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ORIGINAL ARTICLE

PERCEPTION OF NURSING PROFESSIONALS ON THE USE OF THE SAFE DELIVERY CHECKLIST

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ABSTRACT

Objective: to understand how the implementation of the Safe Delivery Checklist has changed obstetric practice in the perception of the nursing team.

Method: qualitative study, conducted between October 2018 and June 2019, with 36 nursing professionals from two public teaching hospitals in the Federal District - Brazil. Narrative technique and content analysis were used.

Results: The professionals understood that the instrument brought benefits and contributed to greater quality and safety in obstetric care, in addition to stimulating a culture of safety. They reported that its use caused changes in routine, which contributed to some team members showing resistance and post-implementation difficulties.

Conclusion: the narratives raised reflections such as health planning, aiming at greater adherence of the nursing team to safe practices and sensitization regarding the importance of the Safe Delivery Checklist tool.

DESCRIPTORS: Patient Safety; Checklist; Maternal-Child Health Services; Delivery, Obstetric; Obstetric Nursing.

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RESUMEN:

Objetivo: comprender cómo la implementación de una Lista de Verificación del Parto Seguro modificó la práctica obstétrica en la percepción del equipo de enfermería. Método: estudio cualitativo, realizado entre octubre de 2018 y junio de 2019, con 36 profesionales de enfermería de dos hospitales públicos de enseñanza del Distrito Federal - Brasil. Se utilizó la técnica narrativa y el análisis de contenido. Resultados: Los profesionales entendieron que el instrumento aportaba beneficios y contribuía a una mayor calidad y seguridad en la atención obstétrica, además de estimular la cultura de la seguridad. Informaron de que su uso provocó cambios en la rutina, lo que contribuyó a que algunos miembros del equipo mostraran resistencia y dificultades posteriores a la implantación. Conclusión: las narrativas suscitan reflexiones como el planeamiento en salud, visando una mayor adhesión del equipo de enfermería a las prácticas seguras y la sensibilización con relación a la importancia de la herramienta de una lista de verificación del Parto Seguro.

DESCRIPTORES: Seguridad del Paciente; Lista de Verificación; Servicios de Salud Materno – Infantil; Parto Obstétrico; Enfermería Obstétrica.

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INTRODUCTION

Childbirth care encompasses the pre-, intra- and postpartum periods, which require essential practices to ensure the safety of health service users. However, in developing countries, there is demand for improvements in the supply and quality of obstetric and neonatal care, in order to reduce the high rates of morbidity and mortality[1-3]. In this context, Brazil, through its policies in the obstetric area, is a signatory of the World Health Organization (WHO) and participated in the global pact for the achievement of the millennium objectives, which, among other goals, aimed to reduce maternal and newborn mortality rates by 75% by 2015, but did not achieve the expected success[4].

Among the strategies recommended by the WHO, one of the most widespread is the use of the Safe Delivery Checklist, a simple and low-cost instrument that can be adapted to the various realities of health services worldwide. The use of the checklist contributes to safety at the time of delivery, prevention and/or reduction of incidents and adverse events and, consequently, a decrease in the related mortality rate. It has items that contemplate safe care to the mother and newborn and is related to the management of the main causes of maternal deaths, such as hemorrhages, infections, hypertensive diseases and maternal and neonatal complications related to delivery and postpartum[5-7].

Even with positive results of adherence to the checklist, there are difficulties in monitoring the maintenance of this adherence over time. In Brazil, for example, of 978 medical records reviewed, 71% had Safe Delivery Checklists with completion of 24% of the items on average, against 0.1% of complete completion, which suggested insufficient training of professionals[5].

The existing evidence on the topic does not fully elucidate the gaps in knowledge, especially regarding the perceptions of professionals about the use of the Safe Delivery Checklist, which may interfere with adherence, justifying this study. Thus, the study aimed to understand how the implementation of the Safe Delivery Checklist changed obstetric practice in the perception of the nursing team.

METHOD

Exploratory descriptive study with a qualitative approach, using the narrative technique as methodological reference[8]. Conducted in two public hospitals of maternal and child reference, in the units of obstetric center and rooming-in, in the Federal District, Brazil. To maintain the anonymity of the institutions, they were named hospital A and hospital B. Both had implementation of the Safe Delivery Checklist in their units since the end of 2017.

In these health units, the flow of care to the parturient woman begins in the obstetric emergency room. After risk classification, they are referred to the delivery rooms, where the main activities are performed: exam collection and orientation, application of strategies for non-pharmacological pain relief, such as ball, horsey, stool, shower, and massage. The obstetric center of hospital A has 85 nursing technicians and 16 care nurses; in hospital B, there are 45 technicians and 11 nurses.

