

A Quality Improvement Study on Improving Communication between Health-Care Provider and Laboring Woman: A Step toward Respectful Maternity Care

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Abstract

Background: Effective communication between health-care providers (HCP) and women during labor is a key component for providing dignified and consented maternity care. The quality improvement (QI) study was planned to improve the communication skills of HCP to provide dignified and consented care in the labor ward. **Methodology:** This study was conducted at the labor ward of a tertiary care hospital. To assess the magnitude of nondignified and nonconsented care, baseline data were collected from the women who had normal vaginal delivery through interviews using a prestructured questionnaire. The HCPs were also interviewed about the reasons for nondignified and nonconsented care. Various change ideas were tested through the plan-do-study-act cycle to sensitize the HCP with World Health Organization recommendations on intrapartum communication. **Results:** There was a marked improvement in communication between HCP and women in labor, i.e., addressing the woman by her name (100%), consent before each clinical examination (93%), and providing information about the progress of labor after each examination (50%). **Conclusion:** A QI approach is feasible and effective as a behavior change intervention to provide dignified and consented care in the existing settings.

Keywords: Consented care, dignified care, effective communication, plan-do-study-act cycle, respectful maternity care

INTRODUCTION

Over the years, there has been a marked improvement in institutional births, but pregnancy-related mortality and morbidity still remain very high. Institutional delivery does not stand as a prerequisite for a woman receiving a good-quality care. Along with all the clinical care needed, experience of care also plays an important role to achieve the outcome. It has been found that disrespect and undignified care is highly prevalent all over the world undermining the care received by a pregnant woman.^[1] There are various studies from low middle-income countries (LMIC) highlighting the health system failure, mistreatment, disrespect, and abuse during pregnancy and childbirth.^[2,3] Seven categories of disrespect and abuse in a facility-based maternity care were identified in a landscape analysis report by Bowser and Hill. It included physical abuse, nonconsented care, nonconfidential care, nondignified (including verbal abuse), discrimination based on specific patient attributes, abandonment of care, and detention in

facilities.^[4] To improve the care during childbirth and to reduce disrespect and abuse experienced by a childbearing woman, the World Health Organization (WHO) has introduced the concept of respectful maternity care (RMC).^[5] RMC is an approach based on human rights to improve the women's experience of labor and childbirth further reducing perinatal mortality and morbidity. A number of interventions have been devised to reduce disrespect and abuse.^[6] Effective communication among health-care providers (HCP) and laboring women is one of the key components to ensure women's needs and

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preferences. To implement the WHO recommendations of effective communication, this quality improvement (QI) process involving series of plan-do-study-act (PDSA) cycles was planned.

METHODOLOGY

The study was conducted in the labor ward of a tertiary care hospital over a period of 8 weeks after the approval of the institutional ethical committee according to the model for improvement propagated by Institute for Healthcare Improvement.^[7] Our labor ward is 14 bedded with two delivery tables and caters mainly high-risk obstetric population of Northern India with 6000 deliveries per annum. On an average, 35–40 women are being managed at a time in the labor room area by six junior residents, two senior residents, and one consultant. A self-designed questionnaire based on the WHO recommendations for effective communications during labor was used to assess the magnitude of nondignified and nonconsented care among laboring women. During the same time, the drivers of/reasons behind nondignified and nonconsented care were collected from HCP (residents posted in labor room) by using a self-designed questionnaire [Annexure 2 and Figure 1]. Broadly, the steps were as follows: (a) measuring baseline data to assess the magnitude of nondignified and nonconsented care as (1) proportion of HCP introducing themselves to women; (2) addressing the patient by her name; (3) informed consent before each examination; and (4) informing the patient regarding the progress of labor, (b) eliciting possible drivers for nondignified and nonconsented care, and (c) conducting a series of PDSA cycles to sensitize the HCP with WHO recommendations of intrapartum communications. The baseline data were collected by interviewing 45 women who had normal vaginal

delivery and proportions of the parameters for nondignified and nonconsented care mentioned above were calculated. The impacts of change of ideas were also assessed by interviewing almost 35–40 women using the same questionnaire used for baseline data. After implementing the new PDSA cycle, data were collected from 30 to 35 mothers after a week from the postnatal ward using the same questionnaire. Simultaneously, qualitative data were also collected from women in labor as well as from the HCP. Descriptive statistics were used for baseline variables and run charts were used to display the impact and progress of intervention in the labor room. The feedback and progress was discussed with the team and suggestions were taken for further improvement.

