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Maternity staff experiences of the transition to digital escalation tools #Whatdoesgoodlooklike?

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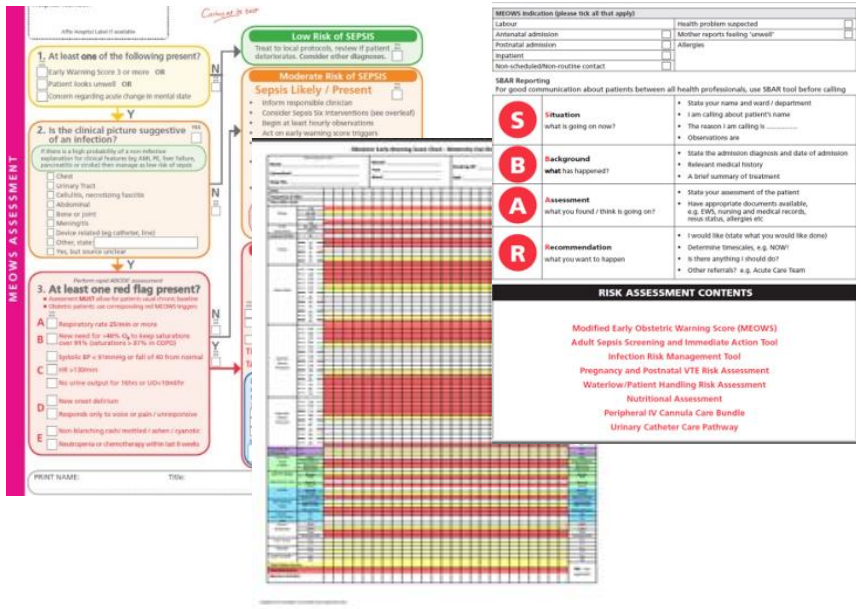
NHS England 2023/ 24 Business Plan

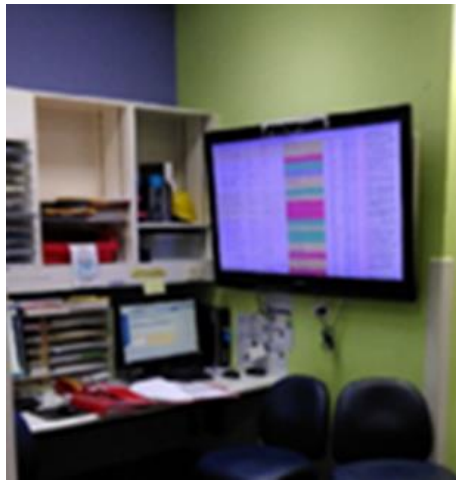
5) Improve maternity and neonatal services

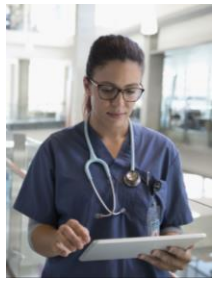
- Improve equity for mothers and babies and deliver care that is personalised
- Retain, grow and invest in our workforce
- Support a culture of safety, learning, and support
- Support the implementation of best practice and use of data

Visual Management Tools (VMTs) in healthcare escalation



Analogue VMTs encompass paper-based, dry-erase white-board and non-electronic devices which support staff decision making

