2013-09-23

Birthing Unit Culture and Its Impact on How Nurses View and Enact Birth Plans

Sebastian, Sandra Jean

UNIVERSITY OF CALGARY

Birthing Unit Culture and Its Impact on How Nurses View and Enact Birth Plans

by

Sandra Jean Sebastian

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES

IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE

DEGREE OF MASTER OF NURSING

FACULTY OF NURSING

CALGARY, ALBERTA

SEPTEMBER, 2013

ABSTRACT

Pregnancy and childbirth are important milestones in the development of a family. Birth plans allow childbearing women to plan and express their wishes for their birth experience. Labour and delivery nurses play a key role in providing care on birthing units in Canada and are uniquely placed to enact a woman's birth plan. A focused ethnographic study was undertaken to examine birthing unit culture and its impact on how labour and delivery nurses care for women with birth plans. Findings revealed three overarching themes (ensuring safe care, teamwork, and connecting with patients) that shaped birthing unit culture and impacted how labour and delivery nurses viewed and enacted birth plans. Organizational influences and individual healthcare provider preferences influenced how birth plans were enacted on the unit. Patient safety was a dominant driver of care. Challenges exist on how to partner with childbearing women and their families while assisting them in the goals for their birth experience. Collaboration is key as providers strive to embrace a woman's birth plan expectations and work toward a shared understanding and partnership in childbirth.

ACKNOWLEDGEMENTS

They say it takes a village to raise a child but I believe it takes a village to assist a graduate student in this journey. By each offering encouragement, compassion, a listening ear, and having faith in me is how I came to this place. Thank you for not giving up on me.

Dr. Debbie White - Thank you for your support and guidance, attention to detail, and dedication to this process. You shared your expertise and knowledge of research and patient safety and expanded my knowledge in more ways than you know.

Dr. Shelley Raffin Bouchal - Thank you for gentle guidance and expertise in ethnography as I struggled under the mountain of data and the growing pains of analysis.

Dr. Jeanne Vanderzalm - Thank you for honest feedback and reflections and challenging me to choose my words wisely.

My Family - There are no words that can adequately express my gratitude for your patience and encouragement, and for the countless hours you let me sit at my computer uninterrupted. Thank you for cheering me on the believing in me.

Friends & Colleagues -Thank you for your advice, your willingness to listen, and the countless times you picked me up and encouraged me to keep going…. I could not of done this without you and you know whom you are….

Labour and Delivery Nurses - Thank you for so generously sharing your stories and reflections about your work. I am so grateful for your honesty, passion and commitment to childbearing women and their families. I am so privileged to write about what you do and shed light on your unique role in nursing.

This is dedicated to my husband Troy,

and our children, Stephen, Jeff, and Ally.

Thank you for your love, support, and understanding.

TABLE OF CONTENTS

GLOSSARY

Artefact – physical and behavioural manifestations in a culture (Fetterman, 2010)

Collaboration –is joint communication and decision-making among interdependent parties involved in joint ownership of decisions and collective ownership of outcomes (Salus Global, 2013)

Electronic Fetal Monitoring (EFM) – the use of an electronic felt heart rate monitor either externally or internally for the continuous evaluation of the fetal heart rate pattern in labour (Canadian Perinatal Programs Coalition, 2009).

Evidence-based practice –a problem solving approach to clinical decisions that integrates the best available scientific evidence with best available experiential (patient and practitioner) evidence (Newhouse, Dearholt, Poe, Pugh, & White, 2005).

External Tocotransducer (TOCO) – a pressure sensitive electronic device for measuring uterine activity transabdominally to detect changes in surface pressure (Canadian Perinatal Programs Coalition, 2009).

HRO (High Reliability Organization) - hazardous environments where the consequences of errors are high but the occurrence of error is extremely low (Baker, Day & Salas, 2006)

Interdisciplinary –group of two or more academic disciplines who work independently in the same setting interacting both formally and informally (Canadian Patient Safety Institute, 2011).

Intermittent Auscultation (IA) - a listening technique of counting fetal heart beats following an established protocol (Canadian Perinatal Programs Coalition, 2009).

Interprofessional – goes beyond the definition of interdisciplinary to include two or more professionals associated with health or social care (Canadian Interprofessional Health Collaborative (CIHC), 2010).

Interprofessional Collaboration – is the process of developing and maintaining effective interprofessional working relationships with practitioners and patients/clients/families and communities to enable optimal health outcomes (CIHC, 2010).

Intrauterine Pressure Catheter (IUPC) - catheter inserted into the uterine cavity to assess uterine activity and pressure electronically (Canadian Perinatal Programs Coalition, 2009).

MORE^{OB} (Managing Obstetrical Risk Efficiently) – a comprehensive performance improvement program aimed at creating a culture of patient safety in obstetrical units (Salus Global, 2013).

Patient Safety: is the absence of preventable harm to a patient during the process of health care (WHO, 2013).

Service Level Definitions (Facility) – Level I (primary care); Level II (secondary care); and Level III (tertiary/intensive care) (APHP & AHS, 2012).

Team - a group of individuals who have specific roles, perform interdependent tasks, and share a common goal (Baker, et al., 2006).

Triangulation – the use of multiple methods to obtain and interpret data about a phenomenon to obtain a more accurate representation of the reality (Polit & Beck, 2008).

CHAPTER ONE

Birth Plans and Childbearing Women

Pregnancy and childbirth are important transitions of milestones in the development of a family. Childbearing women want to be involved in the planning and decision-making of their own birth experience. In Canada, family-centred maternity care (FCC) guidelines promote individualized care and support women to be active participants in decisions related to their birth experience (Public Health Agency of Canada, 2000). A birth plan is a medium through which women can outline their expectations for their birth experience based on their individual knowledge, experience, culture, and belief system. Healthcare providers have a pivotal role in the implementation of birth plan expectations within their individual unit routines and practices.

Background

Childbirth is a powerful life-changing event and has a lasting impact on a woman and her family (Carlton, Clark Callister, & Stoneman, 2005; Lothian, 2006). Women in labour are extremely vulnerable and there is a potential for psychological benefits or damage in every birth experience (Simkin, 1991). Childbirth practices in North America have evolved from generation to generation and are influenced by the social and cultural milieu of the time (Simkin, 1989). Historically, pregnancy and birth occurred surrounded by family with childbirth taking place within the home (Zwelling & Phillips, 2001). Birth has migrated from a home-like environment to a hospital environment surrounded by intervention, technology, and an expert model of healthcare services (Cahill, 2001; Grant, Sueda, & Kaneshiro, 2010).

The socially constructed view of childbirth focuses on medicalization and care practices based on empirical evidence, technology and risk reduction. Walters (1994) defines the medicalization of birth as a social process whereby an expert-based biomedical paradigm

dominates discussion of health and frames it in negative ways usually as illness experiences understood as biological and individualist (as cited in Parry, 2008, p. 785). Griel (1991) outlines that once a life event becomes medicalized it is then described using medical terminology, treated within a medical institution, and people are then regarded as patients (as cited in Parry, 2008, p.785). The decontextualization of birth as a natural family event resulted in a shift of power from women to physicians and resulted in a perceived loss of control for women (Hewison, 1993).

The Public Health Agency of Canada has developed national guidelines for family-centred maternity and newborn care. These guidelines support women's diverse experiences and needs in childbirth proposing that women and their families should expect care that is adapted to meet their individual needs rather than expecting them to adapt to individual provider or institutional needs (Public Health Agency of Canada, 2000). The guidelines are congruent with the four core principles of patient and family-centred care (PFCC): respect and dignity, information sharing, participation in decision-making, and collaboration (Institute of Patient and Family-Centred Care, 2011).

Central to the philosophy of PFCC is the concept of choice. The Survey of Routine Care and Practices in Canadian Hospitals reinforced this by stating that facilitating a woman's ability to choose knowledgeably requires having effective options, flexible policies, sharing all information, and entering into a dialogue while being respectful of all approaches, concerns and opinions (Levitt, Hanvey, Avard, Chance, & Kaczorowski, 1995). Essentially, birth plans promote choice and provide women the opportunity to begin a dialogue with their healthcare provider to discuss individual expectations, options, and choices in childbirth (Moore & Hopper, 1995).

Birth plans were introduced in the early 1980s to enable women to outline their desires and wishes for their birth experience, avoid unnecessary interventions, and facilitate communication with their healthcare providers (Lothian, 2006). The process of birth planning originated from a childbearing woman's desire to educate and understand her own personal values, beliefs, needs and concerns regarding her childbirth experience (Motino Bailey, Crane & Nugent, 2008). In Canada's current healthcare system, the Society of Obstetricians and Gynaecologists of Canada (SOGC) and other healthcare organizations continue to encourage women to discuss birth expectations and develop a birth plan in cooperation with their healthcare providers (Motino Bailey et al., 2008; Public Health Agency of Canada, 2000; Society of Obstetricians & Gynaecologists of Canada, 2013). Regardless of structure and content, birth plans can assist a woman in the planning of her birth and provide a foundation to build trust, promote dialogue, and resolve differences between the woman's expectations and the hospital or healthcare providers' usual practice (Lothian, 2006). In actual practice, birth plans continue to raise concerns about paternalism, patient autonomy, choice, control, trust-based therapeutic relationships, and the discord between evidence-based medicine and preferred obstetrical practice (Motino Bailey, et al., 2008).

Healthcare providers have a great deal of influence on how each woman will remember her birth experience (Hodnett, 2002; Simkin, 1991). Childbearing women have identified they require information, trust, and a continuum of control in their relationship with their healthcare professional (Lothian, 2006; Tiedje & Price, 2008). It is this trust that enables nurses and other healthcare professionals to respond morally to the needs of their patients and is a vital dimension of their clinical practice (Carter, 2009). The relationship a woman has with her healthcare provider is integral to her empowerment in childbirth (Aston, Saulnier, & Robb, 2010) and is

important to discussions between providers and women about their birth plans. Hodnett's (2002) systematic review concur with this statement and outline four key factors that influence a woman's satisfaction with her birth experience: personal expectations, the amount of support from caregivers, the quality of the caregiver-patient relationship, and their involvement in decision-making. Each of these factors is fundamental to the successful development and enactment of birth plans (Brown & Lumley, 1998; Ekeocha & Jackson, 1985; Whitford & Hillan, 1998; Yam, Grossman, Goldman, & Garcia, 2007).

While we know that healthcare providers play an important role in birth, the enactment of birth plans has been a source of debate and controversy within the literature (Simkin, 1989; Lothian, 2006). Much research to date has focused on women's perceptions of the benefits of birth plans (Brown & Lumley, 1998; Kuo, Lin, Hsu, Yang, Chang, Tasa, & Lin, 2010; Lundgren, Berg, & Lindmark, 2003; Moore & Hopper, 1995; Too, 1996b; Whitford & Hillan, 1998; Yam et al., 2007) and the birth outcomes of women with birth plans (Deering, Heller, McGaha, Heaton, & Satin, 2006; Deering, Zaret, McGaha, & Satin, 2007; Ekeocha & Jackson, 1985; Jones, Barik, Magune, Jones, Gregory, & Spring, 1998). Additionally, in the literature healthcare providers vary in their attention and support of birth plans (Kuo et al., 2010; Peart, 2004; Too, 1996a; Yam et al., 2007). Grant et al. (2010) surveyed healthcare provider perceptions of birth plans and noted that birth plans were perceived to contribute to increased intervention and worse overall obstetrical outcomes. Similarly, findings from a recent qualitative study of the perceptions of nurses caring for women giving birth found that birth plans created tension and frustration. Labour and delivery (L&D) nurses viewed birth plans as unrealistic and potentially impeding the caring therapeutic relationship (Carlton, Callister, Christiaens, & Walker, 2009). Given the importance of the patient-caregiver relationship, factors that influence healthcare providers'

attitudes, beliefs, and behaviours about birth plans need to be understood. Within the birth plan literature, there is limited information about how birth plans are incorporated into the plan of care within Canadian birthing units.

The Concept of Culture

Healthcare is a highly complex system where the practices of healthcare professionals are multi-faceted and constantly changing to meet the increasing demand for services. Professional culture consists of a group of materialistic (i.e. roles and responsibilities) and symbolic (i.e. meanings attached to materialistic practices) practices organized around specialized knowledge and skill that is shared amongst its members (Hong, 2001). Culture has been broadly defined to consist of acquired knowledge, behaviours, understandings, values, and belief systems shared by certain groups of people (Richards & Morse, 2007; Roper & Shapira, 2000). Nursing is considered a subculture within the healthcare system with its own unique beliefs, practices, rituals, and routines (Roper & Shapira, 2000). Nurses and other health care providers inhabit the organizational space to provide health service, and this is how organizational space is constructed. “Hospitals are comprised of multiple and distinctive spaces within which nursing is practiced and nursing identities are constructed and performed” (Halford & Leonard, 2003, p. 201). Hospital units become the stage where nurses perform their role and culture is expressed.

Within Canada, L&D nurses are the predominant primary bedside caregivers in birthing units, yet few studies have explored their views of birth plans in light of their day-to-day practice environment (Carlton et al., 2009; Grant et al., 2010). Communication between childbearing woman and healthcare providers is impacted by a variety of factors, and cannot be separated from pre-existing hospital policy and culture (Brown & Lumley, 1998; Kuo et al., 2010; Moore

& Hopper, 1995; Peart, 2004; Yam et al., 2007). It is important to explore how birthing unit culture informs and influences L&D nurses enactment of birth plans.

The Study Context

Within Alberta, Alberta Health Services (AHS) is the main provider of healthcare services in the province. The AHS strategic plan identifies patients, clients, residents, family and community as being central to their success (AHS, 2013). Embedded within these relationships are the values of respect, accountability, transparency, and engagement, safety, learning and performance (AHS, 2013). The AHS quality and patient safety framework recognizes patients as key partners while incorporating the principles of patient and family-centered care: respect, information sharing, participation and collaboration (AHS, 2013). Birth plans and the incorporation of patient involvement in decisions related to obstetrical care are congruent with the philosophy of PFCC. How these values and principles are incorporated into the everyday practices, routines, and processes of healthcare delivery can be understood by studying the culture of patient care units.

In Alberta, over 99% of births take place in a hospital setting with women being cared for by physicians (i.e. family physicians and obstetricians), midwives, and L&D nurses (APHP & AHS, 2012). Between 2011-2012, there were approximately 52,000 live births in Alberta (Statistics Canada, 2013). However, the incidence of women presenting to hospitals with birth plans in relation to Alberta's birth rate is not well known. Despite this, birth plans are well documented in the literature (Ekeocha & Jackson, 1985; Deering et al. 2007; Kuo et al, 2010; Moore & Hopper, 1995; Peart, 2004).

The predominant model of maternity care in Alberta is a perinatal unit with registered nurses caring for women in collaboration with physicians. It is the professional responsibility of

all L&D nurses to support the process of planning for birth by promoting and respecting a woman's desire for choice, control, and participation in her own childbirth experience. L&D nurses are key in the delivery of obstetrical services on the birthing unit and have a challenging role when striving to adhere to a woman's birth plan expectations while complying with hospital routines and practices.

Significance

By conducting this study it is anticipated that the findings will result in the development of recommendations on how to support birth plan expectations in Alberta's healthcare system with the hope of promoting a more collaborative relationship between childbearing women and healthcare providers. Exploring birthing unit culture and the nurse's values, beliefs, and behaviours regarding birth plans will bring new understanding to the dynamic environment and the relationship between a L&D nurse, a childbearing woman, and her family's birth expectations.

Purpose

The purpose of this research study is to explore the social norms, values, and practices of L&D nurses when caring for women with birth plans. How L&D nurses, as a subgroup, carry out their day-to-day care and the influences that impact the care of women with birth plans will be studied. The objectives of this proposed study are to:

1. Identify how birthing unit culture informs nurses' values, beliefs and behaviours regarding birth plans.
2. Identify the structural and interpersonal facilitators or barriers to the inclusion of birth plans into childbirth on a birthing unit.

3. Identify potential strategies to facilitate partnering with childbearing women to support a collaborative practice environment.

Research Question

The overriding research question guiding this study is: What is the everyday practice of labour and delivery nurses as they care for women with birth plans? Further guiding questions during interviews and observations may include: How does birthing unit culture inform and influence the care provided by labour and delivery nurses to women with birth plans? What factors in the birthing unit environment do labour and delivery nurses perceive facilitate or act as barriers to the use of birth plans?

CHAPTER TWO

A Review of the Literature

The purpose of a literature review is to explore what is already known about a specific topic, evaluate the quality of the evidence, and determine if there are any other gaps or inconsistencies noted in the literature. A critical review of both qualitative and quantitative research on birth plan utilization within birthing units was undertaken. The following electronic databases were used: CINAHL, MEDline, Cochrane Database of Systemic Reviews, and the Psychology and Behavioural Sciences Collection. Reference lists of published studies were reviewed to locate additional relevant literature. A combination of the following key search terms was used:

Birth Plan: birth plan(s), birth planning, patient care plans, patient care planning, and patient expectations

Maternity Services: obstetrics, labour and delivery, pregnancy, childbirth, intrapartum care, and birth.

Nurses: maternity nurses, labour and delivery nurses, obstetrical nurses, healthcare providers, and healthcare professionals

Culture: culture, unit culture, nursing culture, beliefs, attitudes, and behaviours

Terms Inclusive/Exclusion Criteria

Abstracts were reviewed for relevance to the research topic, and were included for review if: 1) hospital births occurred within developed countries; 2) published 1985 – 2012; 3) English language; and 4) a research study. Editorials, commentaries, and conference proceedings were excluded. Initially, a total of 93 abstracts were reviewed, and eighteen studies were chosen for this literature review.

Study Designs

Fourteen out of eighteen studies were quantitative research studies. Eight descriptive studies utilized questionnaires/interviews and/or retrospective chart audits as primary data sources **(**Brown & Lumley, 1998; Deering, Heller, McGaha, Heaton, & Satin, 2006**;** Grant, Sueda, & Kaneshiro, 2010**;** Jones, Barik, Mangune, Jones, Gregory, & Spring, 1998; Moore & Hopper, 1995; Pennell, Salo-Coombs, Herring, Spielman, & Fecho, 2011; Sheridan, Yekinni, Oyeye, Ogunleye, Oluyede, O'Sullivan, Greene, & Higgins, 2011**;** Whitford & Hillan, 1998). There were five quasi-experimental studies in which data collection included retrospective chart audits or questionnaires/surveys for data collection (Berg, Lundgren, & Lindmark, 2003; Deering, Zaret, McGaha, & Satin, 2007; Hadar, Raban, Gal, Yogev, & Melamed, 2012; Lundgren, Berg, & Lindmark, 2003; Springer, 1996). There was one experimental randomized control trial (RCT) study (Kuo, Lin, Hsu, Yang, Chang, Tsao, & Lin, 2010). Two studies utilized a mixed-method approach involving triangulation of interviews with questionnaire data (Ekeocha & Jackson, 1985; Peart, 2004), while two qualitative studies utilized interviews as the primary data source (Too, 1996a; Too, 1996b; Yam, Grossman, Gomdan, & Garcia, 2007).

The study participants included the perspectives of pregnant women or a combination of healthcare providers such as nurses, midwives, obstetricians, and family physicians. For ease of description, the birth plan literature was categorized into three key content areas: (1) birth plan formats, (2) birth plan outcomes, and (3) healthcare providers and birth plans.

Birth Plan Formats

A birth plan has been primarily defined in the literature as a written document prepared by a childbearing woman outlining her personal preferences and desires for before, during, and after labour and birth (Brown & Lumley, 1998; Hadar, et al., 2012; Kuo et al., 2010; Yam et al.,

2007). Others have described birth plans as a communication tool, utilized by women to communicate with their healthcare team (Pennell et al., 2011). Peart (2004) in her research notes some women may choose not to write down their birth plans but rather express their desires for their birthing experience verbally to family, friends, and their healthcare providers.

Birth plans vary in format and content and often include information on a woman's preferences regarding: pain management and comfort measures, medications, mode of fetal surveillance, episiotomy and invasive procedures, mode of delivery, emergency considerations, cultural preferences, and newborn care and feeding preferences (Deering et al., 2006; Hadar et al., 2012). Deering et al. (2006) noted the most common requests included in birth plans in their study were: (1) to be allowed to walk during labour, (2) no episiotomy, and (3) no pain medications. Ekeocha and Jackson (1985) reported the most common request by women completing a birth plan was for the presence of their partner/relative/friend, the avoidance of an epidural, and the desire to nurse the baby immediately after birth. Birth plans may be hand written or developed in part using templates from birth education classes or internet-based websites to outline a woman's desires and wishes for childbirth (Pennell et al., 2011).

Formatted birth plans in the literature were described as structured plans outlining preferences for prescribed care choices based on individual birthing unit practices (Berg et al., 2003; Ekeocha & Jackson, 1985; Kuo et al., 2010; Lundgren et al., 2003; Moore & Hopper, 1995; Yam et al., 2007). The plans varied from having predefined categories listing common choices to choose from to plans listings care practices with scales to determine the degree of preference for avoidance (Berg et al., 2003; Ekeocha & Jackson, 1985; Moore & Hopper, 1995). Of interest, a large number of formatted birth plans in the studies listed interventions and procedures no longer supported to be evidence-based routine practices in low risk obstetrical

patients (Ekeocha & Jackson, 1985; Kuo et al., 2010; Yam et al., 2007). For example, in Kuo et al.'s (2010) study the formatted birth plan developed listed perineal shaves, continuous fetal monitoring, and enemas as choices for routine care.

Sheridan et al.'s (2011) in her descriptive observational study examined birth plan content preferences from two distinct ethnic groups of women (Nigerian, n=113; Irish, n=519) residing in the Republic of Ireland. Significant cultural variations in the birth plan content preferences were reported, including: mode of delivery ($p < .001$), fetal heart rate monitoring ($p < .05$), pain relief ($p < .01$), position in labour ($p < .01$), a professional presence ($p < .05$), a labour companion ($p < .01$), and cutting the baby's cord ($p < .001$). For example, Nigerian women preferred no pain relief options compared with Irish women (39.6% vs. 5.8%, $p<0.001$). Even though some preferences were not evidence-based the study did not address the influences behind those preferences. For example, the study did not indicate how long the Nigerian women had been living in Ireland or if either group of women received antenatal education, which could influence preferences for childbirth. Sheridan et al. (2011) reinforced the need for healthcare providers to ensure birth plans allowed for women to express their choices based on cultural variations in pregnancy and childbirth to ensure culturally sensitive care is provided in childbirth.

Birth Plan Outcomes

Maternal Outcomes. Both favourable and non-favourable maternal outcomes were reported for women with birth plans.

Information sharing and decision-making. Overall, in several of the descriptive survey-based studies women who completed a birth plan indicated they felt it increased their knowledge and understanding related to choices in care decisions and provided an opportunity to discuss options/preferences with healthcare providers, family, and friends prior to birth (Brown &

Lumley, 1985; Moore & Hopper, 1995; Pennell et al., 2011; Whitford & Hillan, 1998). One qualitative exploratory study of nine women of low socioeconomic status in Mexico also noted women had increased knowledge of their human rights regarding choices in treatments and interventions after completing a birth plan (Yam et al., 2007). Ekeocha and Jackson (1985) reported in their study that 79% of women (N=100) who completed a birth plan found it to be reassuring and helpful in preparing for birth. Despite these perceived benefits there were other studies whereby women did not consistently report positively about their use of birth plans.

In Brown and Lumley's (1998) survey of women who completed a birth plan (270/1336) only 50% of the women thought it was helpful and an additional 40.3% said it was neither helpful nor unhelpful. Peart's (2004) study of primiparous women (N=42) included birth plans that were formatted, individually written, or verbally expressed. Half of the women (n=21) reported making a plan for birth was unhelpful and were wary about making a plan for their next birth with some noting making useful choices difficult to do in advance.

Berg et al. (2003) studied how completing a birth plan influenced the perceptions of control comparing women with high risk pregnancies or births with women of normal pregnancies or births. For analysis, women in the control (n=271) and intervention (n=271) groups were subdivided into four subgroups (normal pregnancy/normal childbirth –NPNC; complicated pregnancy/normal childbirth-CPNC; normal pregnancy/complicated childbirth-NPCC; and complicated pregnancy/complicated childbirth-CPCC). Women in the complicated pregnancy/normal childbirths (CPNC) experienced a lesser feeling of participation compared to the normal pregnancy/normal childbirth group (NPNC) in both the intervention (p=0.04) and control groups (p=0.02). Brown and Lumley (1998) also reported that the use of a written birth plan was not significantly associated with an increased degree of involvement in decision-

making. Both these studies do not support that birth plans alone enhance feelings of participation in decision-making in childbearing women.

In Too's (1996b) qualitative study of primiparous women with birth plans (n=10) he reported that some women indicated midwives were sensitive to their needs and helped them make decisions whereas others indicated their midwife did not support them to make decisions. Information was cited as key in helping women make informed choices and decisions and knowledge was gained through attendance at the antenatal education classes hosted by the midwives. During labour and birth, some women felt undervalued and unsupported in their ability to make informed decisions with midwives due to ineffective communication, a lack of information, and the medicalized hospital environment (Too, 1996b). Women reported some midwives employed a blanket approach to information sharing rather than targeting individual needs. Women reported more of a partnership model of care when there was open communication, mutual goal setting, and decision making occurring in their relationship with their midwife. Overall, the literature was equivocal in whether the completion or the enactment of a birth plan resulted in increased participation in decision making.

Control and anxiety. The benefits of birth plans on women's perception of control or anxiety varied across studies. Whitford and Hillan's (1998) survey study of women in Scotland (N=91) reported that half of the women (50%) felt the birth plan made no difference to their feelings of control. Peart's (2004) indicated that 95% of the women (N=42) could articulate their plan of care for their birth experience but expressed confusion regarding control as they felt encouraged to have some control while at the same time being prepared to allow the medical staff to change plans as appropriate. Women explained it as being expected to be both in control yet compliant at the same time.

In Too's (1996b) study most women reported that they wanted to be in control during childbirth and there was a positive association with achieving control and a higher satisfaction with the experience of birth. Women indicated some of the midwives were in control and that the lack of privacy and respect caused other women to feel a lack of control. Women felt vulnerable and subject to the decisions of midwives over which they had no control whereas others chose to willingly give that control to their midwife. These results suggest women expected individualized approaches to care during labour and childbirth in order to determine the amount of control they may want during their birth experience.

In Berg et al.'s (2003) study the vast majority of women (intervention and control groups) indicated they still wanted some control even if staff had control whereas Too (1996b) discovered some women wanted personal control while others preferred to give up all control to their midwives. In both studies midwives cared for participants. It is unclear as to why these differences existed. Possible reasons for this variation may be attributed to a variety of factors such as the individual characteristics of the woman, the stage of labour, the presence of antenatal education or preparation prior to birth, and the nature of the relationship with their healthcare provider caring for them during delivery. Interestingly, in Berg's study the control group with complicated pregnancy/complicated childbirth (CPCC) reported a higher sense of control during labour than the normal pregnancy/normal childbirth (NPNC) group ($p=0.006$). During the second stage of labour the normal pregnancy/complicated childbirth (NPCC) group reported a lower on a sense of control compared with the normal pregnancy/normal childbirth (NPNC) group (30.3% vs. 43.7%; $p=0.023$). Also, women in the complicated pregnancy/normal childbirth (CPNC) control group reported a lesser feeling of participation than the normal pregnancy/normal childbirth (NPNC) control group (72.7% vs. 91.3%; $p=0.02$). The varied

results between the control subgroups suggests that the feelings a woman has during pregnancy and childbirth are complex and influenced by a multitude of factors that are not easily defined.

