Hot Topic

Learning from the past and building a better future through the lens of a professional midwifery advocate; healing wounds from a decade of midwifery

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Editor's commentary on this issue's Hot Topic

I selected this reflective piece as the Hot Topic as it movingly summarises the realities of working in the midwifery profession. I am sure that we have all experienced these feelings and reactions ourselves, from others and maybe to others.

Midwifery is a very emotionally interactive profession: more so with the recent demands faced through the COVID-19 pandemic. It takes a breadth of skills and resilience to provide the support and compassion we do to the women we care for. It is therefore not surprising that we sometimes have little left for our colleagues.

We are also all guilty of sometimes forgetting where we have come from and how lacking in confidence we once were. The paper by Nicole Rajan-Brown also included in this issue 'Creating a partnership of care in clinical practice: a student midwife's reflection' (pages 58-60), has a poignant reflection:

'However, as a new student, I felt unable to raise any concerns, feeling a lack in confidence in the face of an experienced midwife.'

We become experienced and confident but we must always remember we once weren't. I thank all authors who share their personal experiences of struggle and commend their strength and kindness as humans in doing so. As a profession we need to look after each other, not just the women and families we care for. Only then can we stand truly together.

ORIGINAL

This reflective piece comes with a 'trigger warning' and contains references to post-traumatic stress disorder, mental health concerns, obstetric emergencies and bereavement care (in midwifery).

Introduction

I am a midwife and the following is a reflection of my personal journey in a decade of midwifery, and growing understanding of the ways in which we can begin to recognise, understand and support frontline staff. This piece of personal reflection explores the experiences and challenges that I, as a midwife, have faced throughout my career and the impact they can have on well-being as practitioners. There will be suggestions for future necessary training and understanding in order to better support midwifery staff.

I have been considering writing something surrounding my experience and exposure to the growing concern of the mental health of care workers in the NHS for some time and the following statements speak for themselves:

- Three East of England Ambulance Trust workers die within the last 11 days: suicide (Selby & Brown 2019).
- Over 300 nurses have taken their own lives between 2011 and 2017 (Milne 2020).
- At least one in 20 midwives has experienced PTSD and this is likely to be a gross underestimation (Sheen et al 2015).
- Stress, anxiety and depression scores well above population norms in midwifery and 66.6 per cent of midwives have been thinking of leaving in the last six months (Hunter et al 2019).

The above statistics are not new findings, yet I can find very little regarding any strategic and standardised change to practice aimed at simply providing the right care to our care providers within the National Health Service (NHS). Too many are suffering and it should not have taken a global pandemic to finally begin to explore how we can care for staff.

We are human, people, individual and never 'just the midwife'. In the beginning …

Midwifery training is like learning how to drive: you gain the knowledge, the skill, and even pass the test, but you never really know what it's going to be like until you start driving alone and develop your own lived experience of the world.

During my midwifery training I recall being particularly concerned about what to say and how to behave when caring for bereaved families so I asked to have exposure to delivering this kind of care. I read the appropriate books that explored language and behaviour and the 'What not to say.' I remember being frightened at the thought of being a qualified midwife on a shift unsupported in this situation, as the hospital I was employed by was often busy and short-staffed. I knew I'd be helped with the paperwork of bereavement care, but not in the emotional and physical support needed for a family experiencing such a loss. So, in my final year of training, I 'took the bereavement lady' alongside an experienced mentor.

I spent time with the family throughout the day and, half way through the shift, another woman arrived at the other bereavement suite as her waters had broken too early; meaning that at some point she would birth her little one much too soon to be able to stay in this world. As per 'typical' shift both of 'our women' birthed at around shift handover.

I answered the call bell to the lady whose waters had broken. She told me she needed the toilet but felt she may have the baby should she get up. I reassured her that this would not be her doing and that, even if she stayed on the bed, if baby was coming, baby was coming. I went on to say I was so sorry this was happening and if she preferred I could get her a bedpan, or I could stay and sit outside the toilet door, or come with her into the toilet. She decided to go to the toilet, I waited outside until she called my name to enter and baby was born into the bedpan. The woman cried, I held her hand and again said I was sorry. After a short silence I offered to take baby from the bedpan. The woman asked to see baby and she said how he looked like a boy (we had already discussed that, at this stage, the sex could be ambiguous as the clitoris can be enlarged on females, therefore making them appear to have male genitalia — I was made very aware not to comment on guessing the gender).

