JOGNN

RESEARCH

Thematic Analysis of Women's Perspectives on the Meaning of Safety During Hospital-Based Birth

Audrey Lyndon, Jennifer Malana, Laura C. Hedli, Jules Sherman, and Henry C. Lee Q5

Correspondence
Audrey Lyndon, PhD, RNC, FAAN, Department of Family Health Care Nursing, University of California San Francisco, 2 Koret Way, San Francisco, CA 94143-0606.
audrey.lyndon@ucsf.edu

Keywords
labor and birth
patient experience
patient safety
women's health

ABSTRACT

Objective: To explore women's birth experiences to develop an understanding of their perspectives on patient safety during hospital-based birth.

Design: Qualitative description using thematic analysis of interview data.

Participants: Seventeen women ages 29 to 47 years.

Methods: Women participated in individual or small group interviews about their birth experiences, the physical environment, interactions with clinicians, and what safety meant to them in the context of birth. An interdisciplinary group of five investigators from nursing, medicine, product design, and journalism analyzed transcripts thematically to examine how women experienced feeling safe or unsafe and identify opportunities for improvements in care.

Results: Participants experienced feelings of safety on a continuum. These feelings were affected by confidence in providers, the environment and organizational factors, interpersonal interactions, and actions people took during risk moments of rapid or confusing change. Well-organized teams and sensitive interpersonal interactions that demonstrated human connection supported feelings of safety, whereas some routine aspects of care threatened feelings of safety.

Conclusion: Physical and emotional safety are inextricably embedded in the patient experience, yet this connection may be overlooked in some inpatient birth settings. Clinicians should be mindful of how the birth environment and their behaviors in it can affect a woman's feelings of safety during birth. Human connection is especially important during risk moments, which represent a liminal space at the intersection of physical and emotional safety. At least one team member should focus on the provision of emotional support during rapidly changing situations to mitigate the potential for negative experiences that can result in emotional harm.

JOGNN, ■, ■–■; 2018. https://doi.org/10.1016/j.jogn.2018.02.008

Accepted February 2018

Audrey Lyndon, PhD, RNC, FAAN, is an associate professor and Chair of the Department of Family Health Care Nursing, University of California San Francisco, San Francisco, CA.

(Continued)

The authors report no conflict of interest or relevant financial relationships.

Calls to make the patient the center of patient safety have been in place since the early days of the patient safety movement. For example, Vincent and Coulter argued in 2002 that the practice of ignoring the expertise and experience of patients was widespread within the safety movement and would prevent the movement's full development. However, despite this and other ongoing calls to incorporate patients' expertise into maintaining safety, overall progress toward this goal has been relatively limited, and the experience of hospitalization can be profoundly disempowering (Mishra et al., 2016). Although safety interventions are traditionally focused on the prevention of physical harm, psychological harm that stems from the experience of an adverse event (Vincent & Coulter, 2002) or the experience of receiving care (Kuzel et al., 2004; Nilsson, 2014; Vincent & Coulter, 2002) can also occur. Furthermore, a growing body of literature on patient perspectives on safety indicates that patients and families have a broader conceptualization of safety than the prevention of physical harm and that their understandings of safety include an emotional or affective component (Daniels et al., 2012; Lyndon, Jacobson, Fagan, Wisner, & Franck, 2014; Rosenberg et al., 2016; Schwappach & Wernli, 2010). Q1

The potential for the experience of care to create harm is of special concern during childbirth. Childbirth is a major life transition and has been described as an existential experience (Nilsson,

FLA 5.5.0 DTD ■ JOGN329_proof ■ 16 March 2018 ■ 4:09 am ■ ce

Quality of communication, participation in decision making, and other factors affect women's childbirth experiences, yet little is known about how women conceptualize safety during birth.

Jennifer Malana, MSN, RN, is a doctoral student in the Department of Family Health Care Nursing, University of California San Francisco, San Francisco, CA.

