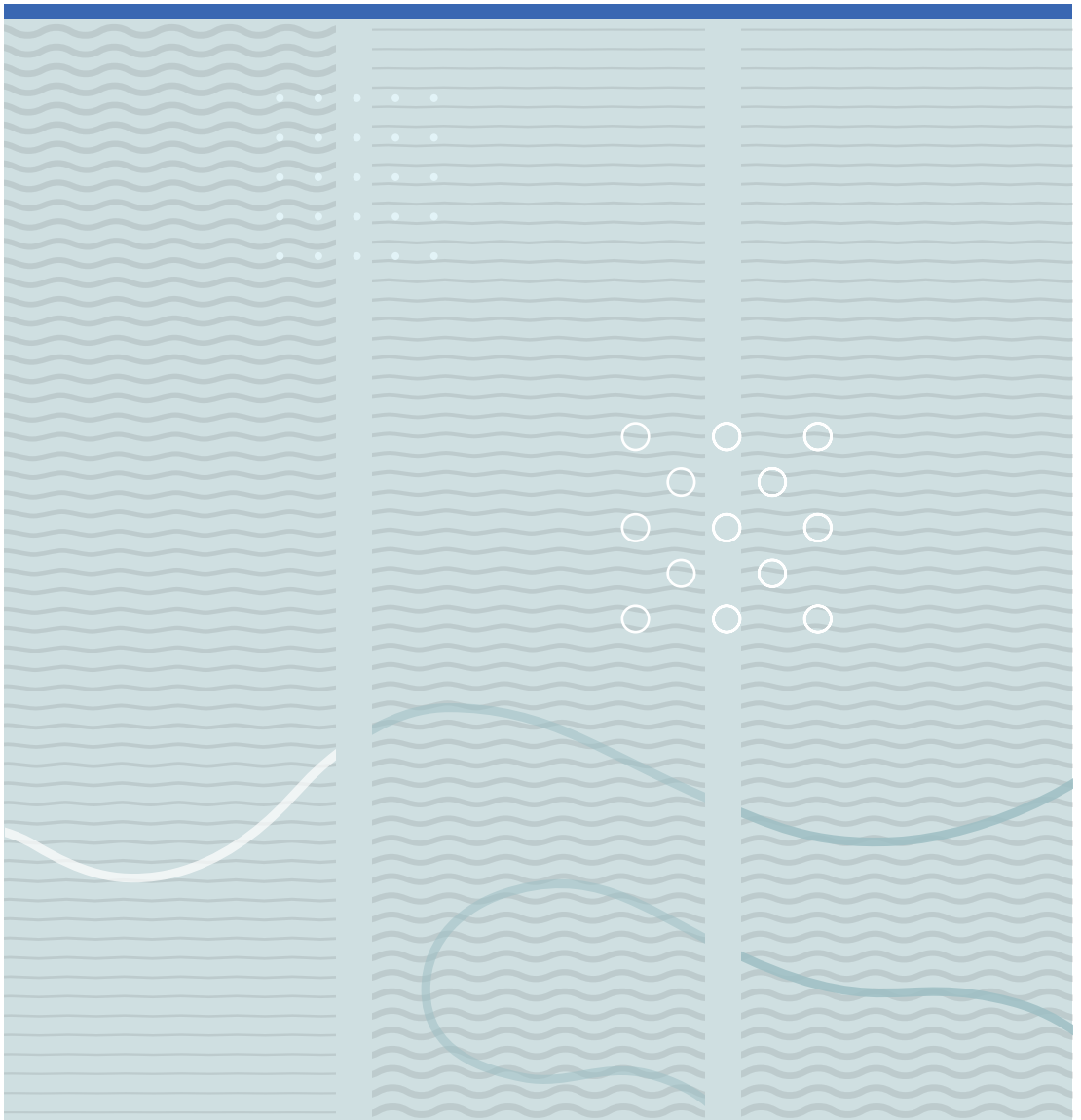


Maria Rønnerhag

Safe Maternity Care

The Perspectives of Childbearing Women and Healthcare Professionals





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The Perspectives of Childbearing Women
and Healthcare Professionals

A PhD dissertation in
Person-Centred Healthcare

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Abstract

The aim of this study was to enable a deeper understanding of safe maternity care as well as to develop, implement and evaluate an intervention to identify women's and healthcare professionals' experiences and perceptions of safe childbirth. This was achieved by exploring the meaning of women's and healthcare professionals' experiences and perceptions of safe and unsafe childbirth (Papers I and II) and healthcare professionals' perceptions of what supports or hinders communication and teamwork, as well as how communication and teamwork promote safe maternity care (Paper II). In addition, the implementation and evaluation of the intervention highlighted the reasons for healthcare professionals' unsafe actions (Papers II and III), including those behind decision-making intended to ensure safe care (Paper III). Data were collected by means of individual and focus groups interviews. The empirical findings from the perspectives of the women revealed the need to be informed, involved and guided through the childbirth process in order to experience safe maternity care (Paper I). From the perspectives of the healthcare professionals, the findings demonstrated the importance of promoting interprofessional teamwork and building capabilities by involving healthcare professionals and elucidating relevant strategies. The findings highlight the importance of facilitating trusting relationships to ensure a safe environment that enables the provision of safe maternity care (Paper II). In addition, the consequences of what managers do or fail to do constitute the meaning of taking responsibility for team collaboration to provide safe care (Paper III). The overall interpretation is based on the empirical findings. The hermeneutic interpretation, theoretical analysis and explanation enabled a deeper understanding. A pattern of dimensions emerged: Fear of childbirth versus feeling safe, Receptivity versus obligation to inform and Mistrust versus trusting relationships. In conclusion, a trusting professional relationship means being confirmed, respected and cared for. A prerequisite is the will and ability to create a trusting relationship that strengthens childbearing women's confidence in the birth process by enabling them to participate in decision-making about care interventions. In contrast, mistrust evokes fear, despair and deprivation, resulting in meaninglessness and lack of

trust in the relationship. It implies that the will and ability to provide information do not exist, thereby increasing unsafe care.

Key words: Adverse event, Decision-making, Experiences, Hermeneutics, Maternity care, Patient safety, Perceptions, Trusting relationships.

List of original publications

This thesis is based on the following papers, which will be referred to in the text by Roman numerals (I-III).

Paper I

Rönnerhag, M., Severinsson, E., Haruna, M. & Berggren, I. (2018). Qualitative study of women's experiences of safe childbirth in maternity care. *Nursing & Health Sciences*, 20, 331-337. doi: 10.1111/nhs.12558

Paper II

Rönnerhag, M., Severinsson, E., Haruna, M. & Berggren, I. (2019). A qualitative evaluation of healthcare professionals' perceptions of adverse events focusing on communication and teamwork in maternity care. *Journal of Advanced Nursing*, 75, 585-593. doi: 10.1111/jan.13864

Paper III

Rönnerhag, M., Severinsson, E., Haruna, M. & Berggren, I. (2019). Risk Management – evaluation of healthcare professionals' reasoning about and understanding of maternity care. *Journal of Nursing Management*, 1-10. doi: 10.1111/jonm.12778

Papers I-III have been included with the permission of the respective journals.

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1 Introduction

This chapter introduces the research area, aims, research questions, research design and how the thesis was structured.

1.1 Research area

This thesis focuses on childbearing women's and healthcare professionals' (HCPs') experiences and perceptions of safe childbirth, as well as an intervention that takes account of patient safety (PS) from the perspectives of childbearing women and HCPs. A woman-centred approach was chosen for this thesis because it has similarities to the concept of person centredness as both focus on interpersonal relationships. A woman-centred approach in the context of PS is holistic, human-rights-based and ensures safe childbirth (de Masi et al., 2017; The World Health Organization WHO, 2015).

The WHO has long argued for recommendations to promote safer childbirth worldwide. PS in the context of maternity care is defined as healthcare structures or processes to prevent harm to childbearing women, new mothers and their children (WHO, 2014a). The ultimate purpose of PS is to improve practice and reduce preventable adverse events (AEs) through the use of best evidence-based interventions (WHO, 2011a).

Research indicates that there is limited evidence to underpin recommendations (Renfrew et al., 2014), new guidelines (Miller et al., 2016) and routines (Homer et al., 2014) to ensure that PS takes account of women's and HCPs' experiences and perceptions of safe childbirth (cf. Chang et al., 2018).

In terms of childbirth, Scandinavian countries have been viewed as the safest countries in the world (Save the Children Federation, 2015). However, after decades of decrease, maternal mortality rates have shown an increase in Europe (Esscher, Högberg, Haglund & Essèn, 2013). Incidents caused by unsafe care during childbirth do not only result in mortality, but may have devastating consequences such as long-term harm (Renfrew et al., 2014). Childbearing women's experiences of unsafe care during childbirth have

recently been reported in the media. Labour wards and maternity care units in Scandinavian countries are considered not safe enough. Inadequate healthcare resources have been reported, putting childbearing women at increased risk. Access to healthcare during childbirth does not always mean that women receive safe care from their perspective. Women have reported that they are concerned and even fearful that they will not receive adequate care and that the care provided will not meet their needs and preferences.

Renfrew et al. (2014) highlighted what childbearing women need and want for themselves and their children in order to be safe when giving birth. Women wanted supportive, skilled care and respectful relationships tailored to their individual needs. They particularly wanted HCPs who combined clinical knowledge and skills with interpersonal competencies (Renfrew et al., 2014). Consequently, to support childbearing women in an appropriate manner, HCPs need the necessary prerequisites and resources, such as the right competence and skills to identify early signs of risks or complications (ten Hoop-Bender et al., 2014) and be prepared to provide timely, evidence-based care (Miller et al., 2016). It is clear that HCPs' performances and skills play a vital role in safe care for childbearing women (Ederer, König-Bachman, Romano, Knobloch & Zenzmaier, 2019; WHO, 2014a).

Despite the progress that has resulted in safer maternity care in most countries and the efforts made to identify preventable incidents, women and children are still harmed during childbirth (WHO, 2016a). The adverse consequences resulting from such incidents are often reported and receive public attention. However, not all incidents receive attention, especially those with less immediate adverse consequences, despite the fact that they occur more frequently. These frequent events, such as failure to follow evidence-based guidelines, are often perceived as quality rather than safety issues. Thus safety cannot be differentiated from quality as there is a link between failure and consequences (Brown et al., 2008a). This reinforces the need to ensure that childbearing women have access to quality, evidence-based maternity care (Miller et al., 2016) that

acknowledges and prioritizes the health and well-being of childbearing women in decision-making and practice to ensure safe childbirth (cf. ten Hoop-Bender et al., 2014).

1.2 Overall aim, specific aims and research questions

The overall aim was to enable a deeper understanding of safe maternity care as well as to develop, implement and evaluate an intervention to identify women's and HCPs' experiences and perceptions of safe childbirth. Three sub-studies were performed as part of the main study (Papers I-III), each related to the overall aim.

The papers specifically aimed to:

Explore:

- the meaning of safety as a process phenomenon by outlining women's positive and negative experiences of safety in childbirth (Paper I)
- HCPs' perceptions of AEs during childbirth with focus on communication and teamwork (Paper II)

Implement and evaluate an intervention to identify:

- HCPs' reasoning about and understanding of AEs in the maternity care context with focus on teamwork (Papers II and III)
- HCPs' explanations of the prerequisites for safe maternity care and understanding of risk management, including the underlying reasons for decision-making intended to ensure safe care (Paper III).

This thesis addresses five research questions:

1. What characterizes women's and healthcare professionals' experiences and perceptions of safe and unsafe childbirth? (Papers I and II)
2. What supports or hinders communication and teamwork? (Paper II)
3. How do communication and teamwork promote safe maternity care? (Paper II)
4. How can HCPs determine the reasons for unsafe actions? (Papers II and III)
5. What components constitute the reasons behind decision-making? (Paper III)

1.3 Research design

In this thesis the research design was guided by the three steps in the Medical Research Council framework (Craig et al., 2013): development, implementation and evaluation of an intervention that takes PS from the perspectives of childbearing women and HCPs into consideration (Papers I-III). The interpretative paradigm was adopted (Gadamer, 2006) with focus on understanding the meaning of individual experiences and perceptions of safe maternity care. This flexible interpretative design employs a hermeneutic approach (Chapter 3, Section 3.2.).

The design of the sub-studies was explorative, descriptive and inductive (Paper I) (Polit & Beck, 2012), while in Papers II and III an inductive interpretative approach based on hermeneutics (Gadamer, 2006) was chosen. Each sub-study (Papers I-III) contributed a new understanding that further guided the research process (Figure 1.). The research design consists of theoretical, epistemological and empirical underpinnings to develop an understanding of safe maternity care.

The overall interpretation (Chapter 3, Section 3.2.1.) of the sub-studies, the interpretative synthesis, was performed by adopting an inductive-deductive hermeneutic approach (Gadamer, 2006). The hermeneutic circle is a resonant part of hermeneutic theory that highlights the relationship between the parts and the whole (Gadamer, 2006), revealing the research process through a new understanding that gradually emerges. Hence, it refers to the reformulation of the text into an interpretative synthesis reflecting the understanding of PS in the childbirth context.

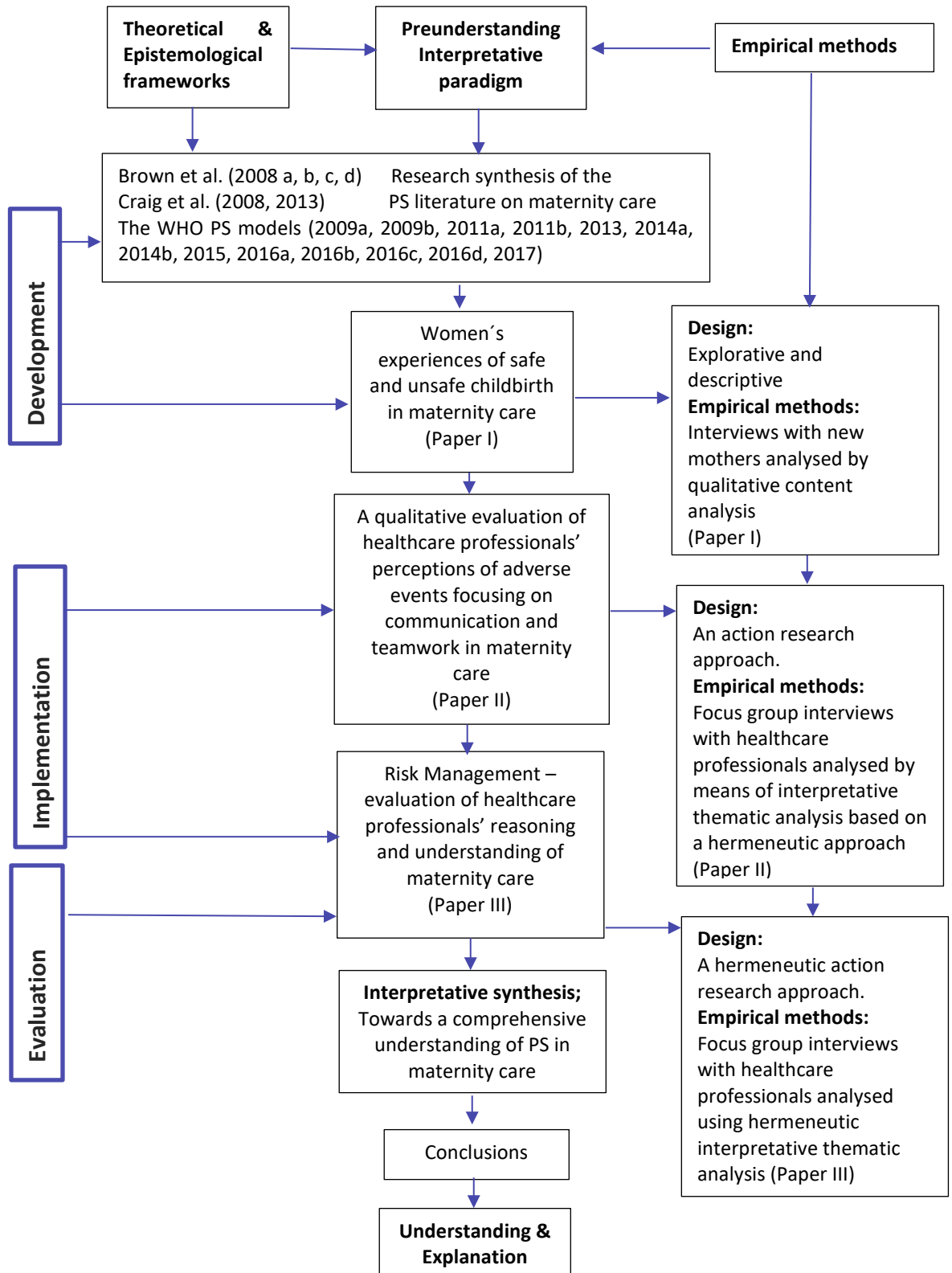


Figure 1. The research design

1.4 Structure of the thesis

The thesis consists of a summary, which outlines theoretical and empirical approaches to PS in the context of maternity care.

Chapter 1 introduces the research area, aims, research questions and research design. Chapter 2 outlines the theoretical framework of PS and previous research related to the topic in the context of maternity care. Chapter 3 describes the epistemological framework, the epistemology of PS research as well as the hermeneutic approach, including the interpretation process in this thesis and the researcher's preunderstanding. Chapter 4 presents the implementation of the intervention, methods for data generation (Papers I-III), analysis methods (Papers I-III) and ethical considerations. Chapter 5 consists of a summary of the findings from the sub-studies. The characteristics of childbearing women's experiences of safe and unsafe childbirth as well as HCPs' perceptions and understanding of AEs in maternity care are presented (Papers I-III). Chapter 6 constitutes the interpretation and discussion of the comprehensive understanding of PS in maternity care followed by the methodological considerations of the study. Finally, the conclusions are presented in Chapter 7. These chapters are followed by references and appendices I-VII, where appendices I-III consist of the three qualitative empirical sub-studies (Papers I-III) included in this thesis. Finally, figures and tables (Appendices VIII and IX) are presented.

2 Theoretical patient safety framework

This chapter presents the theoretical PS framework by outlining the WHO PS models and the empirical research evidence of PS in maternity care with focus on childbearing women's as well as HCPs' experiences of AEs.

2.1 World Health Organisation Patient Safety Models

Implementation of the WHO recommendations builds on various models that constitute a framework for improving PS in healthcare facilities from the perspective of childbearing women, new mothers and their children (WHO, 2016a). PS is a multidimensional concept that involves various levels within the healthcare organisation, thus making the implementation of safe practice complex. PS includes areas such as human factors, systems (WHO, 2009a), cause analysis and risk management (WHO, 2016a). The definition of human factors refers to environmental, human and individual characteristics that influence behaviour and performance in practice, which affect well-being, health and safety (WHO, 2009a).

Risk management focuses on maintaining and promoting safe maternity care by identifying circumstances that place women at risk of harm and eliminating such risks (WHO, 2011a). Thus, risk is defined as the likelihood that an incident will occur. An incident is as an event or circumstance that could have resulted (near-miss), or did result in harm to a person (AE). In this study, harm refers to bodily and/or emotional adverse consequences that could have been prevented (WHO, 2011b).

Despite increased evidence and strategies to reduce the number of incidents and mitigate the harm associated with childbirth, the integration of PS research evidence in maternity care practice is lacking (WHO, 2016a, 2017). There is a need to strengthen the knowledge about PS as well as the skill to apply the principles in practice. Being aware that failures occur is not sufficient, it is necessary to understand why women are harmed and what aspects underlie unsafe care (WHO, 2016a). HCPs need to know how to address

safety issues and how to act in order to protect childbearing women, new mothers and their children from harm (WHO, 2011b, 2016a). All childbirths should be attended by skilled HCPs in order to implement adequate interventions to prevent and manage the risks and complications that could arise (WHO, 2011a). Thus, HCPs have a vital role in the provision of safe maternity care (WHO, 2016b).

In the WHO frameworks (2009a, 2009b, 2011b, 2016a, 2016c, 2016d, 2017) some recurrent integral elements necessary for PS competencies can be identified; communication, teamwork, feedback and leadership. The WHO (2011b) recommendations for improving PS highlight six important domains by which HCPs can enhance the safety of maternity care; contribute to a PS culture, work in teams to ensure PS, communicate effectively, manage safety risks, optimize human and environmental factors, and recognize, respond to and disclose AEs, all of which reflect the safety of healthcare processes (WHO, 2011b).

The WHO provides various approaches for generating knowledge on the underlying causes of unsafe childbirth. One of the approaches relevant for facilitating safe care focuses on “beyond the numbers” by reviewing individual AE cases in maternity care from the women’s perspectives. The framework is designed for HCPs involved in the care, as well as managers and policy-makers responsible for safety. In the cyclic case review, AE cases are selected and the HCPs evaluate the care provided against evidence-based guidelines, local protocols and standards of care in order to take action to ensure safer childbirth. The intervention takes women’s needs, values and preferences into consideration (cf. WHO, 2011a). Consequently, the healthcare process is composed of two complementary domains; the provision of care and the experiences of care. The provision of care requires the implementation of evidence-based practice for managing risks and complications. For the experiences of care, communication, respect, dignity and emotional support should be ensured (WHO, 2016a).

Research initiatives to involve and engage women and HCPs in PS are essential for enhancing the safety of maternity care. Lack of involvement has a negative impact on capacity building for the changes needed to ensure safe childbirth (WHO, 2013a). There

is an existing evidence gap concerning the focus of interventions for understanding the potentials and risks of the healthcare process. Implementation research and evaluations have the potential to inform strategies for safe maternity care (cf. WHO, 2014b, 2015).

2.2 Research evidence of patient safety in maternity care

This part of the PS theoretical framework involves the performance of a descriptive research synthesis of qualitative empirical evidence of women's and HCPs' experiences and perceptions of AEs in the maternity care context guided by Lockwood, Munn and Porrit (2015). The purpose was to contribute to the interpretation of the findings and to assess the applicability of the empirical findings for deepening the understanding of safe maternity care. The review question was; What is the empirical evidence of women's and HCPs' experiences and perceptions of AEs in maternity care?

An initial systematic search for qualitative evidence was performed in the Cinahl database from June-August 2018. In addition, another systematic search was carried out in May 2019 to identify newly published studies of relevance. However, no further relevant empirical studies were found. A broad approach was used in the searches to comprehend the phenomenon. The search terms employed were; Adverse event, Childbirth, Complication, Experience, Harm, Hospital care, Incident, Maternal care, Maternity care, Midwifery, Near-miss, Obstetric care, Patient safety, Perception, Safety, Trauma, Traumatic childbirth and Qualitative. The search limits applied were peer reviewed studies in the English language published between 2008 and 2018 with an available abstract. In addition, an unsystematic search in the Cinahl and PubMed databases was performed and three empirical studies of relevance were found and included. Finally, 17 empirical qualitative studies and mixed method studies focusing on qualitative content associated with women's and HCPs' experiences and perceptions of AEs were selected (Section 2.2.1.-2.2.2.). The literature searches and selection process are presented in the PRISMA flowchart (Figure 2.).