I remember her reaction to seeing baby and she smiled, saying she knew he must be a boy as this pregnancy had been nothing but trouble. She held him, she admired his tiny perfect form and it was an unexpected 'happy' moment. I recall the surprise that happiness could be found alongside such sorrow. She was Muslim and baby would be buried within a short timeframe with a private arrangement, there would be no tests or reporting of the defined gender based on clinical or genetic findings — her baby was her boy. I still fondly remember a brief feeling of peace and have experienced this a few times alongside loss throughout my career.

My mentor was busy, she told me to shout should I need anything and just to wait for the placenta. Yes — this was my first bereavement care experience, yes — I was a student and yes — there really was no other midwife available. This became my understanding of the reality of midwifery care at times.

While I sat with the woman, she handed baby to me and became very pale. I asked her to lean back to see a large gush of blood. I called for my mentor, who told me to get the team — I ran to the delivery suite and called the co-ordinator, shouting '*She's haemorrhaging!*'

The team arrived and I stood back in the corner of the room. Baby had been placed in the cool nursery room next to the two bereavement rooms. The woman in the next room continued screaming. I called to my mentor, asking if I should go to the other room to support the crying woman, feeling like a useless bystander as they managed the ongoing haemorrhage:

'*Yes, she's had diamorphine,*' she replied.

'*Will I be okay?*' I asked.

'*Yes fine!*'

While massaging the uterus of the lady now on a bed, cannula in each arm, drips, pumps, infusions everywhere.

'*But I mean … will I be okay in there alone?*' I repeated, trying to get at the point that I really did not want to be left to deliver baby: I couldn't.

'*It's fine, she's 3*' I was reassured.

She meant she was only 3cm dilated and it was her first baby so I should be okay. I didn't think I could take any more at that point.

On entering the room next door Dad was by the window, head in hands intermittently, and pacing. Mum was on the bed using the gas, eyes wide from opioids, vocal and sweating. She reached out to my hand and held it so tightly. I talked her through her breathing, she cried, a few tears rolled down my face and I remember being ashamed to cry because this was not about me, what right did I have to be sad, my job was to support her. Just breathe, that's it, keep breathing.

I looked down as she screamed with each contraction and saw a black bulge at the vagina, panic rising … and then the night midwife walked in. It was like the midwife had this glow around her, I remember thinking she was like an angel and at that time I had never been so thankful to see another person enter a room. Silently, she wheeled a trolley next to the bed, did not look at me. I pointed saying there's something, silent nod, so calm and graceful in her preparation. Her face was expressionless, unphased and knowing. Experience I guessed.

Dad continues pacing and trying to comfort his wife, she's turned away from him still clinging onto me. I look down, more black bulging and then 'Bang'. He jumps, I jump.

'*It's okay, it's okay, it's waters, it's her waters.*'

Meconium everywhere — he thought it was the head, I thought it was baby's head too. I genuinely thought the baby's head had exploded which seems so silly now and almost shameful to share that, in truth, this is what had crossed my mind — but at the time I just had no idea what I had seen: the waters were black swirling full of meconium in front of the baby's head I didn't know what to expect.

'*It's okay, push*', said the midwife.

I tell Dad to come and stand next to me, I loosen her grip:

'*Don't leave me, don't leave me.*'

'*I'm not, I'm here.*'

I could see he needed her to need him too and I wanted to help them be together in this. In all honesty I wanted to leave, but I felt too guilty and unable to say 'I cannot handle this right now', after all I had asked for experience.

She held his hands, mine over both of theirs. Baby came and then there was silence.

'*Make her cry*' she said.

Just more silent periods and then tears.

