Midwifery Led Continuity Care in Different Birthplaces Scenarios

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Abstract

 This research encompassed an exploration into Maternity Led Continuous Care. It took the form of a synthesis of literature after forming a PICOT question. Significance of the practice problem entailed Midwifery-Led Continuity Care in Different Birth Places Scenario being a relatively new care model. Importantly, the model requires mothers and their infants to be monitored by the same midwife or obstetric team throughout the pregnancy, childbirth, and postal natal period. Consequently, the theoretical framework was one of a Caring model incorporating the former approach. The comprehensive synthesis of literature provided confirmation showing some unique challenges encountered in executing the model. A major challenge related to evidence -based data impacting the science globally. Hence, more documentation of outcomes and events within a research context is required. Ultimately, from an overall perspective there is evidence showing where at the Nursing Science level, Midwives function as primary care givers to pregnant women, internationally. As such, it is hoped that this research will encourage addition to the body of knowledge now existing moving forwards strategic interventions that facilitate application of the model worldwide.

**Introduction**

Midwifery Led Continuity Care in Different Birthplaces Scenarios

Research shows that at the Nursing Science level, Midwives function as primary care providers to women of childbearing age, internationally. While this is true as well as commendable, synthesized data regarding whether differences exist in morbidity and mortality outcomes are not available. This is when compared to other models. Psychosocial consequences between midwife-led continuity models seem obscure. It is either that no specific efficient care models can be identified or the distinction between models overlap. So, measurement of care outcomes become impossible. Further, in comparing midwife- led continuity care model with alternative maternal care types, numerous difficulties are encountered when differentiating between women and the interventions undertaken for them and their infants. Measurement consistency was one of the greatest challenges. This related to women satisfaction with their care when a number of other models were applied. The outcomes were narrated (Sandall & Soltani, 2016).

While satisfaction rates showed marked improvement in studies conducted using midwifery-led continuity care model, no clarity emerged. Actually, cost reduction trends surfaced with difficulties understanding the model. Providers comparing the financial implications of using this model in relation to alternatives, found marked irregularities with cost effectiveness, too. These concerns specifically were focused towards identifying the continuity aspect of this care model. Generally, it is perceived that the care continuity framework is complex as a nursing process, while being critical. Despite strategies to keep healthcare costs down always there is the issue of quality being compromised in almost every case. Therefore, when the Different Birth Places Scenario is conceived costs must be adjusted (Dreiher & Comaneshter, 2016).

 For example, in a community setting, midwifery poses such a challenge. Postnatal care usually embraces a number of home visits. Essentially, mothers’ access pre as well as postnatal care from the same midwife. As such, the limited staff-handovers facilitates enhancement of relationships between mothers and midwives, as well as providers. It allows for more definitive opportunities to identify predisposing conditions before they occur. The face to face interactive home visit sets up the scenario for this to happen. Studies reveal, further, that efficient allocation and routing of midwives in the community setting, could alleviate many challenges encountered in this scenario (Bowers & Cheyne, 2019).

One study examined the use of multiple variant travelling salesmen problem integrating logarithmic measurements in to determine cost effectiveness. They were able to estimate the basics of staff preferences in relation to trade-offs between travel time and continuity of care. They combined the algorithm with a simulation method in assessing staff effects availability and consequent outcomes (de Jonge, & Stuijt, 2016). The specifics of this strategic intervention allowed additionally for evaluating shift patterns implicating part-time schedules. It was discovered that care continuity can be reached with small travel time increases without undue costs. Nonetheless, shift patterns remain unresolved again putting care continuity in jeopardy. The conclusion in this scenario is that perfection in care continuity under these circumstances seem obscure. Perfection can only be achieved if there is flexibility in midwives’ visit schedules during community setting interactions (Sandall & Soltani, 2016).

