Stress, anxiety, and erosion of trust: maternity staff experiences with incident management

Victor Olagundoye, MBBS, MMedSci, MSc, MRCOG; Monica Quinlan, BSc, MSc; Robin Burrow, BA, MA, PhD

BACKGROUND: Adverse incidents in maternity care and other healthcare systems continue to be a major cause of morbidity and mortality, with significant financial costs to healthcare organizations, patients, and their families. Over the last decades, healthcare organizations have focused their attention on improving the quality of patient care, safety, and experience. However, very little attention has been given to understanding and improving staff experience. This is despite the high probability that healthcare professionals who experience their workplace positively will deliver higher-quality care, report incidents more commonly, and actively engage in incident investigation and learning processes.

OBJECTIVE: This study aimed to explore maternity staff's experiences with the incident reporting and investigation process, with specific reference to its impact on trust in local risk management leadership and the organizational process.

STUDY DESIGN: Semistructured in-depth qualitative interviews were analyzed using a methodological procedure for understanding human experiences of complex social phenomena (interpretive phenomenological analysis). The study was conducted in a tertiary university maternity teaching hospital in England with approximately 6000 deliveries per annum. A purposive sample of 10 staff members (2 consultants, 3 specialist registrars, and 5 midwives) was selected, with all participants having been involved in incidents requiring formal investigation during the preceding 12 months. The main outcome measures were the lived experiences, emotions, and perceptions regarding how the incident reporting and investigation process affected their trust in risk management leadership and the organizational process.

RESULTS: Incident reporting and investigation were found to be perceived by staff members as very stressful events with no structured feedback and support system for staff. We found that this led to diminished trust in risk management leadership and the organizational process, with staff relying on colleagues for support and validation of their practice.

CONCLUSION: The study showed that poorly managed processes of incident reporting and investigation result in diminished trust in risk management leadership and organizational processes. It also reinforced the understanding that adverse incidents have a profound impact on the mental health and well-being of healthcare professionals. Factors that could likely mitigate these experiences and effects include: (1) timely updates and feedback from incident investigation; (2) high levels of leadership visibility; and (3) structured support for staff during and after incident reporting and investigations.

Key words: adverse incident, incident reporting and investigation, organizational trust, postevent management, risk management, risk management leadership, staff experience

Introduction

Most healthcare professionals strive to provide the best possible care to their patients. However, humans are fallible, and mistakes leading to avoidable harm—known as "adverse incidents"—remain an inherent part of health care. Accordingly, adverse incidents in health and social care continue to be a major cause of morbidity and mortality, with significant costs to healthcare organizations, patients, and their families.[1] The scale of the problem is enormous. According to Illingworth,[2] approximately 8% to 12% of patients admitted to hospitals will suffer some form of harm as a result of the care they receive, 30% of which is preventable. In the United States, it is estimated that there are >250,000 deaths every year resulting from adverse incidents, making them the third most common cause of death in the country.[3]

Among the medical specialties, maternity care is particularly high-risk. When adverse incidents occur, the consequences are often significant, lasting, and unresolvable, and usually affect both mother and child. Consequently, adverse incidents in maternity care carry a disproportionately high human

From the Birmingham City Hospital, Birmingham, United Kingdom (Dr Olagundoye and Ms Quinlan); Cardiff Business School, Cardiff University, Cardiff, United Kingdom UK (Dr Burrow)

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Corresponding author: Victor Olagundoye, MBBS, MmedSci, MSc, MRCOG. victorola@doctors.org.uk

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AJOG MFM at a Glance

Why was this study conducted?

This study aimed to investigate maternity staff's experiences with adverse incident reporting and investigation and to explore the impact of such investigation on staff's psychological and emotional well-being and organizational trust. The study also aimed to understand local maternity staff experiences with the local risk management leadership and investigated the effects of postincident management on staff.

Key findings

Our study demonstrated that poorly managed adverse incidents can result in diminished trust in risk management leadership and organizational processes. Moreover, adverse incidents can have a profound impact on the mental health and well-being of healthcare professionals. Organizational support for staff involved in incidents should be individualized to ensure maximum benefit to all staff members.

What does this add to what is known?

This study provided insight on the link between trust and staff perceptions of local risk management processes.

and financial cost.[4] For example, the total cost of clinical negligence claims reported in the United Kingdom from 2020 to 2021 was $8703.06 million. Obstetrics accounts for 59% of this cost despite representing just 11% of the 10,816 claims made.[5]

To address the grand challenge posed by adverse incidents, healthcare organizations across the world are increasingly focused on improving patient safety. Following state-of-the-art thinking in industries such as aviation, the challenge of adverse incidents is being addressed in myriad ways. For example, by introducing standardized, evidence-based safety checklists[6] and through concerted efforts to change the culture and practice around incident reporting,[7–9] which has resulted in significant improvements in patient safety.