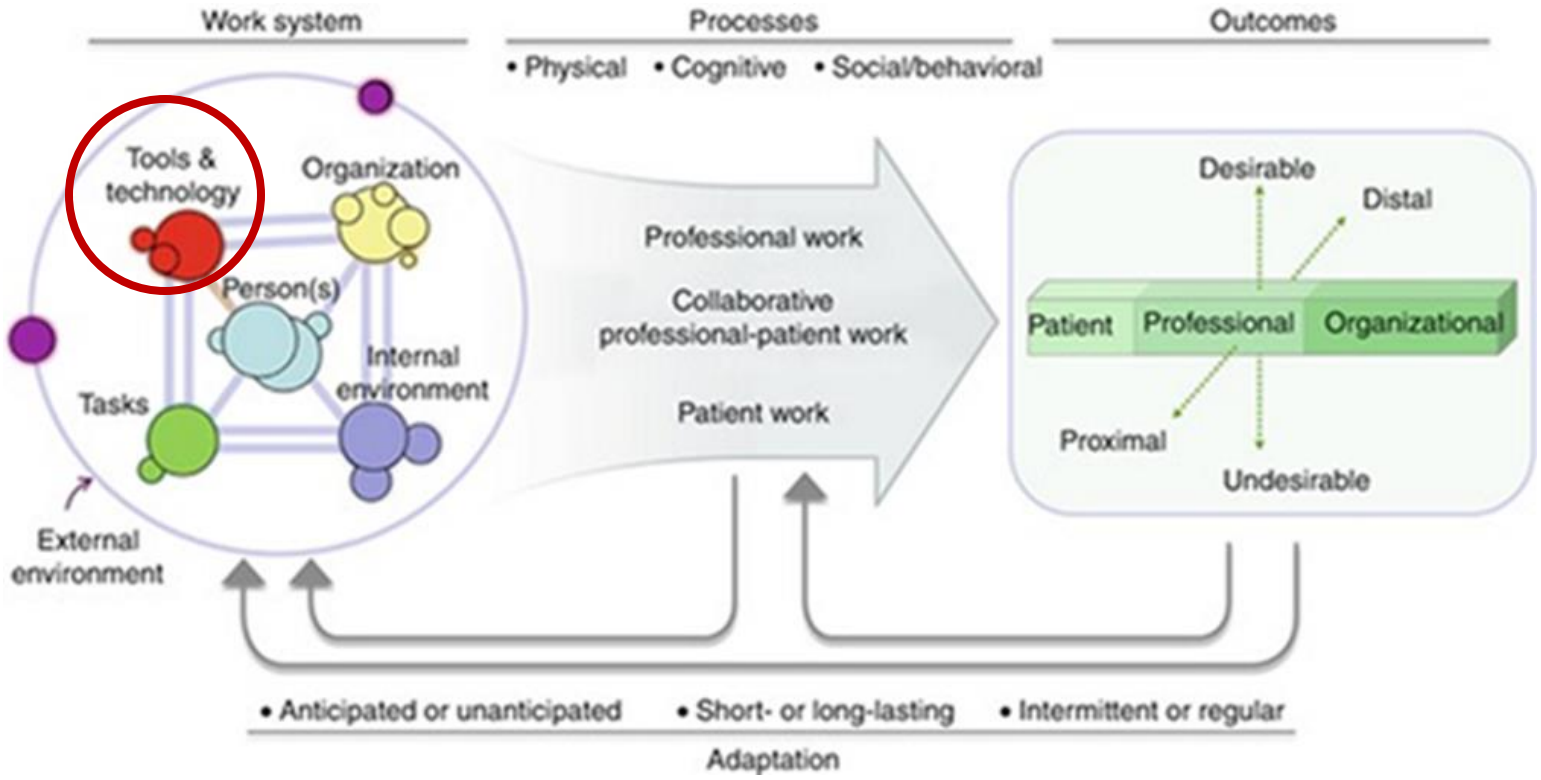




Electronic VMTs encompass all tools accessed by staff requiring either battery or electricity mains support in order to function

Systems Engineering Initiative for Patient Safety (SEIPS)

(Holden et al., 2013, p.1672)



The desired outcomes of SEIPS are:

