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Think pink! A pink sticker alert system for women with psychological distress or vulnerability during pregnancy

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Abstract

The importance of good clinical communication to women during pregnancy and birth is clear. Poor communication in labour is associated with general dissatisfaction, more complaints and a range of perinatal mental health problems including post-traumatic stress disorder (PTSD) and postnatal depression. To communicate effectively, maternity staff needs information about which women are vulnerable and require extra support. To address this, we implemented and evaluated a pink sticker communication system to alert midwifery and obstetric staff to potential psychological difficulties experienced by some women. Evaluation showed this system was viewed positively by women and midwifery staff. Audit of referrals to the perinatal psychology service during this period suggests no woman with a pink sticker developed birth trauma as a direct result of perceived poor care. In addition, the proportion of referrals to perinatal psychology for birth trauma significantly reduced during this period.

Background

Effective empathic communication between midwives and women and their families is imperative to deliver good and effective clinical care. Women who report good communication from their health professional also report greater satisfaction with care (Mohammad et al, 2011), whilst poor communication may lead some women to become reluctant to engage in services (Raine et al, 2009). Empathic communication is particularly important for women with previous or current mental health problems. In the words of one woman 'I don't want to have to keep explaining my situation over and over... it makes me more anxious if I have to go through the story lots of times' (woman attending Psychology service).

Warwick Hospital Perinatal Psychology Service

Warwick Hospital has a dedicated perinatal psychology service which provides clinical input and support to women and their partners during pregnancy and for up to six months after birth. Typical problems include antenatal and postnatal depression and anxiety, grief following perinatal loss, specific fears interfering with medical care (eg needle phobia), high risk pregnancies (eg multiple birth, placenta praevia), exacerbation or monitoring of severe and enduring mental health problems such as bipolar disorder, fear of childbirth and birth trauma reactions including post-traumatic stress disorder (PTSD).

The service has developed over the past ten years and receives 220-250 referrals per year. The largest group of referrals (34% on average from 2006-2008 inclusive) comprises women with postnatal birth trauma and PTSD. These can be broadly divided into women who experience subjective trauma (where symptoms are not

caused by an objectively traumatic birth event but are more likely to arise from interpersonal factors such as feeling isolated or abandoned during labour or perceiving their midwife to be emotionally absent, or even actively hostile) and objective trauma (arising from potentially life-threatening events such as postpartum haemorrhage). Clinical experience suggested some of these women had pre-existing mental health difficulties or specific anxieties, so could be pre-identified as more vulnerable during pregnancy. These include previous trauma, significant anxiety in pregnancy or depression.

These perinatal referrals and reviews of research on birth trauma (Bailham and Joseph, 2003; Olde et al, 2006) clearly highlight the importance of good communication and support from midwifery services during labour. It was therefore critical to find effective methods of improving communication and care of women during labour, particularly when women are more vulnerable through a history of trauma or other mental health problems. Some of these women will be identified antenatally and referred to the perinatal psychology service, so effective methods of communication between psychology and maternity services regarding these women has the potential to improve overall outcome.

Warwick pink sticker alert system

With a growing service at Warwick Hospital, it was not feasible for the perinatal psychologists to discuss each woman's individual needs with staff in person. A system was needed to ensure that information was not lost and helpful information about a woman's mental state, or vulnerability to mental illness was appropriately conveyed to those providing maternity care. Women giving birth at Warwick

Hospital carry hand-held notes which remain with them antenatally and many brightly coloured stickers are used to denote particular needs. For example, an ‘anaesthetic alert’ sticker is used to alert to a particular anaesthetic need, and the neonatal team also utilise stickers, alerting to particular medical issues such as a woman who carries Group B streptococcus. Midwifery staff at the hospital indicated that they are used to stickers, and to being alert to information that stickers convey when reviewing a woman’s notes.