This research proposal addresses the issue of Midwifery-Led Continuity Care in Different Birth Places Scenario. Definitively, midwife-led continuity care models are ones providing women with care from the same midwife or team of midwives. This occurs during the pregnancy, birth and early parenting period. Referral to specialist obstetric care is required for interventions to begin (Sandall, Hatem & Daven, 2019). The modality embraces co-ordination care protocols with interactive relationships for an agreed period on time. Different Birthplace scenarios according to this research proposal relates to hospitals, birthing centers, community centers and home deliveries. This research structure would encompass an outline of the Significance of the Practice Problem; Research Question; Theoretical Framework; Synthesis of the Literature; Practice Recommendations; finally, Discussion and Implications for Nursing and Healthcare. The purpose of this study is to reinforce about Midwifery Led Continuity Care in different birthplace scenarios. As results, I hope to deliver a useful material from the point of view of the practicing nurse, where we can also find an interesting field.

**Significance of the Practice Problem**

Midwifery-Led Continuity Care in Different Birth Places Scenario has its unique challenges because this is a relatively new care model. The apparent difficulty encountered by healthcare teams relate to it not being an everyday availability to clients. Importantly, it is a model requiring that mothers and their infants be monitored by the same midwife or obstetric team throughout the pregnancy, childbirth and postal natal period. Infant follow up assessments occur immediately after delivery being another care critical requirement. This characterizes the modality being continuity-led midwife care. From studies conducted on the method, continuity is not always upheld in the way intended (Fernandez & Roe, 2019).

As such, it is crucial for this study that an investigation be launched into what are the challenges. Particularly, it is finding out reasons for them not functioning as planned and the scenarios where they are best applied. Besides, with the midwifery-led continuity care model, women do not fully understand how it functions to benefit them and their unborn child. While the National Maternity review in 2016 indicated that the model does produce safer care ultimately, by establishing a vison for Maternity care in England, understanding how the model works in different birth place scenarios still cannot be measured (Fernandez & Bick , 2019). Therefore, this study is expected to provide clarify adding to the body of knowledge in this field of science

**Research Questions**

1. How is Midwifery-led continuity care model more efficient than other maternity care models?
2. What are the challenges facing providers when executing this model?
3. How can this model be utilized in different birth scenarios?
4. What birthplace scenarios are more adaptable to this model?
5. What care birthplace scenarios are less adaptable to this model?
6. What can be done to enhance adaptability of maternity - led care model in more birthplace scenarios?

**PICOT Question**

Do (P) pregnant women in different birthplace scenarios receive (O) safer outcomes when the (I) maternity-led continuity care model is applied versus other (models during their pregnancy (T).

P – People: Pregnant women

I – Intervention: Maternity -led continuity care model

C – Contrast: Other models

O – Outcome: Safer Outcomes

T – Time: Duration of Pregnancy

 **Theoretical Framework**

 This theoretical framework pertains to models in Nursing Science. Models facilitate focusing on care intervention applications, rather than medical practice. Since nursing moved away from philosophical underpinnings towards scientific deliberations, bringing theory into play, supporting evidence -based protocols models have emerged as the real deal in the care protocols. They allow for combining levels and types of nursing theories into methodologies explaining how nursing process could be improved as well as understood from a logical premise. For example, in this research the Midwifery-led continuity care model is an explanation of how pregnant mothers could access maternal and infant care through a systemic approach of the same midwife or obstetric team for the entire pregnancy. This model limits multiple providers interference within the patient’s care plan. The advantage of this, nursing process and patient safety are enhanced. These are proven valid evidenced - based practices (Homer & Brodie, 2019)

 Further, it is argued that utilizing antenatal care models efficiently is a current mandatory global policy goal. While this is true, actual implementation could become problematic due to its multifaceted nature. Importantly, opportunities are created for extensive implementation. Sadly, seldom prior evaluations are conducted before the actual implementation. Most times the models applied are rarely understood. This is true of the one being used in the present research investigation. Experts have, however, revealed that very little is known about how processes function and why features do not work. Reasons for providers encountering challenges they do are in explicable. This scenario occurs due to lack of analysis of these models, meaning they may lack the evidence-based practice properties for adequate implementation. There is current evidence informing efficient application of maternal and newborn care (QMNC) framework (McFadden & McNeill, 2016).