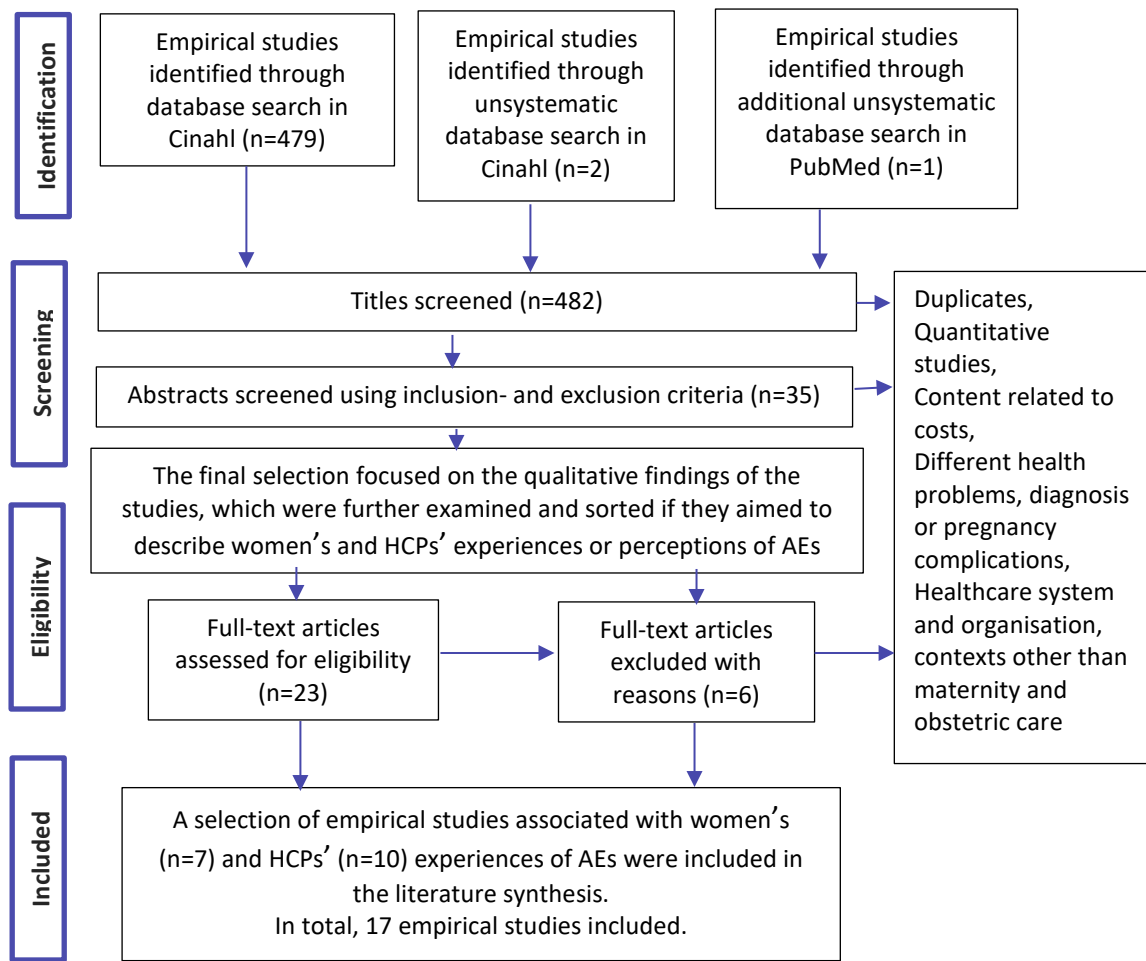


Figure 2. PRISMA flowchart of the literature searches (Moher et al., 2009)

A qualitative interpretative descriptive analysis was performed to explore, analyse and identify patterns (Polit & Beck, 2012) in the empirical studies. In the first step, data were extracted from each study including the aim, method, type of study, participants, analysis and findings, which are labelled in Table 1 (Appendix VIII). First, the findings from the result section in each study were read and re-read several times to gain an understanding of the content. The second step involved grouping relevant findings from the included studies in a preliminary synthesis in the form of concept mapping (Lockwood et al., 2015) i.e., the links between concepts and the meaning behind their labelling. In the third step, the interpretative synthesis was performed to explore the relationships between the findings by; 1) comparing the tentative themes that emerged from the preliminary

synthesis and; 2) integrating and thematising findings to a new pattern of understanding. Finally, 3) four descriptive themes emerged (cf. Lockwood et al., 2015).

In addition, five literature reviews of qualitative research were found, three of which were identified by the systematic search of the Cinahl database. The other two relevant literature reviews were identified by the unsystematic search in the PubMed database and through the references in the PS literature. The summary of the findings from the included literature reviews are described separately from those of the empirical studies (Section 2.2.3.). An additional table, Table 2 (Appendix IX), summarises the literature reviews.

2.2.1 The characteristics of women's and healthcare professionals' experiences and perceptions of adverse events

In total, 17 empirical studies of women's (n=7) and HCPs' (n=10) experiences and perceptions of AEs in maternity care were included in the research synthesis. The characteristics are outlined in four descriptive themes labelled; Childbirth complications, risks and medical interventions; Childbearing women's and HCPs' experiences; Circumstances that contributed to unsafe care and The similarities and differences between childbearing women's and HCPs' perceptions of defining an AE.

2.2.2 Findings of the empirical research evidence

This section presents the findings of the empirical research evidence for each of the four descriptive themes that emerged.

Childbirth complications, risks and medical interventions

The following complications, risks and medical interventions were found; stillbirth, neonatal death (Beck & Gable, 2012; Beck, LoGiudice & Gable, 2015; Dahlen & Capice, 2014; Sheen, Spiby & Slade, 2016), placenta accreta followed by postpartum

haemorrhage (Elmir, Schmied, Jackson & Wilkes, 2012), asphyxia of the child (Heringhaus, Dellenmark Blom & Wigert 2013), shoulder dystocia (Beck & Gable, 2012; Beck et al., 2015), maternal death (Dahlen & Capice, 2014), being close to death (Elmir et al., 2012; Sourza, Cecatti, Parpinelli, Krupa & Osis, 2009), severe perineal trauma (Beck & Gable, 2012; Priddis, Schmied & Dahlen, 2014) and failing to notice something that causes harm (Dahlen & Capice, 2014). In addition, women who had a previous placenta accreta, postpartum haemorrhage or undergone a Caesarean section had a potential risk of complications in a subsequent birth (Elmir et al., 2012). Postpartum haemorrhage is a common risk during childbirth and may cause asphyxia in the child (Heringhaus et al., 2013).

The medical interventions related to complications were; maternal and infant resuscitation (Beck et al., 2015), emergency hysterectomy, Caesarean section (Elmir et al., 2012), vacuum extraction (Puia, Lewis & Beck, 2013), episiotomy (Larkin, Begley & Devane, 2012) and suturing (Priddis et al., 2014). Murphy and Strong (2018) found that women who had experienced a medical intervention as a result of a childbirth complication experienced the event as traumatic. The existence of childbirth complications highlights the subjective experiences of women as central to the development of birth trauma (Byrne, Egan, MacNeela & Sarma, 2017). HCPs were not necessarily traumatised by obstetric emergencies, but instead by witnessing medical interventions and being unable to protect women from harm (Rice & Warland, 2013).

Childbearing women's and healthcare professionals' experiences

This theme reveals women's and HCP's experiences of AEs. Women had the impression that death was imminent, resulting in subsequent flashbacks, nightmares and intrusive thoughts (Elmir et al., 2012). They experienced an AE as shocking, horrifying and being out of control (Elmir et al., 2012; Larkin et al., 2012; Souza et al., 2009). Furthermore, distress, anxiety, anger, frustration, sadness, unfairness, pain, grief (Elmir et al., 2012), as well as feelings of vulnerability and loneliness could be present (Larkin et al., 2012). In addition, women experienced fear for the life and future of their child and family members (Elmir et al., 2012). Women focused on the health and well-being of the child,

fearing that something would happen to her/him (Souza et al., 2009). Parents of a child with birth asphyxia experienced feelings of hovering between hope and despair, as well as helplessness and inadequacy when caring for their child due to fear of making her/his condition worse (Heringhaus et al., 2013). Priddis et al. (2014) found that traumatic childbirth experiences influence women's ability to care for their child (Priddis et al., 2014) and parent-child bonding (Byrne et al., 2017; Heringhaus et al., 2013). Furthermore, parents described witnessing their child's suffering as distressing. They reported that they were on "autopilot" and had trouble sleeping (Heringhaus et al., 2013). Priddis et al. (2014) found that women's experiences of the AE had an impact on their relationship with their partner and that they struggled to redefine a new sense of self following the trauma. An AE was described as a fundamental feeling that remained in the body (Heringhaus et al., 2013), leaving an emotional rather than a physical scar (Elmir et al., 2012). Some women stated that they would not have another child due to their childbirth experiences (Elmir et al., 2012; Larkin et al., 2012).

Witnessing an AE can have harmful consequences for HCPs. An agonising sense of powerlessness and helplessness at being unable to protect women from harm, as well as feelings of sadness, anxiety, anger, fear and numbness could be present, which were perceived as distressing emotions (Beck et al., 2015). Accordingly, HCPs can experience shock and despair (Sheen et al., 2016). An AE could cause emotional distress that influenced HCPs' behaviour and performance, leading to difficulty getting through the shift, symptoms of pain and loss, frustration with inadequate care, inability to show genuine care and recover from the traumatic experience including never forgetting it (Puia et al., 2013). Other findings were that HCPs asked themselves what they could have done differently (Beck & Gable, 2012), felt sympathy for the woman (Rice & Warland, 2013) and felt guilty for being the cause of a traumatic childbirth experience (Dahlen & Caplice, 2014). Schrøder, Jørgensen, Lamont and Hvit (2016) found that HCPs were sometimes aware that they were not at fault yet still felt guilty. This was described as a psychological burden, even in cases where no blame was attached. Such experiences evoked existential considerations with respect to the meaning of life (Schrøder et al., 2016) and deeply affected HCPs (Puia et al., 2013). They considered changing their

careers in order to survive (Beck & Gable, 2012) and were concerned about the consequences for their own health and well-being (Schrøder et al., 2016).

Circumstances that contributed to unsafe care

Larkin et al. (2012) revealed that women often felt alone and unsupported during childbirth. The lack of available HCPs precluded woman-centred care both in the pre-and postpartum period, resulting in experiences of being invisible in childbirth. Some women perceived that HCPs had dismissive attitudes, which caused distress as their childbirth experience became invisible (Larkin et al., 2012). Women experienced a loss of control, low levels of support and in some instances a loss of dignity (Murphy & Strong, 2018), which dehumanised them (Byrne et al., 2017). Women felt vulnerable, exposed and disempowered throughout the birth (Priddis et al., 2014) and these feelings were a result of the actions or inactions of the HCPs (Elmir et al., 2012; Priddis et al., 2014; Souza et al., 2009).

When an AE occurred, HCPs experienced that their belief in the childbirth process was shaken, which influenced practice (Beck et al., 2015). They struggled to maintain a professional role with traumatised women (Beck & Gable, 2012). HCPs perceived that all aspects of their personal and professional lives were adversely impacted (Sheen et al., 2016). Furthermore, they reported contributions to an unsafe maternity care environment. The difficulties concerned not allowing the woman to be heard, lack of respect and the absence of coordinating communication around the care (Lyndon et al., 2014). Their views of the common ground differed (Beck & Gable, 2012; Lyndon et al., 2014; Rice & Warland, 2013). This resulted in disagreements (Puia et al., 2013), unresolved conflicts, imperviousness, inaction and misguided action (Lyndon et al., 2014). HCPs perceived letting down the childbearing women and felt powerless (Beck & Gable, 2012).

Additional findings by Hood, Fenwick and Butt (2010) reveal that HCPs perceived a high level of stress and personal distress when worried about the potential threat of litigation due to working in an environment that was driven by fear of litigation. Schrøder et al.

(2016) found that they feared being blamed by the childbearing women, colleagues and authorities. This influenced their behaviour and professional performance (Hood et al., 2010) and they perceived support from colleagues as vital for managing a traumatic childbirth experience (Sheen et al., 2016). However, support was not always provided and they had nowhere to go to unburden their souls (Beck et al., 2015).

Although there is a need to support HCPs to enable them to manage childbirth complications, be prepared (Dahlen & Capice, 2014) and care for women traumatised by childbirth experiences (Reed, Fenwick, Hauck, Gamble & Creedy, 2014), only two intervention studies were identified that focused on educational and training activities related to practice. The advanced counselling skills acquired during an intervention improved HCPs' confidence to care for women traumatised by their birthing experiences and personally manage stressful situations encountered in practice (Reed et al., 2014). Accordingly, Dahlen and Capice (2014) found that workshops on topics such as dealing with grief and loss and managing fear could help reduce HCPs' anxiety. Obstetric emergency skills workshops may also help HCPs to feel more confident.

The similarities and differences in women's and healthcare professionals' perceptions of defining an adverse event

This theme summarizes the empirical evidence of the similarities and differences in women's and HCPs' perceptions of defining an AE. With regard to women's perceptions of an AE, the existing evidence seems refer to a childbirth where there have been failures and/or complications that resulted in harm to the woman and/or her child (Elmir et al. 2012; Heringhaus et al., 2013; Murphy & Strong, 2018; Priddis et al., 2014; Souza et al., 2009), psychological and/or emotional consequences (Byrne et al., 2017; Elmir et al. 2012; Heringhaus et al., 2013; Larkin et al., 2012; Murphy & Strong, 2018; Souza et al., 2009), as well as the lack of care and support (Bryne et al., 2017; Elmir et al., 2012; Heringhaus et al., 2013; Larkin et al., 2012; Murphy & Strong, 2018; Priddis et al., 2014; Souza et al., 2009). All of the above aspects indicate an unsafe childbirth environment that influences the lives of the women, their families and significant others (Elmir et al., 2012; Heringhaus et al., 2013; Larkin et al., 2012; Priddis et al., 2014).

The empirical evidence of HCPs' perceptions of an AE has similarities to those of childbearing women in terms of the psychological and emotional consequences (Beck & Gable, 2012; Beck et al., 2015; Puia et al., 2013; Rice & Warland, 2013; Schrøder et al., 2016; Sheen et al., 2016). Physical injury as a result of failures and/or complications always seems to be involved in the definition of an AE from HCPs' perspective (Beck et al., 2015; Dahlen & Capice, 2014; Puia et al., 2013). This differs from women's perceptions, as they do not always include physical injury as an element of an AE. Furthermore, HCPs' perceptions highlight the existence of failures in the maternity care environment (Beck et al., 2015; Dahlen & Capice, 2014; Hood et al., 2010; Puia et al., 2013; Reed et al., 2014; Sheen et al., 2016; Schrøder et al., 2016) that have an impact on their interpersonal and interprofessional relationships (Dahlen & Capice, 2014; Lyndon et al., 2014; Rice & Warland, 2013). The findings reveal that being unable to protect women from harm (Beck et al., 2015; Lyndon et al., 2014; Rice & Warland, 2013) adversely impacts on HCPs' personal and professional lives (Beck & Gable, 2012; Reed et al., 2014; Sheen et al., 2016).

To summarize the evidence of this synthesis of empirical studies, women's experiences and perceptions of an AE are complex. The evidence indicates that HCPs' behaviour, performance and the care provided are linked to women's experiences of safe childbirth. This means that HCPs may need to redefine their view of AEs in the light of what these events imply for those affected. The most important finding from the perspective of HCPs was that when an AE occurred they sometimes felt powerless and unable to protect the woman and child from harm. Accordingly, the maternity care environment including the circumstances influences the safety of childbirth. Therefore, relevant PS interventions should be provided to support HCPs and ensure safe maternity care.

2.2.3 Summary of the findings of the literature reviews

The findings from the five literature reviews included revealed the importance of defining traumatic childbirth or an AE from the perspective of childbearing women (Greenfield, Jomeen & Glover, 2016) and recognizing their need to be involved in decision-making

(Elmir, Schmied, Wilkes & Jackson, 2010). Research emphasises the necessity of finding implementation strategies (Elmir, Pangas, Dahlen & Schmied, 2017) for safety management activities (Lyberg, Dahl, Haruna, Takegata & Severinsson, 2018) to prepare for unexpected and unforeseen AEs (Elmir et al., 2017), as well as to ensure the safety of interventions in order to reduce or prevent the consequences of an AE for women and their families (Furuta, Sandall & Bick, 2014).

3 Epistemological framework

As human sciences focus on understanding lived experiences, a qualitative interpretative approach was chosen (Polit & Beck, 2012). The epistemological view of knowledge creation is that it occurs in the relationship between the interpretation and what is understood. This means that the interpretation is developed in a process between the researcher and the phenomenon, i.e., PS in maternity care (cf. Gadamer, 2006).

In this thesis, the epistemology of PS research constitutes the theoretical and methodological framework. The epistemological components that form the basis are: the epistemology of PS research, the hermeneutic approach, the interpretation process and the researcher's preunderstanding.

3.1 The epistemology of patient safety research

PS research seeks to understand context, human behaviour and performance in order to identify, analyse, evaluate and manage risks by determining possible strategies for maintaining and promoting PS (Runciman et al., 2008). PS is to some extent related to risk management issues, which are faced by HCPs in the process of care and concern deviations from the safe limits of practice that have a direct or an indirect impact on childbearing women (Runciman et al., 2008; Vincent et al., 2000). Research that identifies opportunities for overcoming barriers to safe care and addresses the implementation of strategies facilitates approaches within a specific context, as well as the adoption of research evidence to enhance PS. The implementation process consists of several phases; contextualizing research issues, developing a proposal for implementation of the intervention, planning the performance, analysing data, communicating findings and evaluating the research (WHO, 2014b). Thus, researching PS requires that the knowledge gained from previous research should be considered in relation to the design of an intervention (Brown et al., 2008a; WHO, 2014b). This includes an understanding of how personal characteristics, interactions between persons and the strategies used in the healthcare system may constitute a barrier to safe maternity care (cf. Brown et al., 2008a;

Runciman et al., 2008). Brown et al. (2008a, 2008b, 2008c, 2008d) examined the epistemology of PS research for guiding study design and interpretation. They found that although several different methods can be used, no single method can be considered “the gold standard” (Brown et al., 2008c). The authors’ key message is that “one size does not fit all” (Brown et al., 2008d). Hence, a range of aspects must be taken into account in order to determine the design, data collection methods and interpretation (Brown et al., 2008c).

We considered an intervention targeting both childbearing women and HCPs and started to systematically review knowledge (Severinsson, Haruna, Rönnerhag & Berggren, 2015; Severinsson, Haruna, Rönnerhag, Holm, Hansen & Berggren, 2017). In this thesis an intervention was defined as the active element involved in addressing a particular issue or problem that pushes the implementation process forward (Skolarius & Sales, 2015). Characteristics that have been identified as important components of an empirical intervention are; 1) the content or elements of the intervention, 2) characteristics of those involved in the intervention, 3) characteristics of the setting, 4) the mode of providing the intervention, e.g., face-to-face, 5) the level of engagement such as the time invested and the number of sessions over a given period and 6) adherence to delivery protocols (Michie, Fixen, Grimshaw & Eccles, 2009 p.3). Datta and Petticrew (2013) highlight an additional element of importance, the need to evaluate challenges to overcome contextual and implementation issues in order to facilitate a desired change in practice (Datta & Petticrew, 2015). A qualitative evaluation can be of importance for deepening the understanding of an intervention, its influence and to inform practice and policy decisions (Atkins, Odendaal, Leon, Lutge & Lewin, 2015).

Successful implementation and evaluation of an intervention depends on logistical and pragmatic prerequisites such as timing, assessment of associated benefits and harm and the target audience. The prerequisites in each situation have to be considered (Brown et al., 2008d). Brown et al. (2008d) conclude that there is no formula that applies in all circumstances and that using a framework to guide the research process is intended to facilitate judgment and decisions. Thus, using a framework can contribute important

knowledge and understanding of the “chain” or process leading to an incident or AE and the performances of those involved (Vincent et al., 2000). Runciman et al. (2008) and Vincent et al. (2000) state that such an approach can provide important insights into healthcare processes and structures. Highlighting the importance of interventions aimed at understanding the behaviours and performances of the persons involved in healthcare as well as their beliefs and values is a significant prerequisite for understanding how and why things sometimes go wrong (Runciman et al., 2008).

3.2 Hermeneutic approach

Gadamer’s hermeneutics (2006) provides a description of how we can understand and is not a specific method in a narrow sense. According to Gadamer (2006), the interpretation consists of a dialogue between the horizons of the past and the future (Gadamer, 2006) and includes openness to the unfamiliar as well as the familiar in addition to a movement between the whole and the parts of the text. This circular process to achieve knowledge constitutes the hermeneutic circle. Hermeneutics is considered to consist of four fundamental elements; interpretation, understanding, preunderstanding and explanation (Ödman, 2007). Thus, the hermeneutic circle of understanding can be viewed as a constant back and forth interpretative movement. Gadamer (2006) highlights language as an integrated part of a text, reasoning that texts are linguistic and that hermeneutic interpretation is developed by understanding language, which can be achieved through a shared language where a fusion of horizons occurs.

3.2.1 The interpretative process in the thesis

The overall interpretation of the sub-studies, the interpretative synthesis, was performed by adopting an inductive-deductive hermeneutic approach (Gadamer, 2006). The purpose of the synthesis was to compare, explain and present the research evidence provided by the findings, thereby revealing an understanding of PS in the context of maternity care. The main aims of the synthesis were to explore and understand the

relationships between characteristics within the themes in the individual sub-studies (Papers I-III) as well as between the findings and those of previous research (Snilstveit, Oliver & Vojtkova, 2012).

The interpretation paradigm can be visualised by the hermeneutic circle and understood as a dialectic process. As a result of the preunderstanding, questions relevant to the phenomenon were posed to the text (cf. Geanellos, 1999). Examples of such questions were: What are the characteristics of childbearing women's and HCPs' experiences of safe vs unsafe care? What do the childbearing women really want? In order to understand the text it was necessary to question what lay behind the words, thus understanding the text as providing an answer to a question. This dialectic process of questions and answers facilitated new understanding (cf. Geanellos, 1999). The intention was to understand the text and to recreate meaning until a more complete or new understanding of safe maternity care occurred, which is optimal in terms of the prevailing circumstances (Geanellos, 1999).

The synthesis emerged through a hermeneutic and comparative interpretation process, which consisted of three phases. First, an interpretation of each theme in the individual sub-studies (Papers I-III) was performed to identify key characteristics. Characteristics of safe and unsafe care reported by childbearing women and HCPs were reflected on.

The second phase involved comparing characteristics in order to identify repeated meaning patterns. This involved a dialectic movement between the parts and the whole to identify the interconnectedness between the characteristics, summarize the findings and reformulate them into themes. The two aforementioned phases of interpretation were close to the original text. In the third phase, the interpretation process changed into a dialectic movement between the findings and previous research in order to compare and contrast the relationships across all the included research evidence and to provide a comprehensive understanding. The interpretative synthesis that finally emerged advances our understanding of safe maternity care due to the fact that it is based on the perspective of childbearing women and HCPs, thus allowing the fusion of horizons that occurs to be explained and viewed as a whole (cf. Gadamer, 2006).

3.2.2 The researcher's preunderstanding

The researcher's preunderstanding is considered a prerequisite for interpretation of the phenomenon (cf. Gadamer, 2006; Ödman, 1997). This means that the researcher's understanding is based on what she/he already knows (cf. Geanellos, 1998). Identifying my research perspectives and views was challenging, as it required constant reflection and self-awareness. Through on-going dialogue and supervision in a close and trusting collaborative relationship with the research team, my experiences, preunderstanding and understanding were reflected on in light of different views and experiences. This developed my self-awareness both as a researcher and as a person, increasing my comprehension of how the risks to childbearing women can be understood. Consequently, my views and experiences have likely changed and opened up for different possibilities throughout the research process, leading to the emergence of a new horizon. I will point out and explain a few aspects underlying my preunderstanding that might have influenced my understanding of the phenomenon, i.e., safe maternity care.

I believe in the potential of relationships between human beings for feeling and being safe in different life situations. Relationships are central to all care. It is essential for me as a nurse teacher and specialist oncology nurse to understand other people in order to meet their needs and act safely. To enhance my understanding I have adopted a holistic perspective when considering the lifeworld of another person. Before my academic career I worked as a specialist oncology nurse and in the final years of my clinical career I served on a ward for women with gynaecological cancer. Being able to understand the women and their family members was significant for the building of trusting relationships. The ethical values that have guided me when establishing relationships with other human beings are; autonomy, dignity, respect, belief in a person's own ability and belief in the uniqueness of every person. Thus, there are several reasons for establishing trusting relationships. However, such relationships require openness for and between individuals that enables mutual understanding.

4 Empirical methods

This chapter presents the empirical methods, starting with the implementation of the intervention, followed by methods for data generation, analysis and ethical considerations (Papers I-III). The context of this study is maternity care at one regional hospital in Sweden. The HCPs at the labour ward assist at approximately 3,580 childbirths per year. The postpartum stay for new mothers at the labour ward is about four hours. There are approximately 32 obstetricians, 53 midwives and 24 assistant nurses employed on a permanent basis.

4.1 The implementation of the intervention

The development, implementation and evaluation of the intervention (Figure 1., p.5) were guided by Craig et al. (2013) and conducted in three phases: 1) Several research activities were performed to inform the methods for data generation and intervention. A number of electronic data searches were conducted to facilitate the identification of previous research focusing on the links between PS, AEs and near-misses as well as between PS and woman-centred care. The available evidence and theories were used to guide the implementation phase.

2) When planning the implementation it was important to ask the Manager of the Department and Director of the Hospital as well as HCPs to reflect on the proposed intervention. Together with the parties involved, an intervention focusing on safe childbirth tailored to their wishes and local context was designed. This is in accordance with Craig et al. (2013), who state that it is essential to refine the intervention methods by adapting them to local conditions, rather than employing a strictly standardized intervention.