'*Make her cry. **Kayleigh**, make her cry!*'

She used my name: usually I was 'the student' but to this woman I had a name. I had spent most of the last 12 hours with her, talking to her in the bath, comforting her the best I knew how and she used my name. I looked at her:

'*I am so sorry, if I could, I would — but I'm sorry, she's not going to cry.*'

The sound that followed is one that stays with you. Many of my colleagues refer to it, we talk about it, and we know that sound. I imagine those who witness raw grief know that sound too. It sounds different to other cries and I think you actually do more than just hear it: the vibration from it goes right through you and, with some experiences, I think a little of its remnants becomes etched on your very being. I recall thinking about a lecturer sharing with me that '*Some just stay with you*' when referring to difficult experiences, as though we should accept it as part of the job.

I returned the next day to provide the postnatal care. I don't remember if I slept, I don't know if I ate, I remember reaching out to a partner at the time and, in earnest, found it utterly pointless. I remember all my resentment, anger and bitterness being directed that way because the reaction and support that I was given from the person I held dearest wasn't what I needed — but even I didn't know what I needed.

After the whole experience the points that I live with are how I failed to get help the correct way (by pulling the emergency buzzer and declaring 'PPH'), and feeling guilty for wanting to run away from the experience that I had asked for at the beginning of the shift. What I thought would be a great learning opportunity, aimed to make me a better midwife, actually left me feeling powerless and sad with the world.

Objective structured clinical examinations (OSCEs) teach clinical skills, but they don't provide the skills needed to help you learn to cope with being involved in situations that you just could not have imagined. Or how to talk to colleagues about not coping, or how to actively listen to and support others when they find midwifery getting a bit too tough.

The detail in my brain, even after 10 years, remains so clear, yet I don't think this experience is traumatic. I did not feel I had the correct support, or that I mattered, being 'just a student'. But a few very special people listened to my story as many times as I wanted to share it. I cried to a wonderful hospital chaplain who would regularly check in on all those involved when there had been a loss and his gift of time and space 'allowed' me to feel upset as I was a student, I was young and I was junior.

I later went on to provide a great deal of bereavement care and, following some positive feedback, I wondered if my future role lay as a Specialist Bereavement Midwife. However, this experience would later become grounding for my future role as a Professional Midwifery Advocate (PMA).

Where did midwifery go wrong? How can the most caring of people sometimes be the most detached, emotionless or seemingly least feeling of all?

The part of the process where we go wrong is expecting that with experience comes 'resilience': a magical ability to withstand whatever complex situation you may be faced with during your career as you are now an experienced midwife.

There is this whole '*The first cut is the deepest*' feel in midwifery — an expectation that the more you experience something the more capable you become at handling it. I disagree. If you re-open the same wound it will re-bleed, it is the tools and skills that you learn which aid in the re-healing. Over time, with the right support, more advanced techniques are developed to aid wound healing. An emotional assault should be viewed no differently; we need the right resources and more tools.

I am well aware that I will cause a fair amount of conflict in tainting the term 'resilience': the foundation on which an entire model of supervision is built. This same model which I am to promote, instil and lead on implementing. At this time I will simply agree to disagree with some people's interpretation of the word: '*The capacity to recover quickly from*

difficulties; toughness' or '*The ability of a substance or object to spring back into shape; elasticity*' are the first two descriptions you will find on the internet, and thinking that a midwife should or can embody those things is inhumane. The expectation that NHS workers can embody those things is exactly part of the foundation of where things have gone wrong. I continue to try to re-educate myself on what resilience 'should' mean but actually I think the word should be used to describe systems, as opposed to people. How can we build a resilient system of care, listening, support and education for the people who work within it?

In relation to midwifery there is emerging recognition and understanding of the impact of serious incidents on health care professionals, with the estimation of at least one in 20 midwives experiencing levels of symptoms commensurate with a post-traumatic stress disorder (PTSD) diagnosis (Sheen et al 2015).