In contrast to these findings, in the intervention group, the normal pregnancy/normal childbirth (NPNC) reported a higher sense of control than the complicated pregnancy/complicated childbirth (NPCC) group (53.0% vs. 31.6%; p=0.006). There were no differences reported between the four subgroups in the intervention group regarding control during second stage of labour. When comparing the two groups of women (intervention and control) regarding NPNC, NPCC, and CPCC subgroups, no significant differences were found in any of the statements related to the experience of control which may suggest factors other than the completion of a birth plan may affect a woman's perception of control. In contrast, women in the CPNC intervention group reported a higher level of fear related to complications (41.1% vs. 14%; p=0.001) but were more willing to suffer pain for the child's sake (71.2% vs. 40.3%; p=0.029). To summarize, the intervention of a birth plan did not improve the childbirth experience in any one subgroup. In fact, women with complications in pregnancy or childbirth in both the intervention and control groups reported more negative feelings related to fear and control. These findings suggest women at high risk are more vulnerable to negative emotions related to their pregnancy and childbirth.

In Kuo et al.'s (2010) randomized control trial (RCT) study women with pregnancy complications were excluded. Education sessions were provided to the nurses who would be involved in the discussion and preparation of the birth plan with the intervention group. Birth plan preferences were discussed in collaboration with each woman, a nurse, and obstetrician (n=10) and upon consensus was signed off. Those who completed a birth plan reported an increased sense of control as measured by the 29-item Childbirth Control Scale instrument. A

higher level of control was reported in the experimental group (n=155) compared to the control group (n=141) and was attributed to the women exercising self-management of their own birth process (p=<0.001). The researchers suggested that completing a birth plan gave the women information about choices thereby increasing their confidence and allowing them to develop reasonable and realistic expectations of their birth experience. This in turn gave them a perceived increased sense of control and strength resulting in positive psychological effects such as feelings of mastery and participation (t=3.74, p<0.001) and overall postnatal feelings of fulfillment of childbirth expectations (t=2.63, p=0.01). The authors of this study proposed that by participating in the creation of a birth plan women become educated and informed about childbirth which in turn results in self-mastery and an increased sense of control regardless of outcome and is positively associated with increased satisfaction (Kuo et al., 2010). The findings in this study suggest that communication, mutual goal setting, and decision-making may contribute to increased control and overall childbirth satisfaction. While it is difficult to definitively determine the reason for the mixed findings in the various studies it may be the heterogeneous nature of the various studies (design, sample size, and characteristics), as well as the varied types of healthcare providers involved in their care (Peart, 2004; Too, 1996b; Whitford & Hillan, 1998).

In Springer's (1996) study the effect of written birth plans on maternal anxiety in pregnancy was examined. State and trait anxiety levels of primiparous women (N=45) who created a birth plan (n=21) were compared to those women who did not complete a birth plan (n=24) using the State-Trait Anxiety Inventory (STAI) instrument. State anxiety was defined as the transitory emotional state characterized by the subjective feelings of apprehension and/or tension and trait anxiety reflected an individual's proneness to anxiety related feelings. Trait

anxiety was not significantly different at the onset of the study which supports the fact the two samples were similar prior to the intervention of completing a birth plan. There was no statistical difference in state anxiety levels (t=1.95, p=0.06), however there was a strong trend towards decreased levels in the birth plan group. Springer (1996) suggested that if the sample size had been larger statistical significance might have been evident. These results are suggestive that women who prepare for labour and birth by completing a birth plan may have less anxiety related to pregnancy. However, trait anxiety in this study was measured after completion of childbirth education classes and not when the women went into labour, which limits the ability to compare the effectiveness of completing a birth plan on the birth experience.

Overall childbirth satisfaction. In Lundgren et al.'s (2003) study completion of a birth plan did not improve women's satisfaction despite similar sample characteristics (primiparous and multiparous women), sample sizes, and similar healthcare providers (92.2% versus 83.5%, p=0.23). In fact, the findings for women who did not complete a birth plan were more favourable. Women in the control group (n=271) rated supportive behaviours such as listening (92.2% vs. 83.5%, p=0.023), supporting (90.3% vs. 81.6%, p=0.016), guiding (90.3% vs. 80.2%, p=0.007), and respect (90.9% vs. 82.3%, p=0.043) significantly higher than women in the intervention group (women who completed a birth plan). These findings suggest completion of a birth plan may not be the sole factor influencing a woman's overall childbirth satisfaction and that other factors such as the relationship a childbearing woman has with her healthcare provider may play a key role.

In Kuo et al.'s (2010) RCT study of Taiwanese primiparous women (N=286) the primary outcome measure was childbirth experiences with secondary outcome measures of feelings of control and childbirth expectations fulfillment. Control (n=141) and intervention (155) groups

were determined based on single-blind randomization using a block randomization procedure. Both the control and the intervention group (women who completed a birth plan) were asked to complete a Childbirth Expectations questionnaire prenatally followed by a Childbirth Expectations Fulfillment questionnaire, a Childbirth Control scale, and Childbirth Experience questionnaire administered post-delivery. There were no significant differences noted between the two groups in terms of overall prenatal childbirth expectations. However, women who completed a birth plan had higher ratings of enhanced childbirth experience ($t=2.48$, $p=0.01$), control ($t=9.60$, $p=<0.001$), fulfillment of expectations ($t=2.63$, $p=0.01$), and a sense of mastery and participation ($t=3.74$, $p=<0.001$). These findings confirm that the introduction of mutually agreed individualized birth plans has the potential to positively affect the fulfillment of childbirth expectations, increase a woman's sense of control, and positively affect her overall birth experience (Kuo et al.).

Some research findings suggest that lack of adherence to birth plans may not negatively impact a woman's overall satisfaction in childbirth (Whitford & Hillan, 1998). For example, Whitford and Hillan (1998) reported 67% of the women (N=101) stated that even though their birth plan was partially followed or not all, they were quite happy or not bothered at all that the labour didn't follow the birth plan. Of those studies in which a healthcare provider discussed birth plan preferences with women, despite the fact birth plan choices were not entirely followed, women still reported that they were satisfied with their birth experience (Berg et al., 2003; Brown & Lumley, 1985; Ekeocha & Jackson, 1985; Kuo et al., 2010; Lundgren et al., 2003; Whitford & Hillan, 1998). These results suggest that a woman's positive relationship with her healthcare provider may negate the impact of not adhering to a birth plan.

Birth Outcomes. There are diverse birth outcomes for women with birth plans reported

in the literature. Deering et al. (2007) conducted a retrospective chart audit of women who delivered over a three and one-half year period who completed a birth plan (n=64) and matched for age and parity at a 2:1 ratio (n=128). While controlling for age and parity in the sample, there were no significant differences in caesarean section or episiotomy rates. There was a significant difference in the epidural rate for women having a vaginal delivery as women with birth plans received epidural anaesthesia less often (57% vs. 78%, p=0.005). In contrast, Hadar et al. (2011) conducted a three-year retrospective study in a single major tertiary medical center examining the mode of delivery, administration of analgesics, obstetrical lacerations and episiotomy rates. They reviewed patient records and compared women who had completed a birth plan (n=154) to a matched-controlled group (3:1 ratio; n=462). Women with birth plans were likely to have an increased use of epidural anaesthesia (81.2% vs. 68.8%, $p< 0.004$), an increased rate of grade one to two perineal tears/lacerations (72.1% vs. 25.5%; $p< 0.001$), and less intravenous (IV) analgesia (1.3% vs. 10.2%; $p< 0.001$). Further subgroup analysis with women who had spontaneous onset of labour revealed that there were fewer caesarean sections for women completing birth plans (9.3% vs. 19.5%; p=0.01).

Jones et al. (1998) conducted a six-month retrospective chart audit consisting of both multiparous and primiparous women (N=1172) who planned a spontaneous delivery. They reported only 42/1172 women completed a birth plan in their study. To control for confounding variables, women with risk factors such as multiple pregnancies, vaginal birth after caesarean section, and diabetes were excluded from the sample. Jones et al. (1998) reported an increase in forceps delivery for women presenting with birth plans (26.2% vs. 8%; OR=4.1; CI: 2.0-8.3). Specifically, multiparous women were more at risk for operative vaginal (forceps or vacuum) delivery (OR=12, CI: 4.0-38.0). The study findings noted that women with birth plans may have

refused analgesia or augmentation necessitating an operative birth but did not comment whether birth records indicated these reasons. The researchers suggested the possibility of the lack of support from healthcare providers for women who had a birth plan as a possible contributing factor to the operative birth rate although they had no data to support this suggestion.

Methodologically, there are several limitations and challenges in the literature when trying to compare and contrast results on the enactment of birth plans. There were varying sample sizes consisting of varied parity, ethnicity, and education. In addition, the surveys utilized in the majority of the studies were not all validated instruments and measured different constructs related to maternal outcomes. Controlling for confounding variables was not consistently addressed or communicated in the studies under review. For example, whether any study participants attended any antenatal education classes was not always clearly communicated and/or the content of these sessions was not defined. The number of antenatal visits and the type of healthcare provider providing care was not always clear in many of the studies. Studies were not conducted in multiple sites so individual healthcare provider practices and/or unit practices may affect reported maternal and birth outcomes. For example, the mode of fetal surveillance, the types of interventions used for pain management, and the caregiver-patient relationship are just some of the factors that may impact the progress of labour. The types of labour support, the onset of continuous labour support, and the interventions utilized to manage labour were not addressed in detail in any of the studies yet these have been shown to impact birth outcomes (Hodnett, Gates, Hofmeyr, & Sakala, 2012).

Healthcare providers and birth plans. Regardless of the primary purpose of the studies included in this review, a vast majority of the authors commented on women's perceptions of how birth plan expectations were supported or not supported by healthcare providers in the

various practice environments (Kuo et al., 2010; Peart, 2004; Too, 1996b; Yam et al., 2007). Healthcare providers were noted to play a pivotal role in supporting women to fulfill their individual needs in childbirth, connect with the family as a whole, and make a substantial difference to a woman's childbirth experience (Moore & Hopper, 1995; Too, 1996b). The norms and beliefs guiding the discourses of pregnancy and childbirth are complex and influence how the needs of the woman, her family, and the healthcare team are addressed within a birthing unit.

Healthcare provider behaviours. Healthcare provider behaviours vary in each practice environment and may be indicative of individual values and beliefs and/or unit philosophy or culture (Brown & Lumley, 1998; Ekeocha & Jackson, 1985; Grant et al., 2010; Kuo et al, 2010). These types of behaviours were the premise for Jones et al.'s (1998) study where researchers perceived in practice varying degrees of reactions from attending medical and midwifery staff toward women presenting with birth plans and a tendency for these women to be handled with an air of caution. In Peart's (2004) study some women perceived a lack of attention directed toward their birth plans with some caregivers reacting negatively to the concept of a birth plan and not always reading or respecting their plan. Whitford and Hillan (1998) reported that 68% of women (N=101) stated their midwives did look at the birth plan but only 15% of physicians did the same and this suggests there may be a difference in behaviours between healthcare providers. In addition, 63% of women felt enough attention overall was paid to their birth plan yet over 90% of the same sample of women felt the degree of attention paid during the intrapartum period was less than they expected. In contrast, in Pennell et al.'s (2011) study women reported nurse-midwives (98.5%), obstetricians (65.8%), and anaesthesiologists (68.4) were respectful of their birth plans. These studies draw our attention to questioning how the birthing unit culture may influence healthcare provider behaviours as perceived by women in childbirth.

Healthcare provider attitudes. Grant et al. (2010) conducted a cross-sectional survey of healthcare providers (n=103) and childbearing women (n=113) to examine their beliefs and views regarding birth outcomes for women with birth plans. They reported differences between healthcare providers and childbearing women in terms of their perspective of the validity of birth plans and their inability to affect more positive birth outcomes for women. Healthcare providers reported in this study that they felt women with birth plans had: (1) increased risk of caesarean section (65.7% vs. 8.5%, $p<0.001$), (2) increased risk of chorioamnionitis (53.4% vs. 9.7%), (3) increased risk of operative birth (36% vs.7.3%, $p<0.001$), and (4) increased risk of postpartum haemorrhage (29% vs. 11%, $p<0.001$). Interestingly, 65% of all healthcare providers in this study compared to 2.4% of women believed that women with birth plans had worse overall obstetrical outcomes ($p<0.001$). There is no evidence to date supporting that there is a relationship between these birth outcomes and birth plans, yet healthcare providers in this study believed them to be true.

In a recent study in the United States, researchers studied the perceptions of nurses caring for women giving birth within nurse-managed, highly technological-environments (Carlton, et al., 2009). Though not part of the study's primary purpose, researchers unexpectedly discovered birth plans were noted to create tension and frustration for labour and delivery (L&D) nurses. Nurses viewed them as unrealistic and potentially impeding the caring therapeutic relationship. Carlton et al.'s (2009) and Grant et al.'s (2010) studies support the idea that healthcare provider attitudes and beliefs about birth plans warrants further study to determine the influencing factors.

In addition to perceptions about how birth plans influence birth outcomes Too's (1996a) study described how midwives (n=10) perceived childbearing women who completed a birth plan. Midwives in this study described women with birth plans as being more interested,

motivated and involved in their own care, whereas, women without birth plans were described as teenagers, less educated, of low socio-economic status, multiparous women, who may have had total trust in their midwives. How these perceptions impact the care of childbearing women remains to be seen. These studies support the idea there are differing attitudes related to birth plans between healthcare providers and childbearing women. Understanding why these disparities exist is important as the perceptions of healthcare providers could possibly influence the care they provide and predispose childbearing women to those perceived maternal and birth outcomes. It is important to study the factors that influence these beliefs. The enactment of birth plans and the communication with childbearing woman cannot be separated from pre-existing hospital policy and culture. How L&D nurses view birth plans in light of their day-to-day practice environment could be explored through conducting ethnographic research.

Overview

Overall, while the research studies are not strong, the findings do suggest that planning for birth and the formulating of a birth plan can contribute to increased knowledge of choices for childbearing women. However, the research about the presence of birth plans and improved communication with healthcare providers remains equivocal. Thus, the questions that remain to be answered include: What factors influence communication and the enactment of birth plans on a birthing unit? Does unit culture impact how birth plans are enacted in the every day practices of L&D nurses? What is known is that the experience of childbirth is complex and there are a variety of influences on a birthing unit that could impact the enactment of birth plans.

A brief overview of existing research provided little insight on nurses' perspectives on birth plans and how unit culture impacts their relationship with childbearing women. Research to date has historically focused on the woman's perceptions and ideas about birth plans and the

reasons for writing them. Review of the literature suggests birthing unit routines and practices appear to be integral to the successful incorporation of birth plan expectations into care delivery (Brown & Lumley, 1998; Kuo et al., 2010; Moore & Hopper, 1995; Peart, 2004). Noticeably absent from the present body of literature is the perspective of labour and delivery nurses and how birth plans are known to exist within current unit culture along with the challenges to enact birth plans into care. This gap in the literature suggests it is essential to study unit culture and its influence on how nurses enact birth plans. No research study was found that exclusively examined nurses' perceptions of the factors that influence, inhibit or support the use of birth plans from the perspective of the L&D nurse. It is anticipated that the study findings will provide enriched understanding into the complex system of a birthing unit and the L&D nurse's relationship with childbearing women and their families. It is through this understanding that perinatal care to women and their families may be enhanced.

CHAPTER THREE

Research Design

Methodology

Qualitative research designs sit in a naturalistic, interpretive paradigm and are characterized by the belief that multiple realities exist and contextual meanings are constructed by an individual's experience of a particular phenomenon (Polit & Beck, 2008). Knowledge and understanding emerges when one listens to the voices of the individuals experiencing the phenomenon (Munhall, 2012). These multiple realities are fluid and individually constructed and lend themselves to new ways of being and knowing in the world (Fetterman, 2010). "According to naturalism, in order to understand people's behaviours one must use an approach that gives the researcher access to the meanings that guide their behaviour" (Hammersley & Atkinson, 2007, p. 8). The methodology used in this study was focused ethnography that is rooted and derived from ethnography. In this next section an overview of ethnography will be provided along with a detailed description of focused ethnography and the steps utilized in the research design as outlined in Roper and Shapira (2000).

Ethnography. Ethnography is the study of behaviour of individuals or groups within a particular culture and originally evolved from cultural anthropology. Ethnography emerges from a naturalistic perspective with a commitment to the study of culture in its natural setting (Munhall, 2012). Culture is a central concept of ethnography and is defined as the total way of life for a group with learned behaviour that is socially constructed and shared (Munhall, 2012). Rules and behaviours are learned within each particular culture and members may be told how to behave appropriately within it (Roper & Shapira, 2000). "The concept of culture enables the

ethnographer to go beyond what people say and do to understand that shared system of meanings we call culture" (Morse, 1994, p. 160).

Ethnography lends itself to the discovery and understanding of complex societies and human behaviour; what they do, what they say, how they relate, their customs and beliefs, and how they derive meaning from their experience (Streubert Speziale & Rinaldi Carpenter, 2007). "Ethnography provides a framework for studying the patterns, life ways, and experiences of a particular cultural group in a holistic fashion" (Polit & Beck, 2008, p. 64). The study of culture requires researchers to be immersed in the culture for extended periods of time and at times even years. It is through participant observation, symbols, conversations, documents, and various elements embedded within the culture that the researcher gains an insider view of ways of knowing within a specific culture. The process of ethnography is inductive, with no prescribed or predicted outcomes. Ethnography is about gaining insight and understanding into the values and beliefs of a specific culture (Morse, 1994).

Focused ethnography. Focused ethnography is proposed as the qualitative research methodology best suited to answer the research question for this study. "Focused ethnography focuses on a distinct problem and studies it within a single context with a limited number of individuals" (Streubert Speziale & Rinaldi Carpenter, 2007, p. 204). Focused ethnography holds to the same core characteristics as traditional ethnography but completes the study in a shorter timeframe and focuses on a specific topic. A focused ethnographic approach was used for this study as it allowed for an exploration of common behaviours, experiences, values, and beliefs of this particular group of labour and delivery nurses in relation to birth plans.

The practice of nursing is a cultural phenomenon and labour and delivery nurses are a subculture with their own unique beliefs and practices. By studying birthing unit culture the

taken-for-granted behaviours, rituals and practices will become known and provide insight into nurses' practices related to birth plans. By examining nurses' practices when caring for women with birth plans there is a commitment to the discovery of knowledge through the multiple ways of understanding within this culture. This study provided a window into the cultural experiences of childbirth from the view of the nurses that would not otherwise be known. Findings will contribute to increased understanding into this culture and contribute to possible improvements in practice.

Setting

The study was conducted in a Level II hospital located in a large in a large urban population centre in Alberta, Canada (Statistics Canada, 2013). In Alberta, obstetrical centers are categorized based on their ability to provide services ranging from low-risk to high-risk obstetrical services to both pregnant women and their infants. Level I centers consist of rural hospitals located in smaller communities capable of delivering women of ≥37 weeks gestation and may or may not provide caesarean section capabilities. Level II centers are predominantly located in mid-size cities and are capable of delivering women of ≥32 week's gestation with some centers able to care for the neonatal population. Level III centers are located in large metropolitan areas and deliver all gestations of pregnancy and certain Level III centers are capable of caring for neonates of all gestations (APHP & AHS, 2012). Staffing and facilities at the labour and delivery (L&D) unit in this study support the care of low, moderate, and high-risk women and infants of approximately 32 weeks gestation. This L&D unit operates at full capacity with registered nurses caring for women under the care of obstetricians (OBs), general practitioners (GPs), and midwives.

Entry Into the Field

Once ethics approval was obtained, entry into the field was initiated by contacting the manager of woman's health of the hospital and the manager of the L&D unit being studied. Initial discussion around the feasibility of performing this study was by email between the researcher and these two managers. The researcher provided a brief description of the purpose of the study, the method utilized to obtain or collect data, the targeted population in the study, and the proposed time frame for conducting the research.

Once the gatekeepers granted permission to enter the setting and all institutional requirements for conducting the research were obtained an initial meeting with the unit manager was arranged. During this meeting, the researcher provided an overview of the study and discussion ensued as to the best approach to introduce the study to the L&D staff. The unit manager identified possible key informants to participate in the study and facilitated an initial meeting with a senior L&D nurse to provide an overview of the physical structure of the unit.

Sample

The method of selecting participants for this study was purposeful sampling. Purposeful or purposive sampling is a type of non-probability sampling involving participant selection based on first-hand experience and/or specific knowledge of a particular phenomenon of interest (Roper & Shapira, 2000; Streubert Speziale & Rinaldi Carpenter, 2007). L&D nurses who have experience caring for childbearing women with birth plans were the target group.

In qualitative research the sample size must be large enough to identify common themes and concepts (Wood & Ross-Kerr, 2011). Sample size is difficult to determine in qualitative research at the outset of a study but one needs to focus on being able to provide a thick, rich description of a particular topic from the data (Sandelowski, 1995). Generally, sample sizes are

smaller due to the large amount of data generated from this type of research. After discussion with supervisory committee members it was anticipated that approximately five participants would be recruited to participate in semi-structured interviews after each participant observation period was completed.

Participants and Recruitment

The identified participants were L&D registered nurses (RNs) practicing within the designated L&D unit during the study period. The researcher hoped to incorporate perspectives from a variety of L&D nurses with the goal of obtaining the perspectives of key informants with specific in-depth knowledge and experience related to verbal and written birth plans.

Ethnographic research strives to identify key informants who can speak to the phenomenon of interest (Munhall, 2012). Key informants are individuals who provide a detailed account of their insider knowledge of birth plans enacted within the birthing unit culture. The researcher was able to identify key informants after the initial period of observation where the researcher was able to ask focused questions. The hope was that once the researcher had spent time on the unit and offered information sessions, participants would also volunteer to be key informants. Key informants provided detailed rich historical data and information about the nuances of everyday life on the birthing unit (Fetterman, 2010).

Initial recruitment to the study was facilitated with the help of the manager of women's health. Posters outlining the study's purpose and objectives were placed in prominent locations on the unit (Appendix A). The manager facilitated participation of a senior labour and delivery nurse to provide a physical tour of the unit. An overview of the study was also provided by the researcher at the unit report at the beginning of each shift and while on the unit on an individual basis. The focus of the study was on the labour and delivery nurses. Other individuals such as

students, midwives, and physicians who were seen to be able to share their knowledge of the unit culture and their experiences with birth plans were also invited to participate. These informal interviews were captured in field notes.

Formal semi-structured interviews were conducted with five L&D nurses. Demographic information was collected from the participants and included: name (i.e. pseudonym), position title, number of years of L&D experience, country of nursing education, and type of nursing education (i.e. degree or diploma), and any other specialized education related to obstetrics (Appendix B). The interview participants were all identified as registered nurses (RNs). The range of experience in L&D ranged from nineteen months to over thirty years; level of education consisted of two nurses having diplomas and three nurses with degrees including one registered nurse (RN) having experience as an international midwife. This type of information is key to describing who belongs to the culture and contributes to the study findings.

Data Collection

In ethnographic research there are three primary methods utilized for data collection: participant observation, interviews, and the collection of relevant documents such as artefacts that foster understanding of the culture. Ethnographic data collection and analysis is cyclic in nature. The researcher is engaged in the continual process of participant observation, field notes, interviewing, reviewing, analyzing data, and returning to the field to obtain more data (Roper & Shapira, 2000).

Participant observation. Participant observation is central to ethnography and a researcher's involvement can range from participant to observer (Roper & Shapira, 2000). In this study the researcher's role was strictly observation and participation in the care of childbearing women was not undertaken. Due to the legalities of participating as a registered

nurse (RN) in intrapartum care as well as the vulnerability of women in childbirth the researcher would only observe interactions between care providers and/or with patients that occurred outside the labour suites. The researcher was onsite for a total of 102 hours of direct observation time. During fieldwork, the researcher's observations were recorded in the form of field notes to provide context. The notes were recorded post-observation as close to the observation time as possible. The field notes were recorded by the location, the observation number, date, start and end time of the observation period, a description of the event and any perceptions and theory related to the observation. This allowed the researcher to systematically record each observation while allowing suggestions for future questions or observations. After leaving the field the researcher recorded additional thoughts or reflections regarding the observations in a reflective journal thereby allowing thoughts and feelings to be captured in a timely manner.

Spradley (1980) specified three specific phases of observations: "descriptive, focused, and selective" (as cited in Roper & Shapira, 2000, p. 70). The literature does not provide a specific time frame for observation except that the researcher will know when they have enough data to be able to speak to the culture being studied. In this focused ethnographic study observation periods varied in length and occurred at various times (i.e. days, evenings, nights, and included weekdays and weekends) to provide a broad range of observation times and a variety of perspectives and experiences. Initially, the researcher toured the unit and observed unit staff during various times while on shift to provide a general overview of the unit as a whole. More focused observations occurred during eight and twelve hour shifts with specific key informants. Formal semi-structured interviews were conducted with each key informant after observation periods were completed. All observations and interviews occurred over approximately a seven-week period and allowed for a thick description of the culture.

Descriptive phase. The initial period of observation consisted of a general overview of the birthing unit. The purpose of the exploratory phase was to obtain a panoramic view of the people and events being studied. This provided the researcher an opportunity to become aware of the various events on the unit and note topics for further study (Roper & Shapira, 2000). Attention was given to the group members, the observation of patterns of behaviours between the various care providers, and listening to their thoughts and ideas related to their unit. This initial phase consisted of two-eight hour shifts and was an introductory phase of observation to help to familiarize staff with the researcher and the study's purpose.

In the early stages of participant observation the researcher observed the physical structure of the patient care areas noting posters, equipment, and organization and the members of the healthcare team who worked on the unit. By spending time in each patient care area it enhanced the researcher's understanding of the flow of patients in and through the unit. Verbal interactions were observed between various care providers however due to the structure of observation little or no observations were documented between labour and delivery nurses and the childbearing women they cared for on this unit. Informal conversations occurred with a variety of healthcare providers, including registered nurses (RNs), medical residents, general practitioners (GPs), and obstetricians (OBs). These conversations occurred, predominantly at the nursing station within the labour and delivery and triage areas. The researcher documented informal conversations and interactions between L&D nurses around their routines and practices, their respective roles, their physical behaviour and gestures, and their thoughts about birth plans were recorded in the form of field notes. After conducting a general overview of the unit, the researcher moved to more focused and selective observations along with informal conversations while shadowing with five key informants.

Focused phase. Following the initial phase, observations became more focused based on the initial encounters and repeated cultural incidents requiring the need for further exploration. The researcher transitioned to casual informal conversations with various labour and delivery nurses, obstetricians, and medical residents in areas such as the nursing station or the nursing conference room discussing unit routines, practices, and culture along with the incorporation of birth plans into intrapartum care. The intent of these conversations was to glean the overall culture and then focus on key details involving birth plans such as how they are structured, discussed, and incorporated into care as well as the facilitators and barriers as identified by the health care providers. Informal consent was obtained when interacting with any nurses or other healthcare practitioners on the birthing unit. Specifically these providers were informed why the researcher was on the unit and how their input and knowledge related to birth plans would be of value to the present study. Data during these two-eight hour shifts was obtained through initial observations of the unit structure, philosophies, and informal conversations were captured in the form of field notes.

Selective phase. The final phase of observation was selective in nature and this is the phase where the researcher focused on specific attributes of activities and behaviours. During this final phase of observation the researcher obtained written consent (Appendix C) to buddy with five key informants for three – eight hour shifts or two-12 hour shifts in order to gain more in-depth knowledge of the specific topics that have been revealed in the previous phases. As the research unfolded during the initial and focused phases of observation, key topics were made known, and by being selective on the discussions and observations around these topics the researcher utilized key informants to explain them in more detail and depth.