1) system performance

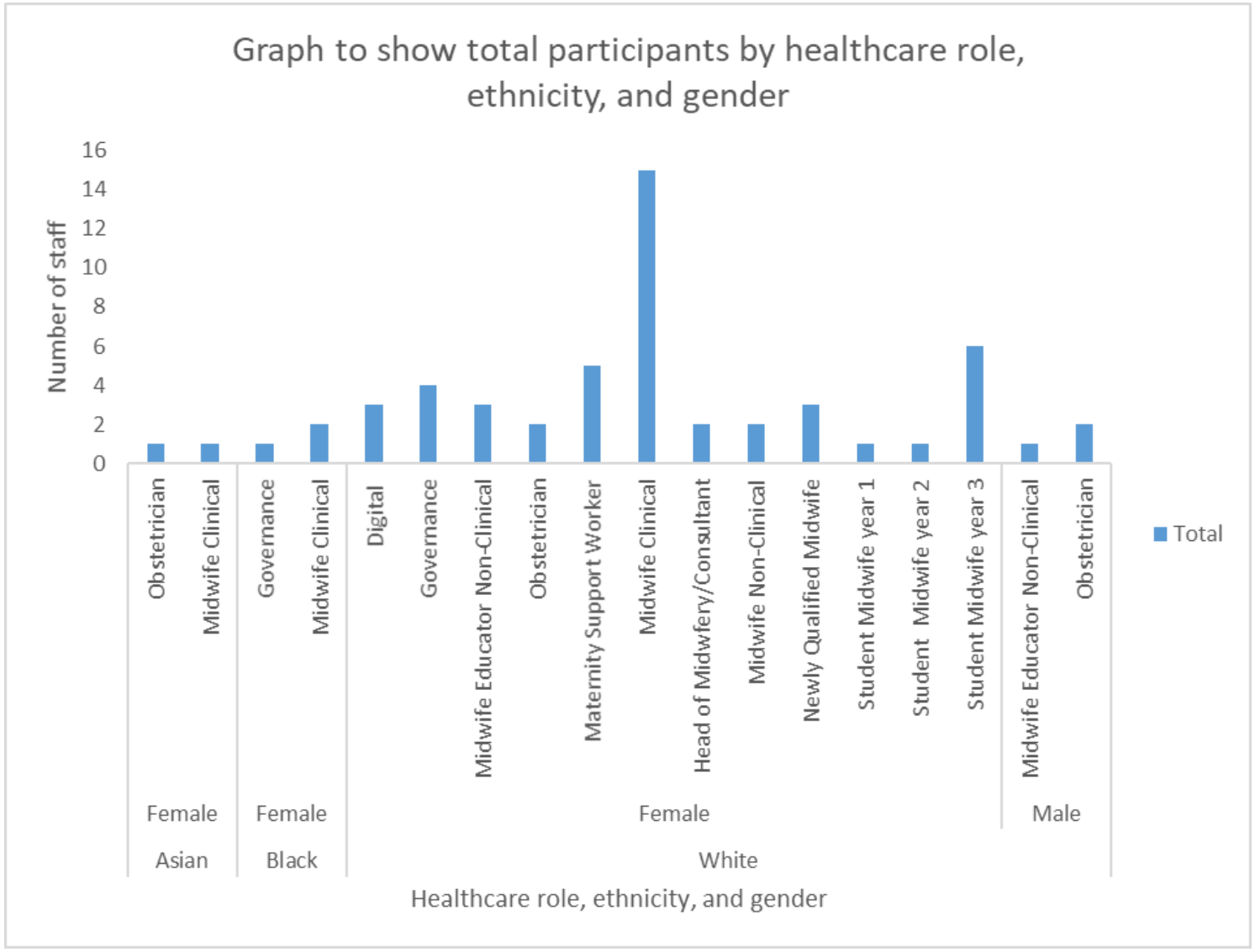
2) human wellbeing

(McNab *et al.*, 2020).

Holden, R., Carayon, P, Gurses, A. et al (2013) 'SEIPS 2.0: A human factors framework for studying and improving the work of healthcare professionals and patients', *Ergonomics*, 56 (11), pp. 1669-1686.