The mind is an incredible thing, able to heal itself naturally. However sometimes an experience may occur, such as an overwhelming event or a repeated subject of distress, which causes the natural coping mechanisms to become overloaded. This can result in disturbing experiences remaining 'unprocessed' and frozen in your brain. Such unprocessed memories and feelings are stored in the limbic system of the brain in a 'raw' form, as opposed to verbal 'story' mode. The limbic system's memories remain detached from the brain's cortex, where language is used to store memories, and can result in feelings of anger, anxiety, panic, fear or despair which can be continually triggered in the present.

The fact that most health care workers, including myself, have such little understanding of the deeper impact our professional experiences can have on our own mind is one of the fundamental issues lacking in health care training. It is only from my personal journey into entering a role whereby I support others and see such effects, that I have been introduced to the need for a far greater understanding of the problems we face.

The first year of being a qualified midwife

Most midwives I speak to will recall their first year, sadly, few of them will offer up their fondest recollection of that time. Midwifery comes at a great cost with high levels of stress, depression and burnout: experiences that are greater for midwives with less than 30 years' experience and those who are younger in age (Hunter et al 2019). This group of midwives will form the bulk of the future midwifery workforce and they are more vulnerable.

Within nine months of qualifying I was based on a busy labour ward and experiencing nearly all the emergencies found in the obstetric emergencies manual. I was told that, because I'd handled things so well and as I had already developed clinical skills as per checklist, such as cannulation (I had developed some competencies as an HCA while studying), I could have my Band 6 a little earlier than the 12 months as all the preceptorship boxes were ticked.

My response, after watching 21 minutes of failed neonatal resuscitation following a placental abruption, was that I did not want to be a Band 6 — and wasn't even sure I wanted to be a midwife anymore. What replayed over and over in my mind was from teachings referring to neonatal resuscitation: 'Drugs equals death … or very poor outcome'. I'd remembered that from my OSCEs and the reality of my experience is that, yes, drugs really do equal death or poor outcome for the family — that fact remains 10 years on. The thing my training never taught me was 'What does it equal for the midwife?'

I was told to go home, rest up, almost a bit like '*Walk it off and we can discuss on your return*'. Of course, you go home and get your statements/factual accounts written as soon as possible, ready for the constructive criticism/feedback/investigation that will follow. On return to work there is often a brief '*Are you okay?*' and maybe even a few tears, but sadly, within midwifery, there appears to be an unwritten rule of 'You had best make this process of dealing with the lows quick' — or else you're not 'resilient' enough to be a midwife.

Where do you go when you need emotional support?

When I think back to my first post-registration wobble I realise I didn't feel like I actually had a supportive person to go to. Everyone 'offered' an open door policy but it came with an unwritten expectation that you wouldn't actually take up the offer; an unspoken fear that needing help makes you look like you can't cope or are not resilient enough.

With my first career low point I attempted to offload on supportive friends or the boyfriend at the time. Unfortunately I didn't feel understood, and some relatives would say things like 'I don't know if this career is too much for you' or 'You knew what I were getting yourself into', which meant I wasn't strong or resilient enough to withstand some things that are part of the vocation. But unresolved old emotions can rear their ugly heads when you find yourself back in a vulnerable place. I found myself feeling alone, constantly jet-lagged, like a complete failure and eventually single. I have absolutely no doubt that midwifery impacted on me in such a way that I inadvertently became a very sad, angry and difficult person to have in anyone's personal life. I believe I am not alone in the price I paid at the time for midwifery.

'Some experiences will just stay with you, or haunt you a little, that's midwifery'

I still despair at being told this and it leaves me with so many questions like: 'Where is the midwifery module on how to care for my emotional well-

being?'; 'How long am I allowed to be upset?'; 'How long is it normal to be upset?'

Later in my career I recall one midwife sharing her experiences of caring for a woman with a pregnancy loss:

'Sometimes I just see the face of that baby randomly, sometimes for no reason, just while I'm walking — I'm okay, it just catches me off guard. But I'm not traumatised or upset by it, I just think, well, that's odd.'

When I asked her how she felt about the idea of caring for a woman clinically on delivery suite again, she told me '*A little anxious*'. When I asked about her caring for a woman experiencing the loss of her baby, she replied she couldn't do it. This is but one example of multiple similar conversations I have had with many midwives.