Field notes and documents of interest. Documents of interest were reviewed when conducting participant observation on the labour and delivery (L&D) unit. Policies and procedures and other various Alberta Health Services artefacts (i.e. mission statement and strategic plan) that could contribute to the understanding of the birthing unit culture were reviewed. Artefacts such as policies and procedures specifically related to birth plans or documents related to a philosophy and/or model of care did not exist according to the L&D nurses and therefore were not obtained in the study.

Another form of data collection utilized was the creation of field notes. Field notes pages were formatted into three columns: (1) description of the event, (2) perceptions/hunches, and (3) literature/theory. During each observational period the researcher made short, concise notes to capture the interactions, behaviours, and experiences on the birthing unit and then expanded on those observations when off the unit to ensure accurate and thorough data collection. Field notes were further documented off the unit as close to the observation period as possible.

Field notes are a written account of observations of environmental structure, participant interactions, casual conversations, and questionings for further clarification in future observations. The researcher recorded the date, time, location, and informant's pseudonym name to ensure chronological recording of observations and informal conversations. These were discussed with the researcher's supervisor and other committee members periodically during the data collection phase of the study. Informal conversations were documented in the field notes and quotations were used as often as possible in order to capture the true thoughts of the labour and delivery nurse. Care was taken to ensure field notes were securely kept with the researcher in a locked briefcase while on the unit during observation periods. Field notes and interview

transcripts were stored in a locked filing cabinet in the student researcher's office/home when the researcher was off the unit.

Interviews. Ethnographers rely on interviews to gain an understanding of the informant's world and the connection between what is seen and heard (Munhall, 2012). Two types of interviews were undertaken during this focused ethnographic study. The first type of interview was informal, open, and flexible. Casual conversations helped to build rapport with insiders. The purpose of these informal interviews was to ask questions and clarify observations immediately after they occurred in order to check the participant's perception of an event against the researcher's perception.

The second type of interview occurred after the participant observation phase with each key informant to allow for more in-depth questions for clarification of observations made while on the unit. Each key informant identified was approached during the selective observation phase and asked to participate in a semi-structured interview lasting approximately one hour. Semi-structured interviews were conducted with these key informants to obtain information regarding nurses' understandings of caring for women presenting with birth plans and lasted from 60-90 minutes in duration (Appendix D).

Semi-structured interviews were to take place off the nursing unit but this proved to be difficult as key informants did not want to meet offsite and unit activity was often conducive to conducting the interviews at the end of each focused observation phase. Two of the interviews did take place off-site due to multiple scheduling challenges with these key informants. One key informant was scheduled to be interviewed on two separate occasions and did not keep either face-to-face interview appointment. Due to additional scheduling challenges and time constraints this particular key informant had her interview done via a secure phone line away

from work as per her request after obtaining written consent via fax machine. This particular interview format was discussed with the advisors prior to conducting the interview. Prior to the start of the interviews the researcher read a brief overview of the purpose of the interview and obtained written consent from each participant (Appendix E). Each participant was informed they could discontinue the interview at any time. Demographic characteristics were recorded in order to determine professional experience in labour and delivery, education and training. Interviews were digitally recorded and transcribed verbatim in written form with aliases used to protect the identity of the participants.

The Role of the Researcher in Data Collection

"Reflexivity of the researcher involves awareness of one's self, one's responses and one's internal state in relation to situations while attempting to understand the patient situation" (Roper & Shapira, 2000, p. 26). The researcher must acknowledge his/her own position with respect to their world they are studying and the way in which they are impacted by it (Morse, 1994). Both the emic (i.e. inside) and etic (i.e. outside) perspectives are important to consider as the researcher explores the culture identified in the study.

With respect to this specific study, the researcher's emic perspective comes from being employed in the area of maternal child nursing over a 21-year nursing career. The researcher began her nursing career in a northern setting practicing in a rural hospital for approximately ten years and then transitioned to high-risk obstetrical care in the United States. During the past ten years the researcher has moved from front-line nursing to education of L&D nurses to management of an intrapartum unit in a Level II center in Alberta. This enabled the researcher to have some understanding of the challenges labour and delivery nurses face in today's healthcare system when providing intrapartum care as well as the importance of patient and family-centered

care (PFCC) principles in the care nurses provide each day. Based on experience, various healthcare professionals are not as supportive of birth plans, whereas others have been accepting of a woman's plan in childbirth. A birthing unit is complex and dynamic and there was a definitive culture that exists on each individual unit. How that culture impacts nurses' views of birth plans and how this may impact their practice in relation to birth plans was the focus of this study.

The researcher's etic perspective comes from that of a novice researcher and the lack of knowledge of level II centers in urban cities in Alberta. The etic role allowed the researcher to see level II obstetrical care in a fresh and new way as well as the fact that as a researcher each step of this research was done in a systematic fashion in consultation with my advisors.

In ethnography there is recognition that the research is neither subjective nor objective and researchers use both perspectives by participating in experiences and then taking a step back to analyze the data (Roper & Shapira, 2000). Two views, side by side, produce a third dimension, that rounds out the ethnographic picture (Werner & Schoepfle, 1987 as cited in Roper & Shapira, 2000, p. 4). To guard against biases informing the research and prevent the researcher from imposing his/her own views into the data in addition to field notes, a reflective journal was kept to record the researcher's personal thoughts and opinions and/or any conflict with philosophies of care evident in the data.

Analysis

"Holistic, contextual, emic, etic, and non-judgmental concepts require the ethnographer to boil down all the information (i.e. observations, interviews, theories, and patterns) that emerged during fieldwork to provide the essence of a culture" (Fetterman, 2010, p. 24). In order to do this ethnographers pull out from the data examples, comments, descriptions which depict

the culture of the area being studied. The aim of data collection and analysis is to portray the culture as informed by the knowledge of the key informants (Munhall, 2012). Ethnographers are active participants in the data collection and analysis (Fetterman, 2010; Munhall, 2012). Analysis of the data is ongoing in the reflexivity of the researcher and the interplay between multiple data sources and the researcher's thoughts.

Ethnographic analysis of the data was performed using the steps outlined by Roper and Shapira (2000) that include: (1) coding for descriptive labels; (2) sorting for patterns; (3) identification of outliers or negative cases; (4) generalizing: constructs and theories; and (5) memoing: reflective remarks. This type of inductive reasoning process starts with "details of the experience and moves to a more general picture of the phenomenon of interest" (Streubert Speziale & Rinaldi Carpenter, 2007, p.10).

Descriptive labels. Roper and Shapira (2000) outline basic domains that help to categorize data in the initial phase of analysis; (1) setting - environment, (2) activities – regularly occur, (3) events – specific activities which occur infrequently, (4) relationships and social structure – patterns in the way people bond together, (5) general perspectives – group members' shared understandings of how things are normally done, (6) specific perspectives related to the research topic – how people understand the phenomenon, (7) strategies – ways of accomplishing goals, (8) process – flow of events transitions, changes over time, (9) meanings – what people say about the significance of their behaviour, and (10) repeated phrases – comments made regular depict patterns of thought (Appendix F).

These basic domains or descriptive labels proved to be a starting point for this novice researcher to categorize the large amount of data. While beginning to categorize the data the domains (i.e. activities, strategies, and process) were difficult to categorize and thus the

researcher combined them into one category named activities. Each category was assigned a specific color and field notes and interview transcripts were reviewed, and each segment of data was categorized according to these domains and color-coded accordingly. The researcher was careful to ensure the source was identified (i.e. observation record date and number or interview). Each color-coded segment of data was extrapolated into one document and named its descriptive label. These were reviewed repeatedly to ensure data was assigned to the appropriate category/label.

Sorting for patterns. The next step was to group these descriptive labels into smaller groups or sets. Each label was reviewed and patterns became apparent in which segments of data were grouped together with the assistance of the researcher's supervisors. These groupings resulted in themes and subthemes.

Outliers. During analysis, events and situations emerged that did not fit within the identified categories. It is important not to discard these as they may help to strengthen or explain study findings (Roper & Shapira, 2000). These outliers were kept with the data but set aside for review periodically during the analysis of the data.

Generalizing. Roper and Shapira (2000) describe this step as a desire to connect findings to theories that help to make sense of the complex and rich data collected during the study. By linking the emic meanings of participants with the etic interpretation of those meanings the researcher can begin to construct a theoretical understanding of the phenomenon in the study (Roper & Shapira, 2000). The themes and subthemes identified were organized and their impact on practice, education, policy and future health care planning will be presented in the discussion chapter.

Memoing. Memoing involves taking the data collected from documents, interviews, and observations and making connections between these pieces of information (Roper & Shapira, 2000). During this step the researcher starts to develop insights and ideas based on those connections. It is the triangulation of various data sources that helps to validate findings and provide a rich thick description. Data analysis was not linear but moved back and forth between these steps of analysis. The researcher kept an audit trail in order to demonstrate that systematic analytic strategies were incorporated in the data analysis phase of the study (Roper & Shapira, 2000).

Rigor

The overarching goal of qualitative research is to accurately represent the experiences and ideas of the study participants (Streubert Speziale & Rinaldi Carpenter, 2007). This study was assessed for rigor by utilizing the framework outlined by Lincoln and Guba (1985): credibility, dependability, confirmability, and transferability (as cited in Polit & Beck, 2008, p. 539). Following is a description of the methods utilized to enhance the rigor of this study.

Credibility. In qualitative research utilizing the naturalistic paradigm acknowledges that multiple realities exist and are constructed. Therefore truth is elusive and the researcher is much more interested in credibility of the study by presenting an accurate description or interpretation of the human experience that could be acknowledged by those having experienced it. The three main hallmarks of credibility in the collection of data are prolonged engagement, persistent observation, and triangulation. In this study each of these were addressed in the naturalistic setting of the study and collection of data from multiple sources (i.e. observation, interviews, and artefact and document examination).

Prolonged engagement and persistent observation during data collection are two strategies to enhance credibility (Streubert Speziale & Rinaldi Carpenter, 2007). The researcher utilized a prolonged period of engagement (i.e. seven weeks), conducted informal conversations with a variety of healthcare practitioners, and conducted in-depth semi-structured interviews lasting 60-90 minutes with five key informants (i.e. labour and deliver nurses). This provided multiple opportunities to obtain data from participants.

Triangulation helped to provide a more complete, contextualized portrait of the phenomenon being studied. Through the use of multiple data sources (i.e. participant observation, informal interviews, and formal interviews) conclusions were validated. Member checking is also considered an important strategy to ensure credibility. By sharing emerging interpretations with participants the researcher provided them with an opportunity to provide insight and determine if they were representative of their reality (Polit & Beck, 2008). Through formal and informal conversations the researcher sought and received clarification on emerging themes to ensure credibility of findings.

Dependability. This refers to the reliability of data over time. Reliability refers to the collection of data that is consistent, stable, and reproducible (Roper & Shapira, 2000). Reliability was enhanced as the researcher observed many events and participated in informal conversations with a variety of people multiple times during the extended period of data collection. In addition, strict attention was paid to the recording of objective descriptions of accounts and the use of quotations of conversations and interviews (Roper & Shapira, 2000). In order to document the rigor of this ethnographic study and achieve dependability audit trails were kept to ensure trustworthiness of the data. The audit trail included field notes, physical environment drawings, a reflective journal, transcribed interviews (i.e. raw data), the coding of

categories and themes, as well the rationale for decisions made during each phase of the research study (Munhall, 2012).

Confirmability. This refers to congruence between two or more people about the data's accuracy, relevance and meaning. Validity refers to the accuracy of the methods used to collect information. By utilizing multiple data sources (i.e. field notes, participant observations, formal, and informal interviews) and triangulating this data validity was enhanced. By constructing open ended-questions, asking the same questions multiple times and in different ways, as well as the period of time spent in the naturalistic setting, the accuracy of the information was increased (Roper & Shapira, 2000).

Transferability. Sample sizes in qualitative research are generally small due to the volume of data to be analyzed. The goal of qualitative inquiry is not to produce generalizations but to allow the data to represent the events, behaviours, and responses of the subjects under study (Morse, 1994). The goal of the researcher is to provide sufficient description in the data so consumers can evaluate the applicability of it to other contexts (Polit & Beck, 2008). The digital recording of interviews along with the detailed field notes taken during observation periods facilitated the ability to include thick descriptions of the study findings and contributes to the ability for other researchers to determine if the findings are transferable to other settings.

Ethical Considerations

Prior to initiating this research study ethical approval was obtained from the University of Calgary Conjoint Health Research Ethics Board. There are special considerations when conducting research on human subjects and incorporation of beneficence, respect for human dignity and justice are principles incorporated into the following processes which were followed during this study:

- Participants were provided with both written and verbal explanations of the purpose of the study, the duration and nature of participation, as well as the data collection techniques utilized during the study.
- Participants were informed that participation in the research study was voluntary and they could withdraw from the study at any time without penalty.
- The names of participants and any identifying information obtained from data collection were kept strictly confidential and pseudonyms were used when recording both written and digitally recorded data. Due to the nature of qualitative ethnographic research anonymity could not be guaranteed.
- Data (written and recorded) obtained through participant observation, informal conversations, field notes, and digital recordings were kept in a locked filing cabinet in the student researcher's office/home.
- Participants were informed of the researcher's role in observation and the necessity of observing their work environment and interactions. The researcher's role of strictly observing and not participating in patient care activities was explicitly outlined to all participants on the unit. The purpose of field notes and what type of things that were recorded was continually outlined to participants to ensure they are aware of the researcher's unbiased approach to data collection.
- Informed consent of participants was viewed as ongoing and transactional. During informal conversations with staff on the birthing unit the researcher continually renegotiated consent with participants regarding their ongoing participation in the study (Polit & Beck, 2008).

- When conducting formal interviews written consent was obtained after discussion of the study's purpose, risks, and benefits of participation (Appendix D).
- Patients receiving care on the labour and delivery unit are in positions of vulnerability. To respect this position the researcher observed interactions that occurred outside of the patient rooms. The researcher did not participate in any patient care during this study.

Limitations

By being on the birthing unit for only seven weeks with varying time frames, there are aspects of the unit culture, routines, and communication that may not have been revealed during the observations. Also, being an outsider may limit what was revealed to the researcher by the labour and delivery staff as they may have been somewhat guarded in their conversations with me during the observation period. As well, being a labour and delivery nurse could influence the recording of unbiased observations, so a reflective journal was kept by the researcher to record personal thoughts and observations.

Delimitations

The researcher chose not to formally interview a variety of disciplines, even though such comparisons might be valuable, in order to allow for more in-depth understanding regarding labour and delivery nurses. Additionally, the researcher did not use structured interviews in order to minimize influence on the nurses on the unit and allow for individual perspectives on the topic of this study.

In this chapter, rationale was provided for choosing focused ethnography as the methodology for this research study. Focused ethnography provides a naturalistic and inductive

approach to qualitative research. "The analysis of ethnographic data is a long and thoughtful process that requires time for reflection in order to achieve understandings of complex events and the people who perform them" (Roper and Shapira, 2000, p. 93). The steps of data generation and analysis as defined by Roper and Shapira (2000) were outlined along with strategies to ensure rigor in this qualitative study.

CHAPTER FOUR

The Cultural Landscape

An ethnographic analysis of the culture of a Level II birthing unit and the care provided by labour and delivery (L&D) nurses is described in this section. The setting and the people who inhabit this area are described in an effort to define the cultural landscape that provides context for understanding the study findings. For example, exploration of L&D nurses' perceived priorities in care exposed their underlying values and beliefs around childbirth and choice and how culture shaped their care of childbearing women who presented to the labour unit with birth plan expectations.

Observations and informal conversations with labour and delivery nurses and other healthcare providers (i.e. obstetricians, general practitioners, and medical residents) along with semi-structured interviews with key informants (i.e. labour and delivery nurses) provided rich descriptive data for analysis. Field observations were reported in the form of field notes using a categorical code indicating the location on the unit (i.e. LDOB – labour and delivery & TROB – triage area) along with a number corresponding to the specific date of the observation. For the purpose of this chapter the observations have been incorporated directly into the document. Quotes from participants are included whenever possible and confidentiality has been maintained by reporting the quotes using assigned pseudonyms. Quotations from participants are depicted in italics and indented or incorporated directly into the text. Collectively these data sources will provide a comprehensive description that begins to shed light on the current birthing unit culture and how birth plan expectations are addressed within that culture.

The Setting

The L&D unit is where a specialized subset of nurses partner with other healthcare providers to provide care to childbearing women and their families. It is within this structure that the birthing unit culture is learned and shared amongst the members who work there. The context for this particular study was a Level II obstetrical unit in an acute care facility within western Canada (APHP & AHS, 2012). This specialized unit provides obstetrical services to childbearing women of ≥32 weeks gestation and reports approximately 6000 births/year. Childbearing women and their support persons present directly to this unit to obtain these specialized services.

The following is an account of the researcher's initial experience on this unit: As one exits the elevators onto the floor of the obstetrical unit, there are large black and white portraits of babies and families. These photos elicit a feeling of welcome and tranquility. As one rounds the corner there is an open area with a small desk to the left and two large doors with opaque glass on the right. This area is noted to be the labour and delivery area and signage indicating that this area is restricted to patients and support persons only. There is signage on the doors entering labour and delivery with instructions for no cell phone use. There are people in purple uniforms and others with housekeeping carts and supply carts wearing different coloured uniforms. There is a flurry of activity as staff members enter a room for a short period and then exit and go to various areas on the unit. This activity elicited the researcher to ask questions such as "Who are these people and where are they all going?" By examining the physical space and the people who work there the hope was to gain insight into how these factors shape the culture of a birthing unit.

The Physical Space

Patient care areas. Both space and place play a critical role in how nursing culture is expressed and hospitals have a variety of distinct spaces/units in which nursing practices. The unit under study is divided into three distinct service areas:

1. Triage – seven triage rooms
2. Antepartum/Induction – five inpatient beds and two induction beds
3. Labour and delivery – ten labour and delivery suites, two operating room theaters, and two recovery room beds

Following is a brief outline of each of the above identified patient care areas within the labour and delivery unit including the health care providers who practice within it and the work that occurs there.

Triage Area. The triage area was located behind the small reception desk at the front of the unit in the main hallway. After entering a small hallway you enter into a semi-circle shaped area with patient rooms on the outside walls and a small nursing desk against the other wall. The triage area was decorated with pale colors and gold-framed pictures. The area was sterile in appearance and decorations were scant and older in appearance. Each triage room contained a patient bed and fetal monitor. The desk area was small and consisted of a computer and small charting area with assessments tools for gestation and fetal heart rate classification as well as other resources. The whiteboard on the wall across from the desk listed patient names, physician names, and reason for presenting to triage, along with registered nurse (RN) room allocation.

The influx of pregnant women who present to the unit was constant and did not begin or end at a certain time of day. One nurse, Sally, described the unpredictable nature of how women present for care at any given time:

> *We're not like a surgical unit or other units where we know that so and so is booked for surgery and we have a space available. You never know how many people are rupturing their membranes out in the community, how many people are starting into labour or whatever is going to happen. I cannot predict who's walking around the corner so that is the unusual part, you could have no patients come through the door in the next 6 hours or you could have 35 coming through the door in the next 6 hours. You can never ever predict it.*

All patients presented to the small nursing desk located on the outside of the labour and delivery (L&D) doors and were greeted by a unit clerk upon arrival. Patients indicated their reason for presenting to the unit and were taken into the triage area to be assessed by a registered nurse (RN). Patients and their support persons were escorted to a triage room and the patient was usually placed on an electronic fetal monitor (EFM). It was here that their history and primary concern for presenting were explored, prenatal records and other test results were reviewed, and maternal and fetal assessments were completed (i.e. maternal vital signs, fetal wellbeing assessment). As a researcher I did not witness triage nurses asking women about their birth plan expectations but should a woman have a written birth plan it was given to the triage nurse and put on the patient's chart for reference. As a researcher only one written birth plan was observed being submitted during observations in the triage area. Observations revealed little or no discussion between nurses and other healthcare providers about birth plan expectations but rather consisted of the medical diagnosis, treatments, and plan of care.

Registered nurses (RNs) determined the patient's acuity by performing a thorough physical assessment and formulating a nursing diagnosis. RNs began documentation of their assessments and then contacted the physician/midwife and/or resident for further assessments and orders to manage their patient's concern. Patients may stay in triage for long periods pending physician availability and/or completion of tests or other related diagnostic interventions that required time to assess the concern and determine the course of treatment. Active labouring

patients were admitted to L&D when there was a bed available or were admitted to the antepartum area for induction or admission depending on their plan of care. Lastly, other patients who required a higher level of service would be transferred outside the facility for more specialized care in another hospital.

There were a number of observations that confirmed how quickly a patient could present and nurses would perform their assessment and determine and carry out their plan of care. For example, one woman appeared quite uncomfortable as she walked by the nursing desk as she was breathing heavily and moaning. A triage nurse went into the room to assess her and determined she was eight centimetres dilated. A decision was quickly made to directly admit the patient to L&D as delivery was imminent and she delivered within the hour. Another patient arrived and was assessed and transferred to L&D and delivered within five minutes of the transfer. During the continuous influx of patients the labour and delivery nurses continued to multitask and prioritize the care they provided.

The triage area was a high traffic area and a busy thoroughfare for both patients and clinical staff. Despite having private rooms in triage, there was limited privacy as patients had to share one bathroom and had limited ability to access showers/tubs to assist with coping with the pain of labour. As well, the nursing station in triage provided little privacy and confidentiality for healthcare providers to discuss patient conditions and treatment plans. At times this was of concern as healthcare professionals discussed the plan of care. For example, a general practitioner (GP) was visibly upset about an admission sent to the antepartum unit who had a birth plan: "*she has a birth plan and she won't let me do an ARM (artificial rupture of membranes)*"…"*all she wants to do is walk, someone should of talked to me. I can't do anything with her there*". "S*he doesn't want antibiotics and she is GBS+, she doesn't want syntocinon.*"

The GP was upset that the patient was not kept in triage or sent home rather than put on the antepartum unit where she (GP) couldn't do anything with her. Nurse Jane apologized and the GP left the triage unit. As an ethnographer I could not help but wonder if when women presented to triage they may be more susceptible to interventions as physicians may feel compelled to intervene and perform procedures to expedite delivery, which may not be in line with a woman's birth plan expectations.

Another example of the lack of privacy during a conflict was a debate between a physician and charge nurse involving an induction patient. The physician walked onto the unit to assess the patient with pregnancy complications who was experiencing pain. The triage nurses called the charge nurse on labour and delivery as the physician wanted to induce this patient. The charge nurse did not want to start this procedure as there was no nurse free to take the patient and no induction beds were available. The physician disagreed and wanted a syntocinon infusion for this patient due to her pain. The charge nurse did not want this done and wanted to wait until the morning when the unit activity had slowed and adequate resources were available. The physician disagreed – a compromise was made and a less resource intense induction was commenced and the patient was admitted to the antepartum unit.

Nurses shared how patients and their families entered the triage area with varying emotions such as hope and anticipation of birth, anxiety or concern, and/or distress in active labour. In triage, women's anxieties build as they await a labour and delivery room while in active labour. Anxiety has the potential to turn to anger at times when women and their support persons viewed the delay as unacceptable as they seek and expect privacy, one-to-one nursing care in labour, and/or other interventions such as epidural anaesthesia. Patients labouring within the triage area were cared for here when space was not available on the L&D unit. Women were

offered both pharmacological and non-pharmacological interventions to help assist them with their pain and discomfort.

The following observations demonstrate how the progression of labour evolves, the needs and expectations of women change over time, and how nurses have to adapt their role and care in the triage area. Nurses were observed prioritizing the most appropriate type and location of care for women labouring on triage. For example, a labouring woman was cared for on triage as there were limited L&D rooms and no L&D nurse available to assume her care. This particular patient requested epidural anaesthesia for pain management. Nurses discussed whether they should transfer this patient to the L&D unit and assign a triage nurse to care for her. A decision was made to keep the patient on triage, as she had not progressed enough in her labour to take the last L&D room. A narcotic medication was ordered and given until a transfer to L&D could take place and this resulted in a delay in the patient obtaining epidural anaesthesia. Another example was when the triage rooms were full and one woman could be heard moaning and crying in one of the rooms. This patient was observed rocking on the bed positioned on her hands and knees as she laboured in the triage room. The sounds became louder and patients and support persons were observed looking around trying to determine where the noise was coming from. The nurse stated she was anxious to transfer this patient to L&D, as there was limited privacy in triage. This patient was actively labouring in the triage area, as there were no L&D beds available. Another triage nurse was observed going into this patient's room to assist her onto a birthing ball for comfort. The triage nurses adapted their care from assessment and treatment to labour support for these types of patients who could not be admitted to L&D due to space restrictions and resource limitations. These examples also demonstrate how there is a delay in care (i.e. epidural anaesthesia and one-to-one nursing) due to resource limitations on the L&D unit.

Nurse Olivia and nurse Nancy reflected the frustration with the triage area layout and its impact on care in the following comments:

> *That's difficult for the patients on triage because they have an expectation, which they should have, that they would be able to have a true room to give them the privacy as well as the one-on-one attention of the nurse and support during their labour. Also in our labour rooms, we have a shower and bathroom whereas on the triage unit, we have seven rooms and we really only have one bathroom there. The patients and their families can..well not so much the patients because they're usually very occupied with their labour situation, but very often the support people that are with them are becoming very anxious and angry at the fact that they aren't moving forward into a labouring room and getting the attention that they deserve.*

> *Alot of communication to people..to explain the situation ..if the unit is really busy there just isn't a bed available on labour and delivery..they will get one as soon as possible..and we'll do comfort measures to make them comfortable. We have them go in the shower or they can have some sedation or go for a walk and not leave the hospital.*

Antepartum/Induction Area. This particular care area was for inpatients requiring medical management or surveillance due to complications in their pregnancy and was staffed by two RNs. It was located down the hallway from triage and had rooms to the left and right and a small nursing station in the middle with computers and charting area. The induction room was for those women being induced for labour until they were in active labour at which time they would be transferred to the L&D unit. Observations on the antepartum/induction area did not reveal any discussion and/or evidence of written or verbal birth plans.

At times this area could be one of unexpected activity when space became an issue on L&D and patients delivered in the induction room. This room was physically removed from additional supports such as other nurses and supplies. During unit observations there were numerous examples of competing patient priorities and reduced capacity to address these needs in appropriate spaces and in a timely manner. When complications occurred nurses had limited staff support and were forced to run for supplies that could potentially delay or inhibit a timely

response. The following is a description of how the nurse clinician intervened to support staff and mobilize resources (i.e. equipment and staff), which were vital to the safe care of a patient.

During an observation period the nurse clinician proceeded to the antepartum unit to check on a pending transfer to a level III center within the city. While on the antepartum unit, a midwifery patient was in the induction room delivering due to a lack of space on the L&D unit. The nurse clinician went into the room, assessed the situation, spoke to the obstetrician (OB) on call to get him to go into the room as fetal heart rate (FHR) decelerations were present. The nurse clinician ran down the hall to get the vacuum machine located on L&D as an assisted vaginal birth was indicated for this patient and mobilized other staff for assistance. The Special Care Nursery team (SCN) was called for the baby and presented for possible resuscitation. The baby was born at 19:46 hours. The nurse clinician returned to the L&D to obtain a cervical repair kit as the patient was actively bleeding post-delivery. Upon returning to the antepartum unit the nurse clinician called the lab to check on the patient's platelets, as the results were not available on the computer. After informing the physician the platelets were within a normal range, she returned to the room to make sure the patient was stable and then continued on with her usual rounds on the unit. The nurse clinician intervened to support staff and mobilize resources (i.e. equipment and staff) that were vital to the safe care of this patient. This example demonstrates how quickly unit activity can change and how quickly resources (i.e. staff and equipment) need to be mobilized to facilitate the best possible outcome for the patient. Furthermore, it demonstrates the main activities associated with the nurse's role.