Despite the considerable work that has been done to improve patient safety, little attention has been paid to healthcare professionals' experience with incident management and its impact on their trust in organizations and their leaders. Trust is a key factor in patient safety; it is the glue that binds not only healthcare professionals and their patients, but also the people involved in the delivery of patient care.[10] To help address this paucity, we present the findings of a small-scale qualitative study of maternity staffs' experiences with the incident reporting and investigation process. We do this firstly to provide insight into how the incident reporting and investigation process is experienced by those involved, and secondly to show how postevent management of clinical incidents can affect trust in extant risk management processes and ultimately affect care quality and safety.

Design

This was a qualitative study conducted in accordance with the prescriptions of interpretative phenomenological analysis (IPA).[11] Central to these prescriptions is the use of semistructured interviews to investigate specific subjective phenomena, such as how risk management processes related to adverse incident reporting are experienced, and what effect this has on individuals' trust in organizations and their leadership. Interviews were conducted by the lead author (trained in qualitative research methods) using a simple questionnaire designed to help elicit participants' experiences and perceptions of particular events (clinical incidents).[12] No hypothesis was formulated a priori; rather, the aim was merely to understand how an event was experienced, and how its management affected the people involved.

Recruitment

A total of 30 maternity staff members were invited by email to take part in a semistructured interview in April 2018. They were informed that the aim of the study was to explore how they experienced the risk management process and how they deemed the effectiveness of risk management leadership during adverse incident investigations, and the impact that this had on their trust in the risk management processes. Inclusion criteria were involvement in an adverse incident (or incidents) leading to formal investigation during a 12-month period (January 2017−December 2017), and not being a member of the risk management group. Of the original sample of 30 staff members, 20 were excluded. Of these 20, 9 had not been directly responsible for the care of the patient when the incident occurred, 7 were away, 2 had already left the Trust, and 2 were members of the risk management group. The remaining sample of 10 staff members agreed to take part in the study and were interviewed.

Sample

The sample size was purposefully small (n=10), reflecting the prescriptions of IPA. The aim was to record in detail the experiences of a small, highly invested group of people with direct experience of the phenomena under scrutiny. The sample comprised 10 maternity staff members: 2 consultants, 3 specialist registrars, and 5 midwives from different ethnic, sex, and religious backgrounds. The sample broadly represented a good balance of maternity staff involved in adverse incidents reported during the study period. None of the staff members were aware of those who were taking part in the study, and all data collected were anonymized.

Ethical issues and processes

The local National Health Service research ethics committee was contacted for ethical approval before starting the study. The committee considered the study a service evaluation involving local maternity staff, and therefore granted

exception and clearance for the study to proceed at the Trust.

Each participant was given a number from 1 to 10 to ensure anonymity and confidentiality. All data were collected, secured, and stored in accordance with the Data Protection Act 2018.

The privacy and feelings of all volunteers were respected throughout the study, and no undue pressure was used to gather information. All participants provided both verbal and signed informed consent before being interviewed. They were made aware that taking part in the study was entirely voluntary, and the research was directed with the appropriate standards of scientific and professional integrity. Each participant consented to the recording of the interview.

Data collection

Consistent with the study's methodological design and ambition to record interviewees' "lived experience" of incident reporting and investigation processes, data were collected via semistructured interviews. These enabled the interviewer to gain detailed insight into participants' experiences, clarify and investigate any ambiguities, and ask more sensitive, personal questions than would be possible using alternative methods. The interviews were conducted in accordance with established protocols for semistructured interviews.[13] They centered on the following 8 core questions that were asked of all the volunteers:

1. Was there a time when you experienced particularly difficult emotions as a staff in maternity?
2. Can you describe your experience with an incident that you were involved in during the preceding 12 months?
3. Which emotions did you experience during and after the incident?
4. How would you describe your experience of the culture around investigating and managing adverse outcomes in the maternity unit?
5. Have you experienced any other emotions since the incident occurred?
6. Can you describe the impact that the incident and these emotions have had on your practice going forward?
7. What aspect of the incident management affected your trust in the process?
8. Can you describe your experience with the core risk leadership?

At the start of the interview, volunteers were asked initial questions to ascertain personal details and demographics for equality and diversity monitoring.

