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Improving intrapartum safety: findings from an ethnographic study

Sandall, J., Rance, S., Mackintosh, N.,

RCM Maternity Services in a Changing World Conference, Manchester, 16th-17th November 2010

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Safety and Risk

- Estimates from World Health Organization show a 1:10 adverse event rate for people who enter hospital in high-income countries worldwide, with about half being preventable.
- Safety paradigm assumes people make mistakes and emphasis on improving system as a safety net
- Risk paradigm focuses on risk to organisation and managing risk creators
- Who selects what is risky usually determined by most powerful voices
- Patient safety movement focus is on health care that sometimes causes harm to the people it is designed to help
- BUT debates in maternity care do not always reflect this gaze on the harmful activities of providers and health-care organisations, but on the behaviours and characteristics of women – working in a risk paradigm

www. who.int/patientsafety/en

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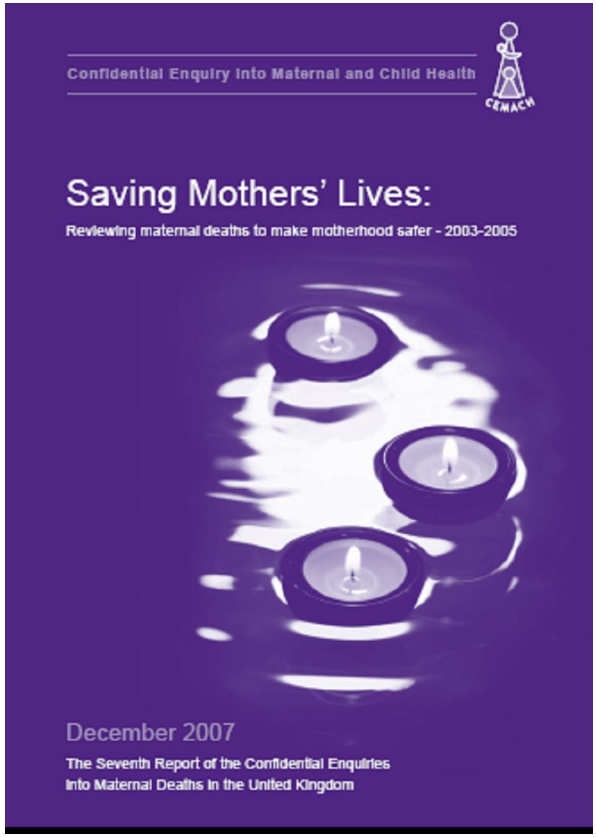
Policy debate about the problem of 'failure to rescue' in maternity care

"There is an urgent need for the routine use of a national obstetric early warning chart, similar to those in use in other areas of clinical practice, which can be used for all obstetric women which will help in the more **timely recognition, treatment and referral of women who have, or are developing, a critical illness".**

CEMACE, Saving Mothers' Lives 2003-2005
Saving Mothers' Lives 2003-2005



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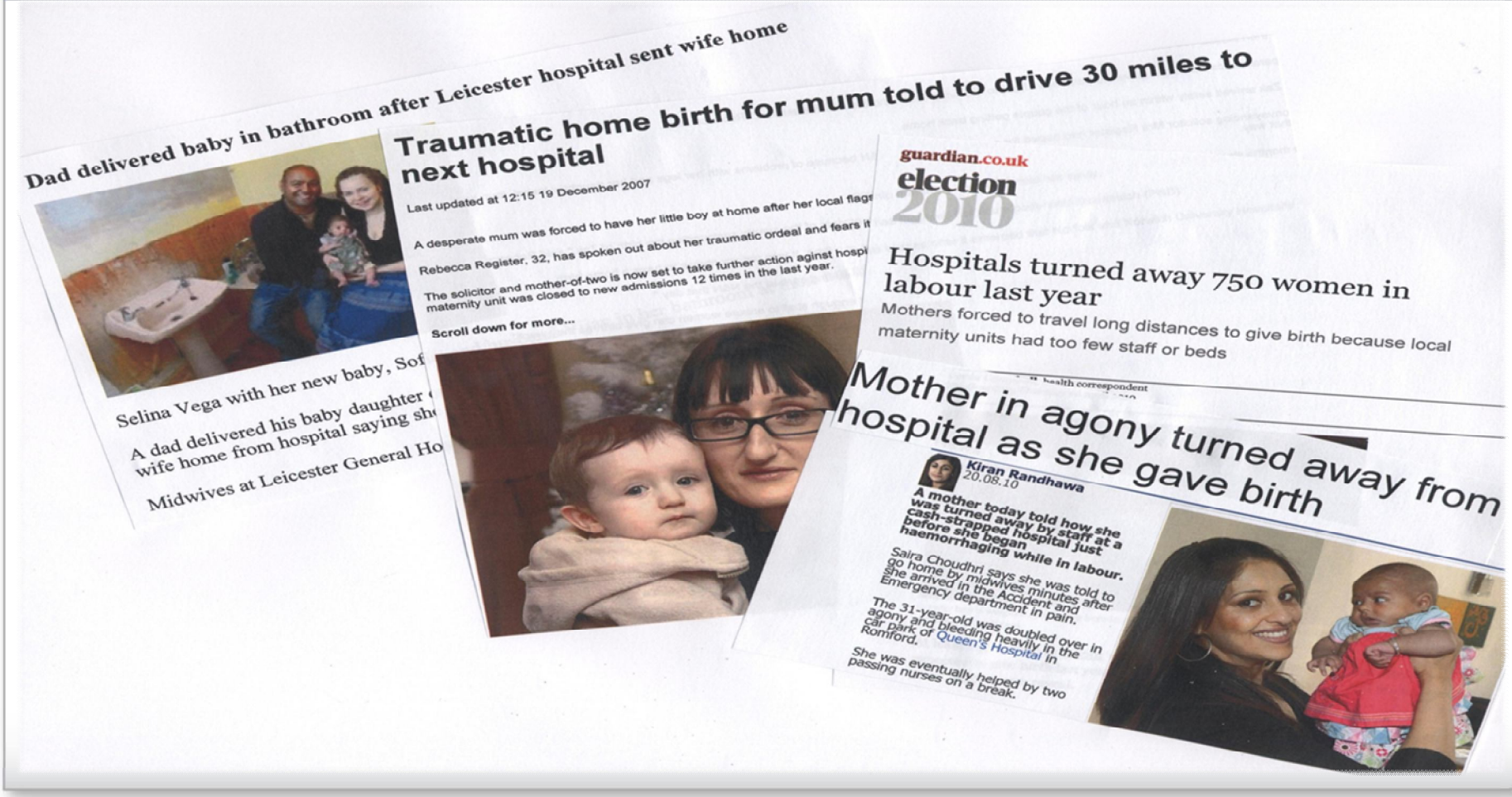
Current context: Are women being listened to?