With this foundation of how care models function being both enhancement and hindrances to care quality, the Middle Range theory espoused by Swanson Caring Theory, guided this Theoretical Framework. It is most appropriate due to the caring assumptions enclosed therein. Specifically, it offers five caring processes: knowing, being with, doing for, enabling, and maintaining belief (Nurse-Clark, 2019). `These can be utilized in nursing education as well as the nursing process. Midwifery-led continuity care model in itself endeavors to provide a caring atmosphere from conception unto early postnatal period for the pregnant woman, fetus and neonate. While not being a distinct midwife caring model combining it with compatible models as in this research investigation, would greatly highlight the caring aspects of Midwife-led continuity care. The truth is that this theory cannot be taken in isolation in this research study whereby, it is sought to review Midwifery Led Continuity Care Different Birth Places Scenario. Precisely, the question is asked Do (P) pregnant women in different birthplace scenarios receive (O) safer outcome when the (I) maternity-led continuity care model is applied versus other models (T) during their pregnancy. Clearly, while the desired outcome is *Safer Care*, the model adopted plays a significant role in this case. Therefore, combining the two theoretical perspectives is rather valuable to this research study. The caring processes are rather relevant (Nurse-Clark, 2019).

*Knowing:* This means acquiring accurate knowledge of the event through scientific evidence. Nursing science functions from the logical premise of evidence-base practice, developed into models of care, especially, in obstetric nursing. This is the knowing being referenced in this assumption (Côté-Arsenault, 2019).

 *Being with:* This means being emotionally present during interactions with the mother, infant and relatives. There is nothing more satisfying than when a mother and relative are being supported, emotionally, by a healthcare provider (Nurse-Clark, 2019).

 *Doing for:* This means that the provider willingly makes him/herself available to the client/patient doing first that which he/she cannot do for themselves as well as completing tasks for which they are licensed to carry out, when assigned (Hutti, 2019).

 *Enabling*: The provider functions as a facilitator in cases when patients/clients are undertaking transitions during the illness or event. As nursing leaders, it a requirement mandating professional development among staff (Nurse-Clark, 2019).

 *Maintaining belief:* This aspect of the care process articulates application of cultural competence when interacting with clients, patients and their loved ones. It could stretch across to other health care providers who may have cultural differences. These differences would force them to have alternative values and belief paradigms. Maintaining beliefs, is allowing everyone to be safe practicing their beliefs be it religious or beyond, while in the same environment (Nurse-Clark, 2019).

**Synthesis of Literature**

A minimum of twenty (20) pieces of literature reporting on primary studies will be explored in answering the PICOT question as well as those posed as research questions. However, the PICOT question will be the focus of these deliberations. One study conducting a primary review of randomized controlled trials (RCTs) revealed that a number of criteria were used to measure the outcomes of midwifery-led care models against alternative ones. They were collectively called ‘models of care.” In some cases, an obstetrician or another doctor heads the professional team. In other scenarios it is the midwife. On occasions responsibilities were shared between obstetrician and midwife. A popularly applied model is the midwife-led continuity care. In this type, the midwife assumes the lead professional role. It begins from initial booking appointment extending towards early parenting periods. Researchers were eager finding out whether mothers and their infants received enhanced care with the midwife-led continuity model in relation to alternative models (Sandall, et.al, 2019).

 Further, researchers found 15 primary studies with a total of 17,674 mothers and babies. They were searched for and found January 25th, 2016. The sample involved low risk of complications women, higher risk, but not at the time facing any serious obstetrical problems. All trials recruited professionally qualified midwives. None of them utilized care models neither were any delivery or services rendered at home. However, valid delivery methods were applied in evaluating care quality evidence. Seven key outcomes were measured. They included, the amount of preterm births preterm birth (birth before 37 weeks of pregnancy); the risk of fetal death during pregnancy or f during the first month post-natal; spontaneous non-induced vaginal birth labour as well as non-forceps assisted; caesarean birth; instrumental vaginal birth such as forceps or ventouse; ripped perineum , and utilization of regional analgesia like epidural (McFadden & McNeill, 2016).

It was discovered that tremendous benefits were derived from women who accessed midwife-led continuity of care. Importantly, they were at least risk for epidural. Additionally, less women episiotomies or instrumental births were reported. Chances of a spontaneous vaginal birth were far more highly probable also increased. Caesarean births incidences remained the same. Remarkably, preterm birth incidences were reduced significantly as well as still birth or infant deaths. In addition, women were more likely to be cared for in labor by midwives they already knew. Care continuity was fully established in each circumstance, since mothers were provided care by the same midwife throughout their pregnancy, childbirth experience even on to early parent procedures (Sandall, et.al, 2019).