After birth, the puerperal woman and the newborn remain in the obstetric center until their condition stabilizes, and then they are referred and accommodated in the rooming house. Hospital A's rooming house has 40 nursing technicians and 12 care nurses; in hospital B, there are 24 technicians and eight nurses.

The population was selected by convenience and for the initial recruitment, contact was made with the heads of the respective units and the invitation was sent to all nursing staff in the three shifts. The sample involved 36 nursing professionals, including technicians and nurses, and was determined based on the saturation of the narratives obtained during the interpretations of the analytical categories. All the participants invited to the study accepted to be part of the sample, so there were no refusals.

The inclusion criteria were professionals with employment relationship, working for at least six months in the Obstetric Center and/or Joint Lodging, and who used the Safe Delivery Checklist in their professional routines. Nursing professionals on vacation, or any other type of leave, whether medical, gala or accompanying, and resident nurses were excluded.

Data collection was performed between October 2018 and June 2019, six months post-implementation of the checklist. Until the data collection of this study, the Center for Quality and Patient Safety had promoted ten training sessions for obstetric care professionals focused on the completion and adherence to the checklist.

For data collection, a semi-structured script was prepared, containing information about the characterization of the participants (age, marital status, level of education, profession, and time working in the delivery sector) and subjective information about the perception of the professional about the use of the checklist: what do you think about your practice with the implementation of the Safe Delivery Checklist? Each interview lasted an average of 25 minutes. Prior to data collection, a pilot study was conducted to adapt and readjust the instrument.

Data collection, transcription, and coding were conducted by a resident nurse and two nursing students from a public higher education institution in the Federal District, previously trained by the researchers responsible for guiding and co-supervising the study. These researchers instructed them based on the following topics: National Program for Patient Safety; how to approach the participants and conduct the interview; the Safe Delivery Checklist; and the relevance of the field diary. All data collected and transcribed were checked by three researchers, who were also responsible for interpreting and structuring the content analysis of the narratives.

The narratives were recorded and transcribed in their entirety, and the records of the researchers' impressions were described in the field diary, which contributed to further analysis. Consecutive readings were made, with clippings of the text content, and the structuring of the information gathered as well. To ensure anonymity, the participants were designated with the letter P and their respective numbers that ranged from 1 to 36, followed by dashes, and with identification of belonging to hospital A or B, for example, P1-A.

The collected narratives were treated through the interpretation and structuring of content analysis[9]. This type of analysis is divided into three aspects: pre-analysis, material exploration and treatment of information. The pre-analysis phase selected the information, considering the relevance, representativeness, homogeneity and pertinence of the data. The exploration of the material consisted in the codification of the results by means of clipping, aggregation or enumeration of the texts. The third aspect is the moment of data interpretation from the theory established by the researcher, the narrative theory.

To obtain the desired scientific rigor for qualitative studies, we used The Standards for Reporting Qualitative Research (SRQR)[10]. The project was submitted to the Ethics and Research Committee of the Teaching and Research Foundation of the Federal District and received approval protocol no. 2,885,771/2018 for the research conducted at hospital A, and opinion approval protocols no. 2,885,743/2018 and no. 3,137,852/2019 for hospital B.

RESULTS

The 36 participants were female, 14 (38.9%) were nurses, of which eight (57%) were generalists and six (43%) were specialists, and 22 (61.1%) were nursing technicians, aged between 25 and 65 years. Regarding the level of education, 26 (72.2%) had higher education, among these, nine (25.0%) were specialists and one (2.8%) had a master's degree. All of them were civil servants and had worked in the sector for more than six months, 20 (55.6%) in hospital A and 16 (44.4%) in hospital B.

After interpretive analysis of the narratives, two analytical categories emerged: Nursing staff perceptions of the implementation of the Safe Delivery Checklist and Contributions of the Safe Delivery Checklist to nursing care.

Perception of the nursing team on the implementation of the Safe Delivery Checklist

This theme gathered the aspects related to the implementation of the Safe Delivery Checklist in the sectors, that is, the perception of the participants regarding the training for its use. The narratives inferred that there was training for the use of the checklist, however, with reports of criticism of the way it was conducted and the restricted amount of training. They pointed out that there was resistance and difficulties regarding adherence to the instrument by some members, justified by the lack of human resources, high work demand, lack of motivation and awareness about the use of the checklist, as well as the team's lack of involvement in the process of its implementation. There were also reports of demotivation due to lack of time off work to participate in training sessions and lack of understanding of the need and purpose of the checklist. The following were identified as units of significance: training, human resources, adherence, and difficulties, according to the following findings:

I think I could have hit the nail on the head a little harder. There are people who do not do it the way it has to be done. So, I think there should be more training. (P-12-B)

Here I cannot do all the parts, we have a lot of work and quick tests to do. (P1-A)

I fill in all the steps whenever possible, the routine is extremely hard, which makes us forget sometimes. (P8-A)