Labour and Delivery Area. The L&D nursing station served as the main hub of activity and a central communication point for staff. The charge nurse moved between all three patient care areas but was predominantly at the L&D nursing station. The L&D area was located behind

opaque glass doors off the main hallway. Signage on the doors stated patient and support persons only permitted in this area. Behind these doors was a long corridor in the shape of a square which winds around past the nursing station to the operating room (OR) theaters and recovery room (RR) areas. Each labouring woman was limited to two people for support and additional family members were discouraged from entering the unit. The researcher did explore the rationale behind this decision but nurses indicated this was a unit rule though the underlying reasons for this were not clearly articulated to the researcher.

The hub of the unit was contained within the nursing station at the end of the hall. This area was where nurses and other healthcare providers gathered for report at the beginning of their shift, obtained chart forms, updated the whiteboard on each patient's status, accessed computer charting and electronic resources, and gathered to exchange both personal and professional stories. The area was small and confined but there was a constant movement of staff in and out of the area with no one professional group assigned to a designated area.

A partial glass wall separated part of the nursing station from the main hallway. Posted on the glass were pictures of eight new hires along with their name, picture, what they loved to do for fun, any information on their significant other, and why they wanted to work in L&D. Nurse Liz indicated they had hired eight new nurses every two months this past year to help staff a new facility. At the side of the nursing station were printers and a computer by the entrance into the OR. Located in this area of the nursing station were pictures of midwives, OB residents and medical residents. Call lists were listed along with the various healthcare providers providing care on the L&D unit (i.e. obstetricians, general practitioners, midwives, OB residents, and medical students).

There was various staff moving around the L&D unit. Staff dressed in blue (i.e. housekeeping), were moving linen carts on and off the unit, scrubbing floors, and cleaning dirty rooms. There was a flurry of activity as nursing staff came in and out of the area at the back of the nursing station near the OR entrance. The labour and delivery unit had ebbs and flows of activity but consisted of a constant juggling of resources to address the non-stop demand placed on staff and resources. Whether there were admissions from triage or transfers from the antepartum area to access labour and delivery suites and/or emergency OR services, it required the communication and coordination of resources.

The following account describes the appearance and functional structure of the labour and delivery rooms along with any variances or similarities between rooms. The L&D rooms were similar in appearance and consisted of a myriad of technological devices: a birthing bed, intravenous (IV) infusion pump, electronic fetal monitor (EFM), infant care center, and other various supplies and equipment. These rooms offered women and their support person access to the various types of technology, privacy, and a private shower and bathroom. The doors to all labour rooms were kept shut as nurses indicated this was to allow for privacy for each labouring woman. Nurse Sally gave me on a tour of the labour rooms. The rooms across from the nursing desk were small, the infant care center was pushed into the wall on one side, and there was little room at the foot of the bed for other equipment. There was a computer keyboard, screen and hard drive on the wall to the left of the bed. Nurse Sally indicated there was usually a rocking chair in the room for the support person. Sally then took me to one of the bigger L&D rooms. This room had the same equipment except there was much more space to move around. There was a blue velour loveseat on the back wall. Nurse Sally indicated there was more storage and

room for birth in this room. Each labour room looked similar to the other with dated furniture and decorations.

Each L&D nurse was assigned to an admitted labouring patient or to an empty L&D room pending an admission. Nurses provided one-to-one labour support to women admitted to L&D but this changed when they covered each other for break relief. Nurses juggled competing demands of caring for more than one patient that required their care and support. Nurse Olivia described this process and how EFM was utilized to limit the risk to the patient:

> *At break time the labour and delivery nurse will also be covering another patient unless there is somebody free around to be doing break coverage. Often you are then called upon to cover in another room, so you are doing break coverage, so if you've got somebody in your room and you are out of the room you are not one-to-one with that patient totally. This is a way to be monitoring the patient when you're out of the room if they're on a continuous monitor.*

The whiteboard. The whiteboard was a large erasable board used to capture patient information pertinent to their care. There was a whiteboard located on triage and the L&D unit that were integral to the unit routines and practices. The nurses viewed it as a safety mechanism to improve communication and patient flow. Documentation on the whiteboard consisted of each patient's name and clinical presentation while capturing the overall activity level and acuity during each shift. Primary L&D nurses, charge nurses, and physicians updated the whiteboard as a patient's condition changed during her labour. Nurses Betty and Sally discussed the significance of the board to the safe, effective functioning of the unit; recognizing that it was also not without Freedom of Information and Protection (FOIP) issues:

> *The whiteboard lists patient names, the status of the patient at this time whether they've ruptured membranes, what's their dilation, what time that dilation was established or decided and if they need antibiotics and small bits of communication like that. It's huge, absolutely huge. I know it's a huge FOIP issue and so it should be but I think if we didn't*

have the whiteboard there'd be a gazillion medication errors and lack of communication would break down and it has to be there. There's no question about it.

Whiteboard is our list for our patient assignments are patient's name, the status of the patient at this time, whether they've ruptured membranes, what's their dilation, what time that dilation was established or decided and if they need antibiotics and small bits of communication like that. It has been in question many times because of FOIP. There are times we thought we were at risk of losing it and we are so used to looking up at that board and knowing what's going on the unit and each nurse is responsible to keep it updated as they examine their patients or as things change. They just think they can't do without because that's how they know what's going on the unit.

Inherent within this culture was a distinct language (i.e. written and verbal) that staff used to communicate with each other. Standardized terms and language were used in their verbal communication and in written documents such as charting, policies, guidelines, and the frequently referenced MORE^{OB} program (Salus Global, 2013). L&D staff referred to patients by their medical status or diagnosis as referenced in the language rather than their names and the whiteboards reinforced this routine practice. As a researcher I wondered if this taken-for-granted aspect of their culture puts patients and families at a disadvantage, as the interpretation and explanation of events during the course of labour and birth would not be easily understood.

The creek. The staff lounge was located at the front of the L&D area inside the double doors and was labelled Priddis Creek. Staff nicknamed this lounge as "the creek". As you walked into the room there was a kitchen area with fridge, tables and chairs, and couches along the wall with a wall unit and television. The furniture and cabinetry was dated but as a researcher I could sense there was a palpable comfort to this room much like one's favourite old chair. This area was utilized mainly by nursing staff but there were times when residents and/or administration came and ate their lunch with the front-line staff. A general nursing staff report took place in this room at the beginning of every shift. This room served as a multipurpose room where both professional and personal conversations occurred during each shift. Staff entered the

room wearing purple scrubs or green OR scrubs. Staff reviewed their assignment sheet, placed their lunches in fridge, and hung their bags on the wall. There were sharing of personal stories (i.e. travel plans, teaching opportunities), discussions of possible shift swaps, laughter, and even one RN (registered nurse) had her feet curled up on the couch while reading a book during her break.

Nurse Betty identified this space as a safe place for staff to come together. Nurse Sally felt the creek served many purposes such as for meals and breaks but also a place to debrief, share stories, and support each other.

> *Well, the Creek is our lounge and it's called the Priddis Creek and yeah we call it the Creek. It's got lounge chairs and it has a little kitchenette room so that's where we hold our meetings, that's where we gather in the morning before shifts, that's where we have our breaks and we eat all our lunches and suppers in there. It just is the place where most of the communication and the coming together as staff.*

Nurse Olivia revealed how the room offers a much-needed private space for reflection after a difficult experience in L&D:

> *Well, it's a place where we can often debrief after a situation. We have a lot of new staff on our unit and so sometimes they've come through some difficult situation and are not feeling how a case goes or feeling that they might or just wanting to debrief, give each other support. I think there is a lot of that that goes on in The Creek. It can really make a difference, I think. Like, there are a lot of times where you see somebody who is almost on the verge of tears or has had something that has really shook them up and just being able to reassure, to her what they have to say, to let them tell the story and get it off their chest and learn that other people have been in similar situations and that sort of thing. So I think that that is one of the biggest things. Also just to get a rest, sit back, put your feet up, and get some nourishment, sustenance so you're ready to go at it again.*

The People

Due to the nature of specialized services within this Level II obstetrical unit, there were a variety of healthcare providers who provided and supported service delivery.

Nursing staff. Nursing unit management consisted of one manager overseeing all of women's health at this site, a manager for the L&D unit and a manager for the postpartum unit, four nurse clinicians who regularly performed the charge nurse role, casual charge nurses, and staff nurses who were subdivided based on skills (i.e. L&D, triage, antepartum/induction, and operating room). Nursing staff consisted of RNs with experience levels ranging from new practitioners (i.e. new graduates) to experienced (i.e. over 30 years) practitioners. There was an extensive orientation plan for new hires followed by other educational offerings, which provided a type of laddering process to progress staff to care for patients with increasing levels of complexity and acuity. For example, one nurse indicated that after about one and a half years, new nurses were trained to work on triage followed by training for the operating room. Each patient care area had varying levels of staffing such as three nurses in triage for seven patient rooms, two nurses in antepartum/induction for seven rooms, and the rest in L&D area primarily providing one to one nursing care for the ten L&D suites.

Medical staff. The medical staff consisted of obstetricians (OBs), general practitioners (GPs), midwives, and anaesthetists who partner in the delivery of care. In addition, there were a variety of medical residents and students such as obstetrical (OB) resident, family practice residents, anaesthesia residents, and medical clerks. The overall structure for medicine for each shift consisted of an obstetrician on-call for specialized obstetrical services followed by family physicians and midwives who were on-call for their respective call groups and provided service to low risk obstetrical patients. An on-call anaesthetist provided anaesthesia services for pain management and surgical procedures. Both obstetricians and anaesthetists had specialized residents who communicated with them and assisted them in the delivery of care. As well, these specialized residents obtained assistance from other medical residents, students, and clerks.

Residents were identified based on specialty and years in the program designated by a color-coded lanyard system. The residents dealt directly with the L&D nurses and charge nurses, and periodically consulted with the specialist on-call.

New hires and students. Recently, a large number of new nursing practitioners were hired and were being trained on the unit. Both new hires and students (i.e. RNs, paramedics, residents, and medical students) were an integral part of the unit environment. In order to differentiate the new nursing hires there was a color-coding lanyard system. For example, nurses shared how new nursing hires wore green lanyards as a visual tool to notify all healthcare providers of their new knowledge and skill. A new RN was charting at the desk and shared her story. This RN was recently trained and had been on L&D for about 18 months. She had previously worked on the postpartum unit and liked the one-to-one nursing here on L&D. Another RN came to the desk (i.e. green lanyard) and indicated she was a new RN to L&D (Kimberly) but was a seasoned RN from palliative care who chose to come to L&D. New hires varied from new graduates to experienced RNs from other areas of nursing and a varied approach to learning was required to address their unique learning needs. However, all new hires regardless of previous experience wore the same green lanyards as the new graduate hires.

Staff spoke of their excitement to have new hires and the different skills they bring to the unit. For example, many of the new hires have extensive skills in electronic devices that have become such an integral part of the healthcare environment. The L&D nurses spoke of the energy they expended in training: an investment that was an important responsibility to promote safe care. Nurse Betty shared her perspective on how these new nurses impact the everyday work on the unit:

I must say that I love young blood and each and every one of them I find once you get to know them…have something to offer and…there's just a fresh new spirit(laughs). I like the teaching to be always buddied with somebody new whether it's a student for a final focus or a 3rd year student or a new staff member. It's exhausting. I find it is tiring and does drain your energy a little bit especially initially when you first get a student and you're always talking and you're always explaining. You do find yourself some days just wishing you could just go do your own thing. It's been about since probably four or five months now solid and I am ready for a break but it's our professional responsibility to train new staff right. I do think it would be nice if there were some recognition for that because I do think you do work double duty. I know it is part of our job description but it would be nice if there were some recognition that it is a tough job. How you mentor is a big responsibility because if you don't do your job right maybe they don't do their job right or maybe they don't want to stay here. You do have that sense of doing your very best because it's kind of partly up to me how their experience is going to go.

Support staff. There was a variety of support staff in the delivery of care. The staff consisted of: SCN (Special Care Nursery) nurses, social workers, respiratory technicians, unit clerks, laboratory technicians and other support departments such as housekeeping, unit aides, nutritional food services, maintenance, and contract/procurement/supply management. Each staff member had a unique role in the delivery of patient care based on their specialty. Nurse Nancy commented on the contribution of support staff to the care on the unit this way:

I really think the cleaners are one of the most valuable aspects of this unit and I make a point of talking to all of them. All day and night I thank them for things and I chat to them all and the service aides. I just think they do such an important job because whatever you're doing in MOREOB..whatever we learn if we haven't got clean beds for these patients coming.

Patients. This L&D unit services a culturally diverse population with varying expectations for birth (Statistics Canada, 2013). Pregnant women ≥32 weeks gestation are the identified population but women at a gestation of ≥20 weeks are seen for pregnancy-related issues. Patients presented directly to the triage area of the unit and bypassed the main emergency department. The following account offers a glimpse of how each individual's situation can impact and shape the care provided by the nurses on this unit. This particular patient was a

multiparous East Indian woman with a history of weakness in her leg and falling, as well as a history of being slapped in the face by her father-in-law. Nurse Penny gave a thorough history and some insight into the cultural aspects of this patient's home life (i.e. the role her in-laws play in the marriage and their influence on their son's relationship with his wife). The patient was nervous, shaking, and upset. Her husband accompanied her and he spoke to her in her native language. Her school-age daughter accompanied her since she had not slept apart from her since birth. As well, other family members were present. Her sister comforted her and shared some of their family history regarding how her sister came to Canada and her own immigration to Alberta. The nurses worked with her sister to help with translation to lessen the patient's anxiety. In addition, they were supportive of the family allowing her daughter to sleep in the triage room with her mother so they would not be separated while on the unit.

Nurses repeatedly identified that patients came in with varying expectations for birth. The nurses discussed how patient and family histories, culture, and education impact women's choices in childbirth. These expectations, were discussed by Nurse Sally and Nurse Olivia:

> *Patients come in nowadays and don't want an epidural and are trying to do it au natural and they maybe have a doula. Because they are of that ..seems like more au natural people want to have a doula to help them get through.*

> *I think there are always some expectations. Whether it be that they're going to have everything possible..any medication, any intervention at all to ease the pain. I think most women are really terrified of the pain and what's to come..the unknown, wanting to be sure the baby is okay. Because a lot of women come in and whether they're real or just imagined, they have concerns about the well-being of the baby, they might have had some horror stories about things going wrong for friends or family.*

Families. Signage on the doors entering the L&D unit indicated only support persons were permitted to accompany a childbearing woman onto the unit. Nurses explained that there was a unit policy that only two support persons could be on the L&D unit. If other family

members did present on occasion they were encouraged to leave the unit. Nurses were the gatekeepers for patient's families to have access to them within the hospital unit. I noted an instance where a nurse enforced this policy of who was allowed onto the L&D unit when family members presented to bring a meal to their family member. The visitors presented at the nursing station asking to see their family member. The nurse clinician indicated this person was unable to come out of a labour room to see them. The visitors insisted and the nurse clinician frowned and appeared not pleased with their insistence but went to talk to their family member. She returned and indicated their family member would not be coming out to see them so the visitors left a meal for him and walked off the unit. As a researcher I could sense the tension between the family members and the nurse clinician regarding family visitation on the L&D unit.

Not all staff on the unit agreed with the practice of limiting family access so work-a-rounds were created based on their patient's preference. Nurse Betty and Nurse Nancy shared their perspectives on limiting family presence:

> *Well we've kind of put a damper on that because we have to extremely limit people that are allowed to come onto labour and delivery so it's basically only two support people in labour…it doesn't matter how much or which family is involved it's no after the baby is born there is no visiting on labour and delivery. I completely ignore that rule. I just have them come anyway. I'm being a bit of I suppose a rebel that way. You cannot in my mind deny a grandparent whose been biting his or her nails in the cafeteria while their daughter is in labour, the right to come and see them. If the mom wants to see her parents then I'm not going to be …that's not my job. My job is to facilitate their experience and if families play a huge role and so they should this is good for healthcare when families get involved this is a good thing.*

> *I like to involve all the family and talk about their children…cause it's only by learning about their past experiences and their past deliveries that you might know what they're going to be fearful about. Did they have a fourth degree tear Are they terrified of pushing? Did they have a stat section? Have they had three previous losses? They are going to be worried sick. Because I know if you've had a miscarriage you know every time you go to the bathroom for the next nine months you look at that toilet paper and think Oh….got past another day. They all relate to that sort of thing so I just like to include them all and the mothers and especially with losses. You know we have this rule*

about two people at the bedside but if somebody really wants their mother and father and the husband there and his mom in room one why not. It's a loss they're going to share this loss, they're going to grieve it together so I will break and rules for that and I just say this is a different situation.

Doulas. Doulas are specially trained laypersons that offer non-clinical support for women and their families during childbirth (Canadian Doula Association, Registry & Education, 2013). They are hired privately by the childbearing woman before delivery and develop a rapport and relationship prior to presenting to the birthing unit. Their role is intended to be one of support and advocacy. The doula works with the couple and healthcare providers to provide supportive care. Nurses provided both positive and negative examples of interactions with doulas on the L&D unit. There was an understanding amongst the nurses that it is the individual themselves that can make or break the communication and collaboration between the nurse, doula, and the pregnant woman. Doulas were seen as beneficial when communication was transparent and the nurse's role and authority was not compromised or challenged. Nurse Sally shared her experience and thoughts:

They're very different doulas out there. Some of them are very supportive to the patient, work well with the nurse and try to help the nurse or find out what the nurse is trying to do and learn that or I'll run and get you this or run and get that. And then there's the doulas that try to take control over that labour and really active manage the labour instead active manage the patient and make medical decisions. I think they're just supposed to be a labour support not making medical decisions. It is kind of bothers me when some of the doulas are present and the patient, if we go in and we say okay your baby's heart rate is down we think we need to put a scalp clip on and we need to do this or whatever and the patient will look up at the doula. It's up to the doula to say yes or no to us whether she can have it or not. I don't think that's given the mom autonomy. She's given over too much control to the lady that's had a weekend course.

In some instances nurses viewed doulas as beneficial, as their presence lessened the need for the nurse to be in the room to provide labour support. Nurse Sarah and Nurse Nancy shared their positive experiences with doulas:

The doulas that I've worked are not many. I've worked with one several times that I adore. I would recommend her to lots of people. They come in as the second support person which can sometimes be an issue because people don't realize their the second support person so then that bumps out the patient's mom or the patient's sister or whoever. They act as a labour coach basically.

I think the majority of nurses, when they first used to come, thought they're just interfering. Now I think things are better and they know their role a bit better and some are just very supportive.

It is through prolonged participant observation and semi-structured interviews that the hidden or taken for granted values and beliefs of labour and delivery nurses were made known. The physical space, the various disciplines who work there, the types of patients, and the governing policies and guidelines are just some of the factors that influenced the culture created within the context of this birthing unit. The value each healthcare discipline placed on each factor played a role in the evolution of the culture that was created. In this particular site, the physical environment, the high volume and diversity of patients and families along with the variety of healthcare providers and students contribute to a highly complex and complicated system that struggled to accommodate patient care delivery. The priorities nurses place on specific aspects of their care contributed to the creation of a very unique and challenging culture in which childbearing women and their families strive to have their voices heard. In the next chapter themes and subthemes identified in the every day practices of labour and delivery nurses will be discussed. Participant's words and actions will be utilized to convey the essence of their meaning.

CHAPTER FIVE

The Cultural Domains of Labour and Delivery Nursing

The Incorporation of Birth Plans

The purpose of this research study was to explore the social norms, values, and practices of labour and delivery (L&D) nurses in relation to the incorporation of birth plans into obstetrical care. How labour and delivery nurses carry out their day-to-day care of women with birth plans along with the facilitators and barriers to the enactment of birth plans were explored. Focused exploration of the values, beliefs, and practices affecting L&D nurses' descriptions, interpretations, and actions related to birth plans were studied with the hope to provide new insights into the enactment of birth plans.

As the study progressed it became evident written birth plans were not a predominant part of a L&D nurse's care as childbearing women rarely presented birth plans on the L&D unit. L&D nurses indicated the majority of women approach childbirth with a verbal plan or expectations for birth and this is very much a part of their role in caring for them on the L&D unit. What became known was the culture of the birthing unit and how it shaped nurses' values, beliefs, and behaviours. The overall culture of patient safety was shown to be paramount and influenced how nurses addressed and navigated birth plan expectations and wishes when providing care.

Analysis of the data collected from participant observations, informal and formal interviews, resulted in three main themes and several sub-themes. The first theme identified was one of *ensuring safe patient care* and was seen as a priority over everything else. Within this theme there were four subthemes*: the burden of responsibility, the unpredictability of labour, patient flow, and the role of technology*. The second theme identified was *teamwork* and

included four subthemes: *skilled practitioners, training new hires, communication and collaboration, and supportive relationships*. The final theme that emerged from the data was *connecting with patients.* This theme focused on birth plan expectations and the nurses' relationships with the women and families they cared for on the labour and delivery unit. Three subthemes were noted: *building rapport, information sharing and expectations, and negotiating care (finding that middle ground).* Each theme and subtheme will be discussed while providing a thick, rich description based on data collected during observations and interviews.

Ensuring Safe Patient Care

Nurse Betty described a typical shift on the labour and delivery unit as "*exhausting, exhilarating, stressful and rewarding*". When nurses were asked to describe their role they outlined their practice of both performing and documenting maternal and fetal assessments and supporting women in labour. The labour and delivery nurses perceived their primary role as being an advocate for both mother and baby with the ultimate goal of care being a safe delivery. Nurses admitted birth plan expectations can be at odds with what the healthcare team view as safe care and that there may be a potential area for conflict when expectations were seen as unsafe. The overall core value of ensuring safe patient care was demonstrated in their everyday practices. Nurse Sarah summarized it this way:

> *I think primarily at the end of the day my job is to protect that mother's life and that baby's life. And hopefully to assess the risks to those …to both of them timely enough that we can still protect their experience.*

Nurses demonstrated their commitment to safe care by the ongoing teaching and learning that occurred amongst them. However, there was little tolerance for error due to the immense consequences to mother, baby, and family. Nurse Sally shared her thoughts on patient safety and teaching nurses when they inadvertently put patients at risk:

> *Patient safety is my biggest. That's the whole thing for me. Patient safety, patient safety, patient safety…this weekend I had a huge chat about that with two of our younger nurses about patient safety. I noticed unintentionally they didn't know what they were doing I guess, didn't realize it was unsafe what they were doing and it was two different safety issues. And I sat down and had a huge talk and said I don't care what you're asked to do or whatever you do the patient safety thing FIRST (emphasized) and then you do that task next.*

The focus on patient safety determined the priorities and care provision for labouring women. Nurses acknowledged that patient expectations were considered in their care planning but safety would supersede these when there was a perceived risk to mother or baby as a result of implementing these expectations. Nurses acknowledged they tried to mitigate conflict and tension with patients by providing rationale for the interventions and actions based on the goal of a safe delivery and outcome.

Routine practices were incorporated into the environment to mitigate risk and enhance safety. Routines such as nursing report were used to communicate vital information and promote consistency in care. The checking of the patient rooms to ensure equipment was readily available and in working order was a routine practice observed during the study. Surveillance was identified as a key responsibility when nurses described their role. Nurses were watchful/vigilant over the potential dangers to both mother and baby during the course of the patient's labour and birth. Nurses spoke of having to take note of subtle changes in a mother's condition and/or being able to react quickly and mobilize resources in order to intervene to mitigate injury to the mother or baby. Nurse Olivia described it as, *an enormous responsibility because if something is going to go wrong, it can go wrong very, very quickly and at other times it's a subtle slow process but the labour and delivery nurse is the person who would recognize, who knows what's going on, so she would be the one there to first identify the fact that there is something or even a potential for something to go wrong with the patient or the baby.* The

nurses' emphasis was to prevent possible complications or threats to their patients. This responsibility and accountability was perceived by the nurses as a heavy burden to carry.

The burden of responsibility. L&D nurses viewed their role as both a privilege and burden. Childbirth was seen as a key milestone and an intimate journey in life in which nurses played a key role. Nurse Betty spoke of the privilege of being in the moment with families when their baby was born, "*It's really a privilege to be part of that (childbirth) versus dealing with illness and you know sickness and death, like you do on some units on a regular basis.*" Many of the nurses alluded to the fact that they felt a heavy burden of responsibility on this unit and Nurse Betty described it as, "*It's kind of a mix of that I can't believe I get paid for what I do because it's such a privilege to be here. At the same time there is a sense of I don't get paid enough for the amount of responsibility and stress we sometimes endure on this unit."*

In their effort to ensure patients receive safe care, nurses viewed vigilance as key in their assessments and care. They spoke of the need to assess each patient's risk and be alert as time was of the essence when things went wrong. Nurses operated on a risk-based system and care in the hospital environment was based on a biomedical model of birth. Nurses were responsible to watch for abnormal signs and be able to recognize those signs in a timely manner in order to act upon them. Each nurse was aware of the unit activity as a whole in addition to her individual patient assignment. Both as individuals and as a collective group, nurses were expected to be prepared mentally and emotionally, and anticipate emergencies and/or respond rapidly to changes in acuity or volume on the unit. Nurse Olivia described it this way:

> *So it's a grave responsibility to be the first responder, so to speak, the first person to notice, to know how to deal with, to know to get help, to know the initial procedures to do any intrauterine resuscitation that might be necessary.*

Nurses spoke of the burden this type of responsibility can have when things do not go as planned and an adverse outcome occurs. They spoke of their own self-reflection, questioning of their knowledge and skill, and how self-doubt creeps into their psyche. Nurse Betty described her ability to debrief with other coworkers as a form of validation that she did the right thing:

> *Well it's an outlet. I think you also are looking whether you are aware of it or not for some validation that you didn't do anything wrong. Perhaps you want to hear that somebody else would of done exactly what you did. Maybe you're looking for some. empathy…people just saying wow that's really rough or some positive feedback that people recognize that you went through a tough case. I think anytime you have to go through any kind of emotional trauma is a strong word but..upheaval …it's good to talk about it. Whether it's work or not but especially at work cause our line of work is …can get so intense.*

Observations confirmed this practice when the researcher witnessed Nurse Betty sharing a story about a case she had been involved in with an obstetrician. Nurse Betty sought validation by the obstetrician who was seen as the expert in obstetrical care. Betty explained a case where suddenly a woman required an emergency caesarean section and she questioned whether she missed something in her nursing care. She outlined her actions and reasoning behind them, the obstetrician stated, "*well, that is what a reasonable person would have done*." Nurse Betty indicated she felt so bad for this patient and others nodded in agreement. As Nurse Betty shared this story as a researcher I could begin to see the complexity of the system in which nurses and physicians work and how omissions and/or unexpected events could potentially occur.

In addition to responding appropriately in an emergency, there were obstetrical practice guidelines and policies and procedures that assisted to guide nurses' practice. Each nurse was accountable to keep his/her knowledge and skills up-to-date. Nurse Betty and Nurse Olivia expressed their desire to learn in order to improve patient outcomes and provide evidence-based care:

In all honestly, sometimes I take a new staff or a student on purpose if it's been awhile because I feel I need to push myself to review policies and protocols because I may have fallen away from that a little bit…I'm just operating more on my gut feeling and so when you read MORE^{OB} it's really good cause it's interesting because it sometimes explains why you do what you do and it's a good refresher.

MORE^{OB} is one of the programs that we use a lot but also we're encouraged to take fetal monitoring courses and there are articles, research, and we have in-services.

