Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Elsevier hereby grants permission to make all its COVID-19-related research that is available on the COVID-19 resource centre - including this research content - immediately available in PubMed Central and other publicly funded repositories, such as the WHO COVID database with rights for unrestricted research re-use and analyses in any form or by any means with acknowledgement of the original source. These permissions are granted for free by Elsevier for as long as the COVID-19 resource centre remains active.
primary caesarean section (VBAC), and the average success rate for VBAC-eligible women who attempted vaginal birth was only 33%.

Townsville University Hospital is a tertiary (level 6) hospital located in North Queensland. The above rates in our institution are 25.1% (overall VBAC rate) and 63.5% (VBAC success rate; highest of WHA hospitals for this period). Ten years ago, our VBAC rate was lower than the national average.

Healthcare is a complex system, and a single healthcare improvement strategy is often not enough to lead to tangible improvements in our maternity system. Our organisation has been on a journey of improvement through collaborative antenatal education by midwives and obstetricians, a community focus on VBAC, implementation of Midwifery Group Practice teams to enhance choice after primary caesarean and midwifery and medical education to normalise VBAC in our unit.

In this presentation, we will describe factors believed to have contributed to the reversal of the trend of intervention and postulate implications for other maternity interventions. These factors relate broadly to consumer-centred care, antenatal education, continuity of care, community engagement, collaborative practice, leadership, and intrapartum strategies for success.

http://dx.doi.org/10.1016/j.wombi.2022.07.081

**O76**

**Women identify benefits with the use of electronic maternity records**

Miss Mariann Hadland 1,2, Wendy Smyth 2,5, Alison Craswell 1,4, Lauren Kearney 2,5, Cate Nagle 2,5

1 Townsville University Hospital, Douglas, Australia
2 Townsville Institute of Health Research and Innovation, Douglas, Australia
3 University of the Sunshine Coast, Sunshine Coast, Australia
4 Sunshine Coast Health Institute, Birtinya, Australia
5 Centre for Nursing & Midwifery Research, James Cook University, Townsville, Australia

Electronic maternity records (EMR) have replaced paper-based pregnancy hand-held records in many maternity care settings with the aim to improve the provision, quality, and efficiency of care. What is not known is whether this move impacts women’s ability to partner in their care. The aim of this study was to ask her whether, from the woman’s perspective, the focus of care has moved from the woman to the digital technology in the maternity care environment.

We conducted a thematic analysis of semi-structured interviews with 18 women across two Australian tertiary public hospitals. The women were interviewed postpartum in the maternity ward and had received care in a variety of care models. Four had relocated from rural and remote communities to give birth. Interviews were digitally recorded and professionally transcribed.

Women viewed digital technology in the maternity care environment positively and described their experiences with the EMR across the pregnancy continuum. Four themes emerged. 1) Midwives got the balance right between technology and caring for me during labour. 2) Digital technology in the birth environment made me feel safe and comfortable. 3) The paperless EMR was convenient to me and my care providers. 4) The electronic maternity record made my care and communication about my care more efficient.

Participating women related an inherent belief that digital advances and progress naturally enhance care and safety. None of the women dwelt on cyber security or concerns regarding governmental storage of digital health data. Women provided examples of woman-centred care they received, and no woman expressed any adverse impact of EMR on their experience of care; they expressed that the midwives “got the balance right” and that the focus of care was still on them and not on the digital technology in maternity care environments.

http://dx.doi.org/10.1016/j.wombi.2022.07.082

**O77**

**Midwifery and Obstetric Emergency Telehealth Service across Country WA aims to improve patient access, outcomes and staff retention**

Mrs Wendy Hoey 1, Ms Kate Reynolds 2

1 Western Australian Country Health Service (WACHS), Perth, Australia
2 Western Australian Country Health Service (WACHS), Perth, Australia

The Western Australian Country Health Service (WACHS) is the largest geographical health service in Australia, covering 2.5 million square Kilometres. The population is diverse, highly dispersed and has widely varying health needs. In 2020-21, there was over 4,200 births across 18 birth sites in country WA, many of which are staffed by just one midwife during a shift. For mothers in country WA, this often means there is no local access to maternity care providers and a need to travel long distances away from home to access maternity care.

The Midwifery and Obstetrics Emergency Telehealth Service (MOETS) was introduced in February 2022 through the existing WACHS Command Centre to deliver expert midwifery and specialist obstetric advice via state-of-the-art bedside technology in real-time to support frontline clinicians, including Emergency Departments (ED) and maternity services. The MOETS offers:

- specialist midwifery and obstetric support at the bedside for unplanned maternity and gynaecological presentations at non-maternity hospitals (Eds);
- consultation and expert opinion through the introduction of new technologies to remotely review cardiotocographs (CTGs) at maternity sites;
- a friendly expert available via phone /bedside screen 24/7 to provide collegiate advice, support, reassurance and opinions to give assurance and confidence to both country clinicians and country families; and
- logistical support for maternity and neonatal transfers; to enable local clinicians to continue provide clinical care.