Map of participants from across England

Total participants by professional role, gender and ethnicity



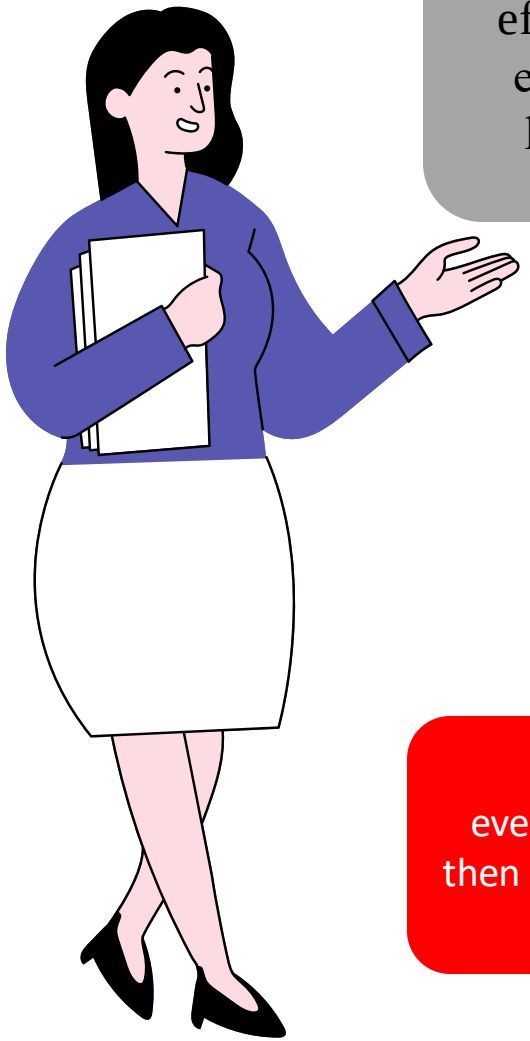
Doctors: Just tell me what you need from me…

"You walk into theatre; you may not have even seen that woman in your life. Because there's no way on earth you've got time to go on to the computer. And flick through all the various places where there may be relevant information. So, you just don't. And you just trust what your colleagues tell you verbally" (Dr3)

"It's very quickly you can see everyone's on your department. But the downside is you need to have access to a device to view it" (Dr2)

"Invisible tasks become visible when you cannot access them" (Dr3)

Managers: Tell me what you did, where, when, and why?



"you might have a system or a tool that really efficiently solves one problem. But it just moves everything… Perhaps even overwhelms it, you know…more obs on 'less sick' people" (M9)

"It's always complicated in every Trust…you have got contracts, licence agreements… you've got your CIO or whoever it is within the trust, the NIO, depending on the format of the trust and structure, and then you'll have systems like that. They're not, they're not specific, or they're not built for maternity" (M10)

"Why have we gotten to that point where we have tick boxes everywhere?… we'll find a box we can tick that says you've done it, so then if you get it wrong it's not their fault, it's your fault, because you got it wrong because you ticked the box" (M7)

Seniors: Trust me, I'm always held accountable, but have limited time to care…

"*Junk mail* - little things like that do tend to take a backseat" (S10)

"novelty that had worn off" (S1)

"And it will automatically flag up queries for sepsis, and any MEOWS triggers. But until that information is input into the computer. It doesn't trigger anything up" (S10)

"Stickers seem to be everywhere at the moment! Every time I go back on DS there seems to be a new one for something else! The start of the CTG, the 10-minute review of the CTG… SBAR, that is now a sticker at our trust…as well as well as the early warning and the neonatal early warning charts" (S2)

Junior staff: Teach me, Guide me, support me, I'm frightened…

"Tool for learning appropriate escalations.
If you don't feel comfortable to speak out, how can you escalate freely?" (J4)