At times it is not until a midwife is 'psychologically safe' within a new setting or role that they are able to reflect back on how some experiences affected them, or even, as I was told from the very point of training — haunted them. Our profession accepts this as normal: to me this is harmful.

The superhero vs the human

Midwives are instilled with the key function of providing 'holistic care' to women and families but we are often not recognised as a human being while at work. Subtle losses of basic human rights, such as not being able to freely go to the toilet if caring for a woman on an oxytocin infusion (because there is no one to relieve you and what if you miss fetal distress while you were taking too long to pee … or worse what if you need to open your own bowels?) What if you want a hot drink? Some of my colleagues still do not dare bring one into the room as this might not seem 'professional' enough, or what if you spill your hot drink and health and safety have to look into it? Water bottles are only acceptable in a heatwave at some trusts.

Introduce a few personal issues to the mix: family ill-health; relationship breakdown; financial concerns; fertility issues; general low mood and snappiness at home causing friction because you've used up all your patience on meeting the needs of those in your care (and some of the time the needs within even a united couple can be on completely different pages).

Sometimes you know every detail of exactly how sad one life can be and feel like a bystander in a helpless cycle of vulnerability; still trying your hardest to do whatever you can to make that given experience that bit more bearable for someone else. There is a job to be done so you become much acquainted with the superhero cape and morphing into a completely different person. You give so much to the career that there is little left to give when at home: the general public gets the best of you and your loved ones get the broken remnants of what remains. So — who cares for our holistic needs?

Peers will often provide fleeting reminders of how to 'empty your cup' when reaching full capacity, nearly always asking 'When's your next annual leave?', as though an escape from the workhouse will cure the problem. Sometimes there are helpful suggestions, like talking to a friend, going for a walk, taking up a therapeutic craft: all activities which require time, motivation, energy and a baseline level of 'get up and go' to nourish oneself. All good ideas, but health care professionals are just not well-equipped for what is often an inevitable eventuality.

So how do we improve a broken system?

I believe we need a system that has a fundamental focus on ensuring that there is a role dedicated to supporting the self-nourishment of individuals, ongoing supportive reflection of what has been working, revisiting well-being and almost monitoring this as a means of maintenance for all health care staff. We have occupational health but, in all honesty, by the time you make it there it's often too late. Accessing support needs to happen before the cups are full and there is no other alternative than the over-spilling, outpouring or tipping over of the entire cup.

Not all distressing experiences will be traumatic. Psychological trauma/PTSD is not limited to those who are survivors of war, abuse or another globally acknowledged unspeakable torture. PTSD is treatable, preventable and recognisable given the right tools. However, despite health care workers being at a higher risk of PTSD due to their increased expose to distressing scenarios, they are ill-equipped for this consequence.

Midwives and NHS workers are not immune to PTSD responses because they don their NHS superhero cape! They are human beings with holistic needs too. It's also about learning what we can do to help and support others when we see they are in need.

My journey

For me, space and time between traumatic events blurred and I eventually changed jobs. I snuck out the back door (so to speak) without having a goodbye event and began a new life closer to home. At that point in time I didn't think I was really affected by my run of events. I felt like now I'd seen these things perhaps I'd done my share and I'd be immune throughout the rest of my career.

I began working in a much smaller hospital, one which I had always intended to join as it was closer to the family. I know I rubbed a few people up the wrong way: feisty, passionate, strong, defensive and questioning why some practices, at the time, seemed outdated.

One morning on coming into work a wonderful midwife caught me off guard just before I'd had the

chance to put on my superhero cape. She simply asked: '*Are you okay?*' I told her I was fine, she looked at me a little too intensely and said: '*Are you sure?*' (Cue silence and glassy eyes.) '*Nope you're not. In the office. Now*'.