In Alberta, all obstetrical units participate in a national performance improvement program called MORE^{OB} (Managing Obstetrical Risk Efficiently – Salus Global, 2013). The Society of Obstetricians and Gynaecologists of Canada (SOGC) developed this program in partnership with the Health Insurance Reciprocal of Canada (HIROC) and other healthcare providers (i.e. obstetricians, family practice physicians, midwives, registered nurses, and healthcare administrators). The program is seen as a guide to care and treatment of pregnancy and birth and is a single point of reference for all obstetrical care providers. The MORE^{OB} (Salus Global, 2013) program provides a shared knowledge and language for all healthcare providers to communicate as they plan and deliver care. The program provided an opportunity for interprofessional education and skills workshops to enhance skill, knowledge, and teamwork. In observations nurses were observed studying for the upcoming MORE^{OB} workshop as well as attending a workshop during the study. This program provided a discussion medium for students and staff to share knowledge regarding evidence-based obstetrical care. Observations confirmed this practice when the researcher witnessed several occasions where registered nurses (RNs) and residents were reading the content. In one particular observation a registered nurse (RN) was seen at the computer reading the MORE^{OB} chapter content and she had a question based on her reading. She engaged in a discussion with an obstetrical (OB) resident standing at the desk and a

discussion ensued between some of nurses and the OB resident around this topic and the plan of care.

The unpredictability of labour. The L&D unit fluctuated in both volume and acuity and was volatile in nature. Not only was there unpredictability to unit activity and processes as nurses strived to deal with the high volumes and volatility, but also labour itself was seen as an unpredictable process. The nurses shared how these factors created an environment that was challenging to manage and impeded their ability to implement birth plan expectations. Nurse Sally described the unit activity, "*It can go anywhere from not much to do to just full blown …you don't know how you're going to get through the next minute let alone the next hour.*" Nurse Betty described the unpredictability as a way to keep the job interesting and exciting:

> *I think that's what keeps our job interesting. Part of what I thrive on is the unpredictability of the unit. I don't think I'm an adrenaline junkie but I like coming to work not knowing what I'm going to be faced with. People say well it's always a birth of a baby in some way but every birth and every experience is so different. You really don't know if you're going to..what you're going to be dealing with and even if things are quiet you never know that in the next 30 seconds you couldn't be dealing with life and death and that's what keeps it exciting.*

Nurses described how the process of labour may change rapidly and how this created a tremendous demand on their expertise and skill. They stressed the importance of communication and teamwork to address these unexpected events and how nurses needed to have a keen sense for the subtle changes over time that could anticipate impending emergencies. Nurse Olivia and Nurse Betty explained it this way:

> *It can be very typical and routine and then all of a sudden an emergency situation can come up so you have to shift gears very quickly and when things go wrong, they can often go wrong…it's quite subtle at first and then all of a sudden it could be very wrong, so you have to be communicating really well with your charge nurse and the doctors that are involved in the care of the patient.*

Our unit is very acute so the responsibility is something that can sort of ..you know having to take charge and take initiative and jump into action can happen from one second to the next and I think that is fairly unique to a unit like ours. Probably much like working in emergency. Perhaps if you are working on a medical floor, which I never have..I mean I admire those nurses greatly but the responsibility is not as …is just as much if not more overall …but um..perhaps you have a little bit more time to deal with it. The acuteness I guess is higher.

Observations confirmed nurses' descriptions of the unit activity in volume and acuity. At times nurses would be sharing stories at the desk and then an emergency would occur and all team members would spring into action to respond. The following observation describes this event:

> Suddenly, a call out to nursing station from a senior nurse in the room – page Dr. D. stat. The nurse from room 21 quickly went to room 22. The charge nurse went into room 22. A call was placed for the nurse clinician to come back to the floor. A second operating room (OR) was quickly set up for the patient in room 22 as a stat caesarean section called (i.e. the fetal heart rate had dropped). The manager presented to desk and was updated on the case in room 22, then paged the OR for another physician. The OB resident was also paged stat to room 22.

This event is only one example of the many emergency responses required of the healthcare team on this unit. There are sudden events, which change the course of treatment and require quick and efficient mobilization of resources for expedited delivery of the mother and baby. The majority of staff members responded when a nurse would call out or a call bell was activated. Team members mobilized to help at the bedside but also anticipated future use of both equipment and personnel (i.e. operating room staff). This required not only the ability to recognize an emergency and assist others but also to make decisive decisions in order to expedite

delivery and potentially improve the final outcome. The following is another example of making clinically astute decisions to mobilize resources to address an emergency:

> Suddenly the nurse clinician came to the desk as there was a stat caesarean section. Nurse Gail jumped immediately out of her chair and went around the nursing station down the hall to the room where there was an emergency. Two other nurses jumped out of their chairs and quickly moved in the direction of the OR corridor while looking at the nurse clinician. The nurse clinician told them to go set up the OR and nurse Betty went to the nurse clinician and asked "*do you want me to go too*?" The nurse clinician indicated yes and they all moved swiftly to the operating room (OR). The nurse clinician went into another room and pulled the obstetrician (OB) out of that room dressed in scrubs and they went down to the room where there was a patient concern. The unit clerk jumped up immediately and started to stamp the chart in preparation for the patient going to the OR. Someone called out "*I'll call Anaesthesia*." Immediately the nursing station was empty and everyone was mobilized to help this patient, there was only the unit clerk left stamping the chart. I walked down the hall and saw many of them in the room and then the patient was swiftly taken across the hall to the OR. The nursing station was now empty and deafly quiet. As a researcher observing this event it felt like everyone was holding their breath as they waited to see whether their actions had averted any adverse outcome to mother and baby.

Patient flow. Nurses spoke of their need to be constantly aware of the status of their own patient and the L&D unit as a whole. The unpredictability of activity, the space limitations, and the overwhelming demand for services posed unique challenges to the delivery of safe care. Nurse Sally described it as follows:

> Y*ou can never ever predict it so you can't say to somebody ..like ..okay I'll call you and have you in here at 8 o'clock, it's just moment-by-moment, hour-by-hour, that's just the way the day goes… You're just dictated by who comes around the corner.*

The nurses had a keen sense of self-imposed responsibility to ensure they used L&D rooms wisely so all patients including those in triage received the safest care possible. Nurse Nancy and Nurse Betty explained it this way:

> *When space is an issue the charge nurse really has to juggle caseloads…the charge nurse will tell you that you should get your patient out as quickly as you can…you know there is people six or seven centimetres waiting on triage for that bed.*

> *We have to keep in mind that if we rush people through in your labour room and through your delivery and afterwards maybe not spending the time with them for bonding and breastfeeding it's not necessary the best for your patient but you're doing that also for the safety of the patient that's waiting in the triage room that needs to be put on a monitor or may need to be induced or may need to deliver. So you always have ..need to keep in mind sort of the bigger picture…that's a responsibility of us as much as we sometimes like to just focus on what we're doing in the room. You have to always have a sense of what's going on the unit and you're also indirectly responsible for those people that need a bed and you have to do your part to make sure that everybody is safe not just your patient.*

Nurses shared how they were acutely aware of the unit occupancy and the potential need to move patients off the L&D unit to the postpartum unit in order to accommodate another labouring woman from the triage area. Observations confirmed many women were admitted from triage in the latter part of their first stage of labour. Nurses shared how some interventions (i.e. rupturing membranes) may be used to expedite delivery and possibly improve L&D access for incoming admissions. Nurse Sally and Nurse Olivia shared their thoughts on how patient flow impacted care:

> *Managing the flow is a huge challenge cause it is busy and just so you don't get yourself in trouble by getting too many..accepting too many inductions in and stuff like that. There are days that I can say that yes we'll say gee you all got a bunch of primes* (primaparous women) *on the board and things aren't moving here and we need something..so maybe we will actively manage some of them…but…even on not busy days …they just come in and even if the woman is progressing ..if they find a bag of waters*

..her vaginal exams are proving that she is progressing they'll come in and rupture her because "oh those bag of waters aren't ruptured yet".

Some days everything just is very smooth sailing and straightforward and as expected and other days we've got all kinds of side issues coming in to complicate things and there are times when we don't have the number beds that area required, so we might be…if you're a labour room nurse, you are thinking that you need to speed up the process, well especially the postpartum process, because we really don't have that much control over the labour process, but there are times when we are desperately short of beds and room for the labouring patients that are backed up in the triage area.

Nurse Sarah spoke of having to stop medical interventions that were underway due to incoming admissions to L&D that required immediate care. There was a prioritizing of services that happens moment by moment to provide safe care.

The nature of the unit I think entirely I've had days where it's so busy I've turned off an induction. Like, how devastating for a patient that's not necessarily my practice but it's not safe to be running an induction for an inactive labouring patient or whatever maybe is a trial of labour or what have you while there are no senior nurses available or every doctor has a delivery happening or they're in the OR with a …a haemorrhage. So the unit is completely a factor on what my day-to-day is like and what my practice becomes or adapts to. I've had to move patients from labour and delivery back to triage or back to Antepartum because there's somebody on triage that is eight centimetres and is going to deliver in the hallway otherwise.

The role of technology. Technology is a vast and expanding area within healthcare as a whole and obstetrics is not isolated from its influence. Nurses spoke of two specific areas where technology was increasingly utilized on their unit: (1) electronic fetal monitoring (EFM), and (2) epidural anaesthesia. They admitted their own over-reliance or overuse of EFM. Nurses identified factors such as past experience, comfort, convenience, and the inability to provide one to one nursing, as some of the reasons for the over-use of EFM. Nurses shared how some women do not want to be on EFM and this can become an issue of conflict between an individual nurse (i.e. the nurses preferred practice and/or a necessary intervention due to intrapartum risk)

and a woman's expectation for her birth experience. Nurse Sarah outlined how technology was a valid intervention when used appropriately:

> *I think I said it as a student once that we rely on technology so much in labour and delivery and it's funny because there's a lot of nurses on our unit who worked in a day where they didn't even check the baby maybe twice in labour and it's substantial how much we've become accustom to knowing what that baby is doing or to think we know what that baby is doing all the time. That said I think it's a bonus as well …there's times where thank God we have it right. I like it but I find to limit it to what's proven by literature you know to still be appropriate and successful, I like to limit it as much as I can.*

During observations nurses spoke of their experiences with EFM and cited convenience, comfort, and trust in the technology as reasons for its extensive use in L&D. During a break Nurse Sarah asked the charge nurse if she ever does intermittent auscultation (IA) with an epidural and she stated, "*no I never have, I'm not comfortable with that and I won't do it…it's more about my comfort.*" Nurse Sarah agreed she doesn't think she can either. The charge nurse then stated "*it's like the admission strip, I won't give that up either*." Nurse Sarah indicated that sometimes she does IA upon admission into triage but then the physician orders a strip anyway.

In addition, past experiences that resulted in unexpected or adverse outcomes influenced nurses' attitudes towards technology. The charge nurse went on to share a story of how if she had done IA she might not have picked up an abnormal fetal heart rate (FHR). Another RN reflected on a similar experience stating, "*If I had done that (IA) I would not have picked up that seven minute deceleration.*" Their self-doubt and questioning of whether they missed something influenced their use of technology to enhance vigilance in their assessments of potential adverse outcomes. Nurse Betty explained how after a particularly difficult case she chose an increased method of fetal surveillance than what was required based on the guidelines, *"I wondered if*

having this case would impact my practice. I did use technology (i.e. EFM) *for a while and then caught myself with a case and said yes we can take her off the monitor and let her walk for awhile." S*he said "*I have to get over that.. I thought maybe I am feeling better and then went back to my normal self*." As a researcher I questioned whether this potentially sets up a hyper-vigilance of labouring women with an increased use of technology despite policies that support less invasive technology or the fact a woman may want a less technological birth experience.

Others indicated that since they could not provide one-to-one nursing, especially during break times, so EFM was used to ensure adequate monitoring and enhance safety. Convenience was also identified by Nurse Olivia as a possible factor for the over-use of EFM.

> *We probably use continuous monitoring more than are the guidelines now because it's often less labour intensive in that you have the patient hooked up to a monitor so you are able to monitor regularly and get those 15-minute intervals that you would maybe not necessarily be able to do if you are intermittent auscultation especially when we're on break. At break time the labour and delivery nurse will also be covering unless there is somebody free around to be doing break coverage, very often you are then called upon to cover in another room, so you are doing break coverage, so if you've got somebody in your room and you are out of the room you are not one-to-one with that patient totally, there is a way to be monitoring the patient when you're out of the room if they're on a continuous monitor.*
>
> *But, I think that we probably, in our unit, we use continuous monitoring more than is necessary or that should be done, just sort of for convenience sake and that restricts the patient's mobility even though we do have telemetry monitoring so they can move around some still….it's not.. These patients might otherwise be spending more time in the shower or moving around the room than they are because they are hooked up to the monitors.*

Despite a nursing unit policy, permitting a less invasive form of fetal surveillance with epidural anaesthesia, the majority of nurses did not utilize this modality. The reasons identified were: patient comfort, the patient's ability to sleep, lack of one-to-one nursing support, and healthcare provider comfort levels with the reliability of IA. Nurse Sarah explained it this way:

> *See now that's one that my comfort level changes. I don't know how comfortable I would be doing IA with an epidural. I don't know if I could do it* (laughs). *I am sure you could but then I guess my concern there is for the first little bit we expect the blood pressure to drop and then fetal heart kind of drops and you have to do some interventions an usually it's just fine. And then you just kind of go back to your IA* (intermittent auscultation) *and follow IA every 15 minutes, same as if you didn't have an epidural. But then you're almost contradicting the point of an epidural I think.*

Nurse Betty admitted to the overuse of EFM on the unit and the influences affecting the decision to use it:

> *It's* (electronic fetal monitoring) *overused because of the use of epidurals so if a mom wants to sleep with an epidural then it's less disruptive for her to have the monitor on versus off. I think it's overused because we get a huge push from the big OB people from the X hospital and where the residents often..initially trained that everybody should have continuous monitoring. So quite often when you have a patient that belongs to the obstetrical group it's continuous monitoring no matter what…no matter what risk factors..it's just because of medical-legal consequences that they just …the monitor strip will tell all.*

These comments suggest some nurses may not be willing to change their individual practice involving EFM even though a woman with a low-risk pregnancy may choose IA for her birth experience.

Nurses also acknowledged the high rate of epidural anaesthesia utilized on their own unit. They believed a consumer driven healthcare delivery system had resulted in a large number of patients requesting and expecting quick access and delivery of epidural anaesthesia when admitted to the L&D unit. Nurses perceived a vast majority of women were not prepared for the pain of childbirth and that this could be a contributing factor to the increase in epidural anaesthesia. Nurse Olivia outlined her thoughts on the reasons for the increased use of epidural anaesthesia:

> *I think we have quite a high epidural rate. At any given time, probably out of the labour rooms we've got 80% or more that have an epidural. Maybe there are ones that don't have the epidural but are wanting one and they're just waiting for Anaesthesia to be available to do that. It seems that most of our patients are expecting that that would be*

their birth plan. They'll tell you when you ask them what their birth plan is they will say they want an epidural. Possibly because they had one the last time or because everybody they know has had one, so that's what they're expecting. You just need to be present..it doesn't mean you have to run out and get an epidural..or…you just need to be there and I think that has been lost over the years and I'm not laying any personal blame it's a change also in the you know..sort of the consumer demand…like people come here with knowledge they can have an epidural if things hurt and it's also part of um…you know the busyness of the unit.

Nurses admitted that the use of technology was changing the role of the L&D nurse. Nurse Betty and Nurse Sally verbalized they felt the skills of labour support were being lost with the high incidence of epidural anaesthesia and the use of EFM.

I have at times felt sad that we have lost that ability to really nurture and support a labouring woman as she labours naturally. I sometimes think the art of providing labour support is lost a little bit..I feel sometimes some of the new nurses don't know that it's normal for a woman to make noise …for a woman to vomit in labour..like I don't …like it all sounds pretty ..you know but it's normal.

I can't remember the last time I saw a nurse sitting at her bedside and rubbing a patient's back. I don't know when it happens. Labour managers. Active labour managers. We don't take the same time or we expect more progress than what..we never had those guidelines ever used to have when I started out that I remember. You know we expect certain amount of progress every two hours. If we didn't get that you're on the ball and pushing efforts. We used to have patients walk for hours around. They are very much technology specialists running those machines and going in and walking in the room and looking at the machine instead of at the patient.

Nurses acknowledged they cared for women differently with epidurals and viewed their role as less labour support and more of a documentation and assessment role. Nurse Olivia outlined how labour support was different when labouring a woman with and without an epidural:

It could be that some of the patients with epidurals would be sleeping and so they are really not needing too much. You know, if it's a long labour they've been up all night, the husband's on the couch and he's snoring and mom is sitting on a chair and the patient is sleeping on the bed too. So that would be a situation where the nurses probably wouldn't be in the room so much. Also, if the patient is awake and has had an epidural, she isn't requiring as much support with physical measures that the nurse might be assisting with, so that would be another thing.

> *The patient that doesn't have an epidural requires a lot more support and needs the nurse's attention, you know, so that you can be suggesting different positions, you can be directing the husband or support person how to support the patient best, whether it be rubbing their back or husband and wife standing together rocking, she's got her arms draped over him. That's often a great way to get through some contractions. So if your patient doesn't have an epidural then there's much more for the labour nurse to be helping the patients and the family support people with because once they have had their epidural then they are very comfortable. They're just lying on the bed. They might even be playing cards or on their phone texting with friends in the outside world. So it's just a total different scenario when you have a patient who is labouring without an epidural as opposed to a patient who is working their way through the labour with all the labour support techniques that you can possibly think of that might work for them under their circumstances.*

Teamwork

Nurses valued other nurses who worked together and were skilled in their role. When nurses shared their stories of teamwork they spoke predominantly of how they worked together to provide care on the unit. There was an expectation that nurses ask questions and seek input from senior nurses in order to provide safe care. Observations confirmed a continual effort by all nurses to assist their colleagues whenever a need was anticipated or verbalized. During an informal conversation in triage, Nurse Jane indicated that she enjoyed working on this unit due to the teamwork. She felt *"other units did not have the same atmosphere"* but on this unit nurses did help each other and worked together to provide care. Nurse Betty reiterated this by her comments:

> *If somebody rings the bell that they need help they don't just get one nurse they will get five nurses, whoever heard that bell is going to go run into that room..so it gives you really a sense that you are never alone.*

There was a shared approach to how nurses cared for patients throughout the unit. When nurses returned from break and most of the rooms were full, nurses moved from room to room to

do assessments, check on patients, remove EFM machines, or strip beds. Nurse Nancy talked about how regardless of patient assignment nurses would respond to someone in need:

> *I think that happens here more here than anywhere because you know how things can go bad so quickly …so you hear somebody call out..if you're free you go. Somebody's fainting in the shower that had an epidural and passing out..you know you've got to get there quickly and help. If somebody calls out um..some people will call out every single time..for…they just want extra help in there but the majority of people will just go and help and just say what do you need me to do.*

Skilled Practitioners. Nurses valued safe competent care, expected all healthcare providers to be accountable for their practice, and to have the knowledge and skills to perform accurate and thorough obstetrical care. They expected each other to be current and up-to-date in knowledge and skill and to be self-motivated to attend educational opportunities to improve their practice. Nurse Olivia identified the online program MORE^{OB} as one means used to standardize practice and enhance knowledge and skill:

> *MORE^{OB} is one of the programs that we use a lot but also we're encouraged to take fetal monitoring courses and there are articles, research; we have in-services, we have educators and they often…there's topics that are brought up and information is passed to us through our emails. There are conferences that are available to us to attend for education purposes.*

Nurses also valued their experience and skills and when senior nurses or other healthcare providers would share stories about practice less senior staff would gather around and listen. The narratives and stories provided new nurses with a look inside the everyday moments of obstetrical nursing care and allowed them to learn nursing practice. Senior nurses were viewed as experts in care and novice nurses would listen intently to learn from their experiences. These gatherings provided new hires with an opportunity to learn the hidden and taken for granted values and beliefs within the unit's culture. These stories allowed senior staff to share their expertise in knowledge, skill, and nursing management that validated them as experts in care and

elevated their position within the unit's culture. As an ethnographer I wondered if the sharing of these stories socializes new L&D nurses to look at birth in the same way as those sharing the stories. Nurse Sally spoke about how these stories helped to teach new hires with the hope of facilitating learning:

> *I think it is a form of debriefing even though we don't think that is what we are doing or we're not aware of it at the time. I think we like we talk and it's a way of relating our stories. I guess the more times you relayed it the less traumatic it becomes. As the more we share maybe we learn..um..it's maybe a way of teaching the younger ones too. I often share tons of stories over the years of um..every now and then I will come up with a new story..a real story that happened and the young ones are just amazed at what did happen before and from what happens now or different cases I've seen this or I've seen that…and I think they learn and grow from some of those stories too. But also it's reminiscing and team building I think…*(chuckles).*and debriefing.*

Training new hires. New hires were provided an extensive classroom and unit-based orientation to prepare them to work in L&D. Nurse Betty spoke of the burden of continuously training new hires:

> *I find it tiring. It does drain your energy a little bit especially initially when you first get a student and you're always talking and you're always explaining and you do find yourself some days just wishing you could just go do your own thing and..yeah it's been about probably 4 or 5 months now solid and I think I am ready for a break but it's our professional responsibility to train new staff. I do think it would be nice if there was some recognition for that. I do think you do work double duty and I know it is part of our job description but it would be nice if there was some recognition that it is…a tough job and how you mentor ..yeah nurses is also ..is a big responsibility because if you don't do your job right maybe they don't do their job right. Maybe they don't want to stay here and so you do have that sense of ..I got to do my very best because it's kind of partly up to me how their experience is going to go.*

Knowledge, skills, and hierarchy were symbolically acknowledged in the wearing of green lanyards by new hires. New hires wore green lanyards to identify their limited knowledge and skill. It was a visual sign that allowed other staff to be aware that these staff were inexperienced and would require additional support and monitoring to promote safe care. Staff indicated over time new hires would be laddered up in skill and position on the unit. For

example, as staff increased their knowledge and skill and demonstrated their ability to handle their obstetrical assignments they were trained for higher risk areas (i.e. triage and operating room). Nurse Sally outlined the qualities she expected new hires to demonstrate:

> *Self-initiative, a keenness to learn, a willingness to hear what they're told, and a keen sense of their patient and staying in their patient's room and sitting there and observing them and learning what labour is like and getting to know all that. Yeah recognizing that when they do things wrong or not necessarily do things wrong but if they're having a time working at getting used to this and struggling a bit come with a plan on how you are going to change this too. I like to see them tell me or make lists or make themselves a plan as to how they are going make this turn around.*

New hires admitted they felt immense pressure and stress to perform and were fearful of making mistakes. They were unsure of their performance and indicated others had been let go due to poor performance during their orientation on labour and delivery. This resulted in a fear of making mistakes and failure as outlined by Nurse Kimberly: *"I almost didn't come back today as Thursday was such a hard shift"…I didn't get to sleep until four am"*. She had tears in her eyes. She shared her story about a delivery where she felt the physician was uptight throughout the labour and that made her feel uptight. *"I began to doubt myself*". There were disagreements on the location of the toco (external tocotransducer) – the doctor felt she didn't know what she was doing. She stated, *"I know how to palpate contractions I just wanted the toco in a place I could pick it up and palpate"*. The physician had gone to the educator about this issue. Kimberly shared how this experience and the physician talking to her in a scolding tone made her doubt her skill and knowledge and question whether she really needed to put herself through this. She discussed this incident with a colleague and stated, *"I'm not sure if this is where I want to be.*"

Other informal conversations confirmed how new hires were unsure of their skill and standing on the unit. They discussed another new RN who was told she was not meeting

expectations and how her picture was no longer on the new hire board at the nursing station and that meant she was no longer working on the unit. One new RN commented she thought, "*expectations are high and tolerance is low"* on this unit. Both indicated they hoped they were doing okay as they had only a few shifts left and then were on their own. They discussed their caution and uncertainty in knowing whether they were doing okay and how feedback should be constructive not *"you are doing well."* The other RN stated, "*makes you wonder what they say about you when you are not here."* These statements suggested new hires see themselves as outsiders until they prove themselves and assimilate successfully into the unit culture. As the researcher I sensed new hires did not feel supported and feared failure and/or not performing to the expectations of some of the nurses.

Senior nurses spoke of a no blame culture where errors were seen as a learning opportunity. However, new hires described a very different culture that consisted of fear, anxiety, and a lack of trust. The following informal conversation with the nurse clinician outlines how a near miss event was handled during her shift:

> The patient had a history of postpartum haemorrhage (PPH) and the buddy RN had gone over with the junior RN what she should do and prepare for this. After delivery the nurse clinician indicated, "*you could hear blood dripping on the floor*" and she told the junior nurse to put the medication in the intravenous (IV) bag. The junior nurse then inadvertently pushed the full medication into the main IV. The nurse clinician said they noticed this, clamped the IV and started another line. The nurse clinician explained her concern that this RN was panicking during an emergent situation and stated that she was "*not sure she will make it here*". The nurse clinician indicated she would discuss this with the manager at a later date. The junior nurse came out of the room later to do

paperwork – her facial expression was flat, was not interacting with coworkers, her head down, and doing paperwork. When the researcher returned to the unit a few days later this particular junior nurse's picture was removed from the new hire wall, as she no longer worked on the unit. This incident contributed to the fear of new hires, their ability to perform and be accepted into this high-risk obstetrical unit, and suggests a Just Culture may not exist on the unit.

Communication and collaboration. Communication and collaboration between healthcare providers was observed in this fast-paced highly complex environment. The sheer volume of patients, staff, and students lends itself to a highly complex system where communication would be essential in order to be a highly effective team. Routines such as general nursing report at the beginning of their shift allowed for staff to be updated on changes on the unit (i.e. equipment and processes). The routine practice of face-to-face verbal report for the obstetricians (OBs) at the L&D nursing station by the whiteboard occurred at specific times of the day and consisted of the current medical status of their patients on the unit. The OB and the OB resident, medical students, and clerks gathered to share information and discuss plans of care amongst their group. Nursing also had verbal report at the L&D nursing station after their general report where the previous RN would share specific information regarding the patient's status and progression in labour. Charge nurses on the L&D unit also came together from each a shift in front of the whiteboard to review each patient's current medical status and plan of care along with other unit concerns or issues.

The use of the whiteboards allowed for each patient's current status to be shared amongst each group and the team as a whole and was seen by nurses to assist with patient flow and safety. The whiteboards were identified as important to providing the staff (i.e. senior staff and charge

nurses) with specific information on each patient's status and progression in labour and alerted them to any possible concerns. Due to the demand on resources, the nurses shared how there was a constant need for the charge nurse to be kept up-to-date from all patient care areas so she could shift resources. Nurse Sally outlined her role in communicating with all team members in order to be informed of the current unit activity and any possible concerns:

> *We give report in the morning nurse clinician to nurse clinician gives report um..if I..also hear about something going on in another room then I will make sure I visit that room and see what's going on too. I introduce myself to the patients and that so they know who I am. Um..then like I said I go around and I check with the um..the educators, the staff person, the charge nurse, the OBs and the GPs and ah..find out what's going on with the Anaesthetists and I communicate that.*

The nursing staff was seen constantly updating the charge nurse as she prioritized care and allocate resources. Staff would consult each other regarding assessments and care decisions. There was a continual mutual exchange of information and education that occurred throughout each shift as they discussed each patient's case. Nurse Betty and Olivia explained how important it was to utilise colleagues for a second opinion or to validate assessments:

> *Yeah, that's done a lot and I don't think it necessarily is exclusive to the newer staff. I think even when you've been here for years it's nice to get another opinion…yeah it's done and it's never..I should hope it's never frowned upon..I've never seen that anyway.*

> *Yes, I think that's very important to because often times it's hard to interpret a strip. It might be difficult to say what the baby's baseline is, what's happening during a contraction, what's happening immediately after a contraction. Sometimes it's quite difficult. It depends where you look at it. You could be….What someone might consider to be an acceleration, could be actually the baseline and so what we are seeing are a lot of decelerations. So that's…it's important to bring out, to share, to compare opinions with other staff just to see what they might think about something.*

Observations confirmed this exchange of patient care information between the various disciplines. OB Report at the whiteboard was one example where the researcher observed discussion amongst the OBs on-call and the various residents regarding the plans of care, blood

tests, and diagnostic tests of various patients on the unit. There were multiple observations of nurses discussing patient diagnostics and treatments along with plans of care. These discussions between the healthcare team (i.e. general practitioners, obstetricians, residents, and nurses) consisted of the medical and nursing management of care with no mention of each patient's personal desires or wishes for their birth experience. The content of these conversations suggests the priority of care was based on the medical needs of the patients with little or no information on the patient's expectations for birth. There was a sharing of information followed by exchange of ideas, knowledge, experience, and expertise to determine the plan of care. The sharing between care providers was a regular part of each shift and there appeared to be a comfort to be able to exchange ideas and a trust to do this in an open environment such as the nursing station.