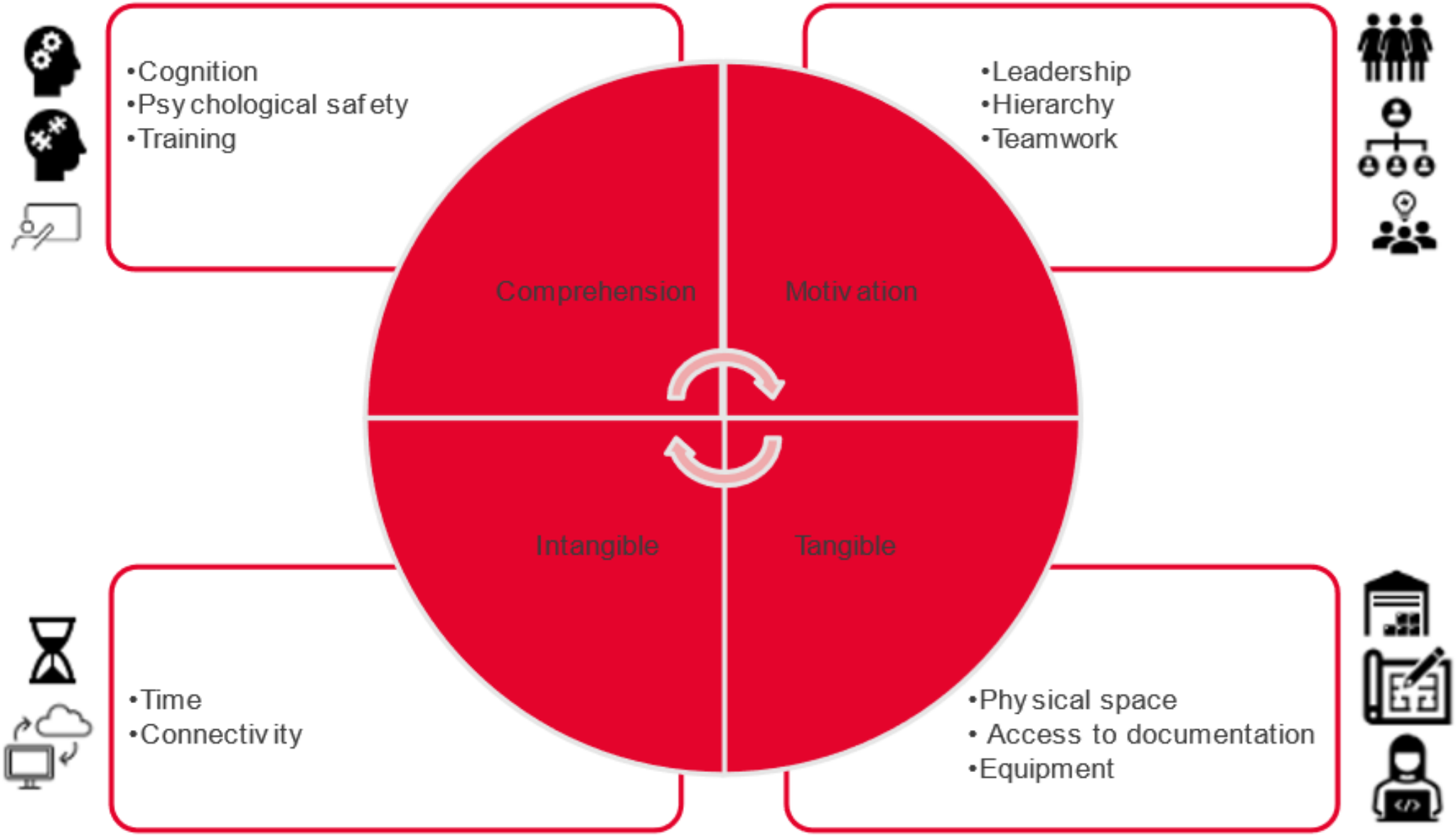
"oh god. Don't want this baby to have high resps because everyone's really busy!
…that's not right, I shouldn't be having that conversation in my head about bothering someone about a baby that's got high resps…
please don't have high resps. Oh my god, it's still got high resps.
Does it really have high resps?" (J15)

"So many options, all linked to audits so it takes longer to complete than actually seeing the women" (J9)

"Why don't we just train people instead of generating more stickers?!" (J7)

"Until you make a mistake, and then when you make the mistake, that's when they go, well actually this is how you… Do you know what I mean? I feel like…You only get full training only after you've made the mistake… just the pressure that everybody's under at the minute" (J20)

Human Factors & Ergonomics



The tool links us all, but the tool alone is not going to fix the problems…

"Because you have not given me the resources, you have not given me the staff…to be able to adequately manage this. So, the tool will only be useful if I had the right level of staff with me. That is ultimately the reality of it. You're only as skilled with your tools as your team is. It's about everything. The tool links us all, but the tool alone is not gonna fix the problems" (S4)

EVIDENCE SERIES

EXPLORING THE NEEDS AND LIVED

EXPERIENCES OF WOMEN HOSPITALISED DURING PREGNANCY IN THE UK:

A QUALITATIVE DIARY STUDY

SUMMARY

There is a global call to optimise antenatal care experiences. Hospitalisation during pregnancy may have a significant impact on the experience of care. Thus, the aim of this study was to explore the needs and lived experiences of those hospitalised during pregnancy.