Dad delivered baby in bathroom after Leicester hospital sent wife home

Selina Vega with her new baby, Sof

A dad delivered his baby daughter
wife home from hospital saying sh

Midwives at Leicester General Ho

Traumatic home birth for mum told to drive 30 miles to next hospital

Last updated at 12:15 19 December 2007

A desperate mum was forced to have her little boy at home after her local flagr

Rebecca Register, 32, has spoken out about her traumatic ordeal and fears it

The solicitor and mother-of-two is now set to take further action aginst hospi
maternity unit was closed to new admissions 12 times in the last year.

Scroll down for more...

guardian.co.uk
election 2010

Hospitals turned away 750 women in labour last year

Mothers forced to travel long distances to give birth because local maternity units had too few staff or beds

health correspondent

Mother in agony turned away from hospital as she gave birth

Kiran Randhawa
20.08.10

A mother today told how she was turned away by staff at a cash-strapped hospital just before she began haemorrhaging while in labour.

Saira Choudhri says she was told to go home by midwives minutes after she arrived in the Accident and Emergency department in pain.

The 31-year-old was doubled over in agony and bleeding heavily in the car park of Queen's Hospital in Romford.

She was eventually helped by two passing nurses on a break.

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Next step to improve safety: the pro-active user

Strategies to improve patient safety have mainly focused on organisation of delivery and provider behaviour and less attention to the ways in which patients already contribute to their own safety (Vincent and Coulter 2002).

Range of strategies have been developed for patients to give voice to concerns – USA *'Speak up for patient safety'* campaign.

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Speak up campaign

Speak up if you have questions or concerns. If you still don't understand, ask again. It's your body and you have a right to know.

Pay attention to the care you get. Always make sure you're getting the right treatments and medicines by the right health care professionals. Don't assume anything.

Educate yourself about your illness. Learn about the medical tests you get, and your treatment plan.

Ask a trusted family member or friend to be your advocate (advisor or supporter).

Know what medicines you take and why you take them. Medicine errors are the most common health care mistakes.

Use a hospital, clinic, surgery center, or other type of health care organization that has been carefully checked out. For example, The Joint Commission visits hospitals to see if they are meeting The Joint Commission's quality standards.

Participate in all decisions about your treatment. You are the center of the health care team.

http://www.jointcommission.org/GeneralPublic/Speak+Up/about_speakup.htm

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Moving to patient self-diagnosis and self-surveillance – embedded assumptions

- Based on experience of patient involvement in chronic disease management, rather than acute episodes of care which may involve life threatening events.
- An undifferentiated view that most/all service users would be willing and able to adopt safety behaviours.
- Additional burden and moral responsibility placed on patients and families not recognised
- Understate difficulty in challenging professionals
- Unproblematised notion of patient empowerment

(Peat, Entwistle et al. 2010).

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Theoretical perspective

Rationality, Rhetoric, and Religiosity in Health Care: The Case of England's Expert Patients Programme, Anne Rogers , Michael Bury , Anne Kennedy, International Journal of Health Services , Volume 39, Number 4 / 2009 Pages: 725 – 747.

Metaphors, discourse, official statements, policy developments, and goals shaping the field of chronic illness, especially surrounding the promotion and uptake of self-skills training in England's Expert Patients Programme (EPP) examined. Self-management policies are part of a shift from patient rights to individual responsibilities.

