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Telephone Triage in Italian Midwifery Care: a Quantitative and Qualitative Study

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Abstract

Background: While telephone triage (TT) is common in other clinical disciplines, its use in midwifery is limited. It has significant potential for managing low-risk cases and reducing unnecessary visits, although logistical and medico-legal barriers remain. The aim of this study was to investigate midwives' experiences and practices in TT management in Italy.

Participants and Methods: A quantitative and qualitative descriptive study involving midwives employed in Italian maternity hospitals was conducted. For the quantitative phase, an online questionnaire was administered via social networks, and for the qualitative phase, midwives were invited to join online focus groups.

Results: The quantitative phase included 224 respondents, 50.9% of whom worked in advanced care maternity hospitals. Approximately 98% received calls from pregnant women, with 59.7% requesting specific information. Training in TT was lacking for 76.8%, while 92.4% lacked tools for managing TT. Key concerns included medico-legal issues and the inability to assess women face-to-face. Key aspects of effective TT management were considered an adequate training and a dedicated service.

For the qualitative phase, 16 midwives participated in two focus groups. Three themes emerged: 1) current TT use and organisation, 2) competencies and resources, and 3) strengths and weaknesses. Despite recognising the numerous strengths of TT in improving clinical practice, midwives do not feel confident in providing telephone consultations, especially for medico-legal reasons, if the TT service is not official and structured.

Conclusions: Standardised systems, training, and dedicated services are crucial to enhancing midwives' confidence and safety regarding TT, ensuring clear documentation, and addressing medico-legal concerns to improve clinical practice.

Keywords: *Telephone triage; Telemedicine; Midwifery.*

Introduction

Italy has been significantly impacted by the COVID-19 pandemic, and the related restrictive measures to prevent contagion have led to a substantial reduction in emergency room visits[1,2]. This scenario has represented a necessary opportunity to implement certain practices, such as the use of telemedicine and telephone consultations, especially in emergency and triage settings[3].

Triage is the initial assessment phase in which patients are evaluated for their relative risk level and subsequently assigned an appropriate priority code based on their clinical condition[4]. This practice is of paramount importance, as it guides patient prioritisation and ensures appropriate care planning[5]. While triage is a well-established and regulated practice in clinical settings, particularly in nursing[6], its application in obstetric and midwifery settings requires specific consideration owing to the particular characteristics of these disciplines[7]. Many clinic disciplines already experimented with the practice of telephone triage (TT) or telephone consultations before the COVID-19 pandemic. Contrastingly, the international literature regarding their use in midwifery care is limited[8], and there are no national data on TT provided by midwives nor on their opinions and experiences regarding this practice.

The potential of TT in midwifery care is significant, especially in managing low-risk women to assess whether they need an in-person visit or another service/specialist or, in the case of the latent phase of labour, to provide information that is useful for a wait-and-see attitude at home until active labour develops. The literature shows that the practice of TT has numerous benefits, such as reducing unnecessary access, decreasing healthcare costs, and improving staff satisfaction[9]. However, persistent barriers that hinder midwives' widespread adoption of TT include logistical challenges and apprehension about potential medico-legal implications[10].

Therefore, the aim of this study was to investigate midwives' experiences and practices in TT management in Italy.

Participants and Methods

A quantitative and qualitative descriptive study that included midwives who were employed at an Italian maternity hospital was conducted. Approval by the Ethics Committee was not required by Italian regulations for this type of study (GU n. 76 of 2008). The participants were informed about and agreed to the use of anonymous data in line with Italian data protection legislation. All participants provided written informed consent prior to inclusion in the study.

Quantitative phase

For the quantitative phase, an anonymous questionnaire was developed based on a preliminary literature review on telephone triage in obstetric and emergency settings, as well as on the main organisational and training aspects described in previous studies[8,10]. Particular attention was given to variables related to professional background, training in telephone triage, availability of protocols and tools, perceived confidence, and organisational characteristics of the workplace.