The checklist is what I tell you, it is good for you to know the patient, but other than that I do not think there is any need. (P6-B)

I participated in the lectures, I know the steps, but still, I do not see the purpose. (P14-A)

The difficulties are the compliance that is low and the availability as in a heavier duty that ends up being left aside. (P7-B)

But the training is demotivating, because there is no release from the duty roster and the professionals are not motivated to perform. (P9-A)

The limitation is that you do not always have that much time to complete it. Maybe the criticism is the implementation suddenly, you should have more training. (P13-B)

It was left wanting. They simply told us, they said, now we will have the checklist, it is here, it is in such and such a place that you go here on the computer, understand? To be able to do the checklist. But nobody sat down and talked and explained to us why. The team needed to be more involved. (P15-B)

Contributions of the Safe Delivery Checklist for nursing care

In this category, narratives on the contributions of the Safe Delivery Checklist instrument to nursing care were grouped. The professionals reported benefits arising from the use of the checklist to guide care: they perceived greater attention in identifying failures and weaknesses in the care of the parturient woman; they glimpsed the checklist as a possibility to avoid forgetfulness; they mentioned the importance of the checklist phases, a standardized direction for care, greater interaction and better communication among team members. It emerged from the narratives that such benefits contribute to qualified nursing care. The units of significance were communication, attention, standardization, sequence, direction and qualification, according to the following narratives:

I participated in the patient safety course, it was incredibly good, it showed some flaws in our care. (P8-A)

The checklist makes you pay more attention to what is being done, so that you don't forget. (P1-A)

I think the four parts of the checklist are important, they are a bit repetitive, but important. (P2-A)

I like the instrument, because you check what has already been done, and then I do mine for the subsequent colleague to see what is happening, understand? (P5-B)

It brought benefits, of course, a lot. Because of these points, that some things were lacking. Too many patients for too few employees. Now with the standardized system it is easier. (P5-B)

It directs a more qualified assistance. Because when the patient is admitted, we already observe if she uses any antibiotics, if she has any health problems such as high blood pressure, diabetes. (P10-B)

So, I think that this checklist model facilitates communication, because it is closed and anyone who reads it understands. (P13-B)

There is more interaction among the team. (P17-B)

DISCUSSION

This study allowed us to understand the perception of the nursing team about their practice with the implementation of the Safe Delivery Checklist in the scenarios studied and could contribute to managers becoming familiar with the factors that have influenced the adherence of the nursing team and provide opportunities to develop activities in order to mitigate/correct the factors that hinder it. It is necessary to reinforce that the checklist is part of the systematization of nursing care, which enables the reduction of adverse events in the care provided.

The narratives analyzed from the first thematic category showed that the insertion of a new technology or tool alone does not guarantee that its use will be effective. The involvement of people in the process is essential to recognize that practice as important, otherwise, adherence to the completion may be low and not show the need it proposes[5,11-12], which was revealed in the narratives of these professionals represented by the appeal to the difficulties in using the checklist.

Despite the training, there were professionals who did not understand the purpose of the instrument and reported demotivation for the trainings and low adherence related to work overload. It was verified that the low adherence to the checklist came from demotivation related to the addition of new practices to their daily routine that, in their

view, contributed to increase the workload. This negative interpretation of the checklist as being unnecessary and/or bureaucratic was also identified in another study and contributed to reducing the adherence and effectiveness of the tool[5].

For the Safe Delivery Checklist to be used correctly and achieve its objective, it is necessary that health institutions adopt a culture of safety and that there is training of professionals to use it. It is necessary that health professionals see this tool not as a mere document to be filled out, but as a strategy that will reduce the occurrence of error and consequently improve the quality of care[13].

As a suggestion for a better use of the instrument, it is necessary to involve the professionals, from the initial preparation of the project, the possible adjustments to adapt it to the reality of local practice, constant training of the entire multidisciplinary team, and continuous supervision of the work process involved.

The use of video cases to raise the awareness of professionals and the implementation of safe obstetric practices in delivery care has proven to be a methodological resource in continuing education. Videos are an educational technology that increases the capacity to share knowledge and experiences with a high number of viewers and can be disseminated via the Internet. Thus, the production of video cases can be considered an alternative to encourage the implementation of the Safe Delivery Checklist in health institutions and support continuing education of the teams[14].

The professionals pointed out difficulties that may influence low adherence and inadequate fills related to work overload. Likewise, the application of the Safe Delivery Checklist in 19 countries, involving 134 professionals and 39 teams, revealed challenges in the view of the participants who pointed, among other reasons, the inability to use the checklist when they were too busy and 30% reported insufficient human resources to support its implementation(7). Similar results were found in another study conducted in Brazil, which showed a percentage of 4% of complete completion of the checklist, present in 61.4% of the medical records of the evaluated surgeries[15].