A thematic analysis rooted in interpretive phenomenology was undertaken on the content of five written diaries produced by pregnant participants whilst hospitalised. Three themes were identified from the data; (1) 'Uncertainty'; (2) 'Loss of control'; (3) 'Vulnerability'. Study findings could usefully be translated into improvements for those hospitalised during the antenatal period.

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INTRODUCTION

A pivotal moment in the history of maternity services was the publication of the Peel report of 1971,[1] which recommended that all women should birth in hospital. Hospitalisation in this report was recommended for a minimum of three days and thus it was recounted that the overt medicalisation of pregnancy overtook domiciliary midwifery care.[2]

Reasons for hospitalisations during pregnancy are varied.[3] Yet in many cases, it is reasonable to assume that hospitalisations during pregnancy will result in parents being separated from their children, and have a significant impact upon the lives of those experiencing it. Consequently, the aim of this study was to explore the needs and lived experiences of women and birthing people hospitalised during pregnancy in the United Kingdom (UK).

Human factors review of a safety-critical system in a pandemic

Helen Elliott-Mainwaring

ORIGINAL

Introduction to Safety-Critical Systems

'Safety-Critical Systems (SCSs) can be defined as systems whose failure could result in loss of life, significant property damage or damage to the environment' (Tarrant 2020:2). Examples of such systems are essential critical infrastructures like health care, public safety and national security, education, financial services, transport logistics and communication, utilities, information technology, essential food production, supply chain and sales (Knight 2002), in fact all the key worker systems which were awarded government protection to maintain services in the UK lockdown during the COVID-19 pandemic (Anon 2020, Cabinet Office & Department for Education 2020).

Scope

When SCSs fail, media coverage tends to swarm with demands for culpability. Sutcliffe (2002) writes that SCSs should at least attempt to reduce the chances of human error, explaining that, despite many accidents being attributed to human mistakes, these are often part of a bigger picture of system error where we need 20/20 foresight to visualise potential issues in system design for futureproofing. This could be applied to the much-publicised lack of Personal Protective Equipment (PPE) and wider system factors for frontline health care workers during the current pandemic. As at April 2020, 19 UK NHS staff had died (Lyons et al 2020). COVID-19 PPE regulations

Who is ultimately responsible and accountable for patient safety in maternity services?

Helen Elliott-Mainwaring

ORIGINAL

This article is written in the aftermath of yet another tragic patient safety story where, in 2017, failings in health care at a United Kingdom (UK) maternity unit resulted in a newborn baby boy tragically sustaining brain damage (Ulke 2020). The senior midwife on duty was taken to a hearing at the Nursing and Midwifery Council (NMC) and held accountable for her failure to question poor decision making by the registrar on duty. What happened is very likely a recurring nightmare for any midwife who has experienced registration within the UK. Sadly our health care system is not designed to allow staff to do the right thing, and each of the recent investigations into poor health care provision within maternity services in the UK has been instigated by the general public, and in particular by local families, rather than by any protective public body, which speaks volumes about transparency and candour within the National Health Service (NHS) (Kirkup 2015. Weaver 2019).

Orchid

Medical Sociology Study Group

Annual Conference Programme

13 – 15 September 2023
University of Sussex

Helen EM

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Other

A midwife's exploration into how power & hierarchy influence both staff and patient safety

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Helen Elliott-Mainwaring

Abstract

My experiences as a legitimate informal whistle-blower have afforded me an understanding of the dichotomy that is Trust allegiance and misplaced brand loyalty over and above both patient and staff safety, such that when poor care is spoken of as a potential or experienced from either angle, the general rule within healthcare management is not to acknowledge, reflect, mitigate and learn in order to improve, but instead to gaslight, deny and subordinate such that from a staff safety perspective they are caught between a rock and a hard place. This paper explores some of the opportunities which healthcare organizations could embrace to positively influence the effects of power and hierarchy on staff safety.

Aims: This paper discusses the bigger picture of maternity services safety.

Methods: This is a discussion piece.