Nurses frequently discussed nursing care and looked to each other for suggestions and/or validation in the management of care. In one observation an RN came to the desk to discuss a delivery with the charge nurse. The nurse stated, "*I felt nothing went right*." They discussed the indications for an in and out catheterization prior to pushing and adequate and safe timelines. The RN indicated the obstetrician questioned her and told her she should have performed an in and out catheter even though she had done this 45 minutes earlier. The RN also discussed her interpretation of the EFM strip with the charge nurse. The nurse clinician discussed the management and interpretation of the EFM strip with the RN and validated her management in this case. This observation demonstrates the continual exchange of information between L&D nurses and how communication and collaboration are part of this practice environment.

Supportive relationships. The relationships nurses shared with each other and their colleagues were important to them. As an ethnographer one could not help but wonder if relational bonds of the healthcare team are stronger due to such a highly stressful environment.

It was apparent in reflections by the staff that when they experienced intense, stressful and emotional events together, the barriers between them were gone and the bonds connecting them were stronger. This insight, was best expressed by Nurse Betty, in the following quotes:

> *I think when you stand up to your ankles in blood and it's three in the morning and you've been there together. You've kind of broken down a lot of barriers socially already so it's like it's almost like nothing is really off limits. You know we are very comfortable with each other cause of what we deal with and how we have to rely on each other in an emergency.*

> *Situations and crises that personally it's we feel safe with each other to share personal information and personal experience. There are very few people that would withhold anything personal that they are going through. Most people here would talk about it and feel supported.*

The atmosphere appeared to be relaxed as senior nurses were comfortable sharing their personal stories. Observations confirmed the sharing of personal stories that would then shift into discussions about past or current obstetrical experiences with ease. It was surreal to see them crocheting at the desk during times of low activity and then see them jump into action when their skill and expertise were required during an emergency. One observation illustrated how the atmosphere was relaxed at the nursing station when nurses shared their personal stories and participated in activities such as knitting and crocheting. Three nurses had no patients and were visiting at the desk with two of them knitting and crocheting while discussing their personal lives and plans. These informal interactions allow staff an opportunity to develop relationships with each other and strengthen their bonds within the culture. One of the staff shared how the assistance and compassion extended outside the day-to-day shifts on the unit. Nurse Sally shared how nurses come together to assist each other outside of the work environment:

> *Helping does not stop at our door or start at our door. We have somebody right now that we are baking food for because their little child is sick and in the hospital. They have four other children at home and their husband's off work trying to manage at home while she is in the hospital all day with the baby. And that's not a unique case, we have done*

tons of that over the years where we've baked for people and we donate money and order them a cleaner to their house or whatever. It is like I said we are supportive outside this hospital.

The sharing of stories provided all nurses with an opportunity to debrief, seek validation, and gain and offer support of their colleagues. Nurses spoke of the shared understanding from their colleagues and how the intense and sometimes traumatic events on labour and delivery can have their emotional toll on staff. Shared empathy provided comfort to the staff. Nurse Betty and Nurse Olivia shared their thoughts on how sharing stories of traumatic events allowed for the emotional support and empathy from colleagues:

Well it's an outlet right. I think you also are looking whether you are aware of it or not for some validation that you didn't do anything wrong. You perhaps want to hear that somebody else would of done exactly what you did. Maybe you're looking for some empathy…people just saying wow that's really rough or some you know positive feedback that um people recognize that you went through a tough case. I think anytime you have.. go through any kind of emotional trauma is a strong word but..upheaval …it's good to talk about it, whether it's work or not but especially at work cause our line of work is so intense.

Let's say a really bad outcome often that nurse will be sick the next day. I'm not saying often…I'm saying…it has happened. Nobody would be surprised if she'd be sick and just needing a shift or two just to kind of wrap her head around it and regain some confidence to come back.. I mean I suppose you know when you talk to your colleagues they just get it versus when you talk to maybe somebody else in your family or a friend. If they don't work in this area they tend to be just shocked. It's like does that really happen and now really all you want to do is you just want to let it out and tell the story. You know I do think it is about healing.

Connecting with Patients

Despite the various roles and responsibilities of L&D nurses it was their connection with their patients that they indicated brought them the most satisfaction in their role. The ability to make a difference for a woman, her baby, and family was paramount to their reasons for nursing on this unit. Nurses spoke of how they strive to honour birth plan requests and how time and the

ability to connect with them helped to understand their needs and wishes for childbirth. Olivia explained how being one-to-one nursing with her patients provided this opportunity:

> *One of the things I think I enjoy most about my work on labour and delivery is the fact that we under most circumstances are doing one-on-one care. So that gives us an opportunity to really get to know our patients and decide which approach would work best in helping support their labour and delivery and their care.*

She went on to share her thoughts about how the ability to connect with her patients impacted her care:

> *Some patients are more communicative than others. Sometimes the nurse feels a connection with the patient so she might want to be in the room because she is enjoying the interaction that she is having with the patient. There are other times when that connection that just doesn't happen, you know, as in any social interactions, there are times where you feel more connected to patients and I think when you do feel more connected to a patient, as the nurse, you're going the extra mile. You're giving them that little extra and you know, it shows in that the patients are just so much more appreciative.*

One of the obstetricians (OBs) shared a story about how the team helped a childbearing woman give birth early so her dying mother could see her grandchild. Based on her comments as the researcher I reflected on how assisting this woman's wish during a very difficult time was seen as important and resulted in the health care team feeling they made a difference for this patient and her family while fulfilling her personal wishes for her birth. The following is a description of this event:

> The OB on-call was sitting at the back and we started up a conversation. She asked me to look at a card she had in her pocket. The card was pink in color and had lilies on the front. This thank you card was from a patient who had a caesarean section earlier than planned as her mother was dying of terminal cancer. She wanted to be able to ensure her own mother saw her grandchild. The obstetrician indicated she saw the patient, had her head to triage for assessment. The obstetrician stated, "*when I got there the nurses*

said…she's NPO" (nil per mouth). The obstetrician said, "*yeah we had her upstairs and her mother holding this little girl in her arms with her daughter…about 45 minutes after closing skin…we went with a lot of puke buckets.*" The grandmother died approximately one week later. The obstetrician indicated she was saving the thank you card from this memorable experience.

Building rapport. Nurses have a unique relationship with their patients in the labour and delivery setting. The relationship is built in a vulnerable and emotionally intense experience and connections need to be formed quickly. The ability to make a connection on some level with a woman and her family is important and nurses valued the ability to nurse one patient and get to know them and support them. Nurses Nancy and Olivia shared their thoughts:

> *I just thoroughly enjoy it and it's just …every day is different, there's not many days I don't bond with people. I try to make that couple feel they're the most special people that they are that day.*

> *One of the big things different is the fact that you do have only one patient to focus on at a time, which I really enjoy because then you feel that you can do the best job that you can do. Whereas on other units, when you are running from one patient to another, you often feel like you are just slapping the surface and putting on band-aids that aren't going to stay. So I feel that there is a lot more satisfaction in the fact that you can be just one-to-one with that patient during the time that they're labouring. So, it gives you an opportunity to really get to know. It seems like that is a way that you can really make a heartfelt connection with your caregivers; when you are so vulnerable and hoping for help because you're feeling so out of control and that's how a lot of women that come in feel.*

The physical space impacted the ability for nurses to have time to develop rapport with their patients. Often admissions were hurried as rooms became available which impacted the time nurses had to develop rapport with women. This was compounded by the fact that post-delivery nurses may be pushed to move women quickly to the postpartum unit and impacted the continuity of care. Nurse Olivia shared her thoughts on how the lack of space on the L&D unit

forced women to labour on triage without the resources and support that one to one nursing could provide. Nurse Olivia indicated, *"they have to labour too much in triage."* She indicated this was not acceptable and not fair to women. She admitted they pushed them through the system to get them delivered and then *"it's a cuddle, breastfeed, and then transfer them to postpartum"*. Nurse Olivia indicated if they had the space they might manage labour differently but they just can't due to the volume and space issues they face. Nurse Nancy agreed with this by sharing how these restrictions impacted birth plan expectations, *"some nurses when they know how busy the unit is and a woman wants this baby to crawl up to the nipple and give it an hour to crawl up to the nipple. Well they don't have that time*." These examples suggest that unit activity and space restrictions play a critical role in how birth plan expectations are enacted on the birthing unit.

Information sharing and expectations. Nurses viewed themselves as experts in labour and birth and believed a large part of their role was the education and teaching of childbearing women and their families on what to expect when labouring and during childbirth. Since the labour process is not predictable they believed their role was to educate families on the process as it evolved over time. Nurse Olivia and Nurse Sally spoke about how communicating with their patients was key:

> *A lot of the day is spent talking with the patients and their family. There is usually the husband and another support person, be it a sister or a friend or mother or whatever. So a big part of the day is explaining what we are doing: we are monitoring; we are supporting them with their concerns on pain in labour and keeping an eye on the well being of the baby. So just a lot of the day is spent explaining and communicating and reassuring and directing and finding out. One of the things I think I enjoy most about my work on labour and delivery is the fact that we, under most circumstances, are doing one-on-one care. So that gives us an opportunity to really get to know our patients and decide which approach would work best in helping support their labour and delivery and their care.*

Most people that come in with a birth plan they're just taken off the internet anyways and when they come in and show them to you and you go down the list and say look …yeah that's everything we do here anyway, but if it's a little different birth plan than one of the just regular run of the mill ones, I like to sit down with them and discuss every point with them. Just run through it with them and once they understand what we do on the unit they go oh yeah, okay. I didn't realize this and oh yeah that and if there's stuff that they are quite adamant about no vitamin k, no nothing, I don't try to talk them into it or whatever I say, well do you know why we give it I just have them understand and they say oh yeah I understand that but I still don't want it…I say well okay fine just sign this paper over here that's fine. You know I am not there to argue with them I'm just there to make sure that they are well informed and they know what decision they're making if they make the decision then to go against what our policy is that's fine with me. I don't get my back up with them.

The majority of the nurses believed that most women came to birth with some expectations or plan. Nurses perceived these expectations were influenced by a woman's preparation for birth, her knowledge of current obstetrical practices, her past obstetrical experiences, culture, and the type of care provider she had for childbirth. Nurses equated verbal expressions of expectations of birth as a plan and written birth plans were viewed to be a more formal request. Written plans were seen as prohibitive to care whereas the verbal expressions of birth plans were viewed in a more positive light. Whether written or verbal the majority presented with verbal expectations of their birth experience. Nurse Olivia, Sarah, and Betty shared their insights:

I think there is always some expectation. Whether they're going to have everything possibly or any medication, or any intervention at all to ease the pain. I think most women are really terrified of the pain, you know, what's to come – the unknown; wanting to be sure that the baby's going to be okay. Because a lot of women come in and whether they're real or just imagined concerns about the well-being of the baby, they might have had some horror stories about things going wrong for friends or family or whatever, so…Well, their concerns come up over the course of time and I think that's another thing, that by being in the rooms a lot with the door closed, you can create an environment that they will open up and tell you about, you know, what they're afraid of or what they've heard about and you can help them through.

I'm still defining that for myself, like the medical side of it all to protect my patient and her baby but I have this really I don't know if it is because I am new (laughs) *but to*

protect their experience as well. The couple's experience...I don't really think it matters how they got to where they are but everybody has an expectation and everybody's backgrounds are so different so I really try to protect the social aspect of it as well.

Probably some set of expectations and sometimes that is I…my plan is to not have a plan and to go with the flow, that's sometimes their plan and quite often that works well because if you're going with the flow it really means that you're sort of going with it. Sort of surrendering to the process a little bit of birth cause you can't be in control but I think we all come with our own set of expectations and whether we have read many books or have gone to prenatal classes or talked to girl friends that have had babies or listened to our mothers or we all have an idea of how things should go.

Nurses acknowledged that written birth plans were discussed amongst the staff but that their occurrence had lessened over the past few years. The incidence of written plans was not known but the verbal expression of birth plans or expectations was certainly a part of their everyday care of labouring women. Nurse Olivia shared her thoughts on how written birth plans are not as frequent as in the past:

I would say maybe in the last five years I would say, or maybe it is since I have been in xx, because I have only been in xx for about five years, but I am seeing less written plans. When I was working in a hospital that served a very highly educated, affluent population we saw a lot more birth plans there than I do now.

Written birth plans were put on patients chart at time of presentation to triage and/or L&D for reference but due to their infrequency nurses felt the majority of discussion was at the point of care on the L&D unit. The most common birth plan expectations were related to: pain management requests, fetal surveillance requests, delayed cord clamping, no episiotomy, skin to skin contact with their baby post-delivery, no caesarean section unless medically indicated, and delayed administration of eye ointment and vitamin K or refusal of both. Nurse Betty and Nurse Olivia spoke of how when assuming care they would often open up the discussion about a woman's expectations or plans for birth or how this may come up during the course of providing care:

Because what I've ever seen written on a birth plan is what we would aim to do anyway unless we couldn't. Things like skin to skin or things like no interventions or things like doing the baby assessment on the mom's chest and I mean it just sort of opens up the conversation and the dialogue between you and the patient about what their wishes and wants are and what they're understanding is cause sometimes they don't even really understand what's written or what that really means.

If someone gives me a birth plan, I often will look at it and then discuss it point by point with them to see exactly what their understanding is of what they are asking and very often the birth plan is not anything that we would not do. I mean, you know, a birth plan might consist of the fact that they want to walk as much as possible in their labour or they perhaps they could go in the shower or using a birthing ball and that they don't want an episiotomy. So those are basically things that we would suggest to the patient even if they didn't have a birth plan.

The perception from the majority of the medical and nursing staff was that women with birth plans, especially those plans/expectations viewed as more rigid, inevitably resulted in more medical interventions during and at birth. Nurse Sally and Nurse Nancy shared their thoughts:

A woman who wants skin to skin, I don't want an epidural or I don't want to have a c-section or I don't want to have an ARM (artificial rupture of membranes)*, I want to be left to labour naturally. The more rigid they seem to be those ones are going to labour forever and end up having to break down taking an epidural and end up having to have an augment of their labour, it just seems like they end up with everything…IUPCs* (intrauterine pressure catheters) *up them, scalp electrodes on, horrendous fetal heart rates. Even if they make it through then the placenta will be stuck and she will have to get an anaesthetic after all for retained placenta, whatever, it does seem like they end up with more complications.*

I often find that the majority of people that have a birth plan, everything seems to go wrong. I think they're expectations are so high that everything is going to be so perfect and then sometimes it doesn't happen and then they seem to be the ones that end up with the augment, the IUPC catheter in and being wheeled off to c-section (caesarean section)*. I don't know whether it's just something that just builds in them you know sometimes with doulas as well they don't want us to do things and they don't want the doctors to interfere. I don't know whether their body just reacts and just the cervixes don't dilate so well.*

Negotiating care - finding that middle ground. Nurses and other healthcare providers believed all women come with some sort of plan or expectation for birth. During observations informal conversations captured some of the thoughts healthcare providers had about birth plans.

The following is one of those conversations: Nurse Deanna indicated that this particular unit does not see written birth plans very often but that all women come with a plan. The general practitioner (GP) stated, women with birth plans "*jinx themselves*". The other two RNs at the desk nodded their heads in agreement. Nurse Deanna states especially when they "*click off the internet*". She indicated that women "*pick stuff we don't do like routine episiotomies or enemas. It's like they don't know what they are talking about."* The GP stated, *"yeah, the most common requests are delayed cord clamping, waiting for the cord to stop pulsating and skin to skin."* Nurse Natalie agreed and stated *"and no vitamin K too"*. Nurse Deanna indicated they need to be *"flexible"* and birth plans make them not be as open to suggestions and then they get interventions they wouldn't normally get like a caesarean section because they didn't want an epidural.

Nurses identified that some birth plans created barriers when they appeared to be taken directly off the internet, listed interventions no longer routinely performed in obstetrics, were unrealistic when the baby was at risk of injury, and were created without some discussion with labour and delivery nurses and/or healthcare practitioners prior to presenting to labour and delivery. Nurse Betty agreed and went on to share her thoughts about birth plans: "*they put stuff we don't even do here. I am all about being their advocate and empowering them that is great but some just print this off the internet and mark down things"*. She goes on to say she can see why they do it, as they want some control in this situation, "*It is their bodies…it's not that they rule the roost per se but they should be able to express what they want in their own birth."* Nurse Betty goes on to share what she thinks should be listed on a birth plan:

> *When it (birth plan) is more thought through and more realistic. Like when something is on a birth plan I don't want my baby circumcised in the room. It makes you wonder well what have you been reading. This is not anything, are you informed? Because I think if*

> *a birth plan looks like it's well thought out and it's actual personal wishes like some people will say I really don't like people talking in the room, I want the room very quiet then that's a personal wish, which is very reasonable. It's not something we might automatically do so that's a good thing to put on the birth plan because it's something that we need to pay attention to.*

Despite the identified barriers, nurses struggled to meet the mother's expectations in the present environment on the labour and delivery unit while striving to adhere to policies and procedures and provide what they perceived as safe care. Nurse Betty explained it this way:

> *I think one of my perceived biggest challenges at times is just finding my middle ground between adhering to protocols and policies and the wishes and wants of our unit which often entails getting them delivered and getting them out just because our volumes are so high versus making this the optimum experience for the family.*

Nurses were clear their priority and goal was a safe outcome for both mom and baby and when birth plan expectations put either of them at risk there was a tension or a potential for conflict. Nurse Betty explained how patient safety overrides a woman's personal plan for birth:

> *So maybe then our role is ..if our role is safety then you have to balance what ..how much to go against the birth plan in order for them to have a safe experience as well.*

Nurse Hannah shared how a woman's desire not to have a caesarean section put a baby at risk. Despite the fact the fetal monitoring strip indicated the baby was having heart rate decelerations, the mother did not want a caesarean section and this caused healthcare providers to be anxious and fearful about the outcome for this baby. Nurse Hannah shared the baby was born not just with some meconium on its body but *"thick chunks of black poop and the baby was black"* and required resuscitation and went to special care nursery (SCN) for care. Nurse Hannah went onto say, *"that shouldn't have happened."* She shared how negotiation at a time of crisis puts the baby at risk when time is of the essence. She goes on to share how healthcare providers are put in a difficult situation trying to explain to parents the rationale for intervention while being aware time to intervention may impact the outcome for the baby:

Well, I think it's often very difficult cause sometimes minutes are ticking by and that's what you're worried about…I've had doctors say, "well you know you want a healthy baby, the only way you're going to have this healthy baby is if we go to the operating room right now." Some people have said "well, we'd rather not" and you say " well, I'm going to write down that you're refusing this" and that's very difficult. It's different for obstetricians, cause they know what the outcome might be and then you know it's all going to be investigated afterwards. So that is…I think that is very difficult for the doctors as well.

In addition, there is an expectation by nurses that women would surrender to the birth process and be flexible to the variances that occur during labour and birth. Nurse Olivia shares her thoughts on birth plans:

I would say that it's a good idea to have a plan, but also to realize that there's possibilities that certain parts of the plan will have to be thrown aside or changed because the bottom line is that we want everybody to be safe, that we want to make sure that we're doing the very best for that baby under the specific circumstances that might come up, so…but that it is a good idea to sort of have a bit of a plan because they know what type of a person they are; what might feel better for them. Sometimes people don't like to be touched. Sometimes people find that touch is really helpful and supportive and so I think the best thing to tell people is, yes, educate yourself, have a birth plan, decide what you might like, what sounds like it would work nicely for you, but be open to the fact that there's sometimes circumstances that come up that these things have to be put aside because the ultimate goal is to have a safe, healthy delivery of mother and baby.

The attitudes, behaviours, and beliefs around birth plans seemed to cross disciplines and were reflected in observations and accompanying comments. The following interaction occurred between the researcher and an obstetrician when discussing birth plans. An obstetrician indicated, *"I had a friend that had a birth plan and she asked me where the best place to put it and I said in a shredder."* She indicated it would be best if they came with none. Another registered nurse (RN) indicated her opinion was that women want some control in their experience…she went onto say *"maybe it's the first thing you do when becoming a mother"*. Discussion ensued whether having multiple care providers contributed to the need to create

something in writing to ensure information is shared amongst healthcare providers. There was a general consensus patients were told to make a birth plan in childbirth classes.

Nurses shared how they would read over a birth plan and have the woman explain her expectations and then spend time discussing them. Some nurses spoke of sharing with patients evidence-based research regarding care practices on the unit whereas others shared experiential knowledge. The biomedical model of birth was the predominant ideology on the birthing unit and it informed the discussions with women regarding their requests and/or expectations. Nurses shared their belief that through discussion and education women would have a better understanding of the rationale for interventions and processes on the labour and delivery unit. These discussions may be influenced by the approach each nurse takes with her patient along with the appropriate timing to ensure a productive discussion. Nurses Sarah, Betty, and Olivia shared how they approached women with birth plans to allow for the mutual information sharing:

> *Though I know it's an educational thing, which is again why I like to go through birth plans. I like to say you've written this down, can you tell me a little bit more about it, where is that coming from, and why did you feel the need to express that one specifically because maybe I can provide a little bit more insight or least some reassurance that hey thanks for letting us know but hopefully it's not an issue.*
>
> *I go through it and quite often if time allows and she's not in too active labour or find a point where - we already do this and if you don't want the vitamin K do you understand the implications of that. Or of course we're going to try to get the baby to breastfeed, we wouldn't give formula anyway unless it was medically indicated. Sometimes it breaks down the wall they* (the patients and families) *already have up (i.e. we need to protect ourselves from the medical people in order to have a better birth experience). After you explain what we normally do the patients say, you* (i.e. the healthcare team) *already do that then good and that is what helps to build some trust with them.*
>
> *I think the first thing I would ask them…I would want to know why, what their understanding is of that particular item on the plan. What does that mean to them, because that might be something that maybe they don't really have an understanding of what it is that they're really asking or not wanting. I would want to sort of get the background on that and see where they're at – why that's important to them. I would probably tell them why that would concern me – why I would feel that wasn't safe or*

realistic, or whether we don't have that particular type of equipment or are not able to do that. Also is it something that's not as per protocol and practice – why it isn't done and then if we weren't able to resolve the situation just by the two of us talking, then I would involve the doctor in the situation. By letting them know what the patient's request is and then perhaps come to some compromise by explaining it to the patient and making sure they understand why it might not be safe or might not be in the best interest of either them or the baby.

Nurses struggled when a patient's expectations were not met despite their best efforts. Their perception was that a safe outcome was the primary goal of childbirth and that despite the journey women should be grateful for this outcome. Nurse Betty shared her experience with a patient who had hired Betty's friend as a doula for labour support. The patient was admitted for induction of labour due to complications in her pregnancy. After consulting with her doula the patient chose to go ahead with the induction. Betty explained how the patient progressed through labour but ended up with an assisted vaginal birth and a huge postpartum haemorrhage (PPH). Betty described the PPH this way, "*the kind that you lose a litre in a minute"*. She stated she ran into this room as she was in charge and they stabilized the patient, gave her blood etc. and she felt wow they (i.e. the doula and the patient) should be grateful for all we have done to save the day and how quickly they reacted. She said goodbye to her friend the doula and she thought she would get a great response about how grateful she (i.e. the doula) was that this particular patient didn't have a home birth. She indicated this was not the response…*"it was more like look what you have done"*. She (i.e. the doula) felt all the interventions caused the next and resulted in the outcome…as least she thought that was their (i.e. the doula and patient's) perception –"*perceptions, how different they can be."* Nurse Betty shared how nurses and their patients can come from very different perspectives and goals for birth.

Nurses verbalized their desire for understanding between their patients and themselves. They wanted the relationship with their patients to be open and consist of discussion and mutual

understanding. Nurses wanted women to know they were there to support, educate, and assist them in the birth of their baby. Nurse Betty and Sarah explained it this way:

> *I'd like them to know that I am there for them. I'd like them to know that I love my job and I'd like them to know that I support their decisions. If they want to have a natural birth I love that because it gives me gives me a chance to shine because I feel that's my strength and I almost get a sense of accomplishment too when it is done. I share that sense of accomplishment but I am there too if they want something completely different. If they say I don't want to feel any pain, then I'm okay with that too. I guess if anything I want for them to see me as a nonjudgmental person that is sort of, on their side and I mean that sounds pretty ideal but I guess that's what I would strive for.*

> *I think you can watch risk factors and say oh, it's not so bad right now but we'll just wait and see and I think mentally we need to start preparing so when I start getting you know decelerations that look to me like they could be become complicated or they're just a little bit funny or whatever it is and I try to do it with all my patients regardless cause I always go over the fetal heart strip because we pop in the room we look at the strip for ten seconds or sixty seconds or whatever it is and then we look at them and go "okay" …then we walk out the room. And so I really try to tell them what I'm looking for, what I tolerate, because they're not stupid, they all see the monitor, they know when that heart rate is going down, you can hear it, and they've all tuned into what numbers to watch. So to make sure that they're aware that there's a level of deceleration that is appropriate and the things that I'm going to start to do when they are a little bit you know questionable…position changing or oxygen or external stimulation or internal stimulation…whatever. So then that way when I ask the mom "can you please roll all the way to your left" she knows…okay this is why not that response where she is oh, but I am so uncomfortable or okay and then she takes her time but you also get her cooperation because she has her understanding.*

Overall, labour and delivery nurses operated from a patient safety perspective that was based on their values and beliefs, and influenced the care provided for women with birth plans. Nurses valued the expertise and support of their colleagues and it is through these relationships that they learned to communicate and collaborate to provide care. Nurses admitted the vast majority of women presented with some expectations for birth and communicated them verbally at the point of care. Nurses discussed expectations and shared information with women and their families in order to come to a shared understanding around the process of labour and birth. Tension arose when expectations were perceived to put a patient's safety at risk. Challenges

existed in striving to address these expectations while nurses were dealing with the unpredictability of labour along with unit acuity and volume. The findings of this study have implications for practice, education, and future healthcare planning and these will be discussed in the next chapter.

CHAPTER SIX

Discussion

The purpose of this study was to explore the social norms, values, and practices of labour and delivery (L&D) nurses when caring for women with birth plans. The overriding research question that guided this study was: What is the everyday practice of labour and delivery nurses as they care for women with birth plans? Further guiding questions included: How does birthing unit culture inform and influence the care provided by labour and delivery nurses to women with birth plans? What factors in the birthing unit environment do labour and delivery nurses perceive facilitate or act as barriers to the use of birth plans?