The intervention allowed HCPs to critically reflect as a team on seven childbirth-related AEs that were reported to the Inspectorate for Health Care (IVO) in Sweden between 2010 and 2015. Four of these were discussed during focus group sessions. Incident

reports are required by the IVO in order to follow-up AEs within the healthcare organization for the purpose of preventing them from occurring in the future.

The seven AE cases were analysed using document analysis (Bowen, 2009). According to Bowen (2009), document analysis is often employed in combination with other methodologies to uncover meaning, develop understanding and reveal insights relevant to the aim and the research questions of the study. The purpose of the analysis was to identify common patterns in the content of the text in order to gain a deeper understanding of PS in the maternity care context. The document analysis was based on the domains developed by the Swedish Association of Local Authorities and Regions (SALAR, 2015) in accordance with the Risk assessment method employed by the Department of Veterans' Affairs, National Centre for Patient Safety (NCPS) (DeRosier, Stalhandske, Bagian & Nudell, 2002). The domains were; communication and information, education and skills, environment and organization, technology and equipment, as well as procedures and guidelines (SALAR, 2015). The focus group sessions that constituted the intervention were guided by the knowledge gained from the previous phases.

3) A modified version of action research (AR) (Papers II and III) guided the implementation process and evaluation of HCPs' experiences and understanding of AEs. AR seeks to explore new ways of doing things, new ways of reflecting and new ways of relating to one another and to the environment (Wittmayer, Schöpke, van Steenberg & Omann, 2014). Following a cyclical process, AR attempts to generate meaningful knowledge through cycles and does not repeat the previous phase (Casey, O'Leary & Coghlan, 2017; Øvretveit, 2014). The planning, acting, reflecting, learning and evaluating actions in the previous cycle or phase inform and shape the next and evolve over a period of time (Casey et al., 2017; Coghlan & Casey, 2001; Øvretveit, 2014). The AR approach is dialogical in nature and relates to creating a meaning-making process (Wittmayer et al., 2014). The dialectical, reflexive, questioning and collaborative form of inquiry was an incentive for conducting a series of focus group discussions (cf. Winter, 2005). The focus group discussions enabled HCPs to share their experiences of practice and explore their own

reasoning about safe maternity care that led to new ways of thinking and being (Papers II and III). The interaction between participants where knowledge, actions and social relations are reflected on has the potential to develop a shared understanding of practice and identify challenges as well as solutions in the specific context i.e., maternity care (cf. McCormack, 2015; Winter, 2005; Wittmayer et al., 2014).

4.1.1 Methods for data generation (Papers I, II, III)

4.1.1.1 Individual interviews (Paper I)

The participants consisted of 16 new mothers recruited at one regional hospital in Sweden. The inclusion criteria were Swedish-speaking women who had given birth within the previous 12 months. The women, who were aged between 23 and 46 years, were invited to participate in the study during a visit to the maternity clinic, where midwives distributed information letters. The individual interviews, which lasted between 30 minutes and an hour, were performed from January to April, 2016.

4.1.1.2 Focus group interviews (Papers II and III)

A total of 22 HCPs participated in four focus group interviews between March and June, 2016. The inclusion criteria were Swedish speaking HCPs employed in the labour ward with at least one year of experience in their profession. The participants were aged from 40-61 years and their work experience ranged between 6 and 32 years. The AE case and theme for the focus group discussion were presented to the participants in advance to enable them to start reflecting on the content. The main focus of the discussions was to reflect on how the participating HCPs perceived the team performance during an emergency and whether the care provided was safe or unsafe when an AE occurred. After each session the content of the group discussions was reviewed to assess the group dynamics and identify the main issues worth following-up in the next session. The experience, knowledge and skills emphasized during the sessions were reflected on in

terms of their significance for safe maternity care. The focus group interviews lasted one and a half hours.

4.1.2 Analysis methods (Papers I, II, III)

The empirical data were transformed into understanding by means of qualitative content analysis (Paper I), thematic interpretative analysis (Paper II) and a hermeneutic interpretation approach (Paper III). The interview text was systematically structured and analysed in line with qualitative content analysis (Paper I) as described by Graneheim and Lundman (2004). Content analysis provides opportunities to analyse manifest and descriptive content as well as latent and interpretative content (Graneheim & Lundman, 2004).

An inductive interpretative thematic analysis (Braun & Clarke, 2006) was adopted (Paper II). The analysis process involves a progression from description to a latent and interpretative level of abstraction more distant from the interview text (Braun & Clarke, 2006). A thematic structure of sub-themes and themes emerged through the analysis process and constitutes an interpretation of the HCPs' perspectives on AEs (Paper II).

A hermeneutic approach (Gadamer, 2006) was used to interpret the interview text (Paper III). A scheme (Appendix III, Paper III, Table 1.) was designed in order to illustrate the interpretation process, which included the following core elements; quotations, interpretation of the quotations, the HCPs' explanations of the prerequisites for safe care, understanding of risk management and finally, the analytical patterns of actions and strategies intended to ensure safe care. To enhance transparency throughout the analysis, examples of analytic themes from the empirical to the more abstract level are provided. A deeper understanding was obtained by reflecting on the prerequisites and working conditions that enable HCPs to ensure safe care.

4.2 Ethical considerations

The study was approved by an Ethical Review Board in Sweden (No: 773-15) (Appendix IV) in order to ensure the protection of human rights in accordance with the World Medical Association Declaration of Helsinki (WMA, 2015, 2018). In addition, the Norwegian Social Science Data Services reviewed the privacy and licensing requirements of the study and granted permission for the project (No: 53865) in accordance with the Norwegian Data Registers Act (Appendix V).

Information was provided to the Manager of the Department and Director of the Hospital involved, both of whom approved the study (Appendix VI). Both verbal and written information outlining the research was communicated to the participants (new mothers, Paper I; and HCPs, Papers II and III), who gave their informed consent (Appendix VII). There was no compensation for participation, which was voluntary and the participants could withdraw at any time without giving a reason. Confidentiality was ensured in accordance with the WMA (2018).

Ethical considerations concern the researcher's responsibility to carefully consider her/his personal approach to data collection. Interviews about safe care and AEs may evoke memories of negative experiences (WHO, 2013 b). In this study, we focused on the possibility that the new mothers (Paper I) and the HCPs (Papers II and III) could become emotionally distressed as a result of their participation in the interviews. Therefore, building trust and developing a relationship that enabled the participants to feel that they were treated with dignity was important (cf. Liamputtong, 2013). During the interviews, we strived to adopt an empathic approach by means of thoughtful questioning, respectful listening and allowing the participants to explore their own experiences of safe maternity care. Furthermore, the research team engaged in ongoing discussions about ethical issues throughout the whole research process and took the well-being of the participants into account.

5 Summary of findings

This chapter presents a summary of the findings from the three sub-studies (Papers I-III) and provides an answer to the research questions (RQ 1-5, Chapter 1., Section 1.2., p.4.). It outlines the characteristics of childbearing women's experiences of safe and unsafe childbirth (Paper I), the characteristics of HCPs' perceptions of AEs focusing on communication and teamwork (Paper II) and their reasoning, explanations about and understanding of risk management in maternity care (Paper III).

5.1 Characteristics of women's experiences of safe and unsafe childbirth

The characteristics of women's experiences of safe childbirth were involvement, guidance and being informed by sharing and receiving trustworthy information, which presupposed attentive, empathetic HCPs who fulfilled their needs by respecting them. The women wanted adequate information about the risks, advantages and disadvantages in order to be involved in the decision-making process. Sharing and receiving meaningful, trustworthy information was considered significant for recognizing AEs during childbirth. A caring relationship highlighted the importance of HCPs' presence for making the women feel cared for, monitored and safe.

The characteristics of women's experiences of unsafe childbirth included a lack of meaningful and trustworthy information that could result in feelings of being misled or lulled into a false sense of security. Not being involved evoked feelings of being invisible, ignored and abandoned. Moreover, it resulted in experiences of doubt, disbelief and lack of trust. Lack of preparation triggered strong emotions such as anxiety, fear and panic, resulting in an experience of losing control. Being lulled into a false sense of security evoked a perception of childbirth as unpredictable and uncertain, which influenced the women's experience of feeling and being unsafe, thus leading to the impression of both themselves and their unborn child being exposed to risks.

5.2 Characteristics of healthcare professionals' perceptions of adverse events focusing on communication and teamwork in maternity care

The characteristics of HCPs' perceptions of AEs during childbirth were the need to promote interprofessional teamwork and build capabilities by involving all team members and elucidating relevant strategies. The findings emphasise important strategies for the promotion of safe maternity care by highlighting what supports and hinders communication and teamwork.

The characteristics of HCPs' perceptions of what supports communication and teamwork were related to recognizing the importance of the decision-making process, while trusting relationships between HCPs and childbearing women were considered to facilitate respectful communication, teamwork and a more efficient decision-making process. Promoting open communication and enabling parental involvement was deemed important for all involved in order to safely manage the childbirth. Prerequisites for maintaining and promoting safe care included competence assessment such as knowing what is expected of a professional, one's responsibility and role, as well as being familiar with guidelines and routines for critical situations. Competence was also related to the ability to interpret situations, as well as foreseeing and preventing possible risks by preparing for them.

The characteristics of HCPs' perceptions of what hinders communication and teamwork included stress, disagreement, lack of respect, fear of being questioned, being unable to communicate thoughts, not being listened to, mistrust and inability to agree on common safety strategies. Difficulties interpreting guidelines could complicate communication and teamwork. Time pressure was considered challenging. Finding it difficult to make correct assessments and decisions could lead to doubts and feelings of missing something significant. The working conditions at the labour ward were characterized by a high workload, technical problems with the equipment, schematic engineering problems, organizational difficulties, staff shortages and in some cases lack of priority for supporting

colleagues. When an AE occurred the HCPs were emotionally affected. The notion that the team could have done something to make a difference was considered stressful and doubts could emerge about whether the communication and teamwork had functioned adequately. Anxiety about making mistakes was perceived as influencing the ability and capacity to provide safe care.

5.3 Characteristics of healthcare professionals' reasoning, explanations about and understanding of risk management in maternity care

The characteristics of HCPs' reasoning about risk management included experiences such as inadequate communication, conflicts, hesitation about how to react in a critical situation, different professional perspectives, lack of guidelines and limited access to qualified personnel, all of which influenced the decision-making process. The results support the notion that these risks to safe care influence the decision-making process. The characteristics of HCPs' explanations of risk management included team communication as well as human and financial resources.

In order to avoid critical situations, the team communication component indicates that managers have an important role in creating a safety climate that allows HCPs to share their views. HCPs need to share knowledge and possess the ability to reason together in order to take important and necessary action. When it comes to risk preparedness and critical situations it was necessary for the team members to feel safe in their relationships. Trusting relationships must be created in order to enhance team collaboration, which requires communication, time and continuity.

The human and financial resources component reveals that there should always be access to qualified personnel in order to avoid situations where the team has inadequate resources. In addition, there is a need to obtain a budget that allows organized support and routines for teams when a critical situation occurs. When an AE had occurred teams

needed time to recover, which requires a routine for accessing resources that can support them. Furthermore, a budget should be allocated that allows them to organize support and provides the prerequisites for making decisions about what actions are necessary to avoid additional burden.

Risk management was understood as the consequences of what managers do or fail to do to maintain safe care. These consequences impair the team members' ability to make safe decisions and concentrate on their assignment to ensure that the safety of childbearing women is given priority, in addition to preventing them from experiencing safe working conditions.

6 Interpretation and discussion

This chapter presents an interpretation of the findings from the sub-studies (Chapter 5., Sections 5.1.-5.3, Papers I-III) and the theoretical framework of PS (Chapter 2) including the WHO PS models (Section 2.1.) and findings from the literature review (Section 2.2) with the intention of developing a comprehensive understanding (Section 6.1.). In addition, the methodological considerations outlining the strengths and limitations of this study (Section 6.2.) are presented.

6.1 Towards a comprehensive understanding of patient safety in maternity care

The overall aim was to enable a deeper understanding of safe maternity care as well as to develop, implement and evaluate an intervention to identify women's and HCPs' experiences and perceptions of safe childbirth. The hermeneutic approach was adopted to deepen the understanding of the phenomenon (Chapter 3, Section 3.2.1.).

According to Palmer (1969, p.p. 242-253), understanding emerges through different levels of interpretation. The understanding of PS in the childbirth context was guided by two levels of interpretation. The interpretation at the inductive level (L_1) represents the characteristics of the findings from the three empirical sub-studies (Papers I-III) i.e., the perspectives of women's experiences of safe and unsafe childbirth and HCPs' perceptions of AEs focusing on communication and teamwork, as well as their reasoning, explanations and understanding of risk management in maternity care. The deductive level (L_2) presents the interconnectedness between the dimensions in the empirical data and the PS literature (cf. Palmer, 1969). A pattern of dimensions emerged: Fear of childbirth versus feeling safe, Receptivity versus obligation to inform and Mistrust versus trusting relationships (Table 3.).

Table 3. Overview of the interpretative synthesis of safe maternity care from the perspectives of childbearing women and healthcare professionals guided by Palmer (1969)*

Perspectives	Experiences of childbearing women outlining positive and negative experiences of safety in childbirth	Healthcare professionals' experiences and perceptions of adverse events with focus on communication and teamwork, as well as their explanations, understanding of risk management and reasons for decision-making
Level 1. The empirical level Induction	Safe childbirth through involvement and guidance; sharing and receiving trustworthy information; and feelings of being misled and lulled into a false sense of security including losing control	Promoting interprofessional teamwork and building capabilities; facilitating relationships based on trust and respectful communication; Consequences of what managers do or fail to do constitute the meaning of taking responsibility; Inadequate support, resources and staff shortages and inability to concentration on their work
Level 2. The relationships between dimensions Deduction	Fear of childbirth versus feeling safe ▪ Receptivity versus obligation to inform •• Mistrust versus trusting relationship •••	

*Palmer (1969). *Hermeneutics: Interpretation theory in Schleiermacher, Dilthey, Heidegger, and Gadamer*. Evanston: Northwestern University Press. ▪Beck et al., (2015); Dahlen, & Capice, (2014); Elmir et al., (2012); Greenfield et al., (2016); Hearinghaus et al., (2013); Hood et al., (2010); Larkin et al., (2012); Lyberg et al., (2018); Rice & Warland, (2013); Sheen et al., (2016); Souza et al., (2009). ••Chang et al., (2018); Elmir et al., (2017); Furuta et al., (2014); Vincent & Amalberti, (2015); WHO, (2013). •••Clark et al., (2015); Cornthwaite et al., (2013); Ederer et al., (2019); Perriman et al., (2018).

Fear of childbirth versus feeling safe

The L₁ interpretation disclosed women's experiences of fear of childbirth. They experienced being invisible, ignored and abandoned. In addition, experiences of fear may be caused by emotional and physical harm. These findings are interpreted as fear and panic, resulting in an experience of losing control. In addition, fear and anxiety about making mistakes and causing harm to women were present in the perspectives of HCPs. HCPs perceived a lack of support to enable them to make safe decisions, thus had no trust or confidence and doubted the safety of their actions. This is in line with the findings from the PS literature, where the main reasons for the fear perceived by HCPs were being

unable to protect women from harm (Rice & Warland, 2013) and failing to notice something that causes harm (Dahlen & Caplice, 2014). In addition, research reports that HCPs experienced difficulties speaking up about safety issues due to fear of reprisals (Dahlen & Caplice, 2014; Hood et al., 2010). The dimension fear of childbirth versus feeling safe can be interpreted as a part of PS. Research indicates that unpreparedness evokes experiences of fear in both women (Elmir et al., 2012; Larkin et al., 2012; Souza et al., 2009) and HCPs (Beck et al., 2015; Hood et al., 2010; Sheen et al., 2016).

Lyberg et al. (2019) identified links between PS and fear of childbirth from the perspectives of women in the maternity care context. The authors found that women's preparedness and knowledge of the risks provided them with an opportunity to take responsibility for themselves and strengthened their capabilities. In addition, an insecure environment breeds fear, which emphasises the importance of understanding fear as a subjective experience, which is significant from a PS perspective. The cause of fear should be identified rather than women's personal characteristics (Lyberg et al., 2019). This is in accordance with the WHO (2016a) statement about the need to understand why persons are harmed and the aspects underlying unsafe care. Dahlen and Caplice (2014) found that interventions focusing on fear could support HCPs and make them feel more confident. Women's sense of being abandoned makes it imperative for HCPs to take responsibility for including the causes of fear when working to enhance PS. The interpretation of the interconnectedness between the empirical findings and the PS literature indicates that the feeling of being unsafe exists both among women and HCPs.

The empirical findings revealed that a high level of involvement is not only linked to a more satisfying experience but also a reduced risk of AEs and could result in more valid decisions. Inclusiveness is a significant aspect for ensuring a PS culture (Ederer et al., 2019). It is not only significant for effective team performance, but also for women's experiences (Corntwaite et al., 2013). Hence a PS culture values inclusiveness (Ederer et al., 2019; Sammer Lykens, Singh, Mains & Lackan, 2010; WHO, 2018).

Receptivity versus obligation to inform

The interpretation at L₁ revealed that sharing and receiving meaningful, trustworthy information was deemed significant for recognizing AEs. Promoting open communication and enabling parental involvement was considered important for the safe management of critical situations. In addition, HCPs need to share knowledge and reason together in order to decide on important and necessary action. The evidence demonstrates an interconnection between receptivity and obligation to inform. This dimension underlines the significance of the decision-making process for identifying and managing potential risks to safe care. Receptivity is interpreted as openness created by involvement, attentiveness and shared understanding developed through expertise and communication.

The PS literature indicates that the involvement of women and their family members provides an opportunity to prepare for unexpected and unforeseen events (Elmir et al., 2017), as well as to ensure the safety of interventions to reduce or prevent the consequences of an AE on women and their family members (Furuta et al., 2014). Sharing meaningful information is important as it is difficult for women and their family members to participate in PS initiatives, such as monitoring the care and speaking up about safety concerns (Vincent & Amalberti, 2015). Women and their family members are aware that their safety is at risk as a consequence not being included in the decision-making process (Chang et al., 2018).

The obligation to inform is significant as it enables women and HCPs to prepare for the process of care. Sharing and receiving trustworthy information is particularly important because clinical decisions involve value judgements. HCPs cannot assume and automatically interpret what women value. Hence, to achieve the best possible decisions, safe care requires a balance between women's values and preferences and clinical information. This concerns a value judgement of the underlying logic and reasons for providing specific information. Clinical information and the women's perspectives can only be integrated through an explicit interaction based on trust between the HCP and the woman, in which relevant information is presented, shared and evaluated (cf. WHO,

2013a). Accordingly, an informed woman is prepared and knows what to expect. This will support women to monitor safety and better manage unexpected and unforeseen events (Elmir et al., 2017; WHO, 2013a).

Mistrust versus trusting relationships

The interpretation (L₂) of women's experiences revealed the dimension mistrust versus trusting relationships. In the empirical findings mistrust was expressed by both women and HCPs. Mistrust was related to the competence, skills, behaviours and performances of HCPs, which influenced both interpersonal and interprofessional relationships. The dimension can be understood as not having confidence or feeling unsafe in their relationships. Safe decisions and interventions require that HCPs have trust in each other and are able to demonstrate their expertise. This involves the ability to share, use and expand thoughts and reflections in advance. According to empirical research, situational and team awareness, woman-centredness, trust and empowerment are important (cf. Corntwaite et al., 2013; Perriman, Lee Davis & Ferguson, 2018). In our context, failure to develop trusting relationships caused doubt, fear and the impression of being unsafe, which make it impossible for women to feel that they are in "safe hands" (Clark, Beatty & Reibel, 2015).

Mistrust is a result of not being involved and able to share and receive trustworthy information. With regard to a PS culture, inhibiting components expressed by HCPs were; anxiety, guilt, blame, disregard, spitefulness and shame (Ederer et al., 2019). There are conditions that need to be fulfilled in order to ensure safe care (Allen, Chiarella & Homer, 2010). The WHO (2011b) highlights contributions to a PS culture; working in teams to ensure PS, communicating effectively, managing safety risks, optimizing human and environmental resources and recognizing, responding to and disclosing AEs. However, all of these contributions to safer maternity care require trusting relationships. Therefore, trust is one of the key components of a PS culture (cf. Ederer et al., 2019). This is noteworthy, as it is possible that HCPs might have made other decisions and acted differently if past circumstances had been different. The evidence of this study indicates

a culture of mistrust, resulting in the failure to manage risks and protect women, their family members and HCPs from harm.

6.2 Methodological considerations

The methodological approach in this thesis was guided by Gadamer's (2006) hermeneutics. The interpretation process of the sub-studies on L₁ is described (Chapter 3, Section 3.2.1) and the interpretation on L₂, i.e. the dialectic interpretation of the whole and the parts, is elaborated on (Chapter 6, Section 6.1), resulting in a new understanding of the phenomenon of safe maternity care.

This thesis has strengths and limitations, which must be taken into consideration when discussing research rigor. There is a considerable amount of important quality criteria consistent with hermeneutic inquiry that are useful (Gadamer 2006; Larsson 2005; Ödman 1997). These criteria are: *consistency, the quality of the empirical data used, contextualization and de-contextualization, transformation of meaning, heuristic value and empirical applicability of results.*

Consistency in a system of interpretation that visualizes how different levels of interpretation are linked to each other means that the interpretation of the parts and the whole is logical, coherent and thus more plausible than other interpretations (cf. Ödman 1997). The interpretation is based on the quality of the empirical findings. We used the research questions to guide the data collection, the analysis to explain the content of the findings, while the hermeneutic interpretation, theoretical analysis and explanation enable a deeper understanding.

The use of focus groups as a data collection method in combination with the modified AR guided the implementation process. As this approach is dialogical in nature it enhanced the possibility to identify challenges in complex situations. Focus groups provided a possibility to explore the HCPs' experiences and understanding of safe maternity care as well as the meanings they attribute to it. The advantages of focus groups are dialogues

and dynamic discussions as well as the possibility to evaluate the participants' experiences on a higher level of abstraction (Liamputtong, 2011). The main focus of the discussions was to reflect on how the participating HCPs perceived the team performance during an emergency and whether the care provided was safe or unsafe. The moderator posed the questions on which the participants reflected in turn and gave everyone the opportunity to express themselves early in the process, thus stimulating the dialogue and ensuring that all participants were heard (cf. Liamputtong, 2011). The tolerant atmosphere in which the conversation took place and the gradually deepened reflection between participants stimulated them to share and express their experiences (cf. Tausch & Menold, 2016). The AE case stimulated the dialogue between the participants, leading to an extended discussion and deepened reflection on PS. After each session we evaluated the content of the group discussion, i.e. a superficial naïve analysis, assessed aspects of the group dynamics and focused on the main issues worth following up in the next session. This provided a possibility for the participants to validate the content and further reflect on PS in terms of its significance for safe maternity care. In addition, we used individual interviews. The combination of these two qualitative data collection methods elicited information that would not have emerged by means of a quantitative method.

A limitation is the composition of the sample. The participants were recruited from one hospital ward and due to scheduling issues, the number of HCPs in each focus group discussion varied from four to seven, which might be considered low. Nevertheless, there was variation in terms of the HCPs' work experience, age and professional discipline, while the group was recruited in order to enable the participants to reflect on their collaboration as a team. Tausch & Menold (2016) found that comparatively small focus groups were appropriate for allowing all participants enough time to share their experiences. Groups of between four and six persons have been found to be optimal (Tausch & Menold, 2016). Time to reflect on working conditions also stimulated the interaction between the participants. The participants in the focus groups were based on a purposeful sample, where the HCPs' roles might have influenced their interactions (cf. O'Nyumba et al., 2018). Underlying differences in the participants' perspectives might

be due to their education and profession. For example, they used various theoretical and conceptual terms and had a different focus on practice based on their roles, responsibility and profession.

Another limitation is that the data analysis focused more on the content generated by the group instead of the process of interaction (cf. Liamputtong, 2011). However, an advantage of focus group interactions is that they provide a possibility to understand the participants' shared experiences of practice, language and culture. Furthermore, the interactions provide the researcher with the opportunity to achieve a deeper understanding of the challenges within a group. Hence, the difference between what individuals say and what they do can be understood (cf. Liamputtong, 2011). The second group of participants consisted of new mothers who were recruited at one regional hospital. The inclusion criteria were women who had given birth in the previous 12 months and received care at a labour ward shortly before and after the birth, able to communicate in Swedish and express themselves in words. In qualitative studies, empirical data are co-constructed by the interaction between the researcher and participant (cf. Malterud, 2016).