The items were formulated to explore the factors that may influence the use of telephone triage in clinical practice, in line with the literature highlighting the importance of structured interviews, documentation tools, adequate training, and organisational support for safe telephone assessment[8-10]. Between October and November 2022, the final 14-item questionnaire was pre-tested and then administered online to Italian midwives using professional social media platforms to facilitate voluntary participation.

Statistical Analysis

The collected data were analysed using Epi Info statistical software version 7.2 (Centers for Di-

sease Control and Prevention, Atlanta, Georgia, USA). We conducted a descriptive analysis using absolute and relative frequencies, average, and range. The results of the quantitative phase of the study were reported following the STROBE checklist[11].

Qualitative phase

Upon analysing and discussing the quantitative data, the working group opted to delve deeper into the study to gain a more comprehensive understanding of the topic. Given the limited prevalence of TT, a qualitative approach was chosen, as this methodology is recommended for exploring individuals' experiences and opinions.

The descriptive phenomenological phase of the study was conducted from March to April 2024. Midwives who were practising in Italy were recruited through convenience sampling involving colleagues who expressed interest in the project.

Participants were invited to join an online focus group and provided written informed consent via email. The focus groups were facilitated by a research midwife experienced in qualitative data collection, and the sessions were digitally audio-recorded and transcribed in full.

The focus group questions were developed through a brainstorming session among the authors, aligning with the specific objectives derived from the scientific literature[8,10] and the results of the quantitative phase of the study. These objectives were formulated into four open-ended questions and summarised into a semi-structured interview form (Table 1). An anonymous form was created to collect key sociodemographic data. The duration of each focus group was guided by the participants' input.

The focus group discussions were fully transcribed and manually coded using the long table analysis method[12]. Data saturation was achieved when no new information emerged from the focus groups[13]. Three authors analysed the data to mitigate subjective biases, adhering to Creswell's methodological framework[14]. The themes that emerged, as well as their interpretations, were discussed among the three authors, while the remaining authors provided oversight to ensure the rigour of the qualitative analysis. The identified themes were shared with the participants via email for their feedback, which was unanimously positive.

The qualitative phase of the study was reported in accordance with the COREQ checklist[15].

Table 1. List of questions for the focus groups.

How is Telephone Triage currently managed in your professional setting?
How was Telephone Triage handled during the Covid pandemic?
In your opinion, what are the strengths of Telephone Triage? And what are the challenges or key aspects to pay attention to?
In your view, what are the most important skills and aspects in managing Telephone Triage?
How could healthcare organizations improve the Telephone Triage in the Midwifery Care?

Results

Quantitative phase

The quantitative part of the study entails a descriptive-observational investigation aimed at assessing the organisation of TT in Italian maternity hospitals and midwives' opinions and experiences on this practice.

The sample consisted of 224 respondents, whose sociodemographic characteristics are reported in Table 2. Specifically, regarding the geographical working area, 72.8% of the sample were from Northern Italy. Subsequently, the work setting was investigated, and 50.9% of the sample were employed in an advanced care maternity hospital. Regarding the age and work experience of the study participants, 53.6% belonged to the 25–34-year age group, with a minimum percentage of respondents > 44 years (5.8%), and 45.5% of the sample were found to have 1–5 years of work experience.

Regarding workplace characteristics (Table 3), a substantial number (71.4%) of respondents confirmed the presence of differentiated clinical-care pathways based on obstetric risk (low risk/modified risk). Additionally, 98.2% reported receiving phone calls from pregnant women during their shifts, with 59.7% of these calls entailing requests for specific guidance. Regarding training, 76.8% of the respondents lacked TT training, and among those who received training, undergraduate education (42.3%) and shadowing experienced colleagues (42.3%) were the predominant methods.