Findings: For some healthcare staff it is preferable to remain quiet, not rock the proverbial boat, and maintain deeply loyal allegiances to their employers over and above public protection. For others, the journey of honesty, integrity and tenacity carries a high price in terms of personal energy, health and financial compromise.

Conclusion: This exploration into how power & hierarchy influence both staff and patient safety has identified and briefly explored some of the tensions created by misplaced brand loyalty inherent within healthcare institutions, and the legacy of harms resulting.

Keywords

Maternity services, power & hierarchy, staff safety, whistleblowing, healthcare safety, incident reporting

Other

I have found my tribe

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Helen Elliott-Mainwaring

Safety cultures work within shared values and assumptions, but these can become complicated by cultural blind spots leading to very public exposures of poor healthcare cultures such as the Bristol Royal Infirmary, Mid Staffordshire, Morecambe Bay, Basildon, and Nottingham.[1–3] Safety culture and open communication in healthcare services are important because organisation theory is defined by colleg… my first MSc in Health, and having focussed on Maternity Services for each of my modules, was grappling with a paper on the 'Ripple effect of service improvement'. I was struggling to conclude because having cited real time examples of cultural apathy within our unit, senior buy in for change was slow to come to fruition. I remember writing to our Head of Midwifery to inform her that I had been called a liar

Women's Needs in Maternity Services in a Pandemic

all4maternity.com/womens-needs-in-maternity-services-in-a-pandemic

All4Maternity 2nd February 2021

Helen Elliott-Mainwaring, Midwifery Lecturer at University of Leicester

Abstract

Much has been written on the experience of medical paternalism during pregnancy, where women are held hostage to their fetus and aspire to be seen to be doing the right thing, being a good patient, and adhering to medical advice. This paper briefly explores paperback literature on women's needs in the light of the Covid 19 pandemic.

Research

How do power and hierarchy influence staff safety in maternity services?

Abstract

Background There are considerable tensions for healthcare staff between their employer allegiance and contracts, patient safety, and their responsibilities to codes of conduct within professional registration, and the NHS Constitution.

Aims The research aim was to identify how power and hierarchy influence staff safety in maternity services and this was achieved by reviewing research papers concerned with personal narratives of staff experiences and perspectives of employment in their profession.

Methods This systematic narrative review was based on the approach of a narrative synthesis, with papers coded using NVivo software.

Findings Power and hierarchy influence staff safety in maternity services by creating challenges to staff safety, which appear to essentially derive from poor communication. The workplace adversity described by participants seems to be linked with 1) psychological vulnerability 1.1) anxiety about the job, and 1.2) dysfunctional organisational and practical conditions 2.1) poor communication and practical conditions 2.2) institutional fragmentation of dysfunctional relationships and 2.3) interpersonal elements feeding into an obstructive culture.

Conclusion The negative influences of the cultural concepts of power and hierarchy on staff safety are significant within maternity services. Discoordination findings, those which stood out as different from the rest, evidenced the possibilities that healthy, psychologically safe working conditions could offer for healthcare staff in improving their prevailing culture.

Keywords

Power | Hierarchy | Psychological safety | Maternity services | Sustainability

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Research

Exploring using NVivo software to facilitate inductive coding for thematic narrative synthesis

Abstract

Background The author conducted a review on how power and hierarchy affect staff safety in maternity services, using a narrative synthesis of staff voices from relevant literature. The review was coded using NVivo software. This article aims to evaluate NVivo as a tool for thematic narrative synthesis.

Methods Selected papers were coded inductively using NVivo software, a subjective idealist approach to knowledge where iteration is achieved at the coding and synthesis stages of the process.

Results NVivo proved to be a versatile tool; the imported files could be word or pdf, the import tab made it possible to upload images and audio files and information could be transferred from OneNote, Outlook and bibliographic software such as Endnote and RefWorks. NVivo software provided numerous options to explore data within different tabs. Users could create relationships between files and different coding options to display the findings in word clouds, hierarchies and charts.

Conclusion NVivo was a user-friendly tool for a novice user, facilitating coding for thematic narrative synthesis. A discussion of the review findings were explored in a previous article.

Keywords

NVivo | Narrative synthesis | Qualitative research | Employee voice | Midwifery safety

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