Contextualization and de-contextualization were used to explain the theoretical construction. In this study, all researchers contributed to the interpretation process. Several structural analyses were applied to different themes as part of the readings and different interpretations were posited to find the meaning. The research team consisted of co-researchers and experts including senior researchers with long experience of conducting research. To maintain reflexivity throughout the interpretation process we constantly discussed whether other logical interpretations of the data could possibly exist (cf. Ödman, 2007). Data derived from focus groups are contextualized (Plummer-D'Amato, 2008), which might influence replication. The transformation of the meaning, explanation of the content of the dimensions and the understanding of the dimensions involved a process comprising a back and forth movement. Finally, we reached consensus in terms of naming the dimensions as well as the umbrella term explaining all parts. We discussed the heuristic value, i.e., the possibility of transferring the meaning to other

contexts. This study has increased the understanding of safe maternity care. The pattern of the dimensions that emerged can be seen as a basic pattern of thought for safe maternity care. This knowledge of the understanding of PS gained by reflecting on HCPs' clinical experiences can be useful in other contexts. The systematic reflection method may enhance work specific learning in complex situations such as AEs.

7 Conclusions

The results of this thesis comprise an understanding and interpretation of safe maternity care in three dialectic dimensions on an individual and interprofessional level that represent both meaningfulness and meaninglessness. In conclusion, the summarized interpretation reads:

A trusting professional relationship means being confirmed, respected and cared for. A prerequisite is the will and ability to create a trusting relationship that strengthens childbearing women's confidence in the birth process by enabling them to participate in decision-making about care interventions. In contrast, mistrust evokes fear, despair and deprivation, resulting in meaninglessness and lack of trust in the relationship. It implies that the will and ability to provide information do not exist, thereby increasing unsafe care.

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Appendix I

Paper I

Rönnerhag, M., Severinsson, E., Haruna, M. & Berggren, I. (2018). Qualitative study of women's experiences of safe childbirth in maternity care. *Nursing & Health Sciences*, 20, 331-337. doi: 10.1111/nhs.12558

RESEARCH ARTICLE

Qualitative study of women's experiences of safe childbirth in maternity care

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Abstract

Few studies have focused on women's childbirth experiences in relation to patient safety. The aim of this study was to explore the meaning of safety as a process phenomenon by outlining women's positive and negative experiences of safety in childbirth. A descriptive explorative design was chosen and 16 interviews were conducted. Qualitative content analysis was used. One main theme emerged: safe childbirth through involvement and guidance, based on four subthemes. The characteristics of women's experiences of safe childbirth included the need to be informed and involved by sharing and receiving trustworthy information. Women's experiences of unsafe childbirth included lack of meaningful and trustworthy information that resulted in feelings of being misled or lulled into a false sense of security. Not being involved evoked feelings of being ignored. In conclusion, this study highlights issues of importance for safe maternity care. The perspectives of childbearing women can contribute to an understanding of how to achieve meaningful improvements to provide safer maternity care.

KEYWORDS

childbirth, maternity care, qualitative content analysis, safe childbirth, women's experience

1 | INTRODUCTION

The World Health Organization (WHO, 2014) defines patient safety (PS) as health-care structures or processes to prevent harm to persons in need of care. Sometimes an unexpected problem, termed an adverse event (AE) or near miss (NM), arises from a health-care encounter. In maternity care, the consequences of an AE or NM can be considerable for both mother and child, and affect the whole family (WHO, 2011). A traumatic birth experience can have a significant impact on the physical and emotional well-being of a woman, her child, and family (Elmir, Schmied, Wilkes, & Jackson, 2010; Greenfield, Jomeen, & Glover, 2016; Priddis, Schmeid, & Dahlen, 2014). Previous studies have described women's experiences of pain, fear, and anxiety, and how these influence their perception of safe or unsafe birth (Boorman, Grant, Gamble, Creedy, & Feenwick, 2014; Haines, Rubensson, Pallant, & Hildingsson, 2012; Van der Gucht & Lewis, 2015). There is also evidence of the link between women's childbirth experiences and their emotional and psychological health, such as

post-traumatic stress (Boorman et al., 2014; Greenfield et al., 2016; Simpson & Catling, 2016). In Elmir et al. (2010) and Greenfield et al.'s (2016) studies, the authors indicated that women are traumatized as a result of the actions or inactions of midwives, nurses, and physicians. Moore, Low, Titler, Dalton, and Sampelle (2014) point to the lack of informed decision-making as a barrier to optimal maternity care. In terms of PS, Sweden has been viewed as one of the safest countries in the world when it comes to childbirth.

Mortality among women (one death/100 000 births) and children (five deaths/1000 births) is low and most women choose to give birth at a hospital (The Swedish National Board of Health and Welfare, [NBHW], 2015). However, PS is often viewed from a health-care provider's perspective (Vincent & Amalberti, 2016) and presented as the absence of AE and NM, rather than an aspect of the childbirth experience that has an impact on women's life. This leads to a limited approach to exploring the experiences of childbearing women, including those who are healthy, and results in a lack of understanding when women feel safe giving birth (Sandall, Devane, Soltan, Hatem, & Gates,

2010). A Swedish National study aimed at investigating maternity care indicates the necessity of better adapting interventions based on women's individual needs, conditions, and to a greater extent, taking women's perspectives and involvement into consideration (NBHW, 2017). This is in line with Severinsson, Haruna, Rönnérhag, and Berggren (2015), who highlight the importance of developing meaningful relationships with women. Aspects associated with women's positive experiences of childbirth are a trusting relationship (Berg, Ólafsdóttir, & Lundgren, 2012; Dahlberg & Aune, 2012); having their personal needs met, including emotional and practical needs (de Masi et al., 2017); and continuous monitoring of mother and child (Sandall et al., 2010; Shakibazadeh et al., 2017). Clark, Beatty, and Reibel (2015) found that women in the late stages of pregnancy and in the postnatal period expressed a need for respect and security in order to feel safe. The relationship with the midwife was important for making women feel that they were "in safe hands". Many women seem to experience both a desire for their autonomy to be respected and a desire to be safe, which appears to reinforce the importance of a trusting relationship. This is in accordance with the WHO guidelines, which state that women's involvement should be promoted to improve the quality and safety of maternity care (WHO, 2013). Safe maternity care for healthy women has received less research attention (Sandall et al., 2010). There are few previous studies of women's experiences of PS in childbirth. Consequently, there is a need to complement existing studies and explore women's experiences of safety in childbirth.

1.1 | Aim

The aim of this study was to explore the meaning of safety as a process phenomenon by outlining women's positive and negative experiences of safety in childbirth.

The research question was: What characterizes women's experiences of safe and unsafe childbirth in the context of PS?

2 | METHODS

2.1 | Design

A descriptive explorative design and qualitative method were chosen to investigate the dimensions, variations, and importance (Polit & Beck, 2012) of women's experiences of safety in childbirth.

2.2 | Participants

The participants consisted of women recruited at one regional hospital in Sweden and invited to participate in the study during a follow-up visit to the maternity clinic. Midwives distributed information letters about the study to the women, and 16 agreed to participate in an individual interview. The inclusion criteria were women who had given birth in the previous 12 months and received care at a labor ward shortly before and after the birth, were able to communicate in Swedish, and express themselves in words. The primary focus of the present study was women's experiences of safety in childbirth, irrespective of the mode of birth. The participants' pseudonyms, total

TABLE 1 Characteristics of the women

Pseudonyms	Total no. births	Child's age at the time of the interview (weeks)	Mode of birth
1 = Alice	3	3	Vaginal birth
2 = Britney	2	4	Caesarean section
3 = Caroline	1	3	Vaginal birth
4 = Denise	1	9	Vaginal birth
5 = Emily	1	3	Vaginal birth
6 = Felicia	2	6	Vaginal birth
7 = Grace	2	17	Vaginal birth
8 = Haley	1	9	Vacuum extraction
9 = Ida	1	4	Vaginal birth
10 = Jennifer	1	2	Vaginal birth
11 = Kay	2	6	Caesarean section
12 = Lindsay	3	4	Vaginal birth
13 = Michelle	2	4	Vaginal birth
14 = Nicole	2	4	Vaginal birth
15 = Olivia	2	12	Vaginal birth
16 = Page	4	13	Vaginal birth

number of births, children's ages, and modes of birth are presented in Table 1.

2.3 | Data collection

Individual interviews were performed by the first author (MR) between January and April 2016. An open interview guide with a focus on the women's experiences of safety in childbirth was used. The initial question was: Can you please tell me about your experiences of being safe or unsafe during childbirth? Examples of follow-up questions were: When did you feel safe or unsafe? What opportunities did you have to influence your care? The interviews, each of which lasted between 30 min and 1 h, were audio-taped and transcribed verbatim.

2.4 | Ethical considerations

The study was approved by an Ethical Review Board in Gothenburg, Sweden (No. 773-15) in accordance with The World Medical Association (2015). In addition, the Norwegian Social Science Data Services reviewed the privacy and licensing requirements of the study and granted permission for the project (no. 53865) in accordance with the Norwegian Data Registers Act. Confidentiality was ensured, and written, informed consent was obtained from all participants, whose names were changed to protect their confidentiality.

2.5 | Data analysis

Qualitative inductive content analysis by Graneheim and Lundman (2004) was performed. In the first step of the analysis process, the interview text was read in its entirety to gain an overview. Second, sentences relevant to the aim were extracted, thus breaking the text down into meaning units. This involves the manifest content, that is,

TABLE 2 Example of the qualitative content analysis of meaning unit, condensed meaning unit, subtheme and main theme (Graneheim & Lundman, 2004)

Meaning unit	Condensed meaning unit	Subtheme	Main theme
"It's a shame...because I am a 'good girl' who can do it myself, I have to manage myself. It's kind of a shame that I get poor care because we were the couple who managed by themselves" (Denise)	It implies a risk of poorer care if the woman is a "good girl" and able to manage by herself	Continuity of a caring relationship versus feelings of being abandoned	Safe childbirth through involvement and guidance

the visible and obvious components in the text, as the meaning units represent the women's experiences. The third step comprised condensing the meaning units while preserving their essence, and the fourth involved thematic analysis of the content. In the present study, these steps concerned interpretation on different levels of abstraction. The main theme represented the final level of abstraction and constituted the meaning of safety in maternity care, as women's positive and negative experiences of safety in childbirth were outlined. An example of the qualitative content analysis is presented in Table 2.

2.6 | Rigor

The four trustworthiness criteria presented by Lincoln and Guba (1985) and Schwandt, Lincoln, and Guba (2007) – credibility, confirmability, dependability, and transferability – were adhered to. Transferability is outlined in Discussion. The research team had regular dialogue about thoughts and beliefs, which provided useful insights and increased awareness. The research team discussed the analysis and emerging themes, which improved credibility and confirmability (cf. Lincoln & Guba, 1985; Schwandt et al., 2007). Dependability was ensured by the authors describing the analysis process. The participants' pseudonyms, total number of births, children's ages, modes of birth, and quotations from participants are presented in order to enhance credibility and transparency (cf. Lincoln & Guba, 1985; Schwandt et al., 2007).

3 | RESULTS

The 16 women aged 23–46 years who participated in this study experienced the care provided by health-care practitioners as essential for being and feeling safe. All participants described safety issues on various levels across a continuum of safe childbirth. Nevertheless, the result reveals that some of the participants were not confident that they or their unborn child was safe. One main theme emerged: safe childbirth through involvement and guidance, based on four subthemes: (i) the need for information versus feelings of being lulled into a false sense of security; (ii) the need to be involved versus feelings of being invisible and ignored; (iii) caring relationships versus feelings of being abandoned; and (iv) a sense of control versus a lack of trust and losing control.

3.1 | Safe childbirth through involvement and guidance

The main theme reflects participants' need to be informed and involved by sharing and receiving trustworthy information, which was

considered significant for a safe birth. Health-care practitioners who were perceived as skilled and guided the childbirth were essential for participant's confidence and a sense of control, as well as for the feeling that both themselves and their unborn child were safe. The participants' experiences of unsafe childbirth included lack of meaningful and trustworthy information that resulted in feelings of being misled or lulled into a false sense of security. Not being involved evoked feelings of being ignored. Absence of trust and confidence in health-care practitioners leading to the participants experiencing childbirth as unpredictable and uncertain, which made it difficult for participants to place themselves in someone else's hands.

3.2 | Need for information versus feelings of being lulled into a false sense of security

In order to feel safe, the participants expected health-care practitioners to provide adequate, clear, relevant information and initiate dialogue. When this need was fulfilled, it helped them to play an active role in the birth. However, when dialogue and information did not materialize, the participants' questions remained unasked. Although they had a clear perception of their bodies, they felt insecure and uncertain about what was required of them and which information about physical signs was important. They reported ongoing internal dialogue, such as: Is this normal? Should I speak up now?

I really wanted to know...In general, I think they give too little information because they are so used to everything. Those simple things...and they do not consider that for every person it is something new. (Kay)

It was vital to experience the information as relevant and trustworthy. Participants wanted adequate information about the risks, advantages, and disadvantages in order to be involved in the decision-making process. Information was sometimes provided too late during the childbirth, which hindered possibilities to prepare themselves and feel safe. Furthermore, participants considered that the information they received was not always consistent with their own preferences and understanding of the situation, and that some aspects were not communicated. The health-care practitioners provided information, yet did not always explain its significance or how it would affect the participants in their present situation or in the future. The women felt that they were lulled into a false sense of security, which made it difficult to understand and judge the situation. Moreover, it resulted in experiences of doubt and disbelief. Participants experienced being misled when their need for trustworthy information was unfulfilled:

It feels as if you are lulled into a false sense of security. I perceived it as a little bit inaccurate. (Denise)

3.3 | Need to be involved versus feelings of being invisible and ignored

Participants expressed a desire to be involved, which included attentive, empathetic health-care practitioners who fulfilled their needs by respecting them. The participants also expressed the importance of being involved for their ability to recognize AE and/or NM during childbirth. They had access to information that could guide the situation and prevent or reduce problems. They wanted to share what was important to them. The women perceived the situation as more comprehensible and manageable when they were involved in the various events and aware of what could occur during childbirth:

The most important thing is how you are treated. That she believed in me, listened to me, and asked me how I felt. That is the most important thing. (Felicia)

I think it is important that you are allowed to feel a part of the birth the entire time, even if you decide to let health-care practitioners make the decisions. (Emily)

A sense of being invisible and ignored arose in situations where health-care practitioners communicated inadequately and no dialogue materialized, resulting in doubts about their own experiences and judgement. They experienced “feeling wrong”, yet waited to mediate their impression. They also felt unsure about when to call for support. There was also concern about disturbing health-care practitioners, resulting in feelings of being a burden. Lack of involvement was related to feeling invisible and ignored, which caused fear and the experience of being unsafe:

I felt objectified, it really feels like that. Even if they come and tell me everything, they don't go into detail. It would have been really nice to feel like a “very special person”. It's small things one needs. They do their job, but if they had done a little more, maybe “stretch out a hand”, it would have been fantastic. (Kay)

3.4 | Caring relationship versus feelings of being abandoned

Participants described the importance of continuity when they needed presence, support, and guidance in order to feel cared for, monitored, and safe:

The midwife who had been with us for several hours actually stayed with me and did not leave us. She never left the room, even when the others did. (Haley)

When a trusting relationship had been established, it was difficult for participants to get to know and inform new health-care practitioners at shift changes and place themselves in someone else's hands. Staff could change when participants were at an advanced stage of childbirth when they felt completely exposed, giving rise to uncertainty about the reporting between shifts and how much the new

team knew about the situation. The absence of a caring relationship and follow up resulted in a sense of abandonment, vulnerability and being unsafe:

Sure, I understand that sometimes they have a lot to do, but they cannot have such...I was so vulnerable and I cannot fight to receive good care. I cannot immunize myself and think it will be fine once I give birth. One doesn't give birth very often in life. I don't think it should be like this, either for those who give birth or for the staff. (Denise)

3.5 | Sense of control versus lack of trust and losing control

The presence of supportive health-care practitioners was important for the experience of control. When the women felt a lack of control, a supportive health-care practitioners who was perceived as professional, communicative, clear, mediating security, and guiding the childbirth was valued. Trust in the health-care practitioners was important for participants to feel safe. The participants were receptive to the expressions and actions of health-care practitioners during childbirth, and their attitudes and behaviors were significant for trust, a sense of control, and safety:

I felt safe and secure. I knew that the midwife had control over me and the situation, and she directed both me and the assistant nurse. (Alice)

I want to trust those taking care of me. If I notice that a person has an eye on me, then I can relax completely and rely on what they say. When I think about it, it's very important to have a person around who can be trusted. (Lindsay)

The degree to which the participants were involved affected their experience of control, as did health-care practitioners who appeared stressed, lacked commitment, and were reluctant to enter into dialogue. Other aspects that influenced the participants' experiences of control were the extent to which health-care practitioners performed observations, physical examinations, and various check-ups of the participant herself and the unborn child. Control was also related to how well the participant was informed about and prepared for different phases, physical examinations, and medical treatment. Lack of preparation triggered strong emotions, such as anxiety, fear, and panic, resulting in an experience of losing control. Participants were afraid that mistakes would occur, as highlighted by one participant:

Then I felt fear and like...how is the baby? Is he still with us? (Olivia).

A lack of trust and confidence in health-care practitioners and their skills could be present, making the participants perceive the outcome of childbirth as unpredictable and uncertain, both for themselves and the unborn child. At a certain stage of labor, the participants felt that they had no choice but to place themselves in

the hands of the health-care practitioners, but lack of trust and control made this difficult. The participants considered it pointless to try to regain control through active participation and felt hopeless, powerless, and vulnerable. Sometimes the participants described the health-care practitioners as unprepared, which was manifested in how they communicated and acted in various situations, leading to the impression of being exposed to risks. These aspects increased the participants' sense of being unsafe. One participant mentioned the experience of lack of control in relation to observations and physical examinations performed by a health-care practitioner:

She had very little knowledge of the technical appliances and stuff (Jennifer).

4 | DISCUSSION

The aim of the present study was to explore the meaning of safety as a process phenomenon by outlining women's positive and negative experiences of safety in childbirth, which was explored by means of qualitative content analysis. The characteristics of women's experiences of safe childbirth included the need to be informed and involved by sharing and receiving trustworthy information, which presupposed attentive, empathetic health-care practitioners who fulfilled their needs by respecting them. Sharing and receiving meaningful, trustworthy information was considered significant for recognizing AE and NM during childbirth. A caring relationship highlights the importance of health-care practitioners making the women feel cared for, monitored, and safe. The findings of our study are in line with those Hollander et al. (2017), who asked women what health-care practitioners could have done to prevent negative childbirth experiences. Only a minority indicated that health-care practitioners could not do anything to prevent the trauma, while the majority stated that better communication and explanation, described as "listen to me" and "support me better" both emotionally and practically were important for preventing a negative childbirth experience. These aspects are related to health-care practitioners' ability to provide safe care and the extent to which women experienced being in control. This is consistent with Jenkins et al. (2015), who argued that care should include continuity of health-care practitioners' relationships with women and provide information appropriate to women's circumstances and needs, as well as with the WHO (2016) framework on patient involvement to strengthen PS. This is also supported by The Norwegian Institute of Public Health (2018), which highlights the importance of including experiences of safety in the definition of PS.

This study reinforces the need to strengthen women's involvement during childbirth, as well as to provide safe maternity care to prevent negative experiences and/or AE and NM. This is important for two reasons. First, the experience of being guided and involved in the childbirth provides a sense of security, control, and well-being that leads to a perception of safe care. Second, including the woman's unique and relevant information in decision-making could result in more valid decisions, and lead to less AE and NM. Sharing and receiving trustworthy information empower women to make choices and

facilitate decision-making. However, it requires health-care practitioners who respond to women's needs, present relevant options, and allow them to express what is most important (Clark et al., 2015; de Masi et al., 2017; Greenfield et al., 2016; Hollander et al., 2017; WHO, 2011). Women's experiences of childbirth are complex and multi-dimensional (Hollander et al., 2017). However, women's involvement in their own care facilitates safe maternity care (de Masi et al., 2017; Greenfield et al., 2016).

The characteristics of women's experiences of unsafe childbirth included a lack of meaningful and trustworthy information that could result in feelings of being misled or lulled into a false sense of security. Not being involved evoked feelings of being invisible and ignored. This is in line with Henriksen, Grimsrud, Schei, and Lukasse (2017), who argued that women were unprepared for complications and inadequate care, and felt that they were not seen or heard during childbirth, which contributed to a negative birth experience (Henriksen et al., 2017). A caring relationship versus feelings of being abandoned indicates that the women's needs were not always fulfilled because health-care practitioners were unable to be available, present, and provide continuous follow ups. This is of importance for two reasons. First, presence is essential for establishing a caring relationship; and second, a caring relationship provides an opportunity to address women's needs and give them a feeling of being in control and in safe hands. This is in accordance with Martijn et al. (2013), who concluded that system-based problems related to staffing levels constitute a threat to PS in the maternity care context. Thus, given the importance of physically attending the childbirth for women giving birth, measures to assure the timely presence of health-care practitioners should result in better monitoring of childbirth and less negative experiences. Furthermore, limited time means less opportunity to establish a caring relationship, and health-care practitioners might avoid initiating dialogue with women when under time pressure (Angel & Norup Frederiksen, 2015).

Being lulled into a false sense of security evoked a perception of childbirth as being unpredictable and uncertain, which influenced the women's experience of feeling and being unsafe, thus leading to the experience of both themselves and their unborn child being exposed to risks. These aspects are likely to influence women's capabilities and might have an impact on the childbirth outcome. In addition, they indicated a link between experienced capabilities and the extent to which the woman is involved in and supported during childbirth. This is of paramount importance, as the results demonstrate that a high level of involvement is not only linked to a more satisfying birth experience but also to less risk of AE and NM. Therefore, it is essential that all health-care practitioners recognize and prioritize women's involvement in their care (Angel & Norup Frederiksen, 2015; Elmir et al., 2010; Greenfield et al., 2016; Sandall et al., 2010). Hollander et al. (2017) indicated that failure to establish a caring relationship could contribute to traumatic childbirth experiences, leading to an increased risk of AE and NM. Furthermore, Entwistle and Watt (2013) suggested that a relational approach can involve recognizing and cultivating a woman's personal capabilities. The impact of health-care interactions on personal capabilities could explain why a relational approach has an intrinsic value and contribute to a more holistic perspective on safe maternity care (Sandall et al., 2010). Health-care

practitioners who were perceived as professional and skilled, and guided the childbirth, were significant for women's trust in health-care practitioners, their sense of being in control, as well as for feeling and being safe, which applied to both themselves and their unborn child. Trust can therefore be interpreted as a part of the phenomenon of PS. Thus, caring relationships should include respect, dignity (Shakibazadeh et al., 2017), trust, and empowerment (Perriman & Lee Davis, 2018), which make a substantial contribution to safe maternity care (Sandall et al., 2010).

4.1 | Strengths and limitations

The strength of the present study was that the participants reflected variations in experiences. The characteristics of the women diverged in terms of age, number of births, and mode of birth. These aspects contributed to a variation in the perspectives on the research question, which generated rich data on women's experiences of safe childbirth. The study was conducted in a specific context and limited geographic area, that is, maternity care at one regional hospital in Sweden. This could influence transferability, which is important in order to provide a description of the research process to enable other researchers to determine transferability (Lincoln & Guba, 1985; Schwandt et al., 2007). Further research within the field of PS, as well as on health-care practitioners' perspectives, is needed in order to provide a more comprehensive view of safe maternity care.

4.2 | Conclusions

This study provides an understanding of significant aspects of childbirth from the perspective of women, and highlights issues of importance for safe maternity care. The perspectives of childbearing women can contribute to deepening the understanding of how to achieve meaningful improvements for safer maternity care.

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AUTHOR CONTRIBUTIONS

Study design: M.R., E.S., and I.B.

Data collection: M.R.

Data analysis: M.R., E.S., M.H., and I.B.

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Appendix II

Paper II

Rönnerhag, M., Severinsson, E., Haruna, M. & Berggren, I. (2019). A qualitative evaluation of healthcare professionals' perceptions of adverse events focusing on communication and teamwork in maternity care. *Journal of Advanced Nursing*, 75, 585-593. doi: 10.1111/jan.13864

**ORIGINAL RESEARCH:
EMPIRICAL RESEARCH – QUALITATIVE**

A qualitative evaluation of healthcare professionals' perceptions of adverse events focusing on communication and teamwork in maternity care

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Abstract

Aim: The aim of this study was to explore healthcare professionals' (HCPs) perceptions of adverse events (AE) during childbirth with focus on communication and teamwork.