Hidden away, sobbing and begging not to be taken to the matron at the time (who I found quite terrifying), out it all came. She was given an outpouring of all the traumatic events and struggles with lack of support that I had experienced which had left me feeling broken. I ended up off sick for two weeks, followed by two weeks of annual leave. One month later that same midwife organised my rota to put me on shift with her and anyone else I felt comfortable around. The postnatal ward has never been my favourite place, but because of her it was there that I felt psychologically safe and began to heal.

This was around seven years ago and it is not until now, as midwives share their similar stories with me, that I am able to recognise a pattern in the ongoing failings of the system in which midwives work. The kindness I was shown that helped me heal is what made me want to be that pillar of support for others. While I feel fortunate to work within a trust that has continued to develop in the culture of care for staff, there remain systemic and organisational changes that must also be made.

Becoming a Professional Midwifery Advocate (PMA) and insight

Over the last year, my career has led me to the path of becoming a Professional Midwifery Advocate (PMA). The role involves using a new model of supervision to support staff, with one of the key functions being Restorative Clinical Supervision (RCS). RCS involves providing midwives with a safe space to think, feel and explore anything they need to. Midwives are problem-solvers by nature and with guided reflective discussions can identify what action is right for them to take. The issue with this is: how can you identify the action needed when you do not have the knowledge or understanding to recognise when you are not quite right in yourself? As I have previously shared, no one teaches you this part.

Leading the PMA service has enabled me to have influence in creating a service which is beginning to recognise and understand the psychological issues that midwives face but it has also highlighted the fundamental issues that exist in midwifery (and the wider health care service): that we have never been equipped with the basics of how to provide such needed care. I have learned that we are completely out of our depth and there is a need for change that goes beyond our implementation of a PMA service and even beyond midwifery — it is at cellular level. It starts with the culture of what we are teaching health care professionals during their training and, more importantly, what we are not teaching them. Also, much of what PMAs do (locally and nationally) has evolved without formal training.

A new pathway and recommendations

To counter this, in developing our PMA service we have linked with the trust clinical psychology department. First, we have developed a business plan to address the lack of PMA training by requesting a minimum of basic level training into the long-term effects of unaddressed PTSD on clinical staff. Second, we have adapted a tool and process for referral to a clinical psychologist following a potentially traumatic event (see Appendix 1).

Currently we are strengthening the means by which the PMA team is notified that staff have been involved in a stressful event to ensure that we offer a one-to-one space for staff to talk and to actively listen with particular focus on their well-being, including how they are sleeping, eating and managing normal daily life, and explore any ongoing needs.

We then follow up with the individual three to four weeks later, providing an open door policy to listen to anything the individual would like to talk through, particularly if there is an element of revisiting the event. We complete the tool (Appendix 1) around the third week catch-up and, if there is a high score or a significantly troubling feature affecting the midwife's well-being, we seek advice from our clinical psychologist link and complete a direct referral to the department for support. While this tool provides us with a basic first step in providing a responsive service to meet the needs of staff and their exposure to such events, this does not tackle the root of the problem. Additionally, this system of referral is only accessible to midwives and maternity support workers and does not begin to address other health care professionals whose exposure to potentially traumatic events may be even more frequent.

'Do the best you can until you know better. Then when you know better, do better' (quote attributed to Maya Angelou).

In spite of the huge steps we have taken so far, we are only now addressing the problems resulting from unresolved PTSD and beginning to have an impact on stopping this continued cycle.

What can universities do?

Universities are responsible for providing the underpinning knowledge for future practitioners and it is vital that they incorporate the recognition of signs of trauma response, and how to begin addressing this situation, in their syllabus. Guidance on what is considered normal processing of events and when to seek help is fundamental, and self-care should be at the centre of all health care professional training. Universities are also in a prime position to develop relationships with psychology academics to

create and pave a better way forward to 'care for the carers' of the future.

My vision of mental health supervision for all health care professionals

This personal reflective account is from a midwifery perspective, yet I anticipate the experience shared may resonate with some health care professionals in other departments. We are always encouraged to have a vision for our future. My vision for the NHS is for a robust model of supervision, trained in the provision of RCS, to be available to every single health care professional, with acute settings as a priority. I would like to see RCS available in a responsive and timely manner to any member of staff who has been involved in an experience which is potentially traumatic to them and, later, as a standard model not only responsive to such an event.