RESULTS

The baseline data showed that the care being provided in the study area was nonconsented and nondignified as none of them were introducing themselves to the women in labor (0%) and did not address the patient/women by their name (0%). Verbal consent was obtained before clinical examination; only in 22% of cases, the information regarding the progress of labor was provided time to time [Run chart Figure 2]. A team of doctors (VS, BS, AA, PS) analyzed the problem and came up with change ideas. The behavior of HCP and laboring women was observed to understand the existing situation. A process map was made indicating the various contacts with different HCPs a woman has from admission till discharge [Figure 3]. A fishbone diagram was made to highlight the drivers of nondignified and nonconsented care [Figure 1]. As suggested by the process map, a laboring mother had to meet minimum six HCP from admission till the delivery so it was decided to make all the residents aware about the nondignified and nonconsented care in the labor room. After

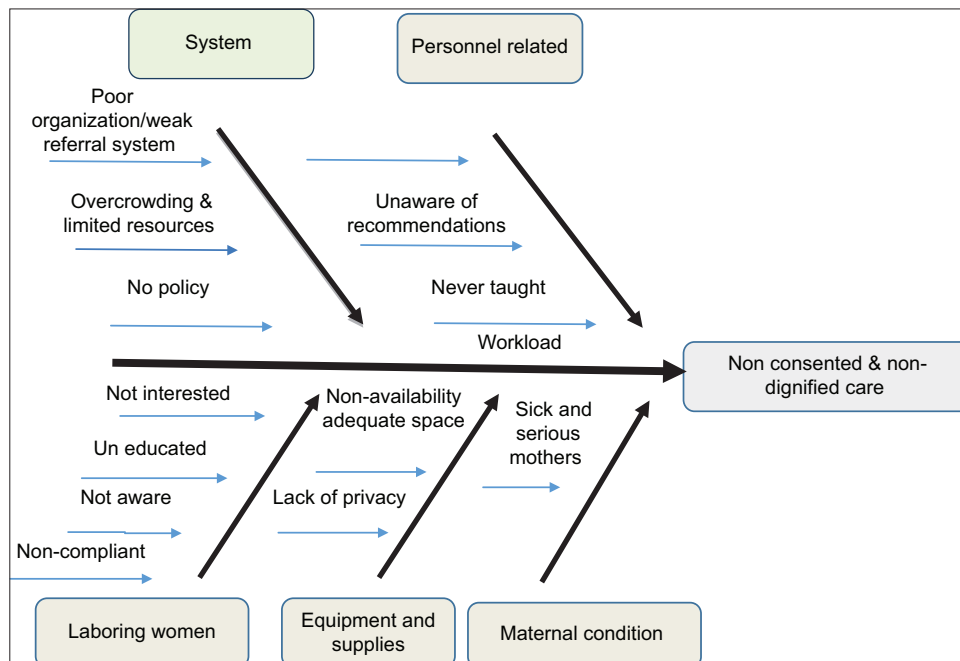


Figure 1: Drivers for nonconsented and nondignified care among health-care providers

multiple sessions, we could sensitize the whole team of residents about the WHO recommendations for effective communication. After five PDSA cycles [Table 1], HCP started addressing women by their name (100%). In 93% of cases, verbal consent was obtained before each clinical examination and time to time information regarding the progress of labor was provided to 50% of cases. However, none of them started introducing themselves to the laboring women.

Qualitative data

The woman gave a feedback that “I do not mind sharing bed with another woman, I would like to come back for my next delivery as the treatment and behavior of the doctor who did my delivery was very nice.”

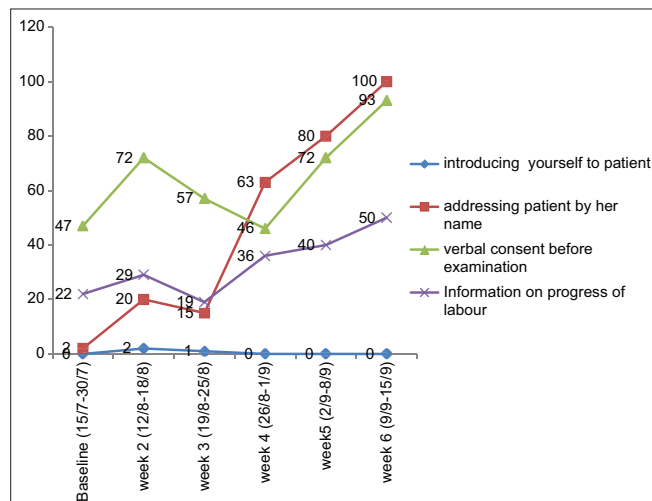


Figure 2: Progress of quality improvement study – Run chart

Another woman said that “I understand the workload and long duty hours of doctors, it is impossible to get the privacy or companion throughout the labor; still my mother was allowed to whenever she demanded.”

One of the junior residents said, “Even we know how to communicate with a laboring woman but it is not possible to work with same spirit and attitude for 12 h a day in a hectic labor room like this.”