Background: Inadequate communication, a poor teamwork climate and insufficient team training are harmful to women. Reviews of reported AE can be used to develop a safety culture based on preparedness for preventing AE and strengthening patient safety (PS).

Design: Action research principles were used to facilitate the implementation and evaluation of this study.

Methods: An interprofessional team of HCPs comprising obstetricians, registered midwives and assistant nurses employed at a labour ward agreed to take part. Data were collected from multistage focus group interviews (March 2016–June 2016) and analysed by means of interpretative thematic analysis.

Findings: Two analytical themes based on five sub-themes emerged; promoting interprofessional teamwork and building capabilities by involving HCPs and elucidating relevant strategies. The findings reveal the importance of facilitating relationships based on trust and respectful communication to ensure a safe environment and provide safe maternity care.

Conclusion: There is a need for formal and informal support for quality interprofessional teamwork. Research on PS may reduce AE related to miscommunication and poor teamwork. We recommend different forms of communication and teamwork training in interprofessional teams to increase the ability to provide feedback. Accumulated research is required for the evaluation of evidence-based models in the PS context.

KEYWORDS

action research principles, adverse events, communication, focus group interviews, maternity care, midwives, patient safety, teamwork, thematic analysis

1 | INTRODUCTION

The ultimate purpose of patient safety (PS) in maternity care is to improve practice and reduce preventable adverse events (AE)

through the use of best evidence-based interventions. Although progress has been made in reducing the number of AE, women are still harmed during childbirth (The World Health Organization [WHO], 2011). A negative birth experience³ is not only difficult for the

woman (Elmir, Schmied, Wilkes, & Jackson, 2010; Lundgren, Karlsdóttir, & Bondas, 2009), but for all concerned including family members as well as healthcare professionals (HCPs) (Collins, 2008). An AE can be defined as an unexpected procedure or system-related problem that occurs during a healthcare encounter (White Hemingway, O'Malley, & Silvestri, 2015) leading to unnecessary harm to a person in need of care (Runciman et al., 2009).

1.1 | Background

Previous research has shown that AE are caused by failure to monitor, observe, and correctly assess risks (Vincent, Burnett, & Carthey, 2014), note defective equipment and carry out pre-operative checks, as well as deviation from agreed guidelines or use of incorrect guidelines (Miller et al., 2016; Vincent et al., 2014). Other causes of unsafe care are delayed or incorrect communication of information about diagnosis or treatment (Hannaford et al., 2013). Failures in communication and teamwork account for 72% of AE in maternity care (Pronovost, Holzmueller, Ennen, & Fox, 2011). These failures are usually a result of disruption in the flow of information between HCPs, leading to errors of judgement in the decision-making process, highlighting the fact that communication, and teamwork are critical components of PS (Cornthwaite, Edwards, & Siassakos, 2013; Pronovost et al., 2011). In addition, miscommunication may be caused by adversarial relationships (Brock et al., 2013; Hunter, Berg, Lundgren, Ólafsdóttir, & Kirkham, 2008) and unclear roles within teams (Brock et al., 2013). Teamwork refers to the skills learned, modified, and reinforced when HCPs work collaboratively to provide competent and safe care (Brock et al., 2013). Inadequate communication, a poor teamwork climate and insufficient team training are harmful to women (Collins, 2008; Cornthwaite et al., 2013). An important component of developing a positive safety culture is the ability to recognize, respond to, receive feedback about, and learn from AE (Allen, Chiarella, & Homer, 2010; Bishop & Boyle, 2016; Lyndon et al., 2015). Reviews of AE constitute an opportunity to learn from incidents and provide a framework for reflection and learning (Bishop & Boyle, 2016; Brock et al., 2013; WHO, 2009a,b; WHO, 2011). Furthermore, they may provide an understanding of the reasons and underlying aspects that contribute to AE (Edwards, 2008; WHO, 2009a). Such reviews can lead to change by contributing to the development of practice and new guidelines (Lyndon et al., 2015; Miller et al., 2016). An analysis of AE can be used to develop a safety culture based on early identification of complications and preparedness for dealing with them. By evaluating AE much can be learnt about the specific context, thus strengthening PS (WHO, 2009a, 2011). The WHO (2009a, pp. 11–12) has endorsed a PS competencies framework for the purpose of indicating evidence-based PS topics that can be implemented in healthcare. Two of them are of specific importance for the present study; *being an effective team player*, which highlights interprofessional communication and teamwork and *understanding and learning from errors*, which presents an opportunity to understand and learn why AE occur.

Why is this research needed?

- Research on patient safety indicates that the majority of adverse events in maternity care are due to poor communication and teamwork.
- It is important to focus on a negative birth experience as it is difficult for the woman, family members, and healthcare professionals involved.
- Evidence-based recommendations on communication and teamwork in the patient safety context are scarce.

What are the key findings?

- This study highlights the significance of promoting interprofessional teamwork and building capabilities by involving healthcare professionals and elucidating relevant strategies for safe maternity care.
- To ensure safe maternity care interprofessional teams need to acknowledge and increase awareness of the essential aspects that constitute trusting relationships and a safe environment.

How should the findings be used to influence policy/practice/research/education?

- The findings indicate a need to develop new guidelines and routines as part of the organizational culture to ensure patient safety.
- The findings can enable healthcare managers to understand how communication and teamwork can be developed to ensure safe care.
- The findings highlight the need for more research to increase knowledge of evidence-based models to determine which are the most effective for improving patient safety.

2 | THE STUDY

2.1 | Aim

The aim of this study was to explore HCPs' perceptions of AE during childbirth with focus on communication and teamwork. The research questions were: (a) What supports or hinders communication and teamwork? and (b) How do communication and teamwork promote safe maternity care?

2.2 | Design

Six action research (AR) principles were used to facilitate the implementation and evaluation of the study (Winter, 2005; cf. Casey, O'Leary, & Coghlan, 2017). The study was developed together with the participants, the Manager of the Department and Director of the Hospital. The HCPs critically reflected (principle no. 1) as a team on

AE that had occurred during childbirth to gain a deeper understanding of aspects that could contribute to safe maternity care. The dialectic critique (principle no. 2) adds to the process of understanding by providing a narrative understanding of participants' perceptions in a specific context, i.e., safe maternity care (cf. Øvretveit, 2014). AR comprises a reflective, collaborative process (principle no. 3) between the researcher and the participants (Casey et al., 2017; Winter, 2005), which seeks to develop an understanding of professional practice (Winter, 2005). The AR process can be perceived as a threat to all the taken-for-granted processes that the participants use to function in and cope with difficult circumstances. It may challenge the participants' perceptions and lead to both contradictions and opportunities for change, which involves risks (principle no. 4). The dialectical, reflexive, questioning, and collaborative form of inquiry creates a plural structure (principle no. 5). The AR process involves integration of theory and practice, thus comprising elements of a change process to transform research evidence into practice (principle no. 6) (Winter, 2005; cf. Casey et al., 2017).

2.3 | Participants

An interprofessional team of HCPs from one regional hospital in Sweden was invited to participate in the study and 22 HCPs comprising obstetricians, registered midwives, and assistant nurses employed at the labour ward agreed to take part. The number of participants at each session varied between four and seven, which is in line with the recommended number of 4–12 participants per focus group (Hummelvoll, 2008). The inclusion criteria were having at least 1 year of experience in their profession and their written consent to participate. All the participants were Swedish-speaking, aged between 40–61 years and the majority were female.

2.4 | The context

The HCPs at the labour ward in the regional hospital assist at approximately 3,580 childbirths per year. The average length of postpartum stay at the labour ward is normally 4 hr. The midwife is responsible for the normal childbirth process and often acts independently. An assistant nurse is sometimes present to support and assist when needed. It is only when the childbirth deviates from the norm that an obstetrician becomes involved. If necessary, teams from other contexts such as anaesthesia and paediatrics are available. Incident reports are required by the Inspectorate for Health Care (IVO) in Sweden to follow-up, reduce, and prevent AE in the healthcare organization. It is the responsibility of each department manager to report AE. This obligation is set out in the Patient Safety Act (SFS, 2010:659). The healthcare organization investigates the causes of the event to take action to prevent similar incidents occurring in the future and to maintain and/or improve PS. The IVO reviews the entire process and returns with a final report.

2.5 | Data collection

The interprofessional team of HCPs attended four focus group sessions, i.e., multistage focus groups (cf. Hummelvoll, 2008;

Liamputtong, 2011). The number of sessions was determined by the need to obtain a trustworthy answer to the research questions. It has been suggested that an appropriate number of focus group sessions is three to five (Liamputtong, 2011). Multistage focus group interviews are suitable because they harmonize well with the reflective process. The purpose of the dialogue and discussions was to allow the group to critically reflect on the AE that had occurred during childbirth and learn through self-evaluation. Two events were presented at each session and the participants were given the opportunity to choose the one they wished to discuss further. The main focus of the discussions was to reflect on how the HCPs perceived communication and teamwork during an emergency and safe and/or unsafe care when an AE occurred. The content of the focus group discussion was evaluated after each session to identify important issues and findings worth following up in the next session. After the first session the subsequent sessions began with feedback from the previous one. The group members were given the opportunity to reflect and comment on the previous content. The focus group interviews took place in a room at the labour ward where the participants would not be interrupted. The interviews were performed by the moderator (IB) and co-moderator (MR). The moderator and co-moderator posed questions for the HCPs to reflect on in turn, giving everyone the opportunity to express themselves early in the process, thus stimulating the dialogue and ensuring that all participants were heard (cf. Liamputtong, 2011). Each session lasted for one and a half hours and the interviews were audio-taped and transcribed verbatim.

2.6 | Ethical considerations

The study was approved by an Ethical Review Board in Sweden (No: 773-15) in accordance with the World Medical Association Declaration of Helsinki (WMA, 2015). In addition, the Norwegian Social Science Data Services reviewed the privacy and licensing requirements of the study and granted permission for the project (No: 53865) in accordance with the Norwegian Data Registers Act. All HCPs employed at the labour ward had an opportunity to obtain information about the study at a staff meeting and were informed both verbally and in writing by the first author MR. There were no compensation for participation, which was voluntary and the participants could withdraw at any time without giving a reason in accordance with the The World Medical Association (WMA) (2015). Those who agreed to participate gave MR their informed consent and confidentiality was ensured.

2.7 | Data analysis

An interpretative thematic analysis (Braun & Clarke, 2006) was performed. While the first author was responsible for the analysis, all authors contributed to the interpretation of the findings. Thematic analysis was chosen as it provides a rich, detailed, and complex amount of data through a systematic procedure (Braun & Clarke, 2006). The interpretative and latent thematic analysis involves an inductive approach and emphasises participants' perceptions of AE. The

development of the themes themselves involves interpretation, not just description (cf. Braun & Clarke, 2006). The text was analysed from an individual perspective to describe the variations in the participants' perspectives within the sub-themes to determine the mutual perspectives of the group (Liamputtong, 2011). This approach considers group dynamics and the interaction between the participants as a means of determining how the themes are mutually formed (Liamputtong, 2011). Saturation occurs when additional information no longer generates new understanding (Liamputtong, 2011) or when further inquiries are unlikely to make the theme more precise (Hummelvoll, 2008).

2.8 | Rigour

The three domain criteria are described in Tong, Sainsbury, and Craig (2007); consolidated criteria for reporting qualitative research (Data S1) guided the identification of the strengths and limitations of this study. To enhance the trustworthiness of multistage focus group data, the four criteria, presented by Lincoln and Guba (1985): credibility; confirmability; dependability; and transferability, were adhered to. The sessions began with feedback, allowing the participants to critically reflect on the content. The feedback was intended to stimulate group dynamics and formed the basis for consensus (cf. Hummelvoll, 2008), thus improving credibility and confirmability. In terms of credibility and confirmability, the constant critical examination of and reflection on the data analysis process by the co-authors was a strength. Being reflexive throughout the research process is of importance. We have strived to share experiences of reflexivity through continuous dialogue associated with the chosen topic to be aware of how our pre-understanding might have influenced different stages of the research process. Personal and professional experiences as well as knowledge may also have influenced the research process. However, we consider it an advantage that the researchers contributed their experiences and unique perspectives to the study, as it provided useful insights, increased awareness, and improved credibility and

confirmability (cf. Lincoln & Guba, 1985). Dependability was ensured by the description of the design, methods, and analysis (cf. Lincoln & Guba, 1985). To enhance the transparency of the findings, the participants' characteristics and context were provided as well as quotations from the participants (cf. Lincoln & Guba, 1985).

3 | FINDINGS

An interprofessional team of HCPs consisting of obstetricians, registered midwives, and assistant nurses agreed to participate in the study. Their experience of maternity care ranged between 6-32 years. Table 1 presents the data extracts, codes, sub-themes, and themes that contributed to the findings. Each sub-theme is illustrated by a quotation from the HCPs. Two analytical themes based on five descriptive sub-themes emerged; *promoting interprofessional teamwork* and *building capabilities by involving healthcare professionals and elucidating relevant strategies*. The findings emphasize important strategies for the promotion of safe maternity care by highlighting barriers to and facilitators of communication and teamwork.

3.1 | Promoting interprofessional teamwork

This theme focuses on the importance of relationships based on trust and respectful communication for achieving valid decisions that ensure safe maternity care. The theme is based on the following sub-themes: *Recognizing the importance of the decision-making process*; and *promoting open communication and enabling parental involvement*.

3.1.1 | Recognizing the importance of the decision-making process

This sub-theme highlights the importance of trust between professionals. Trust was considered to facilitate respectful communication,

TABLE 1 The thematic structure of data extracts, codes, sub-themes, and themes obtained by data analysis

Data extracts	Codes	Sub-themes	Themes
"How much time do we have? How long will it take to perform the various actions? A test has been conducted and we have to consider the results. In what condition is the child? That is the basis for our actions (P5)"	Assessment and decision	Recognizing the importance of the decision-making process	Promoting interprofessional teamwork
"How I communicate information to the parents is important (P6)"	Parental involvement and information	Promoting open communication and enabling parental involvement	
"We always have something that does not function, but I try to change the procedure and solve the problem. It is clear that it is stressful (P4)"	Working conditions, guidelines, and procedures	Prerequisites for maintaining safe care	Building capabilities by involving healthcare professionals and elucidating relevant strategies
"I am thinking of the patient's safety, sometimes you just feel that something is wrong... (P1)"	Competence and skills	Promoting safe care by competence assessment	
"I think we cannot escape from being emotionally affected (P2)"	Feelings and emotional burden	Alleviating the emotional burden to increase the capacity to provide safe care	

teamwork and a more efficient decision-making process. Barriers to communication and teamwork included stress, disagreement, lack of respect, fear of being questioned, being unable to communicate thoughts, not being listened to, mistrust, and inability to agree on common safety strategies. Hence, the interaction between HCPs was considered to influence the decision-making process, where a wrong or delayed decision could lead to the risk of an AE. Making correct assessments and decisions under time pressure was considered challenging. Difficulties making correct assessments and decisions could lead to doubts and feelings of missing something significant. Experiences of doubt included the sense of being unable to make the best decision to ensure safe care for mother and child. One participant expressed, “We are afraid of performing unnecessary interventions and exposing the patient to unnecessary risks. We are also afraid that we may have missed or overstated something in our assessment (P2).”

3.1.2 | Promoting open communication and enabling parental involvement

This sub-theme focuses on communication that could be limited in situations where the woman exhibited insecurity and fear, which were considered unfavourable for the childbirth process. The inability to adequately meet the need for communication and participation hindered the sharing of information. A situation was considered more manageable for all involved when a woman felt safe and communication and teamwork were satisfactory. It was important to have open communication and enable parental involvement to mediate the progress of labour. The participants described striving to involve the woman and her partner by communicating information about choices to facilitate decision-making where possible. Furthermore, it was essential to communicate why HCPs acted as they did and explain that the actions were performed to ensure the safety of the woman and child. It was not always possible to promote the participation of the woman and her partner. The participants expressed that sometimes in an emergency situation there were no alternatives, hence the woman and her partner could not or were not invited to be involved in decisions. This could make the HCPs feel vulnerable and powerless, resulting in a sense of being unable to communicate and meet the need for parental involvement. One participant expressed; “I feel much safer with a woman who collaborates with me than a woman with whom it is almost impossible to communicate ...because I am the one who is responsible for assessing the childbirth and that the outcome is a healthy child (P6).”

3.2 | Building capabilities by involving healthcare professionals and elucidating relevant strategies

This theme concerns pre-requisites for facilitating a safe environment to provide safe maternity care and highlights the fact that respectful communication and teamwork are important aspects of safety. The theme is based on the following three sub-themes: *Pre-*

requisites for maintaining and promoting safe care; promoting safe care by competence assessment; and alleviating the emotional burden to increase the capacity to provide safe care.

3.2.1 | Pre-requisites for maintaining and promoting safe care

This sub-theme concerns familiarity with guidelines, routines, technical equipment, and interpretation of data, which was considered to reduce risks and increase the possibilities to facilitate team communication about safety strategies. Guidelines were important for common approaches, as well as for clarifying responsibility and role assignment. Adherence to and interpretation of guidelines and procedures could sometimes differ between HCPs, which influenced the communication and teamwork. The working conditions at the labour ward were characterized by a high workload, technical problems with the equipment, schematic engineering problems, organizational difficulties, and staff shortages. The working conditions could result in communication that was not always sufficiently clear or sometimes even absent, thus misunderstandings that affected teamwork could arise. Support from colleagues was vital for coping with the working conditions, although in some cases support for colleagues was not prioritized. The participants perceived insufficiency from a PS perspective and wished for a greater margin of safety. One participant expressed; “I think you need good routines. If a woman arrives on a day when the workload is high, there should be guidelines, frameworks and routines to guarantee that the care is as safe as possible regardless of the circumstances. But, of course, things happen when there’s a high workload because of the human factor, they just do (P5).”

3.2.2 | Promoting safe care by competence assessment

Competence included knowing what is expected of a professional, one’s responsibility and role, as well as being familiar with guidelines and routines for critical situations. Competence was also related to the ability to interpret situations, as well as foreseeing and preventing possible risks by preparing for them. Lack of skills related to the technical equipment and difficulties interpreting data could complicate communication and teamwork. One participant expressed; “It’s important to feel comfortable with the device and feel safe with the CTG interpretation (CTG=cardiotocography) to communicate satisfactorily with everyone involved (P5).” Being aware of one’s own limitations and ability to communicate one’s needs were important for avoiding unsafe situations. Teamwork was perceived to increase in emergencies to find strategies for resolving the issue as soon as possible, but at the same time a tendency to delay assessments could occur, posing a risk to mother and child. The participants wished for opportunities to reflect, share experiences, and safety strategies in smaller groups. Obstetrics training and reflection were perceived to support the use of policies and guidelines by transforming them into practice. In addition, they were considered to facilitate

respectful communication, responsibility, role assignment, and teamwork. One participant expressed; "In the corridor you often hear that there is a posterior position in there and everyone prepares themselves in some way and supports those in the room by preparing the necessary equipment and trying to be one step ahead (P4)."

3.2.3 | Alleviating the emotional burden to increase the capacity to provide safe care

This sub-theme concerns the perception of emotional burden. When an AE occurred the members of the team and even HCPs who were not directly involved were emotionally affected. The latter felt for those who had participated in the situation. The notion that the team could have done something to make a difference was considered stressful and doubts could emerge about whether the communication and teamwork had functioned adequately. Some were emotionally affected for a long time after such an event and it was sometimes perceived as difficult to communicate their feelings and thoughts. Based on the participants' perceptions, it was clear that concerns and insecurity about the risk of being personally involved in such an event can arise. Anxiety about making mistakes was perceived as influencing the ability and capacity to provide quality care. One participant expressed; "And I remember sitting there listening to the report and thinking that I was lucky because it could just as well have been me. In our specialty things sometimes happen that you don't want, there could be a period with no events and then an event occurs ... I remember thinking I'm glad it was not me working tonight and that it was hard for those involved (P1)."

4 | DISCUSSION

The themes identified in this study provide some insight into the HCPs' perceptions of communication and teamwork in the context of safe maternity care. Most of the perceptions were positive and aimed at promoting interprofessional teamwork such as finding strategies for recognizing the importance of the decision-making process and, promoting open communication and enabling parental involvement. This emphasizes the importance of trusting relationships for facilitating safe care and reducing the risk of exposing the woman in childbirth to unnecessary harm. The HCPs perceived that a particularly important theme was ensuring safe care by building capabilities by involving HCPs and elucidating relevant strategies to achieve the pre-requisites for maintaining safe care, promoting safe care by competence assessment, and alleviating the emotional burden.

4.1 | What supports or hinders communication and teamwork?

The HCPs in this study expressed the need for both formal and informal support for quality interprofessional teamwork. Our findings also reveal that HCPs possess significant experience, understanding,

and knowledge of safety strategies to improve the environmental conditions for staff and childbearing women. The findings indicate that promoting interprofessional teamwork is of significance for facilitating and recognizing the importance of the decision-making process. Relationships based on trust and respectful communication between professionals within the team made decision-making more efficient and accurate. The environmental conditions influenced HCPs' ability to interact within the team, thus affecting communication and teamwork. The importance of a safe environment where HCPs have the possibility to share their understanding in an open way is a significant component of teamwork (cf. Lyndon et al., 2015). Being an effective team player emphasizes that effective communication is a dynamic process aimed at enabling positive interpersonal relationships to ensure safe care and prevent AE (WHO, 2009a). However, a pre-requisite for trust is that HCPs possess sufficient knowledge and skills to be perceived as competent by others (The Norwegian Board of Health Supervision, 2017; WHO, 2009a). This is in line with the statement by the WHO (2009b) that high performing interprofessional teams demonstrate the knowledge, skills, behaviours, and attitudes that constitute effective and safe collaborative practice. These teams define shared goals, role assignments, responsibilities, and interdependent decision-making. The findings point to the social and behavioural dimension of competence, essential aspects of which are the ability to meet others with respect, listen to and take account of their views and values. Carter Cook et al. (2010) state that all HCPs in the maternity care system should have a safe and respectful environment to practice, grow, and learn. Such a system values HCPs' contribution, supports high performance standards, and respects the providers' human needs and limits. A fair and equitable culture grounded in a system perspective with appropriate assignment of accountability rather than individual blame protects HCPs from harm. Furthermore, it encourages continuous learning and professional development that increase the ability to provide safe maternity care (Carter Cook et al., 2010). The findings from our analysis include barriers to communication and teamwork, namely stress, disagreement, lack of respect, fear of being questioned, not being listened to, and the inability to agree on common safety strategies, which indicate that the HCPs struggle in their efforts to establish respectful and effective teamwork. This is in accordance with Daemers, van Limbeek, Wijnen, Nieuwenhuijze, and de Vries (2017), who found that despite the fact that midwives and obstetricians shared the same goal of providing the best care for mother and child, their collaborative efforts to achieve it were challenged by their different views of care. The findings revealed that feelings of being unable to make the best decision to ensure safe care for mother and child could occur. HCPs in this study were afraid of performing unnecessary interventions and exposing the woman and child to needless risks. A fear of missing or overstating something in their assessment was also present. Miller et al. (2016) highlight two situations on the maternity care continuum; firstly, too little, too late describes care with inadequate resources, below evidence-based standards, or care withheld or unavailable until it was too late to help. Secondly, too much, too soon describes care and

routines that lead to an over-medicalizing of normal pregnancy and birth. This situation includes the unnecessary use of non-evidence-based interventions, as well as the use of interventions that can be lifesaving when employed appropriately, yet harmful when applied routinely or overused (Miller et al., 2016). This reinforces the need to promoting open communication and enabling parental involvement. Satisfactory interaction between HCPs and parents through the sharing of information enhances trust. Parental involvement is important for meeting the woman's needs, being able to provide adequate support, and making more valid decisions. Thus, persons in need of care are essential for the teamwork and should be invited and assisted to participate in decision-making regarding their own care (WHO, 2009a). This is in accordance with Carter Cook et al. (2010), who emphasized that the ideal maternity care system protects, promotes, and supports childbirth and optimal experiences for childbearing women based on shared decision-making and respect for informed choice that takes account of the women's needs, preferences, and values. Evidence-based maternity care should be humane, dignified, and delivered with respect for women's fundamental rights (Miller et al., 2016). As HCPs have a strong influence on childbearing women, they should be aware of the power of communication for creating a climate of trust and enhancing healthcare outcomes as well as women's childbirth experiences (Scholefield, 2007). Research reveals increasing evidence of the relationship between patients' experience of healthcare and safety (Severinsson et al., 2017; Yu, Flott, Chainani, & Fontana, 2016).

4.2 | How do communication and teamwork promote safe maternity care?