Regarding the characteristics of TT service (Table 4), the majority of the sample (92.4%) indicated

Table 2. Participant characteristics (N=224)

Characteristics	N	%
Geographical working area		
Northern Italy	163	72.8
Central Italy	41	18.3
Southern Italy	20	8.9
Setting		
Hub hospital	114	50.9
Spoke hospital	88	39.3
Community	22	9.8
Age of participants (years)		
< 25	45	20.1
25-34	120	53.6
35-44	46	20.5
> 44	13	5.8
Working experience (years)		
< 1	33	14.7
1-5	102	45.5
6-10	37	16.5
11-20	42	18.8
> 20	10	4.5

Table 3. Workplace characteristics (N=224)

Characteristics	N	%
Differentiated clinical and care pathways (low-risk /modified-risk)		
Yes	160	71.4
No	64	28.6
Calls from pregnant women during work activity		
Yes	220	98.2
No	4	1.8
Theme of the questions to be answered (multiple answer)		
Specific behaviour directions	132	58.9
General information	128	57.1
Labour and delivery information	110	49.1
Training in telephone triage (multiple answer)		
Yes	52	23.2
No	172	76.8
Type of training (multiple answer)		
Training with job shadowing	22	9.8
Undergraduate education	22	9.8
Training with refresher courses	12	5.4

Table 4. Characteristics of telephone triage service (N=224).

Characteristics	N	%
Availability of tools for managing telephone triage		
Yes	17	7.6
No	207	92.4
Type of tools present (multiple answer)		
Specific protocols	7	3.1
Specific checklist	7	3.1
Systems for calls recording (paper sheets, software applications, other)	6	2.7
Confidence in managing calls		
Yes, enough	121	54.0
No	68	30.4
Yes, almost all the time	30	13.4
Yes, always	5	2.2
Major concerns (multiple answer)		
Difficulty in not being able to assess face to face	153	68.3
Fear of underestimation of the situation	129	57.6
Medical-legal aspects	117	52.2
Incomplete understanding of the real problem manifested	74	33.0
Inadequate preparation for managing the call	50	22.3
Telephone triage management environment		
Ward's room	122	54.5
Obstetrical emergency room outpatient	40	17.9
Obstetric ward	38	17.0
Dedicated spaces	24	10.7
Presence of dedicated midwifery staff		
Yes	10	4.5
No	214	95.5
Skills and most important aspects in the management of telephone triage (multiple answer)		
Possibility of devoting sufficient time to the call	196	87.5
Appropriate training	137	61.2
Presence of a dedicated service that does not burden other midwifery activities	135	60.3
Presence of quiet environment	114	50.9
Ability to prioritize correctly	113	50.4
Decision-making skills	105	46.9
Active listening skills	100	44.6
Strong communication skills	58	25.9

that they lacked the tools to manage TT in their workplace. Among the minority with such tools, specific protocols (41.2%), checklists (41.2%), and call recording systems (35.3%) were equally represented. Moreover, 13.4% of the participants almost always felt confident, while 2.2% reported that they always felt confident when handling phone calls. Primary concerns included the inability to assess women face-to-face (68.3%), underestimation of clinical situations (57.6%), and medico-legal considerations (52.2%). Additionally, a mere 10.7% reported having dedicated spaces for handling phone calls, and only 4.5% had dedicated midwifery staff in their workplaces.

Finally, the questionnaire probed midwives on crucial skills and aspects of TT management. Notably, among the respondents, dedicating sufficient time to phone calls (87.5%), receiving adequate training (61.2%), and having a dedicated service (60.3%) emerged as highly important.

Qualitative phase

Between March and April 2024, we conducted two online focus groups involving 16 midwives. Most of the participants were aged between 29 and 36 (n = 8) and had been working as midwives for less than 10 years (n = 12). Most of them worked in central Italy (n = 9)—and, to a lesser extent, in the north (n = 4) and south of Italy (n = 3)—mainly in advanced care maternity hospitals (n = 11). The following three themes emerged: 1) current TT use and organisation, 2) competencies and resources, and 3) strengths and weaknesses. The related main representative verbatim quotes are reported in the text.