As the researcher in this study, once immersed into the unit, it became apparent that written birth plans were not an integral part of care. L&D nurses shared that women rarely present written birth plans but rather women verbally express their hopes and expectations for their birth experience during care on the L&D unit. It was evident from participant descriptions that the existing birthing unit culture impacted both the way in which nurses performed their role and how they viewed and enacted birth plan expectations. Three interconnected themes emerged from the data: (1) ensuring safe care, (2) teamwork, and (3) connecting with patients, however, aspects of patient safety were also evident in the theme of teamwork and connecting with patients. The factors that acted as facilitators and barriers to the use of birth plans within each of these themes will also be discussed.

Ensuring Safe Care

Patient safety is a dominant discourse within healthcare. Researchers have shown that the vast majority of adverse events within the healthcare system are largely preventable (Baker et al., 2004). Comprehensive patient safety strategies have been shown to decrease the incidence of

obstetrical adverse events (Pettker, et al., 2009). This birthing unit's participation in the MORE^{OB} (Managing Obstetrical Risk Efficiently) program is one such strategy that influenced not only how healthcare providers approached and provided care, but also it shaped the unit culture.

A desire to provide safe care was a driving force behind the provision of care on the birthing unit. L&D nurses placed a high value on safe outcomes for both mom and baby resulting in surveillance of the subtle and overt risks perceived as inherent in pregnancy, labour and birth. Surveillance has been described in the literature as both a cognitive and behavioural process involving purposeful and ongoing acquisition, interpretation, and synthesis of patient data for clinical decision-making (Kelly & Vincent, 2011). Coralan (2007) suggests the discourse of risk-oriented care in hospital births results in surveillance, measurement, and expert advice. In contrast to a risk-oriented approach, the social model of maternity care is founded on the premise that childbirth is a natural physiological event and the belief the majority of women will have a normal and safe childbirth with little or no intervention (MacKenzie Bryers & Teijlingen, 2010). Regan and Liaschenko (2007) suggest the manner in which nurses cognitively frame childbirth, ranging from understanding it as a natural process to an inherently risky process impacts the care they provide. This is evident through the types of policies, procedures, and care practices that are used to support and frame nursing practice (Hausmann, 2005). The differences in healthcare provider attitudes towards childbirth may be influenced by exposure to those practices within the birthing unit environment and may contribute to the rates of intervention in maternity care (Liva, Hall, Klein, & Wong, 2012) and ultimately how healthcare providers enact the birth plan expectations of women.

Standardized obstetrical guidelines and unit policies and procedures directed patient care on the unit and were seen by nurses to help to control risk and enhance patient safety. Clinical guidelines, policies and procedures are seen as part of a risk management system to eliminate variations in practice and increase control over individual provider practices (MacKenzie Bryers & Teijlingen, 2010) supporting safe practice. The nurse's day-to-day activities and routines on the unit (i.e. pre-checking of patient rooms and equipment, frequency and types of maternal and fetal assessments) were seen by nurses as promoting safe care. However, birth plan expectations that were at odds with healthcare provider competing priorities were seen as barriers to the nurse's ability to provide safe care.

Despite this strong focus on safe patient care and a commitment to evidence-based policies and guidelines there was incongruence noted in actual nursing practice. For example, technology though a dominant part of nursing and medical management of obstetrical care, was not consistently applied using evidence-based knowledge. Nurses shared that despite policies and guidelines supporting the use of less invasive fetal surveillance technology (i.e. intermittent auscultation) for low risk women some nurses chose to incorporate a higher level of surveillance (i.e. electronic fetal monitoring) as part of their routine practice for all childbearing women (Canadian Perinatal Programs Coalition, 2009; Salus Global, 2013; SOGC, 2007). This example supports other findings that suggest evidence-based obstetrical care practices are not consistently applied throughout birthing units in Canada and that variations are likely due to a complex set of factors one of which is individual healthcare provider preference (Canadian Institute for Health Information, 2004; Chalmers, Kaczorowski, O'Brien, & Royle, 2012). Individual healthcare provider preferences not based on evidence-based practice could become a barrier to the enactment of birth plan expectations particularly if those expectations were based on evidence.

Carter (2009) suggests that childbearing women require trust in their relationship with their healthcare providers and not enacting evidence-based practice has the potential to undermine this relationship.

Teamwork

The second theme that emerged from analysis of the data was teamwork. A team is defined as a group of individuals who have specific roles, perform interdependent tasks, and share a common goal (Baker, Day, & Salas, 2006). Teamwork is defined as a relationship between members in both task work and teamwork processes to achieve a common goal (CPSI, 2011). There is growing evidence in the literature that applying high reliability organization (HRO) principles is a way to achieve exceptional performance through high quality and consistent safety (Baker, et al., 2006 ; Riley, 2009). Teamwork is an essential component of achieving high reliability within a health care organization (Baker et al., 2006).

The MORE^{OB} program is founded on the principles of high-reliability organizations (HROs) and promotes that: (1) safety is a priority and everyone's responsibility, (2) operations are a team effort, (3) communication is highly valued, (4) hierarchy disappears in an emergency, (5) emergencies are rehearsed, and (6) interprofessional reviews of routine processes, near misses, and unexpected events (Salus Global, 2013). The program fosters interprofessional team based learning (i.e. simulation skills drills, emergency drills, tracking of near misses, no harm, and adverse events) to improve teamwork and enhance safe outcomes (Salus Global, 2013). Team members were observed reading the online content, performing audits of practice, reporting near miss and no harm events, and participating in interprofessional team training. Observed routine practices and the use of artefacts (i.e. whiteboards, standardized guidelines) informed nursing practice and medical management and assisted in the communication and

coordination of care amongst team members. These shared understandings of management and outcomes were seen by nurses to help set timelines and milestones to assist in the prediction and safe management of labour and birth. Birth plan expectations that were not congruent with the identified management of labour and birth were considered to be ill-informed or uneducated requests as they were in direct conflict with the L&D nurse's usual practice. This may result in the patient no longer being considered an active decision maker in her own birth experience.

Nurse-to-Nurse Relationships. The socialization of novice nurses into the birthing unit culture occurred through standardized unit education and training. Senior nurses shared their expertise, knowledge, and skill thereby assisting in the acculturation of new hires. Hong (2001) suggests experienced members of the culture are key in assisting novice members to assimilate into that culture and experienced members are looked to for guidance, wisdom, and teaching of acceptable behaviours, values, and beliefs. In this study, senior nurses shared stories of obstetrical emergencies and complex cases with the novice nurses. The sharing of stories is important within a culture as they are seen as important and allow for similar beliefs, values, and behaviours to be passed onto the newest members within the culture (Leinenger, 1995). However, the sharing of abnormal and adverse events in labour and birth may contribute to how novice nurses frame childbirth. These strong socially defined roles within the medical model of obstetrical care contribute to an expert model of care and professionalism where healthcare providers have ownership of knowledge and decision making over childbearing women which is counterintuitive to collaborative practice (Peterson, Medves, Davies, & Graham, 2007; CIHC, 2010). This belief of expertise is perpetuated by the L&D nurse's high expectations for performance and resulted in a low tolerance for error due to the possibility of adverse outcomes to mother and baby.

A Just Culture consists of relationships based on trust and respect and promotes the reporting of errors and the collaboration of stakeholders to address risks within an organization (Bashar & Lansbury, 2012). Despite the MORE^{OB} program endorsing this practice, new hires spoke of the burden of high expectations and the anxiety and fear of making mistakes that could lead to punitive actions. L&D nurses spoke of promoting patient safety and a culture of no blame but when new hires inadvertently put patients at risk and/or made an unintended error they felt supportive behaviour was not always evident. Some of the new hires were let go after an error occurred which may have contributed to the perception by new hires that errors would result in punitive action. Also, new hires were required to wear green coloured lanyards as a visual cue to identify their inexperience and knowledge in obstetrical care and that they may require additional support and assistance from members of the healthcare team. This practice though practical, may put new hires in a vulnerable position as they may question their competence while making them fearful of reporting near misses and making errors.

Highly performing teams share a common vision, have a strong sense of confidence and trust, and optimize the ability to collaborate, communicate, and coordinate, while understanding each other's professional responsibilities (CPSI, 2011). Effective teams need to recognize and utilize each other's contributions while taking responsibility to enhance each other's skills including those of the patient (HQCA, 2010). While patients were included in the discussion of care it did not always seem apparent in descriptions that they were considered an equal member of the healthcare team. The findings indicate that near miss and adverse events were viewed with blame resulting in nurses feeling guilty and a lack of trust. These behaviours and feelings are not supportive of a Just Culture nor do they foster the team's ability to perform.

Connecting with Patients

The final theme that emerged from the analysis of data was connecting with patients and the unique relationship between L&D nurses and childbearing women and their families. Nurses valued the ability to provide one-to-one nursing care on L&D as it allowed them the opportunity to get to know their patients, discuss their birth plan expectations, and determine the best approaches to support them during labour and birth. The ability to review birth plan expectations when assuming care, ask questions to clarify reasons for choices, and then provide teaching to outline rationale for certain routine practices and interventions were seen as facilitators to the enactment of birth plan expectations. These interactions between the nurse and the patient allowed for a dialogue to discuss the plan of care along with what to expect during the course of labour and birth. The nurses shared how labouring women admitted to the L&D unit during the latter part of labour limited the nurse's ability to establish a rapport and discuss birth plan expectations. Childbearing women want to establish a rapport with their L&D nurse early in labour so when labour intensifies they can rely on their nurse's personal care and expertise (Fleming, Smart & Eidie, 2012). The practice of labouring women on triage and/or nurses covering two active labouring patients during breaks impedes the nurse's ability to establish rapport and a trusting relationship and serves as a barrier to the enactment of birth plans.

L&D nurses viewed the healthcare team as experts in obstetrical care. Nurses' expertise allowed them to coordinate care and make selective autonomous decisions during the labour and birth process. Some birth plan expectations may be seen as restrictive and may challenge nurses and other healthcare providers to relinquish some autonomy and control in order to promote shared decision making with childbearing women. A patient safety culture promotes patients and families to be part of the healthcare team and there is a commitment to giving them

information (i.e. risks, benefits, and possible outcomes) that is clear and concise to help them make informed decisions about their care (CPSI, 2011; HCQA, 2010). Though observations were not in the patient rooms nurses shared how they discussed these with their patients to facilitate their ability to make an informed decision about their care.

Nurses admitted birth plan expectations were not always met but believed the goal of a safe outcome for mother and baby was a priority for their patients. They acknowledged a woman's birth experience was important but secondary to a safe outcome. Tension and conflict did occur at times when birth plan expectations were not met and/or the woman did not agree with interventions recommended by the healthcare team. Discussions would occur between the nurses, the childbearing woman, her family, and the physician in an attempt to resolve the conflict. Nurses believed women should agree with the healthcare teams' recommendations when the rationale and education was provided. The importance of the healthcare provider relationship with childbearing women cannot be underestimated as it is important to the childbearing woman's satisfaction in her birth experience (Hodnett, 2002). Kuo's et al. (2010) randomized control trial suggested birth plans developed and implemented in consultation with a healthcare providers positively affected a woman's fulfillment of childbirth expectations, sense of control, and impacted her overall birth experience.

Technologies such as EFM and epidural anaesthesia were seen as an integral part of care and have impacted the nurse's role on the birthing unit. Nurses shared how the increased use of technology has contributed to many nurses losing their labour support skills and has perpetuated a highly technological low-touch birthing culture; a move that has the potential to impact the connectedness between the woman, her support, and the healthcare provider. Labour support is described in the literature as the work of providing emotional support, physical comfort, and

advocacy (Barrett & Stark, 2010). Participants shared how nurses believe patients with epidural anaesthesia did not require their support or presence compared to those patients without epidural anaesthesia. These study findings are similar to Payant, Davies, Graham, Peterson, & Clinch (2008) who reported that nurses perceived labour support was not as needed when pain was relieved by epidural anaesthesia. This perception suggests nurses may view pain management as the primary component of labour support but not the emotional aspects of support.

Other studies have suggested nurses are spending less time (e.g. six to thirteen percent) performing supportive behaviours (Barnett, 2008; Gagnon & Waghorn, 1996; Gale, Fothergill-Bourbonnais, & Chamberlain, 2001; McNiven, Hodnett, & O'Brien-Pallas, 1992). The positive impact of labour support was reported in a recent Cochrane review (Hodnett, Gates, Hofmeyer, & Sakala, 2012). In this review continuous labour support resulted in more vaginal deliveries, less intrapartum analgesia, and woman were less likely to report dissatisfaction in their birth experience. The findings in this index study are consistent with authors in the literature who reported that the nurses' ability to provide labour support is influenced by the time managing technology (Zwelling, 2008) and the presence of a culture that is mechanizing and controlling birth through medical interventions (Barrett & Stark, 2010; Zwelling, 2008). The lack of resources (i.e. staff and space) reported by participants was seen to further increase the use of technology and detract from the L&D nurses' ability to develop rapport with their patient, discuss birth expectations, have the ability to provide consistent labour support, and enact birth plan expectations.

Despite the fact patients are considered key members of the healthcare team in a patient safety culture (AHS, 2013; CPSI, 2008; Salus Global, 2013) the current model of obstetrical care and the predominance of a risk aversive lens used by many providers influenced how and if

patients were encouraged to participate in making their own care decisions. Patient and family-centred care (PFCC) is based on the same principles of respect and dignity, information sharing, participation in decision-making and collaboration (CPSI, 2008). This collaboration with families is based on a respect for the knowledge and diversity a family brings as well as a respect for healthcare professionals and their expertise in care (Goldfarb, et al., 2010; Ochieng, 2003). Birth plan expectations allow patients to express their needs, and preferences surrounding their birth experience. They provide an opportunity for patients to share their expertise in their own healthcare while partnering with healthcare providers who are experts in the medical aspects of their obstetrical care. Nurses shared that options and choices for labour and birth were discussed with childbearing women, however, endorsement of the PFCC model of care that promotes a more active role for patients and families to enhance quality of care and patient safety (CPSI, 2012) was not always evident in their descriptions.

Summary

Women come to the birthing experience with beliefs and values and expectations of how they would like their birth experience to unfold. Similarly, nurses and other healthcare providers come to that care experience with values, beliefs, and expectations of how care should and ought to occur to ensure a safe delivery for mother and baby. It is at this intersection that the providers' expectations, the knowledge they bring to the experience, and the unit culture and context in which they work, influence their ability to fully enact a woman's birth plan.

Implications for Nursing Practice and Education

This research has implications for the way nurses are oriented to labour and childbirth. Cultural norms, values, beliefs, practices, and the model of care provided during childbirth are shared and learned during the orientation process. As Hong (2001) notes new graduates who

begin practice strive to adapt to the collective culture on the nursing unit. Consequently, the beliefs and practices that are learned on the unit have the potential to influence both how new graduates develop and define their own obstetrical practice and how they facilitate birth plan expectations.

Nursing and healthcare providers have an opportunity to consider their shared understandings around the philosophy, mission, and values within their unit and organization and how to promote it within the birthing unit. It is important to consider the messages that are conveyed to this new group of practitioners and how educators, managers, and senior leadership can help to convey key philosophies. It is important to consider how medical residents are also oriented into the culture of the birthing unit. These individuals are often placed in charge of managing the care of obstetrical patients and should be encouraged to develop collaborative relationships with the nursing staff as well as patients, families, and other healthcare professionals involved in obstetrical care.

Consideration should be given to the role transition of new graduates into the practice environment and how to address their feelings of anxiety, insecurity, inadequacy, and instability (Duchscher, 2008). Orientation programs for new graduates should include information about professional role transition. The inclusion of both senior and junior staff learning about transition shock and their intergenerational differences will increase understanding about the variances between them. As well, new graduate nurses look to senior nurses as experts in the field of obstetrics and value their knowledge and skill. Mentorship programs should be offered for senior staff to assist junior staff in the integration into the social network of the unit.

In a highly technological environment new hires can benefit from a focused orientation on basic competencies to allow for the gradual acquisition of skills as they gain practice

experience and transition from a novice to expert practitioner (Benner, 1982; Duchscher, 2008). Strategies such as simulation to mimic actual practice can be utilized to allow new learners to gain valuable skills in a non-threatening environment without risk of adverse outcome. As well, nursing leadership can engage with senior leadership to advocate for the allocation of resources to support supernumerary graduate positions to assist with the new graduate's transition into actual practice.

Promotion of a patient safety culture requires multiple strategies to affect practice. A safety culture consists of individual and group values, attitudes, competencies, and patterns of behaviour that support safety. A patient safety culture requires mutual trust, openness, honesty, fairness, and accountability while incorporating the principles of patient and family-centred care (PFCC) (CPSI, 2012). Reporting incidents and safety hazards are to be encouraged while taking a systems-focused approach to patient safety. Senior leadership need to foster and promote a Just Culture when addressing near misses and errors by both modeling behaviours that support it and setting expectations that a punitive and blaming environment is not acceptable. By examining events (i.e. near misses, no harm, and adverse events) and processes with a consistent no blame approach will demonstrate a commitment to a Just Culture. A fair and consistent team-based approach is required as well as a commitment to learning from and not disciplining honest mistakes (CPSI, 2012). Culture develops over time and needs to be fostered by all members to affect practice. This is essential to ensure individual nurses, especially new hires, are not fearful of reprimand, are open to changing processes and are willing to be involved in quality improvement initiatives that enhance safe obstetrical care.

Communities of practice foster ways for healthcare professionals to learn and work together which improves the quality and safety of patient care, improves job satisfaction, and

enhances retention and recruitment of staff (Salus Global, 2013). Strategies such as interprofessional learning activities (i.e. skills drills and emergency drills) and interprofessional policy and practice reviews contribute to mutual understanding while increasing trust and a collective knowledge within the team. Nurses spoke of interprofessional reviews and workshops and the researcher did witness frequent exchanges of perspectives regarding practice between nurses, obstetricians (OBs), general practitioners (GPs), and residents. There is a need to build on these practices and create other mechanisms for staff to relate to each other and share tacit knowledge thereby contributing to organization learning and knowledge that affects the everyday practice environment and improve outcomes (White, Suter, Parboosingh, & Taylor, 2008).

Consideration should also be given to the structural environment of the L&D unit and how the challenges related to space and resources detract from the L&D nurse's ability to enact birth plan expectations. A commitment to adequate staffing levels (one-to-one in active labour) and timely transfers to the L&D unit will allow nurses time and space to create a dialogue before, during and after birth to debrief the experience with their patients. This will not only provide valuable feedback regarding care provision on the obstetrical unit but also create conditions where all team members can discuss and assess their collective practice.

Although there are obvious challenges to building shared understandings between healthcare providers and childbearing women it is important to pursue strategies that can facilitate a respectful relationship while acknowledging varied perspectives and values (Simmonds, Peter, Hodnett, & McGillis Hall, 2013). The ability to create a space for dialogue, for a woman and her support persons to share birth plan expectations is required, but not easily created within the current culture. This dialogue needs to be meaningful for both her and the healthcare providers who care for her. Patients need to be involved in the planning,

development, and implementation of initiatives to enhance shared understanding of patient safety and obstetrical care. Enacting patient advisory councils or patient participation on quality and safety committees in healthcare organizations will serve to foster valuable insight and exchange of information between patients and health care providers (AHS, 2013; Institute for Patient & Family-Centred Care, 2010).

Nurses can advocate for birth plans by committing to strategies that facilitate a woman's ability to have choices and control in her birth experience. Strategies such as developing antenatal classes that are taught at the birthing unit so birth plan expectations can be discussed in relation to unit routines and practices, committing to reviewing birth plans when assuming care, developing a short plan if one is not already done upon admission, ensuring report and/or handoffs to other nurses includes discussion of birth plan expectations, and support women by being physically and emotionally present to work toward their goals for birth while providing safe care. The ability to understand their needs and desires while supporting their autonomy in birth will require a multifaceted approach to care.

In Alberta, various strategies are underway to enhance patient safety and provide quality care, while being efficient and fiscally responsible. The MORE^{OB} program is a provincially funded obstetrical patient safety where interprofessional teams are established to work and learn together to enhance team function and safety on the obstetrical unit. As well, the Health Quality Council of Alberta (HQCA) published a Patient Safety Framework for Albertans in 2010 to guide, direct, and support continuous and measureable improvements in patient safety. There are five key principles outlined in the framework: (1) patients are the primary focus, (2) organizations create a patient safety culture, (3) information about adverse events is shared in a transparent manner, (4) a systems approach to understand and address the complexity of factors

that contribute to error, and (5) a continuous improvement approach strengthens an organization's ability to use knowledge and make informed patient safety improvements (HQCA, 2010). This framework supports that patients should be informed and participate in their own care, as well as have a voice in their healthcare services (HQCA, 2010). It provides a medium by which healthcare providers can work with patients to identify structures and processes that act as barriers to quality care along with the strategies to mitigate their effects.

Nationally and internationally, there is a call for collaborative practice. A practice where multiple healthcare workers along with patients, families, and communities work together to deliver the highest quality of care (CIHC, 2010; WHO, 2010). Numerous reports have been published that provide direction and action-oriented strategies that support a change in culture from one of blame to one of support, a collective provider and organizational understanding of adverse events, and a collaborative model of healthcare delivery (CPSI, 2008, 2011,2012). However, changing culture is a slow and arduous process that involves education and engagement of both healthcare providers and patients in the development of a shared vision, agreed upon methods to minimize risk, and the development of tools and processes to enhance communication and collaboration in care.

Implications for Nursing Research

The findings from this study have shown that patient safety is a dominant driver of care. However, further research is needed to more fully understand how nurses practice within the L&D suite and how patients participate in care decisions that impact their labour and birth expectations. While this study was conducted in one birthing unit, to more fully understand the impact of culture a comparative study of birthing units across all the levels of hospitals providing obstetrical care would provide a rich description of birthing unit culture and those factors that

influence it. As well, a study examining the nursing care and interactions between L&D nurses, patients, and their families within birthing suites would provide more insight into the nurse's role in the enactment of birth plan expectations. In addition, nurses in the study spoke of their heightened surveillance of risks in labour and birth and more research is needed to describe what vigilance is and how it relates to assessment and intervention as well as the nurse's role in this practice setting (Meyer & Lavin, 2005).

Bruce et al (2002) suggests that working collaboratively requires trust, risk taking, and a willingness to let go of control on the behalf of health care professionals. While there are indications that a collaborative model of care in labour and birth has the potential to enhance safety and improve care for childbearing women and their families (Harris, et al., 20120; Salus Global, 2013) more research is needed to determine how this can be implemented given the multiple and competing perspectives that guide practice (Simmonds et al., 2013).

Limitations

The limitations of this study involve generalizability of findings to other sites or groups. This study was conducted in only one Level II birthing site in Alberta. The study did include observations and informal interview data from a variety of healthcare providers but the majority of observations and formal interviews focused on the L&D nurse and her role in labour and delivery. As well, L&D nurses may not have accurately reflected their conversations and interactions with patients in relation to birth plans. Observations occurred only in public areas within the birthing unit and not in L&D suites limiting the researcher from witnessing interactions between childbearing women and L&D nurses related to the enactment of birth plans. Discussions may have occurred involving birth plans and care may have incorporated each individual woman's wishes for birth, but were not observed during the study. Another

limitation is that the researcher was a novice researcher and therefore may have not recorded additional relevant observations or thoughts during the study. To mitigate this, field notes and a reflective journal were kept to capture as much data as possible and select members of supervisory committee reviewed field notes periodically during the study. In addition, the researcher is a labour and delivery manager. While the study was not conducted within the researcher's site of employment she did not bring a pure etic perspective to the study. To help minimize the impact of this limitation, strategies such as the acknowledgement of assumptions of the researcher was assisted by keeping a journal and frequent discussions with members of her supervisory committee throughout the study.

A Final Word

Birth plan expectations are developed with the ideal scenario in mind for a woman's birth experience. In obstetrical practice there is sometimes a divide and lack of shared understanding of what is considered to be best for patients amongst nurses, childbearing women, their families and other members of the healthcare team. If birth plan expectations are to be addressed and discussed in a meaningful way nurses require the time, space, and education to shift their current culture to one of collaborative practice involving all healthcare providers, childbearing women, and their families to work toward the provision of safe, quality care.

CHAPTER SEVEN

A Few Concluding Thoughts

Childbearing women are encouraged to complete a birth plan as part of their planning for childbirth. A birth plan can be in written or verbal form and contains a woman's wishes and preferences for her own birth experience. Birth plans were originally created to start a dialogue between a childbearing women and her healthcare provider. Research has focused on women's perceptions of birth plans with varying maternal and birth outcomes reported (Brown & Lumley, 1985; Deering et al., 2007; Ekeocha & Jackson, 1985; Jones, 1998; Moore & Hopper, 1995; Pennell et al., 2011; Whitford & Hillan, 1998; and Yam et al., 2007) and healthcare provider opinions that women with birth plans have worse obstetrical outcomes (Grant et al., 2010). Noticeably absent from the literature is perceptions of labour and delivery (L&D) nurses regarding birth plans and how they are enacted within an obstetrical unit. The purpose of this research study was to explore the every day practices of L&D nurses as they care for women with birth plans. The study took place in a Level II birthing unit in Alberta.

Focused ethnography was the methodology chosen to guide this study as it allowed for the exploration of common behaviours, experiences, values and beliefs of L&D nurses and examination of how the culture of a birthing unit shapes or informs the values and beliefs of L&D nurses have about birth plans. Data collection included participant observations, informal interviews with frontline staff, and formal semi-structured interviews with five L&D nurses. Analysis of the field notes and interview transcripts were completed using steps outlined by Roper and Shapira (2000) and were outlined in chapter three. Three themes emerged from the data: ensuring safe care, teamwork, and connecting with patients with the overarching theme of patient safety that drives and frames nursing practices on the L&D unit.

The researcher noted that written birth plans were not prominent in the care of labouring women and L&D nurses shared that most women come with a plan but choose to verbally express the plan at the point of care. Birthing unit culture influenced and shaped nursing priorities and care. The preceding chapters outlined aspects related to birthing unit culture such as the physical setting and the people who inhabit it (Chapter 4) along with the attributes that affect and shape the culture (Chapter 5). By examining the priorities of nursing care as discussed and enacted by the L&D nurses the researcher was able to begin to describe this culture and how birth plans are situated within it.

Pregnancy and childbirth are framed based on risk with patient safety as the primary driver of nursing care. Senior nurses played a key role in the acculturation of new hires and how they view childbirth and are socialized within the culture by the sharing of experiences, values, and beliefs; consequently the lens of the senior nurse can influence the practices of the new graduate. All nursing staff was expected to be skilled and knowledgeable while providing nursing care with little to no tolerance of events that reflected an uninformed practice. New hires expressed feelings of fear and self-doubt and a lack of knowledge and confidence as they began their career in L&D, yet few supports were noted during the study to assist in their transition from the ideal into actual practice.

Multiple strategies are needed to create a patient safety culture; the inclusion of patients as part of the team, learning and growing together activities, standardized policies and guidelines, and communication. While organizational influences (i.e. space, human resources, and unit processes) and individual healthcare provider preferences impact the degree in which these strategies are implemented, concerted efforts are required to mitigate their impact.

Labour and birth is complex and there are a multitude of factors that affect this experience. Birth plan expectations are known to be part of the nursing environment on the L&D unit and recent research has suggested they positively impacted a woman's childbirth experience, feelings of control, fulfillment of expectations, and a sense of mastery and participation in her own birth experience (Kuo et al., 2010). How a woman's birth plan can be considered as an integral part of care in light of a patient safety culture is complex and not a simple endeavour. L&D nurses are key providers of care in the L&D unit and are essential to assist women in reaching their goals for their birth experience. Enactment of key nursing strategies such as; acknowledging birth planning as important, creating a space to have a meaningful dialogue about choices in birth, and being present to support women in their birth experience are important to incorporate into care.