Healthcare professionals' perceptions of building capabilities by involving HCPs and elucidating relevant strategies have implications for a safe environment as well as for safe care. The pre-requisites for maintaining and promoting safe maternity care were related to working conditions. The HCPs suggested quality strategies including training for different scenarios, more time for communication and reflection, interpretation of guidelines and routines, in addition to clarification of responsibility, role assignment, and teamwork. This also relates to promoting safe care by competence assessment, which includes the ability to interpret situations, in addition to foreseeing and preventing possible risks by preparing for them. Obstetrics training and reflection support the use of policies and guidelines by transforming them into practice that ensures safe care. Thus, these quality strategies are likely to promote safe relationships that facilitate communication, teamwork, and consensus on common safety strategies. However, teamwork is affected by the safety culture (Bishop & Boyle, 2016), which represents a team's shared perceptions of policies, practices, and procedures (WHO, 2009b). To ensure quality care HCPs' various competences should be brought together in an inter-professional team (ten Hoope-Bender et al., 2014). However, true teamwork needs to develop over time to facilitate effective and positive relationships (cf. Brock et al., 2013). HCPs could lack understanding about what aspects are important and how communication

affects team performance during an emergency (Lyndon et al., 2015) as discrepancies exist between HCPs' knowledge, behaviours, and skills (ten Hoope-Bender et al., 2014). Understanding and learning from errors (WHO, 2009a) constitute an opportunity to comprehend the difficulties and why AE occur (Edwards, 2008; WHO, 2009a). Alleviating the emotional burden is of importance because it influences HCPs' ability and capacity to provide safe maternity care. Therefore, interprofessional teams need support by means of a forum where the HCPs can discuss experiences and objectively reflect on AE. In addition, Scholefield (2007) states that support is vital when HCPs are involved in AE, as some find it difficult to continue working, which may have an adverse influence on their personal lives and health (Scholefield, 2007). However, it is necessary to bridge the gap between competence; "what a person can or is able to do" and performance; "what a person actually does" in a real situation (ten Hoope-Bender et al., 2014). There are barriers that must be overcome and it is not certain that PS interventions will immediately lead to improvements that prevent AE and enhance PS. In addition, social and contextual aspects may facilitate or hinder the implementation of interventions. Wu et al. (2017) highlight some of the barriers to using local guidelines to promote a safety culture, which included fear of blame and judgment, lack of confidence, and inability to lead sessions. Furthermore, lack of support for HCPs and the feeling that it is not safe to be open due to disciplinary reprisals were common (Wu et al., 2017). Therefore, it is crucial that healthcare managers understand how communication and teamwork can be developed to ensure safe maternity care. This reinforces the need for a change of guidelines and routines in the organizational culture to ensure PS.

4.3 | Limitations

Some methodological limitations need to be considered. The sample was recruited from one labour ward. How a group interacts in a specific context may differ from how another group will interact elsewhere (cf. Øvretveit, 2014). Data derived from focus groups are firmly contextualized. *Conformity* refers to the dynamic process whereby participants modify their comments to conform to the majority opinion. Thus, the apparent consensus may merely be the result of group dynamics and not genuine (Plummer-D'Amato, 2008). A disadvantage of multistage focus group interviews is that they may constitute a pressure to achieve consensus, which means that the group members express a common understanding and attitudes despite the existence of divergent opinions (cf. Hummelvoll, 2008). On the other hand, another limitation is the possible power differential between obstetricians, midwives, and assistant nurses that could affect the data. The interpretation of the interaction process, content, and themes needs to be discussed. The findings cannot be transferred to other contexts without forming a judgement of the description provided in the study. However, the co-authors constantly checked and discussed the themes and contextual descriptions to judge their *transferability* to other contexts, i.e., external validity (cf. Lincoln & Guba, 1985).

5 | CONCLUSION

This study involved an evaluation of HCPs' perceptions of safe maternity care by providing a narrative understanding. The findings reveal the need for formal and informal support for quality interprofessional teamwork to maintain and promote safe care. Research on PS may reduce AE related to miscommunication and poor teamwork. To increase the ability to provide feedback we recommend different forms of communication, teamwork training, and reflection in interprofessional teams. Accumulated research is required for the evaluation of evidence-based models in the PS context. However, this necessitates close collaboration between researchers, patients, healthcare managers, and HCPs.

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CONFLICT OF INTEREST

No conflict of interest has been declared by the authors.

AUTHOR CONTRIBUTIONS

All authors have agreed on the final version and meet at least one of the following criteria (recommended by the ICMJE [<http://www.icmje.org/recommendations/>]):

- substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data;
- drafting the article or revising it critically for important intellectual content.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section at the end of the article.

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Appendix III

Paper III

Rönnerhag, M., Severinsson, E., Haruna, M. & Berggren, I. (2019). Risk Management – evaluation of healthcare professionals’ reasoning about and understanding of maternity care. *Journal of Nursing Management*, 1-10. doi: 10.1111/jonm.12778

ORIGINAL ARTICLE

Risk management—Evaluation of healthcare professionals' reasoning about and understanding of maternity care

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Abstract

Aim: To evaluate healthcare professionals' explanations of the prerequisites for safe maternity care and understanding of risk management, including the underlying reasons for decision-making intended to ensure safe care.

Background: Risk management focuses on maintaining and promoting safe care by identifying circumstances that place childbearing women at risk of harm, thus reducing risks.

Methods: A hermeneutic action research approach was chosen. Through a series of focus group sessions, we uncovered healthcare professionals' explanations of risk management.

Results: One overriding theme emerged; the consequences of what managers do or fail to do constitute the meaning of taking responsibility for team collaboration to provide safe care. Inadequate support, resources and staff shortages have consequences, such as inability to concentrate on team communication and collaboration, leading to the risk of unsafe care.

Conclusion: Communication constitutes a prerequisite for both team collaboration and risk management. Thus, communication is linked to the ability of managers and healthcare professionals to provide safe care.

Implications for Nursing Management: In terms of safety management, nurse managers have a significant role in and responsibility for supporting communication training, developing guidelines and providing the prerequisites for interprofessional team reflection.

KEYWORDS

hermeneutic research, nursing management, risk management, safe maternity care, team communication

1 | INTRODUCTION

Risk management focuses on maintaining and promoting safe care by identifying circumstances that place childbearing women at risk of harm and eliminating such risks (The World Health Organization

(WHO), 2011). Van Otterloo and Connelly (2016) defined three components of risk: chance of harm, cognitive recognition, including awareness of potential risks and consequences, and the decision-making process. Patient safety (PS) is defined as healthcare structures or processes designed to prevent harm to childbearing women

(WHO, 2011). The WHO (2009) competencies framework highlights four key areas for improving PS: communication, teamwork, feedback and leadership. Elements that undermine these processes may pose a risk, thus compromising PS (WHO, 2009). Teams comprise healthcare professionals (HCPs) who collaborate to achieve a common goal. The team members share resources, interact and possess skills to coordinate care (Reis, Guerra Paiva, & Sousa, 2018). If a complication occurs, the situation can be equivocal as it may transform suddenly, thus HCPs need to rely on each other to recognize and resolve the problem, which highlights the importance of high-quality teamwork for PS (Maxfield, Lyndon, Powell Kennedy, O'Keeffe, & Zlatnik, 2013). Evidence indicates that inadequate communication and teamwork lead to the risk of harmful interventions and adverse events (AEs) during the provision of care (Lyndon et al., 2013; Wang, Wan, Lin, Zhou, & Shang, 2017). A PS culture requires supportive leadership and management (Liukka, Hupuli, & Turunen, 2017) to align HCPs to the assignment of improving PS by emphasizing the necessity of having a common purpose and enabling them to communicate about their values and beliefs (McFadden, Henagan, & Gowen, 2009). Characteristics of management associated with transformational leadership include the need to engage in order to maintain and promote PS (McFadden et al., 2009). Transformational leadership is related to involving HCPs in decision-making, improved relationships, increased job satisfaction and a reduction in the number of AEs (Merrill, 2015). Trust in leadership forms the basis of a purposeful collaboration between managers and HCPs (Auer, Schwendimann, Koch, Geest, & Ausserhofer, 2014; Fischer, 2016), as well as a fair and blame-free culture (Sammer & James, 2011).

Being involved in an AE can have devastating professional and personal consequences for HCPs as well as for childbearing women. Previous research indicates that in the event of an AE, the infrastructure and capacity to support the safety management activities required to maintain and promote PS are lacking (Auer et al., 2014; Severinsson et al., 2017). Due to the constant changes in and complexity of health care, HCPs require adequate support to act safely (Liukka et al., 2017). Providing feedback about an AE and responding to the consequences are essential for facilitating interprofessional relationships and encouraging learning in order to prevent a similar AE from occurring again (Auer et al., 2014). Managers and HCPs who engage in risk management create quality relationships that have the potential to protect HCPs and childbearing women from harm (Healy, Humphreys, & Kennedy, 2016). Few studies have illuminated the influence of interprofessional relationships in safe maternity care (Rönnnerhag, Severinsson, Haruna, & Berggren, 2018; Severinsson et al., 2017). HCPs' understanding of risk management appears to be inadequately described in the literature. Such knowledge is important for HCPs and managers to improve team functioning.

This study is part of a larger research programme with the primary objective of implementing and evaluating the WHO model that takes PS into consideration from the perspectives of childbearing women and HCPs (Rönnnerhag et al., 2018; Rönnnerhag, Severinsson, Haruna, & Berggren, 2019; Severinsson, Haruna, Rönnnerhag, & Berggren, 2015; Severinsson et al., 2017).

1.1 | Aim

To evaluate HCPs' explanations of the prerequisites for safe maternity care and understanding of risk management, including the underlying reasons for decision-making intended to ensure safe care.

The research questions were as follows: 1. How can HCPs determine the reasons for unsafe actions? and 2. What components form a part of the reasons behind decision-making?

2 | METHODS

2.1 | Study design

A hermeneutic action research approach was applied (Casey, O'Leary, & Coghlan, 2017; Gadamer, 2006). The principles of action research (AR) guided the implementation and evaluation of an intervention. AR seeks to solve specific problems in professional practice and becomes a part of the change process by engaging the participants in reflecting on their own needs or problems (Winter, 2005). Thus, the AR approach is dialogical in nature (Winter, 2005) and was the incentive to employ a series of focus group discussions. To explain, understand and identify analytic patterns of risk management to ensure safe care, a hermeneutic approach inspired by Gadamer (2006) was chosen. Explanation and understanding are dialectically interrelated (Ödman, 2007) and enable the possibility of assigning a meaning to a given phenomenon (cf. Ödman, 2007).

2.2 | Participants and setting

Purposive sampling (Palinkas et al., 2013) was used in for the identification and selection of data. The participants were 22 out of approximately 109 HCPs employed at a labour ward in one regional hospital in Sweden. They comprised Swedish-speaking obstetricians, midwives and assistant nurses. Their work experience ranged between six and 32 years and most were women. The HCPs assist at approximately ten childbirths per day and the length of postpartum stay is about 4 hrs. It was important to ensure that HCPs with different professions who belonged to a professional team participated in the focus group discussions in order to generate data containing contrasting views that contributed to depth as well as breadth (cf. Palinkas et al., 2013).

2.3 | Data collection

The data collection took place between March and June 2016. Due to scheduling issues, the number of HCPs in each focus group discussion varied from four to seven. The focus group discussions were conducted by the fourth and the first author, whose role was to moderate the group discussion in order to stimulate reflection and team communication (cf. O'Nyumba, Wilson, Derick, & Mukherjee, 2018).

The Inspectorate for Health Care (IVO) in Sweden follows up AEs in order to reduce or prevent such occurrences within the healthcare

TABLE 1 Overview of the hermeneutic interpretation (Gadamer, 2006) of team members' understanding of risk management (quotations from participants, explanations of prerequisites, understanding, analytic patterns, themes and the overriding theme of safe care)

Quotations from the participants	Interpretation of the quotations	The team members' explanations of prerequisites for safe care and management	Analytical patterns of actions and strategies for safe care	Themes	The overriding theme
<p>(1) "We have thus said that if you are not a specialist and undergoing education, the obstetrician on call should preferably be present, or at least informed that we are preparing for a vacuum extraction (VE). The childbirth may progress just fine without any complications and the specialist may not even get here on time. However, it is a team decision to use VE (FG1, B)."</p>	<p>The obstetrician on call should be a specialist, available and informed in beforehand that VE will be used. A specialist should be present or on his/her way. VE is a team decision.</p>	<p>The team needs to practice similar critical situations in order to know when a specialist obstetrician should be informed and present. When the importance of collaborative teams is not prioritized, their concentration on their common assignment is affected.</p>	<p>The managers must provide the prerequisites, resources and working conditions for teams to enable them to practice team collaboration in critical situations and be able to know when a specialist obstetrician should be informed and present.</p>	<p><i>Understanding of risk management as team communication</i></p>	<p>The consequences of what managers do or fail to do constitutes the meaning of taking responsibility for team collaboration to provide safe care</p>
<p>(2) "What happens before the critical situation turns into an emergency? How do we communicate then? When the emergency is a fact, I think we work very well; everything has to go as quickly as possible... If something does not work, I receive assistance quickly. We manage those situations just fine. We only have a few minutes and everyone provides support and assistance when needed. The problem in critical situations is the earlier communication, which for some reason makes us end up in with difficulties. There are sometimes situations that we cannot avoid. But how we communicate before that can be reflected on (FG1, D)."</p>	<p>What happens before the critical situation turns into an emergency? How do we communicate then? The problem is the communication a shortly before an emergency. It is what the communication is about that can cause problems. There are situations that cannot be avoided but the form of communication both before and when the situation turns into an emergency can be reflected on.</p>	<p>The team needs time and space to learn through practice, supervision and reflection to develop the ability to communicate and concentrate on their common assignment. When concentration fails complications can occur, even if the team has the knowledge and skills to handle the emergency.</p>	<p>The managers must provide the prerequisites, resources and working conditions for teams. The managers should provide opportunities to practice and learn to collaborate in critical situations in order for team members to develop the ability to concentrate on their common assignment and identify when their concentration fails.</p>	<p><i>Understanding of risk management as team communication</i></p>	

(Continues)

TABLE 1 (Continued)

Quotations from the participants	Interpretation of the quotations	The team members' explanations of prerequisites for safe care and understanding of risk management	Analytical patterns of actions and strategies for safe care	Themes	The overriding theme
(3) "If you notice that the foetal heart beat goes down and there is a bradycardia of fifty that remains there you do not just leave the room without informing the woman that you have to call a doctor. I tell them 'I have noticed this and this' so that they are at least prepared if the situation turns into an emergency. You need to communicate with the parents first (FG1, C)."	Parents' need for knowledge and involvement should be fulfilled by communication. The childbearing woman and her family members should be informed and involved in order to prepare them for the necessary interventions. This means that communication within the team, as well as between the team and parents should be focused.	When communication, information and involvement fail, significant expressions and signs of complications can be overlooked. Insufficient team communication can lead to consequences, such as the team members being hesitant about how to act in a critical situation.	Managers must ensure that teams are given the prerequisites for practise, supervision and reflection on how to communicate in a critical situation with the woman and her family members, as well as within teams. A guideline is needed for how this should be performed to ensure that all parties are prepared when a critical situation occurs.	<i>Understanding risk management as team communication</i>	The overriding theme
(4) "What should I do if I do not agree with the physician's decision? It is really difficult and pushes us to our limits (FG1, D)."	How are disagreements and conflicts handled? To who are conflicts communicated? Who makes decisions about team collaboration problems to avoid conflicts? Disagreements and conflicts create a lack of confidence within teams. Conflicts in teams influence on collaboration and quality of care.	Different views need attention and identification. Priority is needed for support and mediation in order to avoid conflicts. There is a need for teams to understand the significance of collaboration. When a conflict arises, it will affect adequate decision-making, which is significant to safe care.	The managers' must take responsibility for organizing teams that are able to collaborate and identify if there exist conflicts. Furthermore, create prerequisites for conflict management in order to facilitate team collaboration. The managers' should make efforts to promote a non-blaming culture, listen to and receive whistle-blowers.	<i>Understanding of risk management as team communication</i>	
(5) "We need safety margins... There have been emergencies in the surgical ward and an inexperienced physician ended up in a situation that he/she is not really expected to manage (FG1, A)."	Safety margins are needed for access to qualified obstetricians. There have been emergencies where an inexperienced physician had to take responsibility, which is not expected when undergoing education.	Qualified personnel should always be available in order to avoid situations where the team has inadequate resources. The team is obliged to act in a critical situation, despite inadequate resources and insufficient capacity. The team members experience unsafe working conditions, which influences their ability to concentrate on the assignment and provide safe care.	Managers need financial resources to ensure a budget that is adequate for the provision of the necessary resources and qualified personnel.	<i>Understanding risk management as human and financial resources</i>	

(Continues)

TABLE 1 (Continued)

Quotations from the participants	Interpretation of the quotations	The team members' explanations of prerequisites for safe care and understanding of risk management	Analytical patterns of actions and strategies for safe care	Themes	The overriding theme
(6) "Everyone was really emotionally affected and there is actually no organized support that allows/to allow persons to go off duty for the rest of the day. We do not have a routine, but we have talked about it. Maybe there should be... maybe we should call a colleague in order not to expose the team members involved to the burden of taking care of a couple of new parents after such an adverse event (AE). Because it is inhumane. It is clear that when such an event occurs we try to solve it and may call a colleague who lives nearby... But there is no written guideline that we should do that. Such guidelines do not exist (FG1, D)."	Those involved in an AE are emotionally affected and there is no guideline indicating that these persons should be relieved from further duties. This has been discussed because it is inhumane to expect them to take care of new parents after such an event. When an AE occurs, team members try to resolve the situation and call a colleague to assist. But there is no written guideline that this should happen.	The team need opportunities to be able to make decisions and act when additional support from qualified personnel is needed in relation to an AE. When an AE occurs, the team members are emotionally affected, which may influence their ability to concentrate on their assignment.	Managers must ensure that there are guidelines about how to support team members when an AE occurs. There should be a budget that allows organized support in order to provide the team with the prerequisites to make decisions about what actions are needed to avoid placing an additional burden on staff.	<i>Understanding of risk management as human and financial resources</i>	The overriding theme

Note. Participant identification = Alphabetic A-D.
Abbreviation(s): AE: Adverse Event; FG No.: Focus Group Number; VE: Vacuum Extraction.

organisation (2018 & SFS, 22018). The HCPs took part in four sessions at which selected AEs were discussed and reflected on. After each session, the group discussion was summarized with focus on the main issues of value for further discussion. The following session started with a recapitulation of the previous main content for the purpose of deepening the understanding.

The interviews, which were recorded and transcribed, lasted one and a half hours.

2.4 | Thematic interpretation

The transcribed text was interpreted by means of a hermeneutic approach (Gadamer, 2006). We started by reflecting on risk management aspects related to the AEs introduced in the focus group sessions. Thereafter, we designed a scheme in order to illustrate and transform the interpretation process. We chose the core aspects: quotations, interpretation of the quotations, the team members' explanations of prerequisites for safe care, understanding of risk management and finally, the analytical patterns of actions and strategies intended to ensure safe care. We strived to visualize the stepwise interpretation process and enhance transparency throughout the analysis by exemplifying from the empirical level to the more abstract level of analytic themes. Consensus was achieved by further discussions about what was the actual meaning of the team members' expressions and alternative interpretations of the substance inherent in the quotations. A deeper understanding was obtained by reflecting back on the specific context, namely the prerequisites and working conditions that enable team members to ensure safe care.

2.5 | Ethical considerations

The study was performed in accordance with the Helsinki Declaration (World Medical Association, 2015) and approved by the Ethical Review Board in Sweden (No: 773-15). In addition, the Norwegian Social Science Data Services (No: 53865) authorized the study in accordance with the Norwegian Data Registers Act. All participants were informed about the study and that they could withdraw at any time, after which they all agreed to take part and gave their informed consent.

3 | RESULTS

The two analytical themes *Understanding risk management as team communication* and *Understanding risk management as human and financial resources* illustrate how the HCPs comprehend risk management. The overriding theme is understood as *The consequences of what managers do or fail to do constitute the meaning of taking responsibility for team collaboration to provide safe care*. An overview of the hermeneutic interpretation (Gadamer, 2006) of team members' understanding of risk management is presented in Table 1.

3.1 | Understanding risk management as team communication

The availability of qualified personnel was significant for the ability to communicate risks.

However, having several HCPs involved in decision-making could make it difficult to reach agreement. Decision-making required a mutual interdependence within the team. The understanding was that trusting relationships within the team were important for enabling team members to concentrate on their assignment and ensure that the safety of childbearing women received priority in their decisions.

Communication, information and involvement are significant for recognizing expressions and signs of complications, thus enabling interventions to prevent complications developing into an AE. Furthermore, communication enables team members to decide when additional expertise is necessary and request the assistance of specialists. Inadequate communication within the team leads to team members hesitating about how to react in a critical situation. Sharing information about safety risks will increase knowledge and awareness of critical situations, as well as readiness to act.

The understanding was that managers must take responsibility for ensuring that teams are given the prerequisites for practice, including supervision during which team members can reflect on how to communicate in a critical situation, both within the team and with the childbearing woman and her family members. Guidelines and routines for how this should be performed are necessary to ensure that all parties are prepared when a critical situation occurs. Managers have an important role in the development of communication and collaboration skills to facilitate the establishment of confident interprofessional teams. In order to improve working conditions, managers should be present, genuinely care about HCPs, encourage them to openly share knowledge, review AEs and provide a debriefing on safety issues in team discussions. There is a need for organized support and risk preparedness.

The understanding was that different professional perspectives on their assignment could constitute a barrier to communication and collaboration, resulting in conflict and the risk of delayed or wrong decisions. Conflicts can cause concentration difficulties. Although HCPs possessed the necessary knowledge and skills, conflicts could affect their ability to concentrate on their assignment, thus leading to increased risks. Inability to share knowledge, information and achieve consensus gave rise to an experience of unsafe working conditions.

In order to avoid critical situations due to conflicts, managers have an important role in creating a climate that allows HCPs to share their views. The HCPs need to share knowledge and possess the ability to reason together in order to take important and necessary action. In addition, managers should address conflicts and take responsibility for mediation and conflict resolution. Hence, managers should work towards a non-blaming culture by listening to and taking whistle-blowers seriously. Open communication is essential for sharing sensitive personal information or work-related information without fear of blame or reprisals.

3.2 | Understanding risk management as human and financial resources

Safe care is at risk when human and financial resources are limited. The number of qualified HCPs was not always sufficient to manage multiple emergencies that occurred at the same time. There were also emergencies where an inexperienced physician had to take responsibility, which was not expected when undergoing education. In addition, safety margins were needed for access to qualified obstetricians. The understanding was that unsafe working conditions due to limited resources had become a part of daily practice.

In terms of risk management, managers must have adequate financial resources to ensure that the prerequisites for safe care are available. There is a need to obtain a budget that allows organized support and routines for teams when a critical situation occurs. There should always be access to qualified personnel in order to avoid situations where the team has inadequate resources. HCPs should be allowed to send for qualified personnel when an emergency occurs. The team is obliged to act in critical situations despite inadequate resources and insufficient capacity. This influences the team members' ability to concentrate on their assignment, make safe decisions and experience safe working conditions.

When a team is involved in an AE, the HCPs are emotionally affected and some find it difficult to continue working. There were no guidelines indicating that the HCPs involved should be relieved from further duties. This issue was discussed because it was considered inhumane to be expected to take care of new parents after such an event. When an AE occurred, the HCPs tried to resolve the situation and sent for a colleague to assist. Teams need time to recover after an AE, which requires a routine for accessing resources that can support them. Furthermore, a budget should be allocated that allows them to organize support and provides them with the prerequisites to make decisions about what actions are needed to avoid additional burden.

3.3 | The consequences of what managers do or fail to do constitute the meaning of taking responsibility for team collaboration to provide safe care

The HCPs understood that there were several risks to safe care, which they identified. It is evident that inadequate support, resources and staff shortages have consequences, such as inability to concentrate on team communication and collaboration, leading to the risk of unsafe interventions. These consequences impair the team members' ability to make safe decisions and concentrate on their assignment to ensure that the safety of childbearing women is given priority, in addition to preventing them from experiencing safe working conditions. The understanding was that these risks to safe care should be taken seriously.

Managers have a significant role in and responsibility for the development of team collaboration. The team members needed to be safe in their relationships when it comes to risk preparedness and critical situations. In order to enhance team collaboration, trusting

relationships must be created, which require communication, time and continuity. Human and financial resources as well as the availability of qualified personnel are linked and constitute the prerequisites for teams to provide safe care.