 An independent primary study evaluating continuity of care in a community setting as an exploration into the impacts of different birth scenarios on outcomes. Perceptions regarding maternal and infant health interventions were sought too. The focus of this study was acquiring primary knowledge that inform a postnatal care design based on community care interactions. It was imperative that a model be utilized, which could both explore as well as expose many polices in the care analysis. From this exploration, it was hoped that policies would emerge determining key design parameters. These were expected to enhance understanding towards continuity care implications. In this care the Midwife-led continuity care model was not considered the care protocol (Bowers & Cheyne, 2019).

The major concern for this study was whether continuity of care was feasible in a community setting. A number of variables emerged in the study when certain logarithms were applied testing processes and events. This study was conducted in the United Kingdom from a perception that continuity of maternity care entailed specific problems anticipating non-feasibility in this birthplace scenario. Researchers declared that the study itself encompassed a Home Health Care Problem (HHCP) embodying a Multiple Travelling Salesman Problem (MTSP). It was agreed that ultimately when these studies are conducted the goal is reducing travel hours as well as complication in establishing continuity of care feasibility (Bowers & Cheyne, 2019).

Simulation experiments that were conducted in this study revealed that care continuity at the community level is possible under the given circumstances. It was, however, identified that shift patterns along with part-time work greatly disrupts care continuity. During the postnatal period upon which emphasis is placed in this study, care continuity can be realized. The key to its success, nonetheless, lies in flexible home visits schedules. To think that one hundred percent of care continuity is possible is an ambitious presumption. A seventy percent is a feasible expectation based on the simulation experiment evaluations. Care targets must be compatible with prevailing conditions (Bowers & Cheyne, 2019).

 In summarizing the evidence gained from this simulation experiment, researchers claimed that the study is greatly relevant within and without health care boundaries. This study also offers suggestions to environments where time and travel implicates quality care continuity. Significantly, activity flows within the simulation modelling experiment embraces measures such as utilization of waiting time along with processes. It must be noted too that ultimately, continuity of service quantitative measures offers simulation strategies applicable to other care quality criterion, relative to the interactions between staff and their patients or clients (Bowers & Cheyne, 2019).

 The two foregoing citations are entirely different investigations. The first sought to completely review key features of Midwife-led continuity care models versus alternative ones. Fifteen (15) primary studies were assessed for relevance. Obviously, the aims were dis-similar, ultimately the outcomes showed the adjustments, there are distinct differences between randomized controlled trails and simulation experiments. No one is better than the other. There are just not the same. However, the goal in both cases was evaluating how continuity care strategies were applied in unique settings, improved patient outcomes. In both study scenarios researchers utilized measurements peculiar to their desired results. So far, it can be recorded that data was retrieved from sixteen (16) studies, fifteen clusters and one simulation experiment. While these are not at all enough, they represent a whole lot for an investigation of this nature.

 Another study reviewed relates to an ethnographic study of women living in Brazil entitled *Birth Care Providers’ Experiences and Practices in a Brazilian Alongside Midwifery Unit: An Ethnographic Study.* The purpose was exploring beliefs, values, experiences, and practices associated with birthing as well as neonatal care. This was a preliminary study in preparation for opening a new birth care facility structure. It was called *alongside midwifery units* *in Brazil.* Components of the study as well as desired structure embraced an ethnographic ideology. This meant that the design went beyond obstetric best-practices into the cultural competence of serving this community of women. In my point of view this study is relevant to the PICOT question being that, it implicates both providers’ as well as clients/patients’ predisposition to Maternity Care Involvement (MTI) (Nunes, 2016).