Theme 1. Current TT use and organisation

All the participants, except one, declared that in their work settings, there is no structured TT system; therefore, calls are managed in a "confusing" way. Women phone the hospital switchboard, and the calls are forwarded to the obstetric emergency room or obstetrics department based on how the hospital is organised. Sometimes, when precise instructions are not given, the switchboard operator can randomly pass the call to the obstetrics department, obstetric emergency room, or delivery room, and this creates further confusion for both women and staff:

> *Telephone triage is very confusing. It also depends on the number given to women. Some call the ward; others call the obstetric emergency room. When we receive the call, if it is urgent, we have them come to the emergency room immediately. If it is not urgent, we evaluate what to do. It is not easy because it is not structured. (P1)*

Only one participant stated that at her hospital, they recently started a TT project dedicated to low-risk women that is especially for the management of prodromes. The system is well structured and includes call recording and a specific protocol that guides midwives during the phone call, as evidenced by the following quote:

> *Women can have telephone access to triage services without going to the emergency room. So you do a short anamnesis. We have set it up on an obstetric anamnesis. We have a paper medical record of TT in which you fill in all the fields. Our protocol provides for three calls for the same symptoms of the same woman, after which it is recommended to come to the hospital for observation. (P2)*

Most midwives reported that because TT is not structured and is not an official service, they feel the burden of responsibility in making an assessment only by telephone; therefore, this leads them to always end the phone call with the recommendation to go to the emergency room. P5,

the only participant who deals with structured TT, stated that before the start of the project, the midwives "could not tell women not to go to the emergency room" given that the call was not recorded and there was no predefined protocol for assessment. If, however, a structured TT is established, a legal and official connotation is given to this activity:

> *TT is not structured; it is not defined by any protocol ... so most of the time, we do not want to take the responsibility on the phone to leave the woman at home. We almost always tell her that it would be better to come to the emergency room anyway. So in the end, the phone call is of no use. (P5)*

In both focus groups, some midwives clarified to those participants who were more reluctant towards TT that the aim of this tool is not to make a diagnosis but, rather, to assess whether the woman needs an in-person visit or to be referred to another service. Once this aspect was explored, the importance of working in hospitals in which a clear differentiation between low- and high-risk care pathways has been implemented emerged in both focus groups. The midwives repeatedly reiterated the need to reserve TT exclusively for low-risk women at term. In fact, in facilities in which the division between low- and high-risk pathways is implemented, low-risk pregnant women are taken care of by midwives and receive a designated telephone number for requests. In hospitals in which the division of care pathways is not present, the midwife's care of the woman becomes more complex as multi-professional and team management takes over, rendering the organisation of TT complex in terms of roles and responsibilities:

> *TT is not intended to make a diagnosis, which in any case would be the responsibility of the obstetrician and not the midwife, but it is used to understand if the woman should come in person because her condition and symptoms require it. On the contrary, if a woman with a physiological pregnancy at term calls [and] reports contractions that we still assess as prodromes, then we should support her with all the necessary information. (P2)*

The COVID-19 pandemic is a subtheme addressed by the research group to explore its impact on TT practice. The participants stated that during the pandemic, they witnessed a drastic decrease in emergency room visits but, conversely, a notable increase in the number of telephone calls. All the midwives agreed that the investment required was, above all, emotional; in fact, the fear and uncertainties induced by the pandemic, as well as the isolation and restrictions that became necessary, increased the state of anxiety and fragility of pregnant women and new mothers. Calls during the pandemic therefore mainly took on the role of reassurance, an "open door" to which women could refer, even for sometimes very "trivial" reasons. One participant stated that during the pandemic, the hospital equipped midwives with a phone with which they could make video calls and chat with women. Furthermore, home visits increased. This also made it possible to reach a subpopulation of women and couples who, faced with some doubts and having no economic or transportation means, would not have physically reached the obstetric emergency room or, to do so, would have called the emergency number to request an ambulance. Being able to chat with the midwife, send her photos, or video-call her guaranteed to the user that they would be taken care of.