MOETS aims to not only improve the country clinician experience, many of whom work in isolation, and also those who are recently qualified, new starters or agency /locums but to also improve the outcomes and experience for mothers, partners and newborns whilst keeping care closer to home and community. The new MOETS will be formally evaluated to assess the staff experience and patient satisfaction, the improved equity of access, staff recruitment /retention and clinical outcomes, including transfer rates.

http://dx.doi.org/10.1016/j.wombi.2022.07.083

**O78**

**A teddy and a cardboard box: Developing midwifery skills during COVID-19 utilising innovative online learning activities**

Mrs Karen McDonald Smith, Ms Jennifer Eustace, Amanda Carter

Griffith University, Logan Campus Griffith University, Australia

**Background:** The World Health Organisation declared a world pandemic due to COVID-19 on 11th March 2020, presenting challenges...
The ongoing impact of birth trauma can lead to mental health issues such as post-traumatic stress disorder (PTSD) and postnatal depression and anxiety alongside issues with bonding. It is important to understand women’s experiences of birth trauma and to identify factors and characteristics that contribute to the birth trauma experience. In 2021 The Birth Experience Study (BEST) surveyed women who had birthed in Australia in the previous 5 years to explore a variety of factors contributing to pregnancy, birth and postnatal experiences, including what women would choose if they were to have another pregnancy.

Aim: To explore the factors contributing to the experience of birth trauma in Australia.

Methods: This section of the study utilised a mixed methods approach to understanding birth trauma in Australia. From 8,804 completed responses, 2,500 survey participants indicated they experienced birth trauma in their last birth and 2,158 participants left open ended comments on their experiences of a traumatic birth. A qualitative content analysis was undertaken on the open text responses to the survey question. The open-text quotes were analysed using an inductive content analysis where the categories developed from the dataset by a team of experienced and developing research members. A quantitative linear regression was undertaken on the factors contributing to birth trauma.

Findings: There were five main categories, three categories focused on the absence of respectful maternity care. These were ‘Lack of Control’, ‘Lack of Support’ and ‘Lack of communication’. The two remaining themes focused on the ‘Impact of Intervention’ and ‘What’s happening with my baby?’. The quantitative analysis is currently being undertaken and will be presented at the conference.

http://dx.doi.org/10.1016/j.wombi.2022.07.084

O79
Factors contributing to women’s experiences of birth trauma in Australia

Hazel Keedle, Mrs Valerie Bell, Mr Warren Keedle, Hannah Dahlen
Western Sydney University, Penrith, Australia

Background: It is estimated that a third of women experience a traumatic birthing event. Increased interventions during labour and rising caesarean rates can contribute to experiencing birth trauma. The ongoing impact of birth trauma can lead to mental health issues such as post-traumatic stress disorder (PTSD) and postnatal depression and anxiety alongside issues with bonding. It is important to understand women’s experiences of birth trauma and to identify factors and characteristics that contribute to the birth trauma experience. In 2021 The Birth Experience Study (BEST) surveyed women who had birthed in Australia in the previous 5 years to explore a variety of factors contributing to pregnancy, birth and postnatal experiences, including what women would choose if they were to have another pregnancy.

Aim: To explore the factors contributing to the experience of birth trauma in Australia.

Methods: This section of the study utilised a mixed methods approach to understanding birth trauma in Australia. From 8,804 completed responses, 2,500 survey participants indicated they experienced birth trauma in their last birth and 2,158 participants left open ended comments on their experiences of a traumatic birth. A qualitative content analysis was undertaken on the open text responses to the survey question. The open-text quotes were analysed using an inductive content analysis where the categories developed from the dataset by a team of experienced and developing research members. A quantitative linear regression was undertaken on the factors contributing to birth trauma.

Findings: There were five main categories, three categories focused on the absence of respectful maternity care. These were ‘Lack of Control’, ‘Lack of Support’ and ‘Lack of communication’. The two remaining themes focused on the ‘Impact of Intervention’ and ‘What’s happening with my baby?’. The quantitative analysis is currently being undertaken and will be presented at the conference.

http://dx.doi.org/10.1016/j.wombi.2022.07.084

O80
Translating midwifery continuity of care models in rural NSW: Women and maternity staff experiences of implementing a new service

Elyse Prussing
University Of Newcastle, Taree, Australia

Introduction: Midwifery Continuity of Care (MCC) models significantly improve outcomes for women and their babies. Despite this widespread implementation of MCC has not been achieved, particularly in regional areas. This project evaluated the implementation of MCC across two regional/rural communities.

Aim: The aim of this research was to understand the impact of the implementation process over the first 12 months of a new MCC service, across two regional NSW sites.

Methods: A Realist evaluation was used to assess MCC within the structure of existing maternity services, accounting for both women and healthcare staff experiences of this change, exploring; what works, what doesn’t and why. Qualitative data was collected using a Claims, Concerns and Issues Framework to guide focus group interviews, across the two regional sites. Thematic and comparative data analysis was used and informed a Knowledge to Action Cycle to effect model improvements.

Results: Common themes across both participant groups identified that a ‘Trusting Relationship’ was highly valued, a need to review ‘Operational Issues’ and scaling up of ‘model to include all risk’. Thirdly, participants provided feedback on ‘Communication’ between stakeholders and identified opportunity for improvements of the model and implications for future implementation of MCC models

Conclusion: The findings draw attention to concerns that women and health workforce face when transitioning into MCC models. Participants provided feedback on a number of issues, particularly communication surrounding the implementation of MCC. These findings informed service modifications and will support future translation of MCC in regional areas.

Implications Implementation of MCC needs to be evaluated and a robust feedback loop using realist approach can provide valuable information to improve the implementation and design of MCC models; ensuring they meet the needs of rural and regional workforce, women and their communities.

http://dx.doi.org/10.1016/j.wombi.2022.07.086

O81
Clinical outcomes and cost-effectiveness of large-scale midwifery-led, home phototherapy and neonatal jaundice surveillance

Marjan Khajehei 1,2,3

1 Westmead Hospital, Westmead, Australia
2 University of Sydney, Sydney, Australia
3 University of New South Wales, Sydney, Australia

Aim: We aimed to evaluate a large midwifery-led, paediatrician-overseen home jaundice surveillance and home phototherapy (HPT)