Through conversations between a consultant clinical psychologist and senior midwifery and obstetric staff it was decided that a ‘psychology alert’ sticker would work well as a communication device so a bright pink psychology alert sticker was put into place in 2009. This sticker is placed on the front of the woman’s hand-held notes with a page number denoted on it. A second sticker is placed on that indicated page and brief information about the woman’s symptoms and needs is then written within the notes. The purpose of the pink sticker was to communicate with the labour suite to ensure identified women received appropriately tailored, emotionally intelligent care. However, it rapidly became evident that the pink sticker was useful for these women during antenatal appointments as well, with midwives and obstetricians considering the woman’s emotional needs during all visits. In the labour suite the hand-held notes are taken from the woman on arrival and the information conveyed within them, as indicated by the pink sticker, is shared amongst midwives and obstetricians caring for the woman. The system rapidly became known throughout the maternity services as ‘the pink sticker system’ and we use this term throughout for ease of reference.

During the time the sticker was introduced, all midwives in the Trust began receiving mandatory training on perinatal psychology. Information on the pink sticker system was incorporated in this training which combined information about psychological presentations and education on how midwives could support women with mental health problems, or vulnerabilities, through pregnancy and labour. Typical examples of women being given a pink sticker included women who had experienced a previous traumatic birth, had a needle phobia, had lost a baby, had a fear of childbirth, a history of abuse and so on. The combination of the alert sticker with training on perinatal mental health was considered to be an important element.

This pink sticker system therefore aimed to provide a rapid, concise method of communication between psychology and maternity services about a woman's psychological state and needs antenatally and during the intrapartum period. Although we have not evaluated the efficacy of this system a pilot evaluation has been carried out using multiple approaches, including examining referrals to the service and interviews with women and staff. This paper reports the results of this pilot evaluation and discusses the advantages and disadvantages of the pink sticker system for individual women and maternity services.

Method

A pilot evaluation of the pink sticker system was conducted using information from four sources:

- a) A focus group was held with midwives familiar with the pink sticker system (n=4). The midwives ranged across in seniority from at least two years qualified to very senior, and had all cared for a number of women who had

presented to the Labour Suite with a pink sticker on their notes within the last year. This group was interviewed by a researcher independent of the perinatal psychology service.

- b) In-depth discussions were held with women who had a pink sticker on their antenatal notes (n=4) in person or by telephone. All women had delivered within the previous year. They differed in parity and regarding issues for which they were referred to the service. These conversations were held with the same independent researcher.
- c) A number of women who experienced the pink sticker system (n=49) were asked at their postnatal follow-up with their psychologist about their birth, in particular whether they felt the pink sticker had an impact.
- d) The psychology referral database was examined to establish the proportions of perinatal referrals with a diagnosis of birth trauma or PTSD, as the literature suggests this group may be particularly sensitive to improved care and communication.

In conditions a) and b) above, notes were taken of the conversations held, and brief reports of individual responses were collected. Women and midwives participating all gave their consent to participate in a service evaluation of an existing system.

Results

Results were mainly positive and supportive of the pink sticker system. A number of advantages and disadvantages were identified by women or midwives and maternity service managers as follows:

Individuals: Pregnant and postnatal women

Interviews and clinical feedback from women (group, telephone and postnatal follow-up, n=53) were overwhelmingly favourable. No woman felt completely negative about the experience of having a pink sticker on her notes. The majority of women (85%) reported only positive feelings about their experience. These women described how the system made them feel well cared for, well understood, and contributed to an individualised care plan to which they had contributed. They were positive about being able to communicate their particular concerns to midwives via the notes, without having to describe their feelings repeatedly. This was particularly important during labour when they were feeling more anxious, distressed or vulnerable (n=28, 52.8%). All women reported that they had felt respected and their wishes were considered at all times. This made them feel safe and gave them confidence that the midwives understood their particular needs and concerns. Many of these women were pleased that they did not have to repeat their concerns or issues to every health professional they saw (n=21, 39.6%).