 The theme of this study while entertaining a purpose was “between the proposed and the possible.” The research process was interesting. Researchers obtained permission from hospital authorities. Research procedure allowed for observation, interpreting, as well as writing the ethnographical text. Culture was defined from inferences due to words and actions of participants. They were studied as groups of individuals. The manner of commination between and among professionals was observed and recorded. They were expected to provide data relating birth and neonatal care. Additionally, how professional interacted with clients/patients during antenatal care, delivery as well as the postnatal era. Even support of companions were observed. These could be spouses and other relatives of pregnant women. The facility, AMU’s natural environment along with their daily practices were considered influential to the study outcomes. For example, the organization would have their paradigm of expectations which were interpreted too. Participant Observation (PO) was conscious of these variables (Longworth & Kingdon, 2019).

Researchers arrived at some startling conclusions from their participant observations. Strengths and barriers influencing implementing of an AMU’s midwifery birth care model were identified. Remarkable possibilities were also discovered. Many desired outcomes became evident. For example, synchronizing of values, belief paradigms along with maternal neonatal care were interpreted. Applications were most beneficial when professionals and clients demonstrated common knowledge of these artifacts. Interactions became pronounced when support among professionals, clients/patients and relatives was necessary to enhance the level of care. Notable areas concern related to inclusivity of interdisciplinary team functioning on maternity units. It is believed that they should play a more meaningful role in the overall care interventions as well as continuity (Nunes, 2016).

Additionally, they ought to systematically participate in designing AMU’s birth philosophy, which should include care guidelines. Currently, this is not an integrated process within unit functioning. These interventions are important towards enhancing obstetrician’s confidence in achieving birth safety through midwives’ care provisions. They delivery care autonomous provider while being part of a professional. When birth places are shifted various adjustments are required, especially, when care moves outside of the hospital setting. These adjustments implicate a number of factors inclusive of organizational culture, midwife’s participation audits as well as institutional structural adjustment (Douglas & Rosenkoetter, 2015).

 The foregoing study is different from the previous sixteen reviewed in this literary appraisal. An ethnographic design was adopted. This is somewhat unusual to healthcare practice since the focus of this investigation implicates Maternity -let continuity care in different birthplace scenarios. No distinct healthcare model application was observed as part of the maternity care interventions. Importantly, while care did spread across pre, intra and post-natal segments, no mention of the term midwife led- continuity care was made, even though midwifes took the lead role in obstetric care in this scenario. Attempts at making inferences to both hospital and out of hospital birth places were undertaken with limited specificity than the previous studies. The value of the ethnographic study to this investigation is observing how midwifery-led care was administered to women in this hospital setting (Davis- Floyd, 2019).

The eighteenth (18th) study to be reviewed in this literature appraisal consists of 17 independent primary Randomized Controlled Trials (RCTs). The researcher conducted a systemic review of these studies. They focused on *Midwifery-led antenatal care models: mapping a systematic review to an evidence-based quality framework to identify key components and characteristics of care.* The study encompassed A systematic review of RCTs of midwifery-led antenatal care models. These models were Mapped and evaluated comparatively to QMNC framework. Data was data extracted from each model. Forms were utilized to score the information retrieved. Five framework components were found. Researchers teamed up to conduct the data collection process. A quality evaluation applying QMNC framework measurements was conducted based upon an established standardized Randomized Controlled Trial (RCT) criteria (Symon & Pringle, 2016).

Thirteen thousand and fifty (13,050) documents citing 17 RCTs of midwifery-led antenatal care models from Australia (7), the UK (4), China (2), and Sweden, Ireland, Mexico and Canada (1 each) were identified. The QMNC framework scores went from 9 to 25 with an anticipated range of 0–32). Incidentally, many models reported less than 50% characteristics linked to quality maternity care. Care model characteristics were limited. However, actual interventions were strong. The way in which care was organized received the best description component. There were some discrepancies regarding foundations of care philosophy in the studies individually as well as collectedly. Thesis aspect was considered under reported (Allen, Gamble, & Stapleton, 2015).