> Du*ring the lockdown, there was a drastic drop in emergency room visits, there was an increase in home births, and the phone was ringing like crazy continuously for anything. The anxiety of the women was skyrocketing. (P14)*

> *It almost became a psychological consultation. It was difficult to manage the phone calls because they were much less practical and much more emotional. (P8)*

None of the participants stated that the number of telephone consultations managed during the COVID-19 pandemic encouraged health departments to improve the service of TT to use it in a more effective and organised way even after the pandemic.

Theme 2. Competencies and resources

According to the participants, TT requires, on the one hand, some specific selection criteria for the personnel who answer calls and, on the other, specific human and organisational resources.

When it comes to staffing, the two key elements are work experience and communication skills. Working in the obstetric emergency room for some time offers midwives greater confidence in managing cases over the telephone and therefore greater promptness in recognising the symptoms reported by the women. In any case, it is important that the midwives who deal with TT have good communication skills, in addition to specific clinical skills, as lacking direct observation of the woman, her tone of voice, her silences, and the speed with which she communicates are relevant clues. Regarding the organisation, all the participants agreed on the need to have a structured and official TT system with a dedicated midwife. This system should offer a predefined set of questions and ensure the traceability of the information collected:

> *It takes the right words; it takes the right way to talk to that person, knowing how to manage words, tone of voice, [and] speed. You have to do the impossible to be as clear as possible. (P12)*

> *We need a midwife dedicated only to telephone triage. It takes work experience in the emergency room, and it takes a standardised protocol that also includes a checklist and a list of questions to follow to properly frame the clinical and emotional situation of the woman. (P16)*

The only participant who deals with structured TT states that there are no dedicated staff in her hospital, as the service is offered solely to low-risk women who are assisted by the hospital midwives. If the service were advertised and the calls increased in number, it would be essential to have dedicated midwives.

Theme 3. Strengths and weaknesses

Among the strengths, the participants indicated that TT is an effective method of reducing inappropriate access to the emergency room and the improper use of ambulances. Furthermore, TT guarantees women 24-hour access to secure information provided by healthcare personnel. A further advantage of TT is that when the telephone consultation ends with the invitation to come to the emergency room in person, the healthcare staff can already plan the activities and prepare the necessary devices while waiting for the arrival of the woman. One study participant stated:

> *For me, the strength is the continuity because it is reassuring for the woman to have a point of reference. And it is also reassuring for me to know who is coming because we spoke on the phone, and I already have an idea of the reason why I advised the woman to come. (P11)*

Regarding the critical issues, the midwives raise the problem of the language barrier which, in addition to causing difficulties when the consultation is in person, is amplified in TT. In an in-person situation, the woman's triage can be facilitated by paraverbal language, observation of symp-

toms, and the possible use of digital tools that allow women to quickly translate information into Italian using their smartphones. For these reasons, the participants hypothesise the possibility of using a TT system that allows for the rapid availability of linguistic mediators online or via telecall or the use of artificial intelligence so that translations can be obtained in real time, although they are less precise and reliable than those carried out by cultural mediators. Another critical issue mentioned concerns the weight of medico-legal responsibility. Some midwives believe that the TT system should be able to guarantee midwives the same level of medico-legal risk as in-person triage. If the level of risk of TT use were higher, they would probably not feel protected. For this reason, the participants suggest focusing on training triage staff in terms of clinical skills and decision-making as well as effective communication. One participant stated:

> *There are many foreigners who struggle to explain what is happening. Maybe you underestimate a situation that could potentially be serious. (P4)*

Discussion

The findings indicate that the practice of TT is mainly characterised by telephone consultations, which do not have an official connotation. This is consistent with the literature; in fact, Bailey et al.8 state that TT in midwifery care is often an informal service that is managed by midwives who are already occupied with other clinical activities on the wards. Our study has revealed that calls received at the maternity hospital are frequently dealt with hastily or even interrupted owing to the lack of spaces and/or personnel dedicated for this purpose. This exacerbates the workload of midwives, who, if already busy with other clinical duties, tend to provide standardised and impersonalised advice, often opting to recommend in-person visits to the facility.