Another similar result was found in Sri Lanka, Asia, which showed reports of increased workload and little enthusiasm from health care providers for the new additions to routine using the Safe Delivery Checklist. Attitude toward the instrument was found to be satisfactory. However, the adoption rate among all workers was 45.8% and the knowledge about the checklist was 60.1%. Therefore, it was pointed out that it is necessary to increase awareness about the value and correct use of the tool, paying attention to adequate levels of human resources[16].

In India, a randomized controlled trial with training of providers aimed to improve adoption and sustained use of the Safe Delivery Checklist, and demonstrated that the instrument alone cannot improve care, but depends on correct and motivational use. Emphasis was placed on relationship building and mutual respect, which led to trust between trainers and providers, helping to influence change[17].

By identifying the reasons for non-adherence or the cause of resistance, it is possible to facilitate the use of strategies that focus on activities that require continuous training of professionals for awareness, adaptation and maintenance of its use in care[5]. This highlights the relevance of qualitative studies that identify the perceptions of those who use the Safe Delivery Checklist in their professional routines. It is worth mentioning a study in which the implementation process supported by awareness-raising activities with support from the sector head, training and constant feedback provided greater adherence to the checklist[6].

Regarding the second thematic category (Perception of professionals on the contributions of the Safe Delivery Checklist for nursing care), it was revealed the attribution of importance to the instrument and the indication of its benefits for the work process. Similarly, studies indicated that the use of the checklist improves communication and interprofessional relationship and the direction of actions, considering that it gathers

fundamental information of quick and easy application[1,5,18].

Similar data were found in a multicenter study conducted in 19 countries, showing that almost 3/4 of the respondents considered that the use of the Safe Delivery Checklist enhanced patient safety awareness, and more than 2/3 of the respondents identified that it improved communication and teamwork[7]. Another evidence pointed out that around 69.4% of professionals agreed that the checklist stimulated interpersonal communication and teamwork[16].

A Brazilian study pointed out that the Safe Delivery Checklist is an easily applicable instrument that facilitates the work routine from the professional's perspective and contributes to avoid forgetfulness and speed up the approach to many factors related to the client's context[19]. Two studies also pointed improvement in the quality of care and reduction of incidents[5,20], corroborating the findings of this study.

It was observed that nursing care requires constant records of routine procedures in the work process. For nursing professionals, communication represents more than a means to transfer information and interact, but also a way to organize care. And when the instrument is not filled out properly, it hinders the assistance and weakens the monitoring of patient safety.

From these data, it is inferred that training on how to fill out the checklist needs to be continuous. When the team is involved, aware, and motivated to adopt a new practice, it is possible to achieve a high degree of adherence even if no individual reward is established[1,21]. Valuing health education is a political-pedagogical strategy that takes as its object the problems and needs arising from the work process in health[22]. Therefore, the relevance of professionals who implement public policies to be heard and their needs understood through continuous feedback and assertive communication in professional relationships is highlighted.

The limitations of this study are typical of qualitative investigations, which include a restricted sample defined in a non-probabilistic manner and the saturation of the narratives obtained, imposing challenges to the possibility of generalizing the results, in addition to the characteristics of the interpretative analysis of subjectivities that involve the universes of researchers and participants. Moreover, only professionals from the nursing team participated in the study, excluding other professional categories. Nevertheless, it should be emphasized that the nursing team corresponded to the category with the largest workforce and was mostly responsible for completing the checklist.

CONCLUSION

This study fulfilled its purpose in understanding how the implementation of the Safe Delivery Checklist changed obstetric practice in the perception of the nursing team and demonstrated findings that corroborated other evidence. It is relevant for bringing the narratives of the professionals, who recognized the importance of this checklist when considering that the instrument brought benefits and contributed to greater quality and safety in obstetric care, as well as stimulating the culture of safety.

Considering that the tool demonstrates effectiveness for incident reduction and maternal and neonatal mortality reduction, consistent with the National Policy of Integral Attention to Women's and Children's Health, the implementation and monitoring of this tool goes beyond a simple implementation and therefore it is urgent to promote training, in addition to the appropriate provision of human resources.

The implications for future studies and for professional practice become relevant, given the scarcity of verified qualitative publications. The results may contribute for

managers and health professionals to understand the subjective aspects that impact and influence the operationalization of public policies, especially regarding the complete and adequate adherence to the Safe Delivery Checklist. The findings analyzed in the light of qualitative research add value and assist managers in the formulation of health planning by instituting strategies that bring management closer to the demands of workers.

It is noteworthy that the Safe Delivery Checklist is part of the systematization of nursing care in obstetrics and makes it possible to standardize safe and quality care based on the best scientific evidence. These findings cannot be ignored, as they may help other services to organize the implementation of the checklist considering the needs of the workers who use it.

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