to push like they were having a bowel movement in conjunction with their contractions to increase their pushing effectiveness. Contractions are the uterus’s way of pushing the baby out of the body, so having the mother actively push along with contractions increased the effectiveness of the push. Guiding the patient during pushing became imperative when a mother had an epidural and could not feel her contractions well enough to push along with them. Once the baby was closer to crowning, we called the doctor, or midwife, and informed them that their patient was ready to deliver and, if needed, we called respiratory therapy and other nurses to assist during the delivery. During the delivery, I would assist the mother by holding her legs back while she was pushing, provide sutures for the physician, if needed, and perform a count in and out of surgical tools and gauze with the nurse and physician. Once the baby was delivered, the baby was placed on the mother’s chest and cord clamping was delayed for at least a minute or longer if the baby was healthy in order to allow more blood to flow from the placenta to the baby. APGAR (Appearance, Pulse, Grimace, Activity, and Respirations) scores were assessed on the mother’s chest by the nurse at one and five minutes if the baby was healthy but were performed in the baby warmer if the baby

was not healthy so that the nurse and respiratory therapist could perform life-saving interventions if necessary. These interventions generally included suctioning the baby and gently rubbing the baby's back and feet to stimulate crying so that the baby naturally excreted secretions. After the baby was delivered, we would begin an Oxytocin bolus immediately to prevent postpartum hemorrhage and to aid in the delivery of the placenta. After delivery, the bed was put back together, the mother was cleaned up and made more comfortable, a perineal ice-pack was placed, and assessments were performed on mother and baby at routine intervals to ensure their health and wellbeing. The nurse and I would encourage the mother to do skin-to-skin with her baby on her chest because it has been proven to stabilize the baby's temperature, heart rate, respiration rate, and blood sugar. We also would perform fundal rubs on the patient's uterus to help prevent postpartum hemorrhage by helping the uterus return to its original size and firmness prior to having a baby. Once both patients were stable and any anesthesia had worn off, the nurse and I would get the mother up to use the restroom and teach her perineal care using witch hazel infused pads, a perineal spray bottle, pain-relieving spray, and maxi pads. Some important teaching that we would do for the postpartum mother included using the perineal spray bottle to rinse the perineal area from front to back to avoid wiping, placing witch hazel infused pads on their maxi pad to aid with discomfort and swelling, and to utilize the pain-relieving spray to further reduce discomfort. We would also teach them to watch for any excessive bleeding, clots larger than a golf ball, and that her afterbirth pains would be caused by the uterus contracting. After this process, the mother and baby would be transferred to the postpartum unit.

While I spent a great amount of time interacting with nurses and physicians, I had limited experience with the midwife at Willow Creek Women's Hospital due to the fact that she was the only one and was unable to attend all her patient's deliveries. However, I did notice that while

there were several patients who had a midwife as their provider of choice, most patients still chose a physician over a midwife. Furthermore, a handful of patients that chose a physician as their provider also requested to deliver in a low-intervention birth suite but did not have a midwife as their provider. These patients tended to state that although they requested the low intervention birth suite, they still preferred a physician over a midwife. Also, several of the nurses that I spoke with regarding the midwife had negative opinions about the midwife's clinical decisions. I believe that part of this was because the midwife did not possess bedside nursing experience because she went from a bachelor's program into a graduate program for midwifery. Nurses tend to eat their young, and respect generally comes with experience, so the midwife did not have excellent rapport with the nurses in that aspect. The nurses also tended to question some of the midwife's actions. For example, the midwife was planning on a vaginal delivery for a patient that had to have a previous cesarean section due to a shoulder dystocia. A shoulder dystocia occurs when the baby's shoulder becomes stuck above the mother's pubic bone. The nurses did not believe that this patient was a good candidate for a vaginal delivery, but the midwife insisted and had a physician join her in the delivery room just in case any complications occurred. The midwife delivered that patient with no complications and prevented a potential cesarean section. Whether it be from lack of accessibility, lack of knowledge, or lack of respect, midwifery in Northwest Arkansas still has a long road ahead to become as integrated as it needs to be to significantly improve maternal-fetal outcomes.

After my internship at Willow Creek Women's Hospital, I decided that I wanted to have a future in labor and delivery and midwifery. This internship allowed me to delve into all the aspects that surround labor and delivery and have a taste for what the profession is like. Willow Creek Women's Hospital's healthcare team taught me what a great teamwork environment

looked like, provided me with opportunities to grow in my communication skills, improved my critical thinking, and allowed me to practice several technical skills related to labor and delivery. Several of the nurses stated that they never felt alone, and this was evident by how each team member willingly helped each other when in need. Also, each delivery required a small village, and the nurses and other healthcare staff at Willow Creek Women's Hospital worked together effectively to ensure optimal and safe outcomes for mothers and babies. Although I am generally a shy person, this internship allowed me to work on my communication skills by interacting with physicians, nurses, and patients during a stressful time in their lives. Before I had any experience with labor and delivery, I believed that my future was in pediatrics. However, I loved the number of nonpharmacological interventions that can be implemented in this area of nursing. Working with mothers and babies and witnessing what a woman's body could go through physically and emotionally was remarkable. I also enjoyed how personalized labor and delivery was for each patient and that most patients took on a very active role in their care. I plan to utilize this model of care in my future practice and treat each patient as a unique case every time. I will also remember to respect patient's wishes and encourage them to be an active participant in their care to improve their outcomes. Lastly, I experienced the stigma that surrounds midwifery in Northwest Arkansas firsthand. Although this realization was not encouraging, it inspired me to be part of the solution and work to become a certified nurse-midwife in Arkansas. In my current practice, I will work to show my support for midwives and their clinical decisions and share my positive outlook about midwifery care in hopes of influencing others in a productive manner. I will also provide accurate statistics about midwives on maternal-fetal outcomes to clarify misconceptions others may have about the practice. In my future, I hope to continue to improve the awareness of midwifery and increase accessibility for the rural and impoverished patient

populations in Arkansas in order to address healthcare deficits and improve maternal-fetal outcomes in this area.

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