However, a number of disadvantages were mentioned. A small number of women (n=3, 5.6%) mentioned the potential for labelling or stigma. One woman described feeling labelled herself and said she would have preferred a plain pink sticker without the words 'psychology alert' on it. Four women (7.5%) reported that staff on the labour suite appeared to be too busy to read their individualised care plan, and that they needed to be insistent in order for staff to consider the information. Two women (3.8%) described feeling uncomfortable that their difficulties were visibly flagged on their notes and could be seen by all healthcare professionals caring for them. They

felt that only some individuals had a 'need to know' about the psychological issue (eg labour suite midwives) and would have preferred a more targeted approach.

The impact of the pink sticker system on care was generally perceived as positive. Women believed potential difficulties were highlighted early and they received more support than they would have done otherwise. A large number of women (n=44, 83%) believed they had been allocated a more experienced or empathic midwife in labour because of the pink sticker. Almost all women (n=49, 92.5%) felt confident that their midwife had read the pink sticker notes and checked their understanding of these with the women. Finally, around half of the women (n=28, 52.8%) reported that having the sticker on their notes had been equally helpful through the pregnancy as a way to highlight their concerns.

Maternity Service

A number of benefits were highlighted by the labour suite midwives. The communication of key relevant information in one place was valued and midwives felt that they did have time to read the brief summaries provided. The pink sticker system allowed them to quickly identify women needing extra sensitivity or with specific care needs. The pink sticker was universally valued as a means to start a conversation about difficult issues with the woman without expecting the woman to raise the issue herself as well as a tangible marker of the need for increased sensitivity when caring for these women. Midwives valued what they felt was their increased level of knowledge relating to perinatal mental health issues, and themselves raised an important additional benefit of the system in that there was felt to be an increased psychological mindedness of the unit as a whole, with all women receiving an

enhanced level of care, particularly when a 'pink sticker woman' was on the unit; this also translated into an increased awareness of psychological wellbeing during pregnancy. Finally, midwives felt supported in having a clear care plan for women, particularly those with a severe and enduring mental health problem.

In addition there were some suggestions for improvements of the service. Midwives said that there were women who were identified too late to receive psychology input and hence do not receive a pink sticker, and pointed out that some requests on the brief summaries were unfeasible or impractical (such as requesting skin to skin in theatre, where it is too cold).

The midwives' focus group provided some overall comments about the way in which the pink sticker system has affected the whole service in positive ways. They acknowledged that the system works very well, and felt that the emotional understanding provided to women giving birth at Warwick Hospital has been enhanced above the usual. They attributed this to the pink sticker system raising awareness of psychological issues, and the positive working relationship between maternity and perinatal psychology services. They also felt that the system has allowed midwives and obstetricians to provide good emotional care to women with significant and serious mental health problems as the care summaries provide in-depth information about the needs of these women and what the women would like has been discussed and agreed in advance. There was some feeling among the midwives that by assessing the need for psychological support and help antenatally, there may be a decreased risk of adverse postnatal outcomes.

The need for good training and regular updates was acknowledged. Although midwives at Warwick Hospital received four hours of specific training in perinatal psychology, there was little recall of the content of this and an acknowledgement that regular refresher courses are probably essential. However, an overall sense of competence was retained in terms of working with women with particular psychological needs.

An important finding was that on postnatal clinical assessment of women who had a pink sticker on their notes, none of these women developed birth-related trauma symptoms which could be attributed to subjective causes. On examination of the psychology database, there was a clear decline in the proportion of birth-trauma related referrals received from 34% before the system was introduced to 19% in 2013 (see Figure 1). Initial investigation of this finding appears to suggest that trauma as a result of subjectively traumatic birth (as oppose to objectively traumatic events) decreased substantially, indicating this system may have a preventative effect and reduce the number of women traumatised by birth. It may also be the case that more psychologically minded care is acting as a protective device for women who experience objectively traumatic births, preventing the subsequent development of trauma symptoms. Further investigations are currently being conducted to examine this in more detail.