Hege Andreassen and Marianne Trondsena, The empowered patient and the sociologist, *Social Theory & Health* (2010) 8, 280–287.

Increasing use of the term 'empowerment' – both as a political ideal and as a descriptive concept as an interesting entrance to explore the multifaceted expressions of health and illness in contemporary society.

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PSSQ research: managing complications in maternity

- Improving safety in childbirth has been identified nationally as a research priority by the Chief Medical Officer and internationally by the World Alliance for Patient Safety, NPSA, King's Fund in the UK.

- Key concern is role of organisations, providers and service users in prevention, detection and management of complications.

- **Project Aim**

  Understanding how women and their birth partners, and staff experience the complications and emergencies that sometimes occur during labour and birth, and the complexities surrounding the prevention, detection and management of these episodes.

  The role of safety tools such as early warning scores, track and trigger tools, SBAR communication tools. To explore the potential for women and their partners to speak up and contribute to their care during emergency situations.

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Design, methods & data collection exploring how women, their birth partners, and staff experience complications and emergencies during childbirth

Site selection

2 inner city English NHS Trusts

Data collection

March to November 2010

Ethnographic Methods

- Documentary analysis
- Observation of meetings, ward life and key events (200 hours)
- Audio-recorded interviews:
  - 50 interviews with staff and external stakeholders, postnatal women and some partners [ongoing]
- NVivo coding and analysis of fieldnotes and interview transcripts

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The informed user

A: First time she find it the… is the water colour a little changed. Then I called. (…)

Int.: And you said… the colour?

B: I say it's… like green.

Int.: And what did the midwife say?

B: Waiting for me, I'm coming 9.30. For us, also this… for us strange, because I… this all **what I read - … this is, when you have this colour, you must straight away go hospital.** …

Int.: You read that.

B: Yeah. And… C (midwife) says no, waiting… like four… after four hours I'm coming. And we scared, my God, what… four hours! This too long! Actually is not always OK. But OK. And she coming after and she says yeah OK we go to hospital.

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Responding to women's concerns

Int: How easy is it to [raise concerns] within the clinical context?

I Resp: I think it depends on the individual as well doesn't it? […] [One woman] woke up at 4 o'clock in the morning and said to the midwife, ' I really feel unwell, I feel terrible'. The midwife said 'What', and she said 'I can't say, I just really don't feel well'. The midwife fortunately took her sensibly and put her on the monitor, and there was this catastrophic terminal CTG and the woman was very ill, and she just knew. But she's a specific example, and you can get other examples of women who just are over-anxious and need to take that with a pinch of salt. So I can't say I don't know examples, but for every woman like that woman who knew there was something wrong, the vast majority of them just, it's anxiety.

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Users' safety concerns as unfounded

But I was already in pain, really in pain. I said to my boyfriend, 'I really don't want to go home.' I don't know, I just felt, I was like I just don't want to stay. And she said, 'Sorry, but you can't stay, you have to go home.' She's like, the only thing I can do is walk around the hospital, and I was like, 'I can't even sit properly!' And, er, yeah, she said, yeah, 'You have to go home because it takes at least ten hours.' (…) And I said to [partner], my boyfriend, he talked to her as well, and she was like, 'No, we can't keep you here because you're still not… you are closed down there and also you have to [?] contractions…'. (…) We really thought it might take ten hours or longer, so… we had no choice, it was like… And so we took a taxi home again. [Postnatal woman]

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Findings

- Women *did* voice their concerns and sought to promote their own intrapartum safety .
- Users' ability to speak up was affected by situational factors, e.g. presence of partners and known midwives.
- Staff responses to user voice were extremely variable:
  - Some reacted promptly to women's safety alerts;
  - Others were more ready to categorise women who spoke up as 'difficult', 'anxious' or 'manipulative'.
- Factors affecting staff's ability to listen and provide timely responses included organisational culture, bed shortages, and de-valuing of women's knowledge and experience.
- Attentive listening to users' accounts was reported *after* incidents had occurred, rather than in a precautionary way.

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Conclusions and implications for practice – DIY diagnosis?

- Women and their partners *do* speak up in acute emergency situations.
- Attention needs to be paid to *how* services are organised, in order to facilitate listening and response by staff in safety-promoting ways.

- Further data analysis is focusing on:
  - Provider and institutional response
  - Sense-making regarding women's concerns: how do staff decide when to take these seriously?
  - Implications of partners being expected to take responsibility for women's safety in labour.
  - Wishes of women and families to take on additional responsibility
  - Self-surveillance and self-diagnosis
  - Moral responsibility – especially partners

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Acknowledgements

- Thank you: Staff and service user participants

- *Disclaimer: this presentation presents independent research commissioned by the National Institute for Health Research (NIHR). The views expressed in slides are those of the authors and not necessarily those of the NHS, the NIHR or the Department of Health.*

- Contact: jane.sandall@kcl.ac.uk
  http://www.kingspssq.org.uk/