Laura C. Hedli, MS, is a writer in the Division of Neonatal and Developmental Medicine, Department of Pediatrics, Stanford University, Palo Alto, CA.

Jules Sherman, MFA, is a design consultant in the Department of Pediatrics, Stanford University, Palo Alto, CA.

Henry C. Lee, MD, MS, is an associate professor in the Division of Neonatal and Developmental Medicine, Department of Pediatrics, Stanford University, Palo Alto, CA.

2014). Women's birth experiences can hold particularly affirming or destructive power in their lives that can reverberate for years (Nilsson, 2014; M. Simpson & Catling, 2016). Physical harm is also not uncommon during birth, and serious maternal morbidity and mortality are of national and international concern. Estimates of the number of women who experience their births as traumatic range from 5% to 48%, and births without adverse physical outcomes may still be perceived as psychologically traumatic (Elmir, Schmied, Wilkes, & Jackson, 2010; M. Simpson & Catling, 2016). It is important to understand women's perspectives on safety during birth to prevent or mitigate physical and psychological harm. Fear (Hollander et al., 2017), loss of control (Beck, Gable, Sakala, & Declercq, 2011; Hollander et al., 2017; O'Donovan et al., 2014), desire for clear communication (Hollander et al., 2017), participation in decision making (Beck et al., 2011), and emotional support from health care providers (Beck et al., 2011; Hollander et al., 2017; Nilsson, 2014) are known to be important factors in childbirth experiences. However, the question of how women conceptualize safety during in-hospital birth has not been examined. The purpose of this study was to explore the experiences and understanding of safety during the labor and birth of one group of women.

Methods

Design

This qualitative descriptive study used thematic analysis of interviews conducted individually and in small groups with a purposive sample of women residing in the San Francisco Bay Area who had previously given birth in a variety of settings. The study was approved by the institutional review boards at the University of California, San Francisco and Stanford University.

Participants and Settings

Seventeen women ages 29 to 47 years participated: 3 were interviewed individually as the only respondents to the invitation for that day, and 14 were interviewed in groups of two to four. Two participants did not report demographics. All of the remaining participants completed high school; nine had bachelor's degrees, and five had graduate degrees. Eight participants were employed. Thirteen participants reported their race as White, one as Asian, and three were unknown. Ten participants reported their ethnicity as non-Hispanic/Latino, three declined to state their ethnicity, and four were unknown. Participants reported a range of birth experiences from "easy" and "straightforward" to those with serious maternal or newborn complications, including potentially life-threatening conditions such as HELLP syndrome (hemolysis, elevated liver enzymes, and low platelets) and extreme prematurity. Participants gave birth at a range of facilities, from community hospitals to academic medical centers. Interviews took place in an academic medical center conference room or at the home of a hospital-affiliated parent advisor.

Procedures

Women were recruited purposively by a hospital-affiliated parent advisor with the use of flyers posted physically and online. An investigator or research team member conducted the interviews, which lasted 90 minutes and were recorded and professionally transcribed verbatim. All participants gave signed informed consent and received a $25 gift card.

We conducted individual and small group interviews to explore women's perspectives of safety during the time immediately before, during, and immediately after in-hospital birth and aspects of care and the environment that made them feel safe or unsafe during this time. We used a semistructured interview guide that covered the birth experience, the physical environment, clinical interactions, and what safety meant (see Table 1). We did not define *safety* because we were interested in women's perspectives of safety, and we did not want to shape their responses with a priori definitions.

Analysis

We analyzed transcripts thematically using the approach of Braun and Clarke (2006). We read transcripts closely for surface and underlying meaning, developed codes to represent units of meaning, and developed themes by identifying patterns of meaning within and across transcripts. We used memoing to develop themes and relationships between concepts. Two investigators (J.M. and L.H.) conducted primary coding, reviewed this coding with senior investigators, and resolved discrepancies to consensus. Four investigators (J.M., L.H., J.S., and A.L.) wrote memos for the various themes