4 | DISCUSSION

The HCPs' understanding of risk management was revealed through a series of focus group sessions. An overriding theme emerged; *The consequences of what managers do or fail to do constitute the meaning of taking responsibility for team collaboration to provide safe care*. This study provides an insight into aspects that may play an important role in a more comprehensive model for explaining risk management in relation to childbirth. It demonstrates that a deepened understanding of the decision-making process has the potential to facilitate concentration and make team members more aware of the risks involved. It is important to acknowledge what is necessary, as lack of knowledge and clinical experience may increase the difficulty of making safe decisions. Not recognizing what is required for safe care will lead to consequences for both childbearing women and HCPs.

The extent of team collaboration influenced the team members' ability to concentrate on their assignment and make decisions to ensure that childbearing women's safety was prioritized. HCPs experienced insufficient communication, conflicts, and hesitation about how to react in a critical situation, different professional perspectives and lack of guidelines, all of which influenced the decision-making process. It is evident that the results of this study support the notion that these risks to safe care are the reasons behind the decision-making process. This understanding is not surprising, despite the fact that it has not been fully understood in maternity care.

More specifically, the reasons for decision-making are dependent on experience-based knowledge in order to decide whether or not an action or intervention is safe.

The results revealed that conflicts between team members influenced the decision-making process in a critical situation. These results are congruent with the evidence presented by Lyndon, Zlatnik, and Wachter (2011) and Jacobson, Zlatnik, Powell Kennedy, and Lyndon (2013) that a challenge to effective interprofessional communication included differing professional views on childbirth management leading to conflict. In addition, differences in perceptions of risk can potentially result in miscommunication and increase the probability of inadequate care (Van Otterloo & Connelly, 2016).

The results can be hypothesized by Ofstad's (1961) theory of determinant structures: high-integrated and low-integrated decisions. High-integrated decisions are based on a person's values. These values are a part of the individual's personality, and therefore, the personal characteristics of the HCPs are of significance for decision-making. Decisions that involve personal characteristics and values are more difficult in nature and may concern what and who will be prioritized in a critical situation when resources are inadequate. Low-integrated decision-making is carried out without any deeper reflection. This reinforces the need for open communication, supervision

and reflection in interprofessional teams in order to learn, identify different professional perceptions and share values pertaining to risk management activities. Thus, communication constitutes a prerequisite for both team collaboration and risk management.

Moreover, the results of this study revealed that team members need to be safe in their relationships when it comes to risk preparedness and critical situations. In order to enhance team collaboration, trusting relationships must be created. Thus, a PS culture built on respect, attentiveness, collaboration and competence is necessary to ensure safe care (cf. Lyndon et al., 2011).

In addition, Weis, Zoffman, and Egerod (2013) found that person-centred communication increased sensitivity to person-specific issues by raising HCPs' awareness of the need to acknowledge childbearing women's personal experiences in critical situations. This may facilitate the transformation of women's needs into a motivation for PS. In addition, it can increase the team members' awareness of the situation and enable them to make safe decisions when a critical situation occurs (cf. Berridge, Mackintosh, & Freeth, 2010). Risk management requires that HCPs have knowledge and are able to identify, judge and communicate potential risks and consequences as well as determine the likelihood that a certain complication will occur. Non-identified risks cannot be addressed, and their emergence can cause surprise and negatively influence safe care. Hence, a consequence of risk management includes the actual action taken as a result of the decision-making process (Van Otterloo & Connelly, 2016). This is in accordance with the WHO (2009) for improving the PS culture.

Incidents such as an AE are rarely caused by a single problem (Jha, Prasopa-Plaizier, Larizgoitia, & Bates, 2010). The results of this study revealed that human and financial resources as well as the availability of qualified personnel are linked and constitute the prerequisites for teams to provide safe care. In terms of risk management, managers must have adequate financial resources to ensure that the prerequisites for safe care are available. The team is obliged to act in critical situations despite inadequate resources and insufficient capacity. This influences the team members' ability to concentrate on their assignment, make safe decisions and experience safe working conditions. Jha et al. (2010) highlight the fact that inadequate staffing distracts HCPs, necessitates a higher reliance on previous practice to successfully perform significant interventions and prevents adequate team communication. These aspects are likely to create a working environment characterized by unsafe processes (Jha et al., 2010). Furthermore, inadequate financial resources often force persons to take greater risks (Vincent & Amalberti, 2016).

4.1 | Strengths and limitations

The issue of rigour was addressed using interpretative research criteria. These criteria included four principles (Thorne, 2016, pp. 233–235); (1) *Epistemological integrity* implies that the research process should be explained in a logical way and that the research questions should be consistent with the epistemological standpoints. Based on the theoretical and empirical understanding of the research phenomenon, the study was designed with the intention of engaging the

participants in reflection on the specific context of safe maternity care. For this purpose, the AR approach was applied, as it is dialogical in nature (Winter, 2005) and was thus the incentive to employ focus group discussions; (2) *Representative credibility* concerns the way in which the phenomenon under study was sampled. The findings presented should reflect the participants' interaction in terms of variations that appear during the interpretation process to uncover meaning, develop understanding and reveal insights relevant to the aim and the research questions of the study; (3) *Analytic logic*, (Table 1) illustrates the interpretations that visualize how different levels of interpretations which links the individual parts to each other to clarify their relevance for the interpretation process as well as for the consensus achieved. The interpretation should be coherent with the parts and the whole perspective, while the pattern that emerges should be more logical than other interpretations (cf. Gadamer, 2006; Ödman, 2007). To avoid bias, all members of the research team contributed to the interpretation process and continually discussed the findings from different perspectives to gain a deeper understanding of the meaning of risk management in maternity care.

There are some methodological limitations that need to be addressed. The composition of the focus groups and roles of HCPs as well as the discussion theme might have influenced participants' interactions and sharing of views (cf. O'Nyumba et al., 2018). This means that replication could be less precise. The number of HCPs in each focus group discussion might be considered as low. Another limitation is that the analysis focused on the content generated by the group instead of the process of interaction (cf. Liamputtong, 2011). Nevertheless, rich data were obtained with regard to the aim of the study.

The previously discussed quality criteria are significant for the (4) *interpretative authority*, which refers to the transparency of the research process that enables other readers to reach reasonable conclusions to determine the trustworthiness and transferability of the findings to other contexts (cf. Thorne, 2016). The strengths and limitations of this study were assessed by The Consolidated Criteria for Reporting Qualitative research (COREQ) (Tong, Sainsbury, & Craig, 2007, Supplement S1).

5 | CONCLUSIONS

In conclusion, the results demonstrate that a deepened understanding of the decision-making process has the potential to enhance concentration and make team members more aware of the risks involved. Not recognizing what is required for safe care will lead to consequences for both childbearing women and HCPs. In this regard, it is important to acknowledge what is necessary. HCPs who experience unsafe working conditions below a recognized standard may either become resigned to the situation or not remain in the workplace. This influences the healthcare organisation's capacity to provide safe care to the population. Accumulated research that explores safety management activities and decision-making and how these are linked to staff turnover is needed.

6 | IMPLICATIONS FOR NURSING MANAGEMENT

The role of nurse managers includes the development of communication training. Nurse managers should also provide feedback and develop trusting relationships in order to achieve significant changes in the PS culture such as supervision and training to enhance analytical reasoning and awareness of which aspects pose a risk to safe care. In addition, such changes may facilitate the development of guidelines. These aspects are likely to increase job satisfaction, knowledge and team situational awareness in critical situations. Prerequisites for enabling interprofessional team reflection are HCPs' willingness to change, sufficient time and continuity. In terms of safety management activities, nurse managers have a significant role in and responsibility for the development of competent communication and team collaboration.

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AUTHORS' CONTRIBUTIONS

MR, ES and IB were responsible for the study design. MR was responsible for the data collection and analysis. MR, ES, MH and IB contributed to the interpretation of the findings. All authors contributed to the discussion. MR was responsible for writing the manuscript. ES, MH and IB contributed to the critical revision of the intellectual content. ES and IB supervised the study. All authors provided feedback on the draft manuscript and approved the final version. They all adhered to the criteria pertaining to roles and responsibilities in the research process recommended by the International Committee of Medical Journal Editors (ICMJE) (<http://www.icmje.org/recommendations>).

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section at the end of the article.

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Appendix IV

Ethical approval by the Ethical Review Board in Sweden



Regionala etikprövningsnämnden i Göteborg

Projektansvarig:

Ingela Berggren
Högskolan Väst
Institutionen för hälsovetenskap
461 86 Trollhättan

Dnr:
773-15

Exp. 2015-11-02

Forskningshuvudman: Högskolan Väst

Närvarande beslutande:

Lars-Åke Ström, *ordförande*
Bibbi Ringsby-Jansson, *bitr. vetenskaplig sekreterare*
Jesper Lundgren, *vetenskaplig sekreterare ärende 763-15*

Ledamöter med vetenskaplig kompetens:

Johan Berlin
Elisabeth Björk Brämberg (*deltog inte i ärende 708-15 p.g.a. jäv*)
Sally Boyd
Bengt Brülde (*deltog inte i ärende 763-15, 787-15, 789-15*)
Kerstin Grundén
Karin Klinga Levan
Peter Korp
Helle Wijk (*deltog inte i ärende 708-15 p.g.a. jäv*)

Ledamöter som företräder allmänna intressen:

Beatrice Toll
Manijeh Mehdiyar
Robert Engström (*deltog ej i ärende 763-15, 786-15, 787-15, 789-15*)
Lars Muregård
Curt Hedlund

Projekttitel: Personcentrerad säker vård. Utveckling, implementering och utvärdering av WHO:s patientsäkerhetsmodell i obstetrisk vård.

Beslutsprotokoll från sammanträde med Regionala etikprövningsnämnden i Göteborg, Avdelningen för övrig forskning, den 26 oktober 2016

Föredragande: Karin Klinga

Godkännes med villkor

att informationsbrevet till patienterna kompletteras med uppgift om att deltagandet i studien kan avbrytas utan att det påverkar eventuell framtida vård, att kodlista förvaras åtskild från datamaterialet samt att koder och datamaterial förvaras på separat medium (usb eller liknande) i låst och brandsäkert utrymme, samt att data förvaras i minst 10 år för att möjliggöra granskning,

2015
Rättelse med tilläggning
av 26.8 Förvaltningslagen
2015-11-11
Barbro Mörning, EPN, Sbg

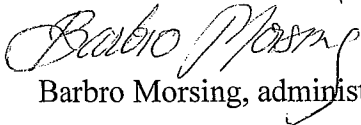
att formuleringen i informationsbrevet till patienterna om att "inga av de uppgifter som Du eventuellt har lämnat kommer att användas" förtydligas så att det framkommer varför uppgifter samlas in, hur de kommer att användas och vilka begränsningar som finns, och

att sökanden i informationsbrevet till patienterna övergripande redogör för vilken typ av frågor som kommer att ställas i intervjuerna, samt anger kontaktuppgifter till personuppgiftsombud.

Nämnden uppmanar sökanden att överväga möjligheten att utöka urvalet till att också inkludera andra grupper av forskningspersoner, än de som kan uttrycka sig och göra sig förstådda på svenska språket. Detta då det i den grupp som exkluderas kan finnas erfarenheter av betydelse för studiens frågeställningar.

Beslutet kan överklagas till Centrala etikprövningsnämnden. Skrivelsen ska vara ställd till Centrala etikprövningsnämnden men skickas eller lämnas till Regionala etikprövningsnämnden i Göteborg. Överklagandet ska vara underskrivet av behörig företrädare för forskningshuvudmannen. Denne kan lämna fullmakt till forskaren att skriva under. Bifoga i så fall fullmakten. I skrivelsen ska anges vilket beslut som överklagas och den ändring som Ni begär. Överklagandet ska ha kommit in till Regionala etikprövningsnämnden senast tre veckor från det att klaganden fick del av beslutet.

Att denna avskrift i transumt överensstämmer med originalet intygar:



Barbro Morsing, administrativ sekreterare

Appendix V

Ethical approval in accordance with the Norwegian Data Registers Act

Maria Rønnerhag
Institutt for sykepleie- og helsevitenskap Høgskolen i Sørøst-Norge

3603 KONGSBERG

Vår dato: 03.05.2017

Vår ref: 53865 / 3 / AGL

Deres dato:

Deres ref:

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 27.03.2017. All nødvendig informasjon om prosjektet forelå i sin helhet 03.04.2017. Meldingen gjelder prosjektet:

53865	<i>Personsentrert sikker vård- utveckling, implementering of evaluering av WHO's pasientsikkerhetsmodell i obstetisk vård</i>
<i>Behandlingsansvarlig</i>	<i>Høgskolen i Sørøst-Norge, ved institusjonens øverste leder</i>
<i>Daglig ansvarlig</i>	<i>Maria Rønnerhag</i>

Personvernombudet har vurdert prosjektet, og finner at behandlingen av personopplysninger vil være regulert av § 7-27 i personopplysningsforskriften. Personvernombudet tilrår at prosjektet gjennomføres.

Personvernombudets tilråding forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, ombudets kommentarer samt personopplysningsloven og helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, http://www.nsd.uib.no/personvernombud/meld_prosjekt/meld_endringer.html. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, <http://pvo.nsd.no/prosjekt>.

Personvernombudet vil ved prosjektets avslutning, 01.01.2021, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Kjersti Haugstvedt

Audun Løvlie

Kontaktperson: Audun Løvlie tlf: 55 58 23 07

Vedlegg: Prosjektvurdering

Dokumentet er elektronisk produsert og godkjent ved NSDs rutiner for elektronisk godkjenning.

Appendix VI

Information letters to the Manager of the Department and Director of the Hospital



Till Sjukhuschef och Stabschef

Forskning om personcentrerad säker vård

Information om forskningsprojektet; Personcentrerad säker vård - Utveckling, implementering och utvärdering av WHO:s patientsäkerhetsmodell i obstetrisk vård.

Patientsäkerhet är ett prioriterat område i hälso- och sjukvården och patienten skall också få möjlighet att vara delaktig i beslut som fattas gällande sin egen vård. Det är betydelsefullt att få ökad kunskap, dels om patientsäkerhet, dels om patientens inflytande i sin egen vård. Forskningsprojektet utgår från WHO's rekommendationer för kvalitet och säkerhet i hälso-sjukvården. Syftet med studien är att skaffa ökad kunskap och utveckla strategier för patientsäkerhet. Modellen beaktar patientsäkerhet utifrån patientens och hälso- och sjukvårdspersonalens perspektiv.

Bakgrunden till forskningsprojektet är följande: WHO (2014) lyfter fram patientsäkerhet som ett prioriterat område i hälso- och sjukvården. Genom att hälso- och sjukvårdspersonal involverar patienten mer i sin egen vård, ges möjligheten att vara mer delaktig i beslut som fattas gällande sin egen vård. Detta kan förebygga risker och felaktig behandling. Det är därför av betydelse att hälso- och sjukvårdspersonal skaffar sig ökad medvetenhet och kunskap för att kunna främja samt öka patientens inflytande i sin egen vård.

Forskningsprojektet innebär för personalen en intervention bestående av diskussioner i grupp med ca 6-8 personer. Detta innebär att personalen under ca 1,5 timmar diskuterar patientsäkerhet med utgångspunkt i en incident. Incidenter kommer med omsorg och noggrannhet väljas ut tillsammans med gruppdeltagarna. Utgångspunkten är att gruppdeltagarna skall känna sig trygga med den incident som väljs ut för diskussion. Gruppdiskussionerna genomförs vid fyra tillfällen och kommer att utgå från ett samtalstema i enlighet med WHO:s rekommendationer för patientsäkerhet.

Datainsamlingen innebär att personalen kommer att spelas in på ljudband under gruppdiskussionerna samt deltar i en fokusgruppsintervju. Datainsamling sker också genom individuella intervjuer med patienter gällande deras upplevelser i samband med vård.

Underlag för analys i detta forskningsprojekt kommer också bestå av redan insamlad data i form av dokumenterade händelseanalyser av incidenter som inträffat (Lex Maria) och vilka rapporterats till Inspektionen för Vård och Omsorg (IVO). Dessa händelseanalyser kommer att vara utgångspunkten för gruppdiskussionerna.

För att möjliggöra forskningsprojektet behöver jag Er tillåtelse att ta kontakt med kliniker inom [REDACTED] som kan vara intresserade av att delta i forskningsprojektet. Jag behöver också Er tillåtelse för att få tillgång till de dokumenterade händelseanalyserna.

Forskningsprojektet leds av mig, doktoranden Maria Rønnerhag och den vetenskapliga anknytningen omfattas av ett doktorandprogram vid Högskolan Buskerud och Vestfold i Norge. Forskningsprojektet är ett samarbete mellan nämnd högskola och Högskolan Väst i Trollhättan, Sverige, där jag också tjänstgör som universitetsadjunkt. Jag är specialistutbildad sjuksköterska i cancervård och har flera års värdereferens. Detta forskningsprojekt möjliggörs i samarbete med [REDACTED] och Dig som sjukhuschef samt stabschef.

Denna information och intyg gällande forskningsprojektet kommer att ingå i en forskningsetisk ansökan vid Forskningsetisk kommitté, Göteborgs Universitet.

Med vänliga hälsningar

Sign:

Doktorand Maria Rönnerhag

Kontaktuppgifter:

Doktorand
Maria Rönnerhag
Högskolan Väst
Institutionen för Hälsovetenskap
Gustava Melins gata 2
461 32 Trollhättan
Email: XXX
Telefon: XXX

Handledare
Professor Elisabeth Severinsson
Högskolan i Buskerud och Vestfold
Sentre for Kvinner's, Familie og Barns Helse
Fakulteten for helsefag
Campus Vestfold, Tönsberg
Email: XXX
Telefon: XXX

Handledare
Docent Ingela Berggren
Högskolan Väst
Institutionen för Hälsovetenskap
Gustava Melins gata 2
461 32 Trollhättan
Email: XXX
Telefon: XXX

Intyg

Härmed intygas att doktoranden Maria Rönnerhag ges tillåtelse att kontakta kliniker inom [REDACTED] [REDACTED] Att sjukhuschef och stabschef delgivits information om forskningsprojektet muntligt, skriftligt och samtycker till forskningsprojektet, samt att det finns resurser som garanterar forskningspersonernas säkerhet och integritet (datasekretess) vid genomförandet av forskningsprojektet; *Personcentrerad säker vård - Utveckling, implementering och utvärdering av WHO:s patientsäkerhetsmodell i obstetrisk vård*. Detta innebär att:

Forskningspersonerna informeras om avsikten med undersökningen och samtycker till att delta.

Forskningspersonerna informeras om att beslutet de tagit om att delta inte påverkar dem.

Forskningspersonerna kan när som helst avbryta utan att ange skäl eller att det kommer ha konsekvenser för dem.

Alla upplysningar kommer behandlas konfidentiellt, vilket innebär att åtgärder vidtagits för att skydda deltagarnas integritet och insyn i privatlivet.

Ort och datum:

Signatur:

.....

.....



Till Verksamhetschef och Avdelningschef

Forskning om personcentrerad säker vård

Information om forskningsprojektet; Personcentrerad säker vård - Utveckling, implementering och utvärdering av WHO:s patientsäkerhetsmodell i obstetrisk vård.

Patientsäkerhet är ett prioriterat område i hälso- och sjukvården och patienten skall också få möjlighet att vara delaktig i beslut som fattas gällande sin egen vård. Det är betydelsefullt att få ökad kunskap, dels om patientsäkerhet, dels om patientens inflytande i sin egen vård. Forskningsprojektet utgår från WHO's rekommendationer för kvalitet och säkerhet i hälso-sjukvården. Syftet med studien är att skaffa ökad kunskap och utveckla strategier för patientsäkerhet. Modellen beaktar patientsäkerhet utifrån patientens och hälso- och sjukvårdspersonalens perspektiv.

Bakgrunden till forskningsprojektet är följande: WHO (2014) lyfter fram patientsäkerhet som ett prioriterat område i hälso- och sjukvården. Genom att hälso-och sjukvårdspersonal involverar patienten mer i sin egen vård, ges möjligheten att vara mer delaktig i beslut som fattas gällande sin egen vård. Detta kan förebygga risker och felaktig behandling. Det är därför av betydelse att hälso- och sjukvårdspersonal skaffar sig ökad medvetenhet och kunskap för att kunna främja samt öka patientens inflytande i sin egen vård.

Forskningsprojektet innebär för personalen en intervention bestående av diskussioner i grupp med ca 6-8 personer. Detta innebär att personalen under ca 1,5 timmar diskuterar patientsäkerhet med utgångspunkt i en incident. Incidenter kommer med omsorg och noggrannhet väljas ut tillsammans med gruppdeltagarna. Utgångspunkten är att gruppdeltagarna skall känna sig trygga med den incident som väljs ut för diskussion. Gruppdiskussionerna genomförs vid fyra tillfällen och kommer att utgå från ett samtalstema i enlighet med WHO:s patientsäkerhetsmodell.

Datansamlingen innebär att personalen kommer att spelas in på ljudband under gruppdiskussionerna samt deltar i en fokusgruppsintervju.

Datansamling sker också genom individuella intervjuer med patienter gällande deras upplevelser i samband med vård.

För att möjliggöra forskningsprojektet behöver jag Er tillåtelse. Jag kommer att behöva hjälp av dig som avdelningschef, när det gäller vilken personal som kan vara intresserad att involveras i projektet samt vidarebefordra skriftlig information till personal och patienter om projektet.

Forskningsprojektet leds av mig, doktoranden Maria Rønnerhag och den vetenskapliga anknytningen omfattas av ett doktorandprogram vid Högskolan Buskerud och Vestfold i Norge. Forskningsprojektet är ett samarbete mellan nämnd högskola och Högskolan Väst i Trollhättan, Sverige, där jag också tjänstgör som universitetsadjunkt. Jag är specialistutbildad sjuksköterska i cancervård och har flera års vårderfarenhet. Detta forskningsprojekt möjliggörs i samarbete med [REDACTED] och Dig som verksamhetschef samt avdelningschef.

Denna information och intyg gällande forskningsprojektet kommer att ingå i en forskningsetisk ansökan vid Forskningsetisk kommitté, Göteborgs Universitet.

Med vänliga hälsningar

Sign:

Doktorand Maria Rönnerhag

Kontaktuppgifter:

Doktorand
 Maria Rönnerhag
 Högskolan Väst
 Institutionen för Hälsovetenskap
 Gustava Melins gata 2
 461 32 Trollhättan
 Email: XXX
 Telefon: XXX

Handledare
 Professor Elisabeth Severinsson
 Högskolan i Buskerud och Vestfold
 Sentre for Kvinner's, Familie og Barns Helse
 Fakulteten for helsefag
 Campus Vestfold, Tönsberg
 Email: XXX
 Telefon: XXX

Handledare
 Docent Ingela Berggren
 Högskolan Väst
 Institutionen för Hälsovetenskap
 Gustava Melins gata 2
 461 32 Trollhättan
 Email: XXX
 Telefon: XXX

Intyg

Härmed intygas att verksamhetschef och avdelningschef vid kliniken/avdelningen

..... delgivits
 information om forskningsprojektet muntligt, skriftligt och samtycker till forskningsprojektet, samt att det finns resurser som garanterar forskningspersonernas säkerhet och integritet (datasekretess) vid genomförandet av forskningsprojektet; *Personcentrerad säker vård - Utveckling, implementering och utvärdering av WHO:s patientsäkerhetsmodell i obstetrisk vård*. Detta innebär att:

Forskningspersonerna informeras om avsikten med undersökningen och samtycker till att delta.

Forskningspersonerna informeras om att beslutet de tagit om att delta inte påverkar dem.

Forskningspersonerna kan när som helst avbryta utan att ange skäl eller att det kommer ha konsekvenser för dem.

Alla upplysningar kommer behandlas konfidentiellt, vilket innebär att åtgärder vidtagits för att skydda deltagarnas integritet och insyn i privatlivet.

Ort och datum:

Signatur:

.....

Appendix VII

Information letters to and consent forms for the participants



Till Dig som patient



Forskning om personcentrerad säker vård

Information om forskningsprojektet; Personcentrerad säker vård - Utveckling, implementering och utvärdering av WHO:s patientsäkerhetsmodell i obstetrisk vård.