 A study of interest, which could add value to this literature synthesis thesis as it relates to the selected theoretical framework adopting Swanson’s five care process into understanding the midwife- led Care model in different Birthplace scenarios is *Application of Caring Theory to Nursing Care of Women Experiencing Stillbirth.* The researchers conducted a primary investigation. The reason for this investigation was to find out the extent Midwives accurately utilized the caring process espoused by Swanson's middle-range theory as an intervention for comfort as well as emotional support for women grieving the loss of their fetus during labor and childbirth. It was a secondary analysis of primary qualitative interview. Twenty (20) 20 labor and delivery nurses were recruited during grounded theory intervention. A content analysis of how they applied using interactions with women who were grieving loss of their fetus was conducted. The five caring process assumptions of Swanson theory was used to ode behavior as well as interactions over the evaluation. Research concluded that application of the five caring processed were effectively utilized by labor and delivery nurses. Women were therapeutically comforted. while the pain did not go to alleviate the pain of the loss offering comfort. While these were the conclusions, it is clear that this is merely one birthplace scenario (Nunes, 2016).

It was communicated that nursing care at this level did not focus on a specific model such as Midwife -let continuity. This seemed not to have existed. The focus was on bringing emotional support to mother and relatives. As such, providers gave attention to protecting and preserving dignity; understanding what the woman was feeling, offering information and explanation on coping with the disappointment. It was important too that she refrain from feeling guilty as well as blaming anyone. Researchers finally declared that the theory was very useful as a support in this particular situation but might not be tart efficient for when someone is going through labor itself (Gordon, 2019).

 **Practice Recommendations**

Maternity led continuity care model is one among many applied in obstetric nursing across the world. It is more utilized in some countries than others. In attempting to answer the research and PICOT question, many recommendations could be made for future. In reflecting it was asked:

 1 *How is Midwifery-led continuity care model more efficient than other maternity care models?* While at this point of the investigation the answer to this question is inconclusive the recommendation is for more research in the practice of the model since there is limited data on its effectiveness

2 *What are the challenges facing providers when executing this model?* The obvious challenge relates to solid evidence -based data of its impact within the science globally. Hence, more documentation of outcomes and events within a research context.

*3 How can this model be utilized in different birth scenarios?* From this research, it was discovered that middle range theories were being used for comforting mothers and relatives during and after stillbirths. It is recommended that the Midwife-led continuity care model be combined with caring interventions. The model can be applied in different birthplace scenarios s

*4 What birthplace scenarios are more adaptable to this model?* Based on research findings the most appropriate application of this model is within the clinic-hospital setting. Therefore, maternity centers or hospitals should make deliberate attempts to use this model throughout the system.

*5 What birthplace scenarios are less adaptable to this model?* The community settings seemed most difficult to translate this model due to schedules in meetings clients as well as costs.

*6 What can be done to enhance adaptability of maternity - led care model in more birthplace scenarios?* Training and in some cases adequate funding. In shortage of professionals there is not guarantee that care continuity is possible.

PICOT Question

Do (P) pregnant women in different birthplace scenarios receive (O) safer outcome when the (I) maternity-led continuity care model is applied versus (C) other models during their pregnancy (T).

P – People: Pregnant women

I – Intervention: Maternity -led continuity care model

C – Contrast: Other models

O – Outcome: Safer Outcomes

T – Time: Duration of Pregnancy

 The answer to this question is the Midwifery -led Continuity care model, but there are limitations, which must be addressed.

**Project Description**

 This project of literature review was conducted to investigate what degree of preparation and skills must midwives acquire to deliver Midwifes Led Continuity of Care (MLCC) to pregnant women and in which scenarios has the Midwifes Led Continuity of Care (MLCC)experience been the best in different experiences worldwide. My literature review project responded to the conditions in which these services extended to the community and under the concept of continuity of care that allowed successful outcomes in the care of pregnant women who receive the accompaniment of midwives, where childbirth care was freely decided by them. Given the intimate and personal nature of maternal and even family decisions about pregnancy and childbirth care this is an important topic with recognized increased trends worldwide. Also, because the nature of this topic, in my review included qualitative and quantitative research, processes. Publications from the last 5 years that address the topic of interest, specially focused in the extension and acceptance in US territory, but international experiences were selected. It also included the search engines utilized. No less than 30 articles, from 2014 to 2019 were reviewed. They constituted the body of literature using internet access applying the following search tools: Google Scholar, CINAHL, Medline, PubMed and Cochrane database, also the Ana G Mendez Virtual Library. The following keywords were used in my search: midwifery, continuity of caring, place of birth, women’s views, maternity care, birthplace preferences. The literature review design was effective because of the availability, although disperse literature of already conducted research studies on the selected topic under study. Given the nature of the search, both qualitative and quantitative research were included. More so, the pool of online meta-databases was essential while selecting specific articles based on the topic of study. Therefore, search engines were based on the keywords above mentioned. The search was allowed the determination of key variables to adequately address my research questions and problem statement.