Throughout the interview volunteers were encouraged to talk freely about their experiences. The interviewer did this purposefully, using the interview's semistructured format to investigate salient events, perspectives, and experiences being described.

Interviews were conducted in a quiet, private office within the hospital at a time suitable to the volunteer. Each interview lasted between 42 and 67 minutes and was digitally recorded and later transcribed verbatim. Transcripts were anonymized to protect the identity of participants and checked for accuracy against digital recordings before analysis.

Analysis

Reflecting IPA's conventions for analyzing qualitative data, the interview transcripts were subjected to a 3-stage process of analysis as follows: (1) initial transcript review and familiarization, (2) identifying and noting emergent themes, and (3) connecting and collating emergent themes.

Results

All volunteers spoke openly, often animatedly, and occasionally emotionally about their experiences with the incident reporting and investigation process.

Four main themes emerged from their accounts: (1) the human response to adverse outcomes, characterized by guilt, self-blame, and anxiety; (2) lack of trust in local risk management processes, derived from poor communication; (3) limited leadership visibility; and (4) lack of structured support systems, leaving staff relying solely on colleagues for support.

Human response to adverse outcomes: guilt, self-blame, and anxiety

All volunteers in the study explained how deeply adverse incidents affected them, describing the experience as the most difficult time in their careers.

They described feelings of considerable anxiety, guilt, grief, upset, anger, fear, blame, loneliness, and sadness, with statements such as:

> "The first thing I always do is look into myself and say I haven't done enough. Something has gone wrong. It's because of me."

> "I always feel guilty whether it's right or wrong."

> "You have a couple of sleepless nights..."

These feelings have the potential for negative effects on family and working lives with long-lasting consequences including posttraumatic stress disorder.

Three of the volunteers described considerable difficulty in returning to work or the site where the incident occurred. One participant involved in a stillbirth described experiencing panic attacks every time the emergency buzzer went off.

> "It took me about 3 weeks to go back into that theater where the incident happened. I wasn't mentally ready to go in."

> "It was very difficult to come to work the next day and face that lady."

Two of the volunteers who were involved in a case of maternal death reported feeling overwhelmed with sadness when they discovered that the deceased woman was the same age as them and had children of similar age to that of their children:

> "She was a similar age to me, with children of similar age, and I think that is what bothers me."

> "I realized she had children of the same age as mine... that upset me."

"I was quite upset, I cried coming to work next day...."

Eight of the 10 volunteers felt they could have done more to prevent the incident(s) from happening, whereas 6 of the volunteers were worried about what colleagues and other staff thought of their practice.

"I should have done the delivery earlier. I should have acted sooner."

"Could I have expressed it more, that I was concerned about this decreased fetal movement... I felt vulnerable, you worry about what others think...."

Lack of trust in the local risk management process: poor feedback and communication

All volunteers except 1 reported not receiving feedback or updates on the investigation into the adverse incident that they were involved in:

"I wrote it (statement). I sent it. I had no acknowledgement they've received the statement."

"We never seem to get anything back... you never hear anything... we want to know the outcome."

"... we need to know what was the outcome, what was the lesson learned?"

Two volunteers expressed that good communication should go beyond providing feedback and include updates on patients' progress. They described the impact of the lack of such communication on their emotional and mental well-being in terms of feeling isolated and lonely, leading to lack of trust in the system.

One volunteer felt that risk management leadership did not understand how it feels to be a frontline worker and be involved in an adverse incident:

"... for my mental well-being I would have liked to be kept in the loop as to how the baby is doing...."

"If there was one thing, just knowing what the outcome would be, because when you are involved in an incident it might just put you at peace—knowing that actually, this was X, Y, Z."

Lack of trust in the local risk management process: lack of leadership visibility

All the midwives expressed a feeling of disconnection between them and the risk management leadership. They felt that the risk management team was only seen when there was an incident:

"They are quick to attend and ask for a statement when an incident occurs, but also quick to leave once the statement has been given."

"I find that they are very quick at requesting an incident form, very quick if something goes wrong."

"I don't think I've seen anyone from the risk team officially with regard to this incident...."

"They need to be seen more on the floor...."

One midwife reported that her trust in the risk process was significantly affected because of the lack of visibility of the risk management team on the delivery suite floor.

Lack of structured support system: staff relying on colleagues for support

Lack of structured support for staff involved in incidents was a consistent theme. Participants reported that support either was not provided, or when it was, it was too little, too late. In addition, it was often felt that when support was provided, it was often inappropriate. For example, one participant who took part in Schwartz Rounds described it as "being put on display" given that many people who were not involved in the incident were also present, whereas some of those involved were not; the experience of this staff member highlights the need for individualized staff support.