Another doctor said, “Even I want to inform each and everything to each laboring women, but what I have realized over the time, it is useless to inform them as once you explain them everything, the very next moment they will ask you to repeat everything to their husband, mother in law or some relative or even neighbors too.”

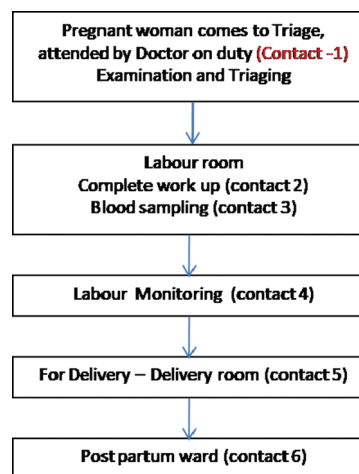


Figure 3: Process map

Table 1: Details of plan-do-study-act cycle				
PDSA cycle	Plan	Do	Study	Action
1	Assess the feasibility of sensitizing residents posted in the labor room about the WHO recommendation of communication	Team of residents posted in day duty was sensitized at start of duty	Team members could not be gathered at one time for group discussion due to overcrowded labor room	To sensitize doctors in small and different groups of 2–3 members as per their availability
2	To assess the feasibility of sensitizing doctors in different groups separately	In 3 days, the whole team of 8 doctors posted in the labor room was sensitized	Feasible, residents were ready to adapt WHO recommendation for communication with laboring mother	Regular reminders needed to change the practice
3	To assess the impact of above intervention	Postpartum women asked to fill exit questionnaire (same used in collection of baseline data)	Improvement noticed in 3 out of 4 aspects of communication under study i.e., addressing women by her name 20%, informed verbal consent 72%, progress of labor 29%	Frequent WhatsApp messages (Image of WHO recommendations) used for regular reminders
4	To assess the impact of the above intervention after putting regular reminders	Postpartum women asked to fill exit questionnaire (same used in collection of baseline data)	Fall in progress achieved in PDSA-3 Addressing women by her name 15% Informed verbal consent 57%	To sensitize doctors posted on weekends
5	To Assess the impact of the above intervention after including doctors on weekend duties	Postpartum women asked to fill exit questionnaire (same used in collection of baseline data)	Marked achievement started addressing women by her name 80% Informed verbal consent 72%	To adopt WHO recommendation of effective communication between doctor and laboring women as a policy

PDSA: Plan-do-study-act, WHO: World Health Organization

DISCUSSION

In the present study, WHO recommendations for effective communication were successfully implemented by using QI methodology. In spite of limited space, resources, and huge burden of laboring women at a time, it was feasible to provide dignified and consented care. After multiple PDSA cycles, there was a marked improvement as HCP started addressing women by their name (0%–100%), verbal consent was obtained in 93% of cases which was earlier found to be in 47%. In spite of the workload, in 50% of cases, HCP were able to inform the complete progress of labor and once or twice in almost all the cases.

The quality of care during childbirth depends on how care is provided by HCP and how care is experienced by a woman with available resources, skills, and knowledge.^[8] The need and priorities of women differ and it is difficult to quantify, prioritize, and meet their needs. Our society is patriarchal and women have limited control over decision about their care and consent and approval is always obtained from family members (husband or mother in law) as a routine. Still, each woman in labor needs emotional support, privacy, and birth companion. Compared to high-income countries, the challenges faced by obstetrician in LMIC are totally different. For example, in the facility of the present study, due to space constraints, laboring women have to share beds, birth companion cannot be adjusted and one doctor has to monitor 5–6 laboring women on an average. American college of Obstetrician and Gynecologist has special recommendations for obstetricians and gynecologists for effective communication which cannot be applied in our setup.^[9]

With QI approach, it was possible to quantify the recommendations and implement and monitor the progress. In spite of the fact that every HCP wish to provide respect and quality care to each laboring woman, this study showed the prevalence of nondignified and nonconsented care in the facility of the current study. It was feasible to change the behavior of HCP and provide RMC with existing resources and staff. Even HCP felt satisfied when they were told about the progress and positive feedback shared by the patients. The limitation of the study suggests that out of four parameters studied, HCPs were not able to introduce themselves as they found it difficult to repeat their name again and again in the same room. However, with significant improvement in the parameters of consented and dignified care through effective communication, this study reveals that RMC can be achieved despite the odds.

CONCLUSION

This pilot study has provided an insight into the feasibility of providing dignified and consented care to the laboring women irrespective of resources, facilities, or workload. QI approach can be used as a behavior change interventions to provide dignified and consented care. Laboring women do understand the limitations and are ready to adjust, what they need is effective communication, empathy, emotional support, kindness, privacy, and companion wherever possible. Although this study has demonstrated success over a short span with no extra resources in a tertiary care setting, for long-term sustainability, it needs to be monitored regularly.

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Conflicts of interest

There are no conflicts of interest.

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