Prior to accessing this, staff need to be taught what a trauma response in oneself looks like. To equip all staff with this basic understanding and knowledge, the use of Trauma Risk Management (TRiM) training for *all* staff and ongoing support utilising TRiM managers would be a beneficial start (Strongmind Resilience 2016). Following this there should be the implementation of small supervision teams in all departments with their model based on the A-EQUIP model of supervision (NHS England 2017), allowing for wider benefits to a safe and effective health care service (drawing on actions from risk management, education and quality improvement actions) and entirely separate from the investigatory processes, such as the PMA model.

I would like to see:

- a service that presents an effective model of supervision — having a designated safe space with honoured time to sit, talk and reflect on any single event which awakens uneasiness in an individual and can be safely explored — accepted as 'normal', not 'different'
- a service whereby you are not expected to find courage to seek out help but it is routinely offered, honoured and available to all
- a service that supports practitioners to address the feelings left in themselves in a nurturing space which can lead to personal growth, as opposed to potential psychological harm
- a culture in which no-one questions your 'resilience' or personal ability to cope with an event and where it is accepted that we are all human and need this service of support as standard and priority, not as a luxury.

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Appendix 1. Initial pathway of support and assessment tool following a potentially traumatic clinical event.

As part of the 'Reset your day' drive the co-ordinating midwife should encourage the multi-disciplinary team to voluntarily meet prior to leaving the workplace to reflect upon any stressful incident. We aim to start together and leave together, resetting our day and aiming to reduce potential anxiety in returning for the next shift.

The staff member should be offered and encouraged to have time to think, feel and reflect upon situation with support of Professional Midwifery Advocate (PMA) via RCS within 1 week of event and then ongoing if requested during the next 3 weeks. This may be with the PMA for the day or with the named PMA for the staff member if wanted.

The staff member should be supported in the initial period to re-share experience as many times as needed with supportive colleagues whose role is to actively listen (without judgement, opinion or comment on events other than reassurance).

Exploration of an interim period in an alternative clinical setting should be discussed with line manager. Encouragement to remain in the clinical setting in which the situation has occurred (yet supported to care for those who are less likely to have complicated outcomes) should be facilitated wherever possible for as long as the individual feels necessary in order for the clinical setting to become a place of 'safety' once again.

3 weeks following event:

A one to one with a PMA should offered and encouraged and will incorporate restorative clinical supervision (RCS) and completion of the following screening scoring:

(PC-PTSD-5) QUESTIONS **During the LAST MONTH have you:**	Tick if present
1. Had nightmares about the event(s) or thought about the event(s) when you did not want to?	
2. Tried hard not to think about the event(s) or went out of your way to avoid situations which remind you of the event(s)?	
3. Been constantly on guard, watchful or easily startled?	
4. Felt numb or detached from people, activities, or your surroundings?	
5. Felt guilty or unable to stop blaming yourself or others for event(s) or any problems the event(s) may have caused?	
Total score (the SUM of present symptoms)	SCORE =

SCORE of 0 – 2 offer:	SCORE of 3 – 5:
• Ongoing PMA & line manager support as frequent as staff member feels helpful • Self-referral to Occupational Health if midwife feels appropriate • Signpost to insight, wellbeing and chaplaincy service should midwife feel any are appropriate	• Complete the follow on Questionnaire 20 Questions – (DSM-5 PCL-5) and send the **results of both scores** to Clinical Psychology **Email:** clinical.psychology@trust.nhs.uk with subject field **'URGENT MIDWIFERY REFERRAL'**

PTSD checklist DSM-5 (PCL-5): Complete screening tool to send to Clinical Psychology if SCORE 3+:

During the past MONTH how much were you bothered by:	Circle score				
	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful event?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful event?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behaviour, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "super-alert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

TOTAL SCORE=

E-mail referral to: Clinical.psychology@trust.nhs.uk as 'URGENT MIDWIFERY REFERRAL' with summary of details.