The integration of quantitative and qualitative findings allowed a more comprehensive interpretation of telephone triage practice in Italian midwifery care. While the survey provided an overview of the organisational characteristics, training background, and perceived confidence of midwives, the qualitative phase helped to explain the reasons underlying these results.

In particular, the quantitative data highlighted the limited availability of training, protocols, and dedicated resources, whereas the focus groups clarified how the absence of structured systems leads to uncertainty, increased perceived responsibility, and defensive clinical behaviours. The qualitative findings also helped to interpret the high importance attributed by respondents to training, dedicated staff, and organisational support, showing that these elements are considered essential to ensure safety and professional accountability in telephone triage.

Overall, the combination of quantitative and qualitative data suggests that the main barriers to the implementation of telephone triage are not related to its perceived usefulness, but rather to organisational, educational, and medico-legal factors. This methodological integration strengthens the interpretation of the results and provides a more complete understanding of the current situation in Italy. Bailey et al.8 report that the calls are frequently undocumented and that midwives' attributes in TT are not evaluated. In this regard, the lack of guidelines, protocols, and standardised documentation systems emerged as a key organisational issue. This informal and unofficial approach to TT translates into significant medico-legal apprehensions for midwives who are involved in the process. As noted by many authors10,16, the main legal concerns that

staff encounter in TT include failure to identify the nature and urgency of the problem, inadequate responses, indirect communication with the patient, insufficient or absent documentation of telephone calls, and breaches of patient privacy.

In terms of the skills and attributes required, according to Bailey et al.10, the profile of a midwife performing an effective TT includes being experienced and confident, possessing effective communication and counselling skills, and having strong clinical knowledge and advanced decision-making abilities.

One of the most common fears among the midwives included in our study is the inability to accurately assess the nature and urgency of a situation over the phone. Some midwives worry that they lack the appropriate experience to make informed decisions by phone. Therefore, training focused on enhancing skills and confidence in this practice is crucial[8].

Presumably, the insecurity felt by midwives is also due to the intrinsic remote nature of the TT practice itself. First, evaluations rely solely on auditory information. Consequently, some clinical details, which are sometimes crucial in midwifery for determining the priority level of a situation, may be missed. Second, the midwife seldom personally knows the woman with whom they are speaking on the phone, and the clinical documentation may not be immediately available during the call.

Another issue relates to the ability to speak directly with the woman, instead of having to communicate through a third party, such as her partner. It is well known that when messages are relayed through a third party, there is a risk that not all information is conveyed accurately owing to this mediation[10]. Another scenario in which an in-person assessment is necessary, as a telephone assessment may not be adequate, is when the woman's first language is different from the primary language spoken in the country in which the maternity hospital is located. In such cases, it is essential to use the services of an in-person cultural mediator[8].

Moreover, the process of listening becomes more difficult when the woman is experiencing heightened anxiety or fear, as these emotions can hinder her ability to articulate her concerns or relay crucial clinical information accurately. This can lead to misjudgements regarding the urgency and nature of the situation. Therefore, if the woman exhibits signs of anxiety or makes multiple calls, it is advisable to encourage her to visit the healthcare facility in person[8]. All these factors can negatively impact the clinical assessment and decision-making process.

Consistent with the literature, despite the fears and uncertainties attributed to the practice of TT, the participants in our study also recognise its numerous strengths and advantages. First, this tool would enable more appropriate management of patient flow to hospitals, thereby reducing the number of unnecessary visits. As a result, a more efficient use of staff and resources would be achieved, enhancing the quality of care for already admitted patients in terms of time and concentration[8,17].