Discussion and Learning Points

Overall, the pink sticker psychology alert system was perceived positively by both women and midwifery staff. Only 15% of women reported disadvantages of the system, and all these women also reported positives. In order to address the

disadvantages reported by women, it is likely that no wording or different wording (other than 'psychology alert') will be more acceptable. The minority view from women that staff did not have time to read the pink sticker summaries occurred in less than 10% of cases. Nonetheless, feedback will be given to senior maternity staff and labour suite supervisors to ensure that pink sticker summaries are given due attention.

Midwifery staff reported many advantages and impacts on nonspecific aspects of care with other women. However, the main disadvantages mentioned were that some women were referred too late to receive a pink sticker and impractical requests made on pink sticker summaries. Psychology staff utilising pink stickers will be given joint training from senior psychologists and senior midwives on the appropriateness of various requests to ensure that those requests made on pink sticker summaries are feasible. In terms of the late referrals, new refresher updates on perinatal psychology have recently commenced at Warwick Hospital for all midwifery staff and the importance of early referral will be highlighted to ensure that all women who need a pink sticker can receive one. However, it is recognised that some women feel unable to talk about their concerns until very late in pregnancy, and it is unlikely that late referrals can be completely eliminated.

The decline in PTSD referrals during this period is particularly encouraging. However, it is important to recognise that this is not in itself clear evidence that the pink sticker system is the reason for this decline. It is possible that women with birth trauma are being referred less often to the perinatal psychology service for other (unknown) reasons, although this seems unlikely as overall referral numbers to Psychology have continued to increase year on year. In addition, no other aspect of

the emotional care given to women in labour has changed, and these results are very promising. The overall reduction in referrals for traumatic birth from 2006 to 2013 was 44%. Crucially, no woman delivering with a pink sticker developed trauma symptoms which could be attributed to poor communication or negative perceptions of care during her delivery experience.

The utility of a quick, effective communication device such as the pink sticker has been clearly underlined. The pink sticker itself was designed to promote understanding of the issues and concerns of an individual woman but appears to have a broader impact, such as increasing the psychological mindedness of the maternity services as a whole during the antenatal and intrapartum periods. Relevant information from the pink sticker summary is also passed on to the postnatal ward, and hence has an impact in this setting also. This evaluation has strengths in terms of having conducted face to face groups and interviews with patients and midwives, and in gathering information from a number of sources. It must be recognised that the interviews were conducted by the women's own clinical psychologist, and this may inhibit some women from being open about perceived disadvantages of the pink sticker system.

The implications of this study for clinical practice are that an integrated communication device between perinatal psychology and maternity services, supported by appropriate training, can increase the skill level and knowledge of midwives and obstetricians caring for perinatal women. Specifically, this appears to reduce trauma in a perinatal population, probably by reducing the level of subjective trauma resulting from perceived poor care. The findings that no woman with a pink

sticker developed birth trauma, and the overall reduction in the proportion of trauma-related referrals, are encouraging, and suggest that identification of vulnerable women to midwifery staff could reduce the risk of non-optimal care, potentially resulting in reduced postnatal trauma. Further examinations of case files will be conducted to investigate whether it is possible to identify protective factors for women, and to establish whether the reduction in birth trauma is in fact due to a reduction in subjective factors.

Key Phrases

Good communication is crucial between a labouring woman and her healthcare professionals. There is evidence that poor communication can lead to an increase in mental health problems postnatally. The intervention of a 'psychology alert' pink sticker on women's antenatal notes provides a rapid and effective means of communication between psychology and maternity services. The introduction of the pink sticker system is viewed positively by midwives and women and appears to have a significant effect in terms of reducing the level of birth-related trauma.

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Figure 1. Decline in referrals to the perinatal psychology service for birth trauma or PTSD following the implementation of the psychology alert system.

(For editors: 2006-2008 = 34%, 2009 = 32%, 2010 = 28%, 2011 = 27%, 2012 = 21%, 2013 = 19%)