 The information obtained from the literature review was kept for a period of 5 years, locked in the principal’s home office of the principal investigator. After five years, the information was destroyed by a paper shredder and discarded. The Principal Investigator and his mentor accessed the information obtained.

**Project Evaluation Results.**

 After the data is collected, the analysis was done with selected information that were included in the final report. In the analysis of data, one of the steps is to remove the errors that might have occurred during data collection. Several processes wee measured during data analysis, all related to the information available in different literature that was examined. A flow-diagram was constructed to show all literature obtained using keywords, of the excluded literature because they did not meet inclusion criteria, the availability to full text and other considerations. A review of both primary research evidence and systematic reviews, mainly using quantitative evidence was conducted. Also, epidemiologic studies were utilized in my search.

Summarize tables with all citation are presented in Appendix A & B; appendix A is used for the summary of primary research evidence, and appendix B for the summary of the systematic reviews.

 Appendix A includes the citation, question or hypothesis, theoretical foundation, research designed and sample size, key findings, recommendations or implications, and level of evidence (I to VII), of each article. Appendix B also showed citation, question, search strategy, inclusion/exclusion criteria, data, extraction and analysis, key findings recommendation/implications, and level of evidence ranging from Level I to Level VII. Each article was evaluated as relevant information, not to specifically answer my research question.

**Discussion and Implications for Nursing and Healthcare**

Each study expressed implications for Nursing and Healthcare. The nature of the research, setting as well as the context in which the research process was undertaken greatly implicate nursing. For example, the ethnographic study conducted in Brazil observing providers’ roles in prenatal the clear implication is that while Midwifery-led continuity model was not used, the necessity became obvious. Team spirit was obscure. The focus was on cultural competence rather than adopting a relevant model that would enhance maternity care within that setting. In situations where Midwife-led continuity care models were utilized distinctly outcomes were more satisfactory. Nursing Science and Healthcare must enforce Midwife-led continuity care model as a preference.

**Plans for Dissemination**

 Disseminated was by presenting an oral demonstration with PowerPoint to professor and students of this course. A poster with brief information of my research and results was displayed at Ana G Mendez, SFC, gallery. A hard copy of the whole project was made available at the Ana G Mendez, SFC Library, with open access to other students interested on this project and its results.

**Summary and Conclusion**

 There is evidence to prove that at the Nursing Science level, Midwives function as primary care giver to pregnant women, internationally. This is true as well as commendable. However, synthesized data regarding whether differences exist in morbidity and mortality outcomes were not conclusive. This is in comparison to other models. Psychosocial consequences between midwife-led continuity models seem obscure. This investigation sought to find out the impacts of Midwifery Led Continuity Care in Different Birth Places Scenario. It was concluded that Midwife – led continuity care model is most effective in hospital settings but very difficult to translate within community settings or home delivery context. While very effective it was not the preference model in most instances. It should become one in most modern-day institutions.