Moreover, TT reduces unnecessary trips to the hospital for pregnant women8. Women at full term, especially first-time mothers, often visit their chosen maternity hospital two or three times in the hours leading up to active labour. With access to a TT service staffed by dedicated midwives who are skilled in communication and equipped to offer pain management strategies during the

prodromal phase at home, unnecessary hospital visits could be minimised. Once any conditions requiring in-person assessment have been ruled out, the number of women accessing obstetric emergency rooms would decrease. Consequently, for low-risk women, arriving at the maternity hospital during only the active phase of the first stage of labour would also reduce their likelihood of receiving unnecessary treatments. This is an important aspect to take into consideration given that national data show a medium-high level of medicalisation and overtreatment during pregnancy, childbirth, and puerperium[18].

It is interesting that the COVID-19 pandemic has apparently been unable to give an impetus to the diffusion of official and well-structured TT services in midwifery care in Italy. However, we hypothesise that this is partly owing to the limited national implementation of the differentiation of obstetric risk levels, as also emerged in the focus groups. Having a care pathway dedicated to low-risk women would allow the selection of a specific target group of women whose care is provided exclusively by midwives. This would make the midwifery personnel dedicated to TT more confident in answering calls and managing telephone consultations. This aspect is probably an expression of the current status of the midwifery profession in Italy. In fact, the latter is influenced by the partial application of both the guidelines of the Italian Ministry of Health[19] on the adoption of the midwifery-led care model for low-risk cases and the legislation on midwives' autonomy[20].

Limitations

Considering the voluntary participation and the convenience sampling, this study may have been affected by self-selection response bias[21], with midwives who are interested in the topic being more inclined to participate. In addition, the geographical distribution of respondents was not homogeneous, with a clear overrepresentation of Northern Italy, which may reflect differences in organisation of maternity services across the country. This imbalance may limit the generalisability of the findings to the entire Italian context, as organisational models, availability of resources, and implementation of midwifery-led care pathways may vary between regions. Moreover, with specific regard to the qualitative part of the study, some nuances and meanings from the respondents' original language (Italian) may have been lost in translation. However, despite these limitations and to the best of our knowledge, this is the first study conducted in Italy specifically examining midwives' opinions, attitudes, and practices related to TT. Further research should investigate this area to assess its efficacy, particularly in contexts in which TT is an established practice.

Conclusions

This study provides a significant contribution to our understanding of midwifery TT practices and experiences in Italy. Although midwives generally consider TT to be useful, they feel constrained in their roles, particularly owing to medico-legal concerns. There is an urgent need to implement appropriate logistical and organisational strategies. For example, the development and adoption of standardised systems are essential to ensuring the existence of clear and precise documentation that guides the TT process, making it safer for both midwives and women. Tools such as call-recording forms and specific training are effective and cost-efficient in enhancing midwives' confidence in TT, aiding in the standardisation of call management processes. Im-

proving TT practices could help midwives tailor the service to better meet both their workplace requirements and women's needs.

Declarations

Artificial Intelligence (AI) – Assisted Technology Statement

No AI-assisted technologies were used in the preparation of this manuscript.

Authors' Contributions

All authors meet the 4 authorship criteria as defined by the International Committee of Medical Journal Editors (ICMJE). Each author has contributed substantially to the conception and design of the study, the analysis and interpretation of data, and the drafting / critical revision of the manuscript, as follows: SC, SG - Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Project administration, Supervision, Validation, Visualization, Writing-original draft, Writing-review & editing; CDV, CG - Data curation, Investigation, Methodology, Project administration, Supervision, Validation, Visualization, Writing-original draft, Writing-review & editing; MM, APM - Data curation, Investigation, Project administration, Supervision, Validation, Writing-original draft.

All authors have approved the final version of this manuscript.

Conflict of Interest

No conflict of interest to declare.

Data Availability Statement

The data used and/or analyzed during the current study are available upon reasonable request from the corresponding author.

Ethics Approval

Approval by the Ethics Committee was not required by Italian regulations for this type of study (GU n. 76 of 2008).

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Informed Consent

All participants provided written informed consent prior to inclusion in the study.

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