"If that is how it is dealt with afterwards (Schwartz Rounds), I don't think it is productive or helpful because to talk in front of a large number of people you kind of feel on display...."

All volunteers consistently described receiving telephone calls from colleagues offering their support. They described relying on fellow staff for support or to validate their practice when there was an adverse incident. Most volunteers said they would discuss the incident repeatedly with different colleagues to get their opinion on the management:

"Somebody would ring me and say 'I heard this happened, are you alright?'... Just a colleague. It is more of a courteous colleague call so that you know that your colleagues still have your back and respect you...."

"I felt myself looking and asking people 'What would you do, what's your opinion?'"

"My teammates, the ones on the floor with me, are very fantastic in supporting you, extremely, extremely good...."

Most of the volunteers felt that, far from receiving support, there was "finger pointing" and a general fear of being blamed. Some felt that the risk leadership gave more prominence to cases with suspected substandard care than to well-managed incidents.

One consultant felt he was not supported because he was a senior clinician, whereas one midwife who was redeployed after the incident felt she was being punished.

"... I received very little support both from my manager and the risk management team..."

"It has been quite a difficult case and they are not following you up and they are not seeing how you are."

Discussion

This study reinforces previous studies reporting that adverse incidents have a profound impact on the mental health and well-being of healthcare professionals.[14–18] The impact of adverse events on maternity staff is particularly

pronounced.[19] Firstly, because maternity patients are generally young and fit, and secondly, because adverse incidents in maternity can very often be sudden and catastrophic (eg, intrapartum stillbirth, maternal mortality) or have a lifelong impact on mother and infant (eg, severe hypoxic-ischemic encephalopathy at birth).

The fact that most volunteers in this study vividly remembered the incidents they were involved in, some as long as 12 months after they had occurred, demonstrates their significant and lasting effects. They triggered great suffering and what is called a "transformative experience,"[20] with a high degree of potential to trigger burnout, anxiety, and depression.[14,15] This is significant for many reasons, including the ongoing effects that such incidents have on patient safety. Studies have shown that one adverse incident can lead to another.[16–18,21] Safety is further eroded significantly because adverse incidents cause emotional, physical, and psychological stress among affected staff.[21]

Furthermore, this study shows that poorly managed incident reporting and investigation result in diminished trust in risk management leadership and organizational processes. This is relevant because staff who do not trust organizational systems and processes are less likely to engage with them.[22,23] Secondly, if staff do not trust the risk management process and the people in charge of them, they are unlikely to report incidents, accept the outcomes of investigations, and implement recommendations.[24–26]

The consequences of these effects on the quality and safety of health care can be profound. However, they can also be mitigated through proactive leadership practices,[27] such as engagement with the affected individuals, and paying attention to their psychological well-being.

Although structured support for staff is highly recommended, it is important that it is not used as a one-size-fits-all approach. In this study, one staff member was critical of the Schwartz Round, which is one of the initiatives started by the Schwartz Center for Compassionate Healthcare in Boston, Massachusetts. It is a forum for clinical and nonclinical staff to come together to reflect and share their stories, feelings, and the emotional impact of caring for a patient or following an incident. Leadership should ensure that staff are familiar with all the available supports in their unit so that staff members can choose what they deem appropriate for themselves.

Strengths and limitations

This study focused on the link between staff perceptions of local risk management process and trust. Furthermore, the study investigated this link and the more general experience of adverse incident reporting and investigations in depth.

Although the study provided a deep insight into the link between staff perceptions of the risk management process and trust, the result was limited to a particular group of staff members, from a particular maternity unit, at a particular point in time. Universal generalizations should not be made. However, the insights and experiences reported are likely to be common among other maternity staff members. Future research should test whether this is the case.

Conclusion

Although the overwhelming impact of adverse incidents on patients and their families is well-documented, there is still lack of recognition and acknowledgment among many healthcare organizations of the profound and lasting effects of such incidents on healthcare professionals. This study highlights the need for awareness among healthcare leadership of the magnitude of the effects that adverse incidents have on staff members. On the basis of our findings, we make 3 recommendations to reduce the effects of incident reporting and investigation processes, and the likelihood that trust will be eroded. We recommend that: (1) staff receive timely updates and feedback from incident investigations; (2) risk management leaders sustain high levels of visibility before and during incident reporting and the investigation process; and (3) structured support be received by staff members during and after incident reporting and investigations. ■

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