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Appendix A

Summary of Primary Research Evidence

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Citation** | **Question or Hypothesis** | **Theoretical Foundation** | **Research Design (include tools) and Sample Size**  | **Key Findings** | **Recommendations/****Implications** | **Level of Evidence** |
| Blustein, J., & Liu, J (2015).  | What are he risks of Cesarean Section Delivery? | None was utilized in this research | Randomized controlled Trial | Cesarean section in long term could indicated future Cesarean section deliveries | Cesarean Sections should be a last resort or done only when vaginal delivery is contra indicated | 111 |
| Bowers, J., & Cheyne, H. (2019).  | What does Continuity od care looks like in community midwifery? | None Identified in the research studies | Review of Literature from studies | Continuity of care was useful but not practiced in its entirety in healthcare settings at the community level | More research must be conducted ascertaining needs as well as how Continuity of care could evolve. | VI |
| Côté-Arsenault, D. (2019).  | What Theory is useful in Improving perinatal care? |  Caring Model Nursing Theoretical Framework | Review of Studies from literature |  Theory application allowed maternity care to be more standardized. | More health care setting should include theory to their practice and not just evidence |  1V |
| Dreiher, J., & Comaneshter, D. (2016)   | What is the relationship between continuity of care and community health outcomes | No theoretical framework could be identified | Population survey |  Continuity od care is essential for community health maintenance, but collaborative efforts is necessary | Staff ratios must be carefully regulated for mothers in the community to receive adequate care |  1V |
| Fernandez, T., & Bick D. (2019)  | What should be the protocol for RandomizedControlled trials in midwifery care indications ofpreterm birth? | No theoretical Frame work was identified since they were trying to create one from the trial | Randomized controlled trial of women with preexisting preterm birth | It was identified that continuity of care was the only sure way of successful outcome for mothers and infants. | From the findings the protocols identified even though inconclusive should be used as a pilot in future in deriving more evidence. | 11 |
| Fernandez, C., & Roe, Y. (2019).  | What are the best continuous care models for indigenous women in Australia? | No standard theoretical framework was recognized | Opinion seeking Survey | Midwifery-led continuance of care while new and was not thoroughly researched had much evidence of being useful in the Australian indigenous society | Midwifery-led continuous care models could be implemented in the country among indigenous women | V1 |
| Gordon, S. (2019).  | How can Communication and Coordination of Complex Perinatal Patients be improved |  None was identified | Survey of mothers with complex prenatal conditions | Patterns of communication related to providers standardizing communication procedures were observed as being vital to improving communication among these women. It must be related to their culture. | Standardization of a culturally competent communication model was recommended | V |
| Longworth, H., & Kingdon, K. (2019).  | What are the expectations and experiences of fathers whose women are giving birth? |  | Phenomenological study consisting of fathers whose women are expecting to deliver infants | Nothing new was derived from the study, but confirmation of what already existed | More studies on the topic is recommended – Level V |  |

Legend:

**Level I:** systematic reviews or meta-analysis
**Level II:**  well-designed Randomized Controlled Trial (RCT)
**Level III:**  well-designed controlled trials without randomization, quasi-experimental
**Level IV:**  well-designed case-control and cohort studies
**Level V:** systematic reviews of descriptive and qualitative studies
**Level VI:**  single descriptive or qualitative study
**Level VII:** opinion of authorities and/or reports of expert committees

Appendix B

Summary of Systematic Reviews (SR)

| **Citation**  | **Question** | **Search Strategy** | **Inclusion/Exclusion Criteria** | **Data Extraction and Analysis** | **Key Findings** | **Recommendation/****Implications** | **Level of Evidence**  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| Allen, J. Gamble, J., & Stapleton, H. (2015). | Does the way maternity care is provided affect neonatal outcomes for young women | Key words and Internet data bases | Studies from 2016-2020 that received, or researcher Maternity let care or alternatives | Studies that were not compatible with the inclusion criteria | There were insignificant variations in outcomes when alternative models were adopted | More research must be conducted to derive evidence- based data adding to the body of knowledge |  V |
| de Jonge, A., & Is Continuity of care a valid model for modern maternity care Stuijt, R. (2016).  | Is continuity of care a valid model to which women gravitate? | Key words and internet databases | Studies from 2016-2020 that received, or researcher Continuity care models alternatives | Studies that were not compatible with the inclusion criteria | Women preferred to have the same provider throughout their care. This proved more beneficial to their overall outcomes infant and mother | More research must be conducted to derive evidence- based data adding to the body of knowledge |  V |
| Symon, A., & Pringle, J. (2016).  | Does Midwifery-led antenatal care produce more favorable outcomes than other models? | Key words and internet data bases | Studies from 2016-2020 researching Midwifery-ledantenatal care models | All studies that did not meet the inclusion criteria | Midwifery led care produced many favorable outcomes. | It should be implemented as a pilot project since there is limited research on the intervention |  V |

Legend:

**Level I:** systematic reviews or meta-analysis
**Level II:**  well-designed Randomized Controlled Trial (RCT)
**Level III:**  well-designed controlled trials without randomization, quasi-experimental
**Level IV:**  well-designed case-control and cohort studies
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