1. Bakgrund: Patientsäkerhet är ett prioriterat område i hälso- och sjukvården och patienten skall också få möjlighet att vara delaktig i beslut som fattas gällande sin egen vård. Det är betydelsefullt att få ökad kunskap, dels om patientsäkerhet, dels om patientens inflytande i sin egen vård. Forskningsprojektet utgår från WHO's rekommendationer för kvalitet och säkerhet i hälso-sjukvården. Syftet med studien är att skaffa ökad kunskap och utveckla strategier för patientsäkerhet. Modellen beaktar patientsäkerhet utifrån patientens och hälso- och sjukvårdspersonalens perspektiv.
2. Förfrågan om deltagande: Jag är intresserad av att komma i kontakt med Dig som patient med en förfrågan om Du vill dela med dig av dina erfarenheter om samtalstemat patientsäkerhet vid en intervju.
3. Hur går studien till: Intervjun genomförs på en enskild plats som du själv väljer. Intervjun tar ungefär 30-60 minuter, vilken tas upp på ljudband. Intervjun kommer att beröra frågeställningar så som till exempel: Kan du berätta om din situation i samband med [REDACTED]? Vad var betydelsefullt för dig i din situation? Vad betyder delaktighet för dig? Vad innebär "patientsäkerhet" för dig? Upplevde du dig säker i samband med din vård på [REDACTED]? Du kommer senare meddelas mer specifika uppgifter om tidpunkt samt förutsättningarna för intervjun, om Du tackat ja att delta.
4. Vilka är riskerna: Att delta vid intervjun kan eventuellt innebära att Du känner dig känslomässigt berörd. Om Du har frågor är du välkommen att ta kontakt. Skulle Du önska ytterligare stöd i form av en samtalsperson kommer du att hänvisas till professionell samtalsperson.
5. Finns det några fördelar: Dina upplevelser av säkerhet, bristande säkerhet och säkerhetskultur är betydelsefulla, därför att dessa kan ge möjlighet att utveckla färdigheter hos hälso- och sjukvårdspersonal för hur patienten kan ges möjlighet till ökad delaktighet och inflytande i vården, vilket också kan ha betydelse för säker vård.
6. Hantering av data och sekretess: Ansvarig för dina personuppgifter är: Högskolan Väst i Trollhättan. Alla uppgifter som framkommer under intervjun, kommer att behandlas konfidentiellt, vilket betyder att inga av uppgifterna kommer att kunna härledas till Dig som enskild person, påverka ditt privatliv eller eventuell framtida vård. Dina svar kommer behandlas så att obehöriga inte kan ta del av dem. Detta innebär att datamaterial i form av inspelningar från ljudband samt dokument kommer att koda (dvs. avidentifieras och ersättas med en siffra och/eller bokstäver). Koder och datamaterial kommer att förvaras på separata enheter så som till exempel USB och/eller hårddisk i ett låst och brandsäkert utrymme. Datamaterialet kommer att sparas i minst 10 år för att möjliggöra granskning av forskningsprojektets resultat.

7. Hur får jag information om studiens resultat: Resultaten kommer att bli offentliggjorda genom publicering av vetenskaplig artikel för att fler personer inom forskningsområdet skall kunna ta del av betydelsefulla resultat för säker vård. Uppgifterna som samlas in från intervjun kommer att sammanställas i en text/teman som är gemensamma för flera deltagare. Den information som är relevant för området patientsäkerhet, kommer att användas.
8. Ersättning: Ditt deltagande medför inga kostnader för Dig och någon ekonomisk ersättning för att delta utgår inte.
9. Frivillighet: Deltagandet är frivilligt och Du kan när som helst avbryta utan att ange något skäl eller att det får några följder för Dig. Inga av de uppgifter som Du eventuellt har lämnat kommer att användas i något annat syfte än det som anges för detta forskningsprojekt. Om Du har några frågor är Du välkommen att ta kontakt.
10. Informerat samtycke: Om Du önskar delta i studien vill jag be Dig underteckna informerat samtycke och lämna formuläret enligt följande alternativ: 1.sända det informerade samtycket till doktoranden enligt angiven adress, 2.ta kontakt med doktoranden via telefon och avtala en tid för intervju. Det undertecknade informerade samtycket lämnas då i samband med Din intervju.

Ansvariga och kontaktuppgifter:

Doktorand
 Maria Rönnerhag
 Högskolan Väst
 Institutionen för Hälsovetenskap
 Gustava Melins gata 2
 461 32 Trollhättan
 Email: XXX
 Telefon: XXX

Handledare
 Professor Elisabeth Severinsson
 Högskolan i Buskerud och Vestfold
 Sentre for Kvinner's, Familie og Barns Helse
 Fakulteten for helsefag
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Handledare
 Docent Ingela Berggren
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 Gustava Melins gata 2
 461 32 Trollhättan
 Email: XXX
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Personuppgiftsombud
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Med vänliga hälsningar

Doktorand Maria Rönnerhag



Informerat samtycke

Jag har fått skriftlig och muntlig information om syftet med studien och är införstådd med informationen. Jag har getts möjlighet att ställa frågor och få dem besvarade. Jag samtycker till att delta vid en intervju om samtalstemat patientsäkerhet.

Ort och datum:

Signatur:

.....

Namnförtydligande och hur jag kommer i kontakt med Dig, telefonnummer:

.....

Forskningsprojektet är godkänt av Regionala etikprövningsnämnden i Göteborg 2015-11-02

Dnr: 773-15



Till Dig som hälso- och sjukvårdspersonal

Forskning om personcentrerad säker vård

Information om forskningsprojektet; Personcentrerad säker vård - Utveckling, implementering och utvärdering av WHO:s patientsäkerhetsmodell i obstetrisk vård.

1. Bakgrund och syfte: WHO (2014) lyfter fram patientsäkerhet som ett prioriterat område i hälso- och sjukvården. Det är därför av betydelse att hälso- och sjukvårdspersonal skaffar sig ökad medvetenhet och kunskap för att kunna främja samt öka patientens inflytande i sin egen vård. Detta kan förebygga risker och felaktig behandling. Forskningsprojektet utgår från WHO's rekommendationer för kvalitet och säkerhet i hälso-sjukvården. Syftet med studien är att skaffa ökad kunskap och utveckla strategier för patientsäkerhet. Modellen beaktar patientsäkerhet utifrån patientens och hälso- och sjukvårdspersonalens perspektiv.
2. Förfrågan om deltagande: Jag önskar komma i kontakt med Dig som hälso- och sjukvårdspersonal, med en förfrågan om att Du vill dela med dig av dina erfarenheter om samtalstemat patientsäkerhet vid fyra gruppdiskussioner och en fokusgruppsintervju.
3. Hur går studien till: Forskningsprojektet innebär för dig som personal en intervention bestående av diskussioner i grupp med ca 6-8 personer. Detta innebär att Ni under ca 1,5 timmar diskuterar patientsäkerhet med utgångspunkt i en incident där patientsäkerheten anses vara åsidosatt. Incidenter kommer med omsorg och noggrannhet väljas ut tillsammans med Er i gruppen. Utgångspunkten är att Ni skall känna er trygga med den incident som väljs ut för diskussion. Gruppdiskussionerna genomförs vid fyra tillfällen och kommer att utgå från ett samtalstema i enlighet med WHO:s rekommendationer för patientsäkerhet. Datainsamlingen innebär för dig som personal att gruppdiskussionerna kommer att spelas in på ljudband dvs. en gruppintervju.
4. Vilka är riskerna: Att delta vid intervjun kan eventuellt innebära att Du känner dig känslomässigt berörd. Om Du har frågor är du välkommen att ta kontakt. Om ytterligare stöd i form av en samtalsperson önskas, kan Du få hjälp med att kontakta professionell samtalsperson.
5. Finns det några fördelar: Att hälso-sjukvårdspersonal får en medvetenhet, kompetens och metoder gällande patientsäkerhet. Resultaten kommer att belysa den evidensbaserade grunden för behovet av teamarbete, effektiv kommunikation, hantering av säkerhetsrisker, men också hälso-och sjukvårdspersonalens och patienternas upplevelser av bristande säkerhet och säkerhetskultur. Detta kan ge möjlighet att utveckla färdigheter för hur patienten kan ges möjlighet till ökad delaktighet och inflytande i vården, vilket också kan ha betydelse för säker vård.
6. Hantering av data och sekretess: Ansvarig för dina personuppgifter är: Högskolan Väst i Trollhättan. Alla uppgifter som framkommer under intervjun, kommer att behandlas konfidentiellt, vilket betyder att inga av uppgifterna kommer att kunna härledas till Dig som enskild person eller påverka ditt privatliv. Dina svar kommer behandlas så att obehöriga inte kan ta del av dem.

7. Hur får jag information om studiens resultat: Resultaten kommer att bli offentliggjorda genom publicering av vetenskaplig artikel.
8. Ersättning: Ditt deltagande medför inga kostnader för Dig och någon ekonomisk ersättning för att delta utgår inte.
9. Frivillighet: Deltagandet är frivilligt och Du kan när som helst avbryta utan att ange något skäl eller att det får några följder för Dig. Inga av de uppgifter som Du eventuellt har lämnat kommer att användas om du väljer att avbryta ditt deltagande. Om Du har några frågor är Du välkommen att ta kontakt.
10. Informerat samtycke: Om du önskar att delta i studien vill jag be dig underteckna informerat samtycke enligt nedan och lämna formuläret enligt något av följande förslag: 1.till avdelningschef på [REDACTED], 2.ta med formuläret till din första gruppdiskussion, 3.sända det informerade samtycket till doktorand enligt adressen. Du kommer meddelas mer specifika uppgifter senare om tidpunkt samt förutsättningarna för gruppdiskussionerna och fokusgruppsintervjun, om Du tackat ja till deltagande.

Ansvariga och kontaktuppgifter:

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Med vänliga hälsningar

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Informerat samtycke

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Ort och datum:

Signatur:

.....

Namnförtydligande och hur jag kommer i kontakt med Dig, telefonnummer:

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Forskningsprojektet är godkänt av Regionala etikprövningsnämnden i Göteborg 2015-11-02
Dnr: 773-15

Appendix VIII

Table 1. Overview of the empirical studies

Table 1. Overview of the empirical studies

Authors, Year & Country	Aim	Method, Type of study, Participants & Analysis	Findings	Contributions to the key themes presented in Chapter 2.2, Section 2.2.1			
				1	2	3	4*
Beck & Gable (2012) United States	To determine the prevalence and severity of secondary traumatic stress in HCPs and explore HCPs' descriptions of their experiences of attending traumatic births.	Mixed methods study. 464 HCPs. Qualitative content analysis.	The participants' experiences of being present at traumatic births revealed six themes: Magnifying the exposure to traumatic births, Struggling to maintain a professional role while with traumatized patients, Agonizing over what should have been, Mitigating the aftermath of exposure to traumatic births, Haunted by secondary traumatic stress symptoms, and Considering foregoing careers to survive.	X	X	X	X
Beck, LoGiudice & Gable (2015) United States	To determine the prevalence and severity of secondary traumatic stress in HCPs and to explore their experiences of attending traumatic births.	Mixed method study. 473 HCPs. Qualitative content analysis.	The types of traumatic birth described by the HCPs were foetal demise/neonatal death, shoulder dystocia and infant resuscitation. Six themes emerged: Protecting my patients: agonizing sense of powerlessness and helplessness, Wreaking havoc: trio of posttraumatic stress symptoms, Circling the wagons: it takes a team to provide support or not, Litigation: nowhere to go to unburden our souls, Shaken belief in the birth process: impacting midwifery practice, and Moving on: where do I go from here?	X	X	X	X
Byrne, Egan, Mac Neela & Sarma (2017) Republic of Ireland	To explore the subjective experience of birth trauma among first time mothers. It aims to separate the potential effects of peripartum depression from birth trauma by limiting the investigation to women who reported birth trauma, without peripartum depression.	Mixed methods study. Seven women. Interpretative phenomenological analysis.	The primary superordinate theme recounted how the identity and individuality of women are ignored and discounted throughout the childbirth process. Identity is challenged and altered as a result of women's incompatibility with the maternity care system. The existence of birth trauma highlights the subjective experience of women as central to the development of birth trauma.	X	X	X	X

Table 1. To be continued

Authors, Year & Country	Aim	Method, Type of study, Participants & Analysis	Findings	Contributions to the key themes presented in Chapter 2.2, Section 2.2.1			
				1	2	3	4*
Dahlen & Caplice (2014) Australia and New Zealand	To determine the fears of HCPs when it comes to caring for childbearing women.	Intervention study. Qualitative research approach. 700 HCPs. Concepts were grouped together to form categories.	HCPs reported their most frequent fears. These were death of a baby, missing something that causes harm, obstetric emergencies, maternal death, being watched, being the cause of a negative birth experience, dealing with the unknown and losing passion and confidence around normal birth. HCPs were concerned about being blamed if something went wrong.	X	X	X	X
Elmir, Schmied, Jackson & Wilkes (2012) Australia	To describe women's experiences of having an emergency hysterectomy following a severe postpartum haemorrhage.	Qualitative research approach. 21 women. Interpretative thematic analysis.	The findings revealed the major theme, Between life and death and three sub-themes, Being close to death: bleeding and fear, Having a hysterectomy: devastation and realisation and Reliving the trauma: flashbacks and memories.	X	X	X	X
Heringhaus, Dellenmark Blom & Wigert (2013) Sweden	To describe the experiences of becoming a parent of a child with birth asphyxia treated with hypothermia in the neonatal intensive care unit.	Qualitative research approach. 26 parents. Qualitative latent content analysis.	Becoming a parent of a child with birth asphyxia was a strenuous journey of riding an emotional rollercoaster from being thrown into a chaotic situation which started with a traumatic delivery to later processing the difficult situation of believing the child might not survive or would be seriously affected by the asphyxia. The prolonged parent-child separation due to the care and parents' fear of touching their child seemed to hinder the parent-child bonding.	X	X	X	X

Table 1. To be continued

Authors, Year & Country	Aim	Method, Type of study, Participants & Analysis	Findings	Contributions to the key themes presented in Chapter 2.2, Section 2.2.1			
				1	2	3	4*
Hood, Fenwick & Butt (2010) Australia	To describe HCPs' experiences and perceptions of external obstetric scrutiny; to explore and describe HCPs' perceptions of being directly or indirectly involved in giving evidence at medico-legal proceedings; to identify and describe the impact of these experiences on HCPs' clinical practice and personal wellbeing and to inform professional and employment organisations on how to support HCPs who face legal proceedings.	Qualitative research approach. 16 HCPs. Thematic analysis.	The findings suggest that the participants were very unprepared, both personally and professionally, to deal with the consequences of working within an environment that was the centre of a number of high profile legal proceedings and an extensive external review. The participants described their work environment as becoming increasingly stressful and permeated by a culture of fear.			X	X
Larkin, Begley & Devane (2012) Republic of Ireland	To explore women's experiences of childbirth.	Low intervention moderating style. Qualitative research approach. 20 Women. Thematic analysis.	Three main themes were identified; Getting started, Getting there and Consequences. Women experienced labour in a variety of contexts and with differing aspirations. Control was an important element of childbirth experiences. Women often felt alone and unsupported. The busyness of the hospital units precluded women-centred care both in early labour and in the period following the birth. Some women did not wish to have another baby due to their childbirth experiences.	X	X	X	X

Table 1. To be continued

Authors, Year & Country	Aim	Method, Type of study, Participants & Analysis	Findings	Contributions to the key themes presented in Chapter 2.2, Section 2.2.1			
				1	2	3	4*
Lyndon, Zlatnik, Maxfield, Lewis, McMillan & Powell Kennedy (2014) United States	To explore HCPs' perspectives on whether they experience difficulty resolving patient-related concerns or observe problems with the performance or behaviour of colleagues involved in intrapartum care.	Mixed methods study. 1,932 HCPs. Inductive thematic analysis.	Participants reported experiencing situations in which women were put at risk due to the failure of team members to listen or respond to a concern. Participants reported unresolved concerns regarding another HCP's performance. The overarching theme was clinical disconnection, which included disconnection between HCPs about women's needs and care plans, as well as disconnection between HCPs and administration about the support required to provide safe and appropriate care. Lack of responsiveness to concerns on the part of colleagues and at administrative level contributed to resignation and defeatism among participants who had experienced such situations.			X	X
Murphy & Strong (2018) United Kingdom	To focus on the events during and after the birth, while also setting the births in their medical context – providing an account of medical issues during the pregnancy, medical interventions during labour and recording any medical issues with the neonate as well as postnatal depression and/or other psychological sequelae for the woman.	Qualitative research approach. Five women. Thematic analysis.	All participants who had a medical intervention during labour described the event as traumatic. Three of the women had an emergency caesarean section and one had a ventouse assisted delivery. Analysing the accounts of the women produced four narrative themes; Experiencing birth trauma, Being invisible, Just get on with it, and Making things better.	X	X	X	X

Table 1. To be continued

Authors, Year & Country	Aim	Method, Type of study, Participants & Analysis	Findings	Contributions to the key themes presented in Chapter 2.2, Section 2.2.1			
				1	2	3	4*
Reed, Fenwick, Hauck, Gamble & Creedy (2014) Australia	To describe HCPs' experiences of learning new counselling skills and delivering a counselling intervention entitled Promoting Resilience in Mothers' Emotions.	Intervention study. Qualitative research approach. 42 HCPs. Thematic analysis.	Participants felt confronted by the level of emotional distress some women suffered as a consequence of their birth experience. Four major themes were extracted: The challenges of learning to change, Working with women in a different way, Making a difference to women and me, and A challenge not about to be overcome. The advanced counselling skills acquired by the midwives improved their confidence to care for women distressed by their birthing experience and to personally manage stressful situations they encountered in practice.			X	X
Rice & Warland (2013) Australia	To enable HCPs to describe their experiences and to determine if they are at risk of negative psychological sequelae similar to those in other caring professions.	Qualitative research approach. 10 HCPs. Thematic analysis.	The participants described their emotional distress due to feeling 'stuck' between two philosophies. Feelings of responsibility for women and babies' outcomes and repeatedly questioning what they could have done differently to prevent a traumatic birth were also reported. Feeling for the woman emerged as a major factor in HCPs' experiences of witnessing a traumatic birth.	X	X	X	X
Priddis, Schmied & Dahlen (2014) Australia	To explore how women experience and make meaning of living with severe perineal trauma.	Qualitative research approach. 12 women. Thematic analysis.	The findings describe how women feel vulnerable, exposed and disempowered throughout the labour, birth, suturing and postpartum period and how these feelings are a direct result of the actions of their healthcare providers. In addition, the expectations and reality of the birth experience influenced the postpartum period for women, impacting upon their ability to mother their newborn child and the relationship with their partner.	X	X	X	X

Table 1. To be continued

Authors, Year & Country	Aim	Method, Type of study, Participants & Analysis	Findings	Contributions to the key themes presented in Chapter 2.2, Section 2.2.1			
				1	2	3	4*
Puia, Lewis & Tatano Beck (2013) United States	To discover the impact of perinatal loss on HCPs.	Qualitative research approach. 91 cases described from the perspectives of HCPs. Qualitative content analysis.	Six themes emerged from the foetal and infant loss experiences, with the final overarching themes from perinatal loss including Getting through the shift, Symptoms of pain and loss, Frustrations with inadequate care, Showing genuine care, Recovering from traumatic experience and Never forgetting.	X	X	X	X
Schrøder, Jørgensen, Lamont & Hvit (2016) Denmark	To describe the numbers and proportions of HCPs involved in traumatic childbirth and their experiences of guilt, blame, shame and existential concerns.	Mixed methods study. 1,237 HCPs. Thematic analysis.	The findings revealed five categories; The patient, Clinical peers, Official complaints, Guilt and Existential considerations. Although blame from patients, peers or authorities was feared, the inner struggles with guilt and existential considerations were dominant. Feelings of guilt were reported by participants and several agreed that the traumatic childbirth had made them think more about the meaning of life.		X	X	X
Sheen, Spiby & Slade (2016) United Kingdom	To investigate HCPs' experiences of traumatic perinatal events and to provide insights into experiences and responses reported by HCPs with and without subsequent posttraumatic stress symptoms.	Qualitative research approach. 35 HCPs. Thematic analysis.	Event characteristics involved severe, unexpected episodes contributing to feeling of being "out of a comfort zone." Emotional upset, self-blame and feelings of vulnerability to investigative procedures were reported. Participants described being personally upset by events and perceived that all aspects of their personal and professional lives were affected. The participants' valued talking about the event with peers, but perceived support from senior colleagues and supervisors to be either absent or inappropriate.	X	X	X	X

Table 1. To be continued

Authors, Year & Country	Aim	Method, Type of study, Participants & Analysis	Findings	Contributions to the key themes presented in Chapter 2.2, Section 2.2.1			
				1	2	3	4*
Souza, Cecatti, Parpinelli, Krupa & Osis (2009) Brazil	To investigate women's experiences related to the burden of severe maternal morbidity.	Qualitative research approach. 30 women. Thematic analysis.	Two major themes were identified, one more closely related to the experience of a critical condition and the other to the experience of care. A complex set of reactions was found in the women who survived, indicating the occurrence of acute stress-related disorders.	X	X	X	X

AE = Adverse Event

HCP = HealthCare Professional

*Contributes to the themes; 1) Childbirth complications, risks and medical interventions 2) The experiences of childbearing women and healthcare professionals 3) Circumstances that contributed to unsafe care and; 4) The similarities and differences in perceptions of defining an AE between childbearing women and healthcare professionals.

Appendix IX

Table 2. Overview of the systematic literature reviews

Table 2. Overview of the systematic literature reviews

Authors, Year & Country	Aim	Method, Type of study, Participants & Analysis	Findings	Key aspects of content
Elmir, Schmied, Wilkes & Jackson (2010) Australia	To describe women's perceptions and experiences of a traumatic birth.	Literature review of ten qualitative studies. A meta-ethnographic approach was used. Women. Thematic analysis.	Six themes labelled: Feeling invisible and out of control, To be treated humanely, Feeling trapped: the reoccurring nightmare of my childbirth experience, A rollercoaster of emotions, Disrupted relationships and Strength of purpose: a way to succeed as a mother.	To recognize women's need to be involved in decision-making.
Elmir, Pangas, Dahlen & Schmied (2017) Australia	To undertake a meta-ethnographic study of healthcare professionals' (HCP) experiences of adverse labour and birth events.	Literature review of 11 qualitative studies. HCPs. Thematic analysis.	Four themes emerged: Feeling the chaos; Powerless, responsible and a failure; It adds another scar to my soul; and Finding a way to deal with it. HCPs felt relatively unprepared when faced with a real life labour and birth emergency event.	To find implementation strategies to prepare for unexpected and unforeseen adverse childbirth events.
Furuta, Sandall & Bick (2014) United Kingdom	To explore women's perceptions and experiences of severe maternal morbidity and its potential impact on their lives through a synthesis of qualitative studies.	Literature review of 12 qualitative studies. A meta-ethnographic approach was used. Women. Categorizing of findings.	Women's experiences of severe maternal morbidity were categorised into three areas: Experiencing the event of severe maternal morbidity; The immediate reaction to the event (physical experience, perception/interpretation of their situation, and emotions), and The aftermath (either a negative or positive experience). Women's perceptions and experiences of severe maternal morbidity could be compounded by inadequate clinical management and care.	To ensure the safety of interventions in order to reduce or prevent consequences of an AE on women and their families.

Table 2. To be continued

Authors, Year & Country	Aim	Method, Type of study, Participants & Analysis	Findings	Key aspects of content
Greenfield, Jomeen & Glover (2016) United Kingdom	To review the literature pertaining to “traumatic birth” and produce a definition of the concept.	Literature review of 22 qualitative studies. Women. A concept analysis framework was used.	The attributes of ‘traumatic birth’ are that a baby emerged from the body of its mother at a gestation where survival was possible. This birth involved events and/or care that caused deep distress or disturbance to the mother and the distress has outlived the immediate experience.	To define the concept traumatic childbirth from women’s perspectives.
Lyberg, Dahl, Haruna, Takegata & Severinsson (2018) Norway	To conduct a meta-study of qualitative empirical research to explore the links between patient safety (PS) and fear of childbirth in the maternity care context. The review questions were: How are patient safety and fear of childbirth described? and What are the links between PS and fear of childbirth in the maternity care context?	Literature review of nine qualitative studies. Women. Thematic analysis.	Four descriptive themes emerged: Physical risks associated with giving birth vaginally; Control and safety issues; Preventing psychological maternal trauma and optimizing foetal well-being; and Fear of the transition to motherhood due to lack of confidence. The two overarching analytical themes were: Opting for safety and An insecure environment breeds fear of childbirth, which represent the links between PS and fear of childbirth. The findings indicate the need for increased commitment to safe care and professional support to reduce risks and prevent unnecessary harm in maternity care.	To ensure safe childbirth by implementing strategies for safety management activities.

AE = Adverse Event

HCP = HealthCare Professional

PS = Patient Safety

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