Childbearing women play a key role in their own patient safety and collaboration with them is beneficial to providing safe care. How to successfully partner with childbearing women and their families in childbirth is not clear and varies between practice environments. More research is needed to determine the best way to ensure safe quality care while partnering with childbearing women and their families in the creation and enactment of birth plans in childbirth.

There are multiple factors that enter into shaping a birthing unit’s culture. Challenges exist on how to incorporate childbearing women and their families as our partners to work toward the provision of safe care while assisting them in the goals of their birth experience. Collaboration is key as we strive to embrace a woman’s birth plan expectations to start the conversation and work toward shared understanding and partnership in childbirth.

References

Alberta Perinatal Health Program & Alberta Health Services. (2012). Provincial Perinatal Report 2010.

Alberta Health Services. (2013). AHS Quality and Patient Safety Strategic outline. Retrieved from http://www.albertahealthservices.ca/org/ahs-org-patient-safety.pdf

Alberta Health Services. (2013). AHS Strategic Plan. Retrieved from http://www.albertahealthservices.ca/org/ahs-org-image-strategic-direction.pdf

Alberta Health Services. (2013). Health Advisory Councils. Retrieved from http://www.albertahealthservices.ca/8327.asp

Aston, M., Saulnier, C., & Robb, K. (2010). Not just another delivery: women's maternity care experiences of provider client relationships. *Women's Health & Urban Life*, *9*(1), 32-49.

Baker, D. P., Day, R., & Salas, E. (2006). Teamwork as an essential component of High Reliability Organizations. *Health Services Research, 41*(4), 1576-1598. doi: 10.1111/j.1475-6773.2006.00566.x

Baker, G. R., Norton, P. G., Flintoft, V., Blais, R., Brown, A., Cox, J., Etchells, E., Ghali, W. A., Hebert, P., Majumdar, S. R., O'Beirne, M., Palacios-Derflingher, L., Reid, R. J., Sheps, S., & Tamblyn, R. (2004). The Canadian adverse events study: the incidence of adverse events among hospital patients in Canada, *Canadian Medical Association Journal*, *170*(11), 1678-1686. doi: 10.1503/cmaj.1040498

Barnett, G. V. (2008). A New Way to measure Nursing. *CIN: Computers, Informatics, Nursing*, *26*(4), 199-206. doi: 10.1097/01.NCN.0000304805.23499.3f.

Barrett, S. J., & Stark, M. A. (2010). Factors associated with Labour Support Behaviours of Nurses. *The Journal of Perinatal Education, 19*(1), 12-18. doi:10.1624/105812410X481528

Bashaw, E. S., & Lounsbury, K. (2012). Forging a new culture: blending Magnet principles with Just culture. *Nursing Management, 43*(1), 49-53. doi:10.1097/01.NUMA.0000419492.49675.25

Benner, P. (1982). From novice to expert. *The American Journal of Nursing*. *82*(3), 402-407. Retrieved from http://www.jstor.org/stable/3462928?origin=JSTOR-pdf.

Berg, M., Lundgren, I., & Lindmark, I. (2003). Childbirth experience in women at high risk: is it improved by the use of a birth plan? *The Journal of Perinatal Education, 12*(2) 1-15.

Brown, S. J., & Lumley, J. (1998). Communication and decision-making in labour: do birth plans make a difference? *Health Expectations, 1*, 106-116.

Bruce, B., Letourneau, N., Ritchie, J., Larocque, S., Dennis, C., & Eliott, M. R. (2002). A multisite study of health professionals' perceptions and practices of family-centered care. *Journal of Family Nursing*, *8*(4), 408-429. doi: 10.1177/10748402237515.

Cahill, H. A. (2001). Male appropriation and medicalization of childbirth: An historical analysis. *Journal of Advanced Nursing*, *33*(3), 334-342.

Canadian Doula Association, Registry, and Education. (2013). Retrieved from http://www.doulacare.ca/whatisadoula.cfm

Canadian Interprofessional Health Collaborative. (2010). National Interprofessional Competency Framework. Retrieved from http://http://www.cihc.ca/files/CIHC_IPCompetencies_Feb1210r.pdf

Canadian Institute for Health Information. (2004). Giving birth in Canada: A Regional Profile. Retrieved from https://secure.cihi.ca/free_products/GBC2004_regional_e.pdf

Canadian Patient Safety Institute (2011). Canadian Framework for Teamwork and Communication. Retrieved from http://www.patientsafetyinstitute.ca/English/toolsResources/teamworkCommunication/Documents/Canadian%20Framework%20for%20Teamwork%20and%20Communications.pdf

Canadian Patient Safety Institute (2012). Canadian Incident Analysis Framework. Retrieved from http://www.patientsafetyinstitute.ca/English/toolsResources/IncidentAnalysis/Documents/Canadian%20Incident%20Analysis%20Framework.PDF

Canadian Patient Safety Institute (2008). The Safety Competencies: Enhancing Patient Safety across the Health Professions. Retrieved from http://www.patientsafetyinstitute.ca/English/toolsResources/safetyCompetencies/Documents/Safety%20Competencies.pdf

Canadian Perinatal Programs Coalition (2009). Fundamentals of fetal health surveillance: a self-learning manual (4th ed.). Halifax: Canadian Perinatal Programs Coalition.

Carlton, T., Callister, C., Christiaens, G., & Walker, D. (2009). Nurses‘ perceptions of caring for childbearing women in nurse-managed birthing units. *Maternal Child Nursing*, *34*(1), 50-56. doi: 10.1097/01.NMC.0000343866.95108

Carlton, T., Callister, L., & Stoneman, E. (2005). Decision making in labouring women: Ethical issues for intrapartum nurses. *Journal of Perinatal & Neonatal Nursing*, *19*(2), 145-154.

Carter, M. A. (2009). Trust, power, and vulnerability: A discourse on helping in nursing. *Nursing Clinics of North America*, *44*, 393-405. doi: 10.1016/j.cnur.2009.07.012.

Chalmers, B., Kaczorowski, J., O'Brien, B., & Royle, C. (2012). Rates of interventions in labour and birth across Canada: Findings of the Canadian maternity experiences survey. *BIRTH, 39*(3), 203 - 210. doi: 10.1111/j.1523-536x.2012.00549.x

Coralan, M. C. (2007). Towards understanding the concept of risk for pregnant women: some nursing and midwifery implications, *Journal of Clinical Nursing, 18*, 652-658. doi: 10.111/J.1365-2702.2008.02480.x.

Deering, S. H., Heller, J., McGaha, K., Heaton, J., & Satin, A. J. (2006). Patients presenting with birth plans in a military tertiary care hospital: a descriptive study of plans and outcomes. *Military Medicine*, *171*, 778-780.

Deering, S. H., Zaret, J., McGaha, K., & Satin, A. J. (2007). Patients presenting with birth plans: a case-control study of delivery outcomes. *The Journal of Reproductive Medicine*, *52*(10), 884-887.

Duchscher, J. E. B. (2009). Transition shock: the initial stage of role adaptation for newly graduated Registered Nurses. *Journal of Advanced Nursing*, *65*(5), 1103-1113. doi:10.1111/j.1365-2648.2008.04898.x

Ekeocha, C. E. O., & Jackson, P. (1985). The 'birth plan' experience. *British Journal of Obstetrics and Gynaecology*, *92*, 97-101.

Fetterman, D. M. (2010). *Ethnography: step by step* (3rd ed.), Thousand Oaks, CA: SAGE Publications.

Fleming, S. E., Smart, D., & Eidie, P. (2012). Grand Multiparous women's perceptions of birthing, nursing care, and childbirth technology. The *Journal of Perinatal Education*, *29*(2), 108-117. doi: 10.1891/1058-1243-20.2.108

Gagnon, A. J., & Waghorn, K. (1996). Supportive care by maternity nurses: A work sampling study in an intrapartum unit. *BIRTH, 23* (1), 1–6. doi: 10.1111/j.1523-536X.1996.tb00453.x

Gale, J., Fothergill-Bourbonnais. F. & Chamberlain, M. (2001). Measuring nursing support during childbirth. *Maternal Child Nursing, 26*(5), 264-271.

Goldfarb, F. D., Devine, K. M., Yingling, J. T., Hill, A., Moss, J., Ogborn, E. S., Roberts, R. J., Smith, M. A., & Pariseau, C. (2010). Partnering with professionals: family-centered care from the parent perspective. *Journal of Family Social Work*, *13*(2), 91-99. doi: 10.1080/10522150903487081

Grant, R., Sueda, A., & Kaneshiro, B. (2010). Expert opinion vs. patient perception of obstetrical outcomes in labouring women with birth plans. *Journal of Reproductive Medicine*, *55*(1-2), 31-35.

Hadar, E., Raban, O., Gal, B., Yogev, Y., & Melamed, N. (2012). Obstetrical outcome in women with self-prepared birth plan. *The Journal of Maternal-Fetal and Neonatal Medicine, 25*(10), 2055-2057. doi: 10.3109/14767058.2012.678438

Halford, S. & Leonard, P. (2003). Space and place in the construction and performance of gendered nursing identities. *Journal of Advanced Nursing*, *42*(2), 201–208. doi: 10.1046/j.1365-2648.2003.02601.x

Hammersley, M. & Atkinson, P. (2007). *Ethnography: Principles in practice* (3rd ed.), London, UK: Routledge.

Hausmann, B. (2005). Risky business: framing childbirth in hospital settings. *Journal of Medical Humanities*, *26*, 23-38. doi: 10.1007/s10912-005-1050-3

Health Quality Council of Alberta. (2010). Patient Safety Framework for Albertans: Provincial Framework. Retrieved from http://www.hqca.ca/assets/pdf/Sept20/HQCA%20Patient%20Safety%20Framework%20081010.pdf

Hewison, A. (1993). The language of labour: an examination of the discourses of childbirth. *Midwifery, 9,* 225-234.

Hodnett, E. D. (2002). Pain and women's satisfaction with the experience of childbirth: A systematic review. *American Journal of Obstetrics & Gynaecology, 186,* S160-72. doi: 10.1016/S0002-9378(02)70189-0

Hodnett E. D., Gates S., Hofmeyr G., and Sakala C. (2012). Continuous support for women during childbirth. *Cochrane Database of Systematic Reviews*, Issue 3. CD003766. doi: 10.1002/14651858.CD003766.pub2

Hodnett, E. D., Lowe, N. K., Hannah, M. E., Willan, A. R., Stevens, B., Weston, J. A., Ohlsson, A., Gafni, A., Muir, H. A., Myhr, T. L., and Stremler, R. (2002). Effectiveness of nurses as providers of birth labour support in North American hospitals: A randomized control trial. *JAMA, 288*(1) 1373-1381.

Hong, G. (2001). Front-line care providers' professional worlds: the need for qualitative approaches to cultural interfaces. *Forum: Qualitative Social Research, 2*(3), 1-16. Retrieved from: http://www.qualitative-research.net/index.php/fqs/article/view/903

Institute for Patient & Family-Centered Care (2011). Patient and family-centered care core concepts. Retrieved from http://www.ipfcc.org/faq.html.

Jones, M. H., Barik, S., Mangune, H. H., Jones, P., Gregory, S. J. & Spring, J. E. (1998). Do birth plans adversely affect the outcome of labour? *British Journal of Midwifery, 6*(1) 38-41.

Kelly L. & Vincent, D. (2011). The dimensions of nursing surveillance: a concept analysis. *Journal of Advanced Nursing, 67*(3), 652-661. doi: 10.1111/j.1365-2648.2010.05525.x

Kuo, S., Lin, K., Hsu, C., Yang, C., Chang, M., Tsao, C., & Lin, L. (2010). Evaluation of the effects of a birth plan on Taiwanese women's childbirth experiences, control and expectations fulfillment: a randomized controlled trial. *International Journal of Nursing Studies, 47,* 806-814. doi: 10.1016/j.ijnurstu.2009.11.012

Leininger, M. (1995). *Transcultural nursing: Concepts, theories, research and practices* (2nd ed.). New York: McGraw-Hill.

Levitt, C.; Hanvey, L.; Avard, D.; Chance, G.; and Kaczorowski, J. (1995). Survey of Routine Maternity Care and Practices in Canadian Hospitals: Ottawa: Health Canada and Canadian Institute of Child Health.

Liva, S. J., Hall, W. A., Klein, M. C., & Wong, S. T. (2012). Factors associated with differences In Canadian perinatal nurses' attitudes toward birth practices. *Journal of Obstetric & Gynaecologic Nursing, 41,* 761-773. doi: 10.1111/j.1552-6909.2012.01412.x

Lothian, J. (2006). Birth plans: the good, the bad, and the future. *Journal of Obstetrical & Gynaecologic and Neonatal Nursing. 35,* 295-303. doi: 10.1111/j.1552-6909.2006.00042.x

Lundgren, I., Berg, M., & Lindmark, G. (2003). Is the childbirth experience improved by a birth plan? *Journal of Midwifery & Women's Health, 48*(5), 322-328. doi: 10.1053/S1526-9523(03)00278-2

MacKenzie Bryers, H. & van Teijlingen, E. (2010). Risk, theory, social and medical models: A critical analysis of the concept of risk in maternity care. *Midwifery, 26*, 488-496. doi: 10.1016/j.midw.2010.07.003

McNiven, P., Hodnett, E. & O'Brien-Pallas, L. L. (1992). Supporting women in labour: a work sampling study of the activities of labour and delivery nurses. *BIRTH, 19*(1), 3-8.

Meyer, G. & Lavin, M. A. (2005). Vigilance: the essence of nursing. Online Journal of Issues in Nursing, *10*(3), 1091-1103.

Moore, M. & Hopper, U. (1995). Do birth plans empower women? Evaluation of a hospital birth plan, *BIRTH*, *22*(1), 29-36.

Morse, J. M. (1994). *Critical issues in qualitative research methods*. Thousand Oaks: CA: SAGE Publications.

Motino Bailey, J., Crane, P., & Nugent, C. E. (2008). Childbirth education and birth plans. *Obstetrics and Gynaecology Clinics of North America, 35*, 497-509. doi: 10.1016/j.ogc.2008.04.005

Munhall, P. L. (2012). *Nursing research: a qualitative perspective* (5th ed.). Sudbury, MA: Jones & Bartlett Learning.

Newhouse, R., Dearholt, S., Poe, S., Pugh, L. C., & White, K. M. (2005). Evidence-based practice: A practical approach to implementation. *Journal of Nursing Administration, 35*(1), 35-40.

Ochieng, B. J. N., (2003). Minority ethnic families and family-centred care, *Journal of Child Health Care, 7*, 123-132. doi: 10.1177/1367493503007002006

Parry, D. C. (2008). “We wanted a birth experience, not a medical experience”: exploring Canadian women’s use of midwifery. *Health Care for Women International, 29,* 784-806. doi: 10.1080/07399330802269451

Payant, L., Davies, B., Graham, E. D., Peterson, W. E., & Clinch, J. (2008). Nurses’ intentions to provide continuous support to women. *Journal of Obstetric, Gynaecologic & Neonatal Nursing, 37,* 405-414. doi: 10.1111/j.1552-6909.2008.00257.x

Peart, K. (2004). Birth planning – is it beneficial to pregnant women? *Australian Midwifery, 17*(1), 27-9.

Pennell, A., Salo-Coombs, V., Herring, A., Spielman, F., & Fecho, K. (2011). Anaesthesia and analgesia-related preferences and outcomes of women who have birth plans. *Journal of Midwifery & Women’s Health, 56,* 376-381.

Peterson, W. E., Medves, J. M., Davies, B. L., & Graham, I. D. (2007). Multidisciplinary collaborative maternity care in Canada: Easier said than done. *Journal of Obstetrics & Gynaecology Canada, 29*(11), 880-886.

Pettker, C. M., Thung, S. F., Norwitz, E. R., Buhimschi, C. S., Raab, C. A., Copel, J. A., Kuczynski, E., Lockwood, C. J. & Funai, E. F. (2009). Impact of a comprehensive patient safety strategy on obstetric adverse events. *American Journal of Obstetrics & Gynaecology,* 200, 1.e1-1.e6. doi: 10.1016;j.ajog.2009.01.022

Polit, D. F. & Beck, C. T. (2008). *Nursing Research: Generating and Assessing Evidence for Nursing Practice* (8th ed.). Philadelphia, PA: Lippincott, Williams, & Wilkins.

Public Health Agency of Canada (2000). Family-Centred Maternity and Newborn Care: National Guidelines. Retrieved from http://www.phac-aspc.gc.ca/hp-ps/dca-dea/publications/fcm-smp/index-eng.php.

Regan, M. & Liaschenko, J. (2007). In the mind of the beholder: Hypothesized effect of intrapartum nurses' cognitive frames of childbirth caesarean section rates. *Qualitative Health Research, 17,* 612-624. doi:10.1177/1049732307301610

Richards, L. & Morse, J. (2007). *Readme first for a user's guide to qualitative methods* (2nd ed.). Thousand Oaks, CA: SAGE Publications.

Riley, W. (2009). High reliability and implications for nursing leaders. *Journal of Nursing Management, 17,* 238-246.

Roper, J. M. & Shapira, J. (2000). *Ethnography in nursing research.* Thousand Oaks, CA: SAGE Publications.

Salus Global Corporation (2013). Managing Obstetrical Risks Efficiently (MOREOB). Retrieved from http://www.moreob.com.

Sandelowski, M. (1995). Sample size in qualitative research. Research in Nursing & *Health, 18,* 179-183.

Sheridan, C. P., Yekinni, I., Oyeye, G., Ogunleye, K., Oluyede, G., O'Sullivan, K., Greene, R. A., & Higgins, J. R. (2011). Comparing birth plan preferences among Irish and Nigerian women. *British Journal of Midwifery*, *19*(3), 172-177.

Simkin, P. T. (1989). Childbearing in Social Context. *Women & Health*, *15*(3), 5-21. doi**:**10.1300/J013v15n03_02

Simkin, P. T. (1991). Just another day in a woman's life? Women's long- term perceptions of their first birth experience. Part I. *BIRTH*, *18*(4), 203–210. doi:10.1111/j.1523-536X.1991.tb00103.x

Simmonds, A., Peter, E., Hodnett, E. D., & McGillis Hall, L. (2013). Understanding the moral nature of intrapartum nursing, *Journal of Obstetric, Gynaecologic & Neonatal Nursing, 42*(2), 148-156. doi: 10.1111/15526909.12016

Society of Obstetricians & Gynaecologists of Canada (2007). Fetal Health Surveillance antepartum and intrapartum consensus guideline. *Journal of Obstetrics and Gynaecology, 29*(9), S3-S56. Retrieved from http://sogc.org/wp-content/uploads/2013/01/gui197CPG0709r.pdf.

Society of Obstetricians & Gynaecologists of Canada (2013). How to write a birth plan. Retrieved from http://www.sogc.org/health/pregnancy-birth-plan_e.asp

Springer, D. (1996). Birth pans: the effect on anxiety in pregnant women. *International Journal of Childbirth Education, 11*(3), 20-25.

Statistics Canada (2013). Births, estimates, by province and territory. Retrieved from http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/demo04a-eng.htm.

Statistics Canada (2013). From urban areas to population centres. Retrieved from http://www.statcan.gc.ca/subjects-sujets/standard-norme/sgc-cgt/notice-avis/sgc-cgt-06-eng.htm.

Streubert Speziale, H. J. & Rinaldi Carpenter, D. (2007). *Qualitative research in nursing: Advancing the humanistic imperative* (4th ed.). Philadelphia, PA: Lippincott Williams & Wilkins.

Tiedje, L. B. & Price, E. (2008). Childbirth is Changing: What Now? *Maternal Child Nursing, 33*(3), 144-150.

Too, S. K. (1996a). Do birth plans empower women? A study of midwives' views. *Nursing Standard, 10*(31), 44-48.

Too, S. K. (1996b). Do birth plans empower women? A study of their views. *Nursing Standard*, *10*(31), 33-37.

White, D., Suter, E., Parboosingh, I. J., & Taylor, E. (2008). Communities of practice: creating opportunities to enhance quality of care and safe practices. *Healthcare Quarterly*, *11*, 80-84. doi: 10.12927.hcq.2008.19654

Whitford, H. M. & Hillan, E. M. (1998). Women's perceptions of birth plans. *Midwifery*, *14*, 248-253.

Wood, M. J., & Ross-Kerr, J. C. (2011). *Basic steps in planning nursing research: from question to proposal* (7th ed.). Sudbury, MA: Jones and Bartlett Publishers.

World Health Organization. (2010). Framework for action on interprofessional education and collaborative practice. Retrieved from http://whqlibdoc.who.int/hq/2010/WHO_HRH_HPN_10.3_eng.pdf.

Yam, E. A., Grossman, A. A., Goldman, L. A., and Garcia S. G. (2007). Introducing birth plans in Mexico: An exploratory study in a hospital serving low-income Mexicans. *BIRTH*, *34*(1), 42-48.

Zwelling, E. (2008). The emergency of high-tech birthing. *Journal of Obstetric and Neonatal Nursing*, *37*, 85-93. doi: 10.1111/J.1552-6909.2007.00211.x.

Zwelling, E., & Phillips, C. R. (2001). Family-centered maternity care in the new millennium: is it real or is it imagined? *Journal of Perinatal & Neonatal Nursing*, *15*(3), 1-12.

Appendix A

Poster

UNIVERSITY OF CALGARY
NURSING

Nursing Unit Culture: Nurses and Birth Plans

My name is Sandi Sebastian and I am conducting a research study as my thesis project towards my Masters of Nursing at the University of Calgary.

Study Purpose: To study how birthing unit practices and routines influence how labour and delivery nurses incorporate birth plan expectations into their care.

Study Design: Exploratory focused ethnographic study

I need VOLUNTEERS – nurses who have knowledge related to this topic of study. Informed consent procedures will be followed and confidentiality is assured. Please take part in this important study that will explore the world of labour and delivery from the perspective of a labour and delivery nurse.

Please contact me at your earliest convenience if you are interested in participating in this study OR if you have questions.

E-mail: sjsebast@ucalgary.ca

Cell: 403-318-1814

Appendix B

Interview Demographic Information

Name	
Position Title	
Number of years of nursing experience	
Number of years of L&D experience	
Level of Education - Diploma	
Level of Education - Degree	
Level of Education - Advanced (midwifery)	

Appendix C

Consent for Observations

UNIVERSITY OF CALGARY
NURSING

TITLE: Birthing Unit Culture: Nurses and Birth Plans

SPONSOR: None

INVESTIGATORS:
Debbie White, RN PhD, Associate Professor and Associate Dean of Research
Faculty of Nursing, University of Calgary
Phone: (403) 333-5555
Email: dwhit@ulcagary.ca

Sandi Sebastian, RN, BScN, MN Student
Faculty of Nursing University of Calgary
Phone: (403) 318-1814
Email: tsseb@shaw.ca

This consent form is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, please ask. Take the time to read this carefully and to understand any accompanying information. You will receive a copy of this form.

BACKGROUND

Childbirth is a powerful life-changing event and has a lasting impact on a woman and her family (Lothian, 2006; Carlton, Clark Callister, & Stoneman, 2005).
Family-centred maternity care guidelines in Canada support women being an active participant in decisions related to their birth experience to ensure individualized care is delivered. A birth plan outlines a woman's expectations for her birth experience based on her individual

knowledge, experience, culture, and belief system. Healthcare providers have a challenging role in striving to adhere to a woman's birth plan while complying with hospital routines and practices.

An important step toward understanding birth plans is examining the labour and delivery nurse's perspective to determine how birth plans are defined and incorporated within their birthing unit culture. Studying unit culture and nurse's ways of knowing within their culture will bring new understanding to the dynamic environment and relationship between a labour and delivery nurse and a childbearing woman.

WHAT IS THE PURPOSE OF THE STUDY?

This purpose of this research project is to explore how birth plans are understood within a birthing unit, and the influences that facilitate or act as barriers to the utilization of birth plans as perceived by labour and delivery nurses.

WHAT WOULD I HAVE TO DO?

As a labour and delivery nurse, you will be asked to participate in an observation. The student researcher will observe you as you go about your everyday labour and delivery work but will not observe direct care within the labour and delivery suites. The observation will take place for 3-8 hour shifts during your usual scheduled shifts at your hospital. Although the student may ask questions in order to understand what you are doing or thinking as you work, you WILL not be interrupted or distracted while you are working with patients, families, visitors, or other healthcare providers, or with the various documents, information systems and records.
The student researcher may take some notes during the observation in order to capture the interactions or events that occur during this observation period. These notes will refer to the activities and texts that you are engaged in as part of your everyday work. Observations will help to describe and understand birthing unit culture and how birth plans may or may not be enacted on this unit.

WHAT ARE THE RISKS?

There are no identified risks to participating in this study. Although there are no foreseeable risks to you as a result of your participation in this research, being observed as you conduct your routine work may make you self-conscious. You may experience some feelings of vulnerability or anxiety. Your practice is not being judged or evaluated. The student researcher is only interested in learning from you as an expert in your work environment.

WILL I BENEFIT IF I TAKE PART?

Participating in this study may not directly benefit you, but first-hand knowledge of the facilitators and barriers within the unit culture may help other nurses gain awareness and insight related to birth plans and their use/non-use on this particular unit. It is hoped that you will find the observation an enjoyable experience.

DO I HAVE TO PARTICIPATE?

Your participation is voluntary. You do not have to answer any questions you do not wish to answer, and you may terminate the observation at any time. You may choose to withdraw from the study by informing the student researcher of your wishes.

WILL I BE PAID FOR PARTICIPATING, OR DO I HAVE TO PAY FOR ANYTHING?

Participants in this study will not be paid. Observations will take place during your routinely scheduled work, on a date and time that is convenient to you.

WILL MY RECORDS BE KEPT PRIVATE?

The student researcher will make notes about what is observed and recorded in a journal. This data will not contain information that links the observation directly to you. Your name and the names of any persons or organizations you mention will be deleted, altered, or replaced with pseudonyms

No personal identifying information will be collected for this study. Your participation in the observational component of this research study cannot be kept anonymous, as others in the unit may notice the student researcher observing your work. Your observations will not be singled out but rather collected on the unit as a whole.

Only the student researcher, the academic supervisors, and the University of Calgary Conjoint Health Research Ethics Board will have access to the field note data. After the research project is completed, any hard copy data will be shredded. The data will be stored electronically, on a password-protected site, for a period of twelve years, and then destroyed.

Descriptions of what the student researcher observed and quotes of what you said during the observation period may be used in any writing based on this research. This data and the quotes will be presented in a way that conceals your identity and the identity of the hospital in which you are employed.

IF I SUFFER A RESEARCH-RELATED INJURY, WILL I BE COMPENSATED?

In the event that you suffer injury as a result of participating in this research, no compensation will be provided to you by: the University of Calgary, Alberta Health Services – Calgary Zone or the researchers. You still have all your legal rights. Nothing said in this consent form alters your right to seek damages.

SIGNATURES

Your signature on this form indicates that you have understood to your satisfaction the information regarding your participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigators or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time without jeopardizing your health care. If you have further questions concerning matters related to this research, please contact:

Dr. Debbie White (403) 210-9627

If you have any questions concerning your rights as a possible participant in this research, please contact The Director, Office of Medical Bioethics, University of Calgary, at 403-220-7990.

Participant's Name	**Signature and Date**
Investigator/Delegate's Name	**Signature and Date**
Witness' Name	**Signature and Date**

The University of Calgary Conjoint Health Research Ethics Board has approved this research study.

A signed copy of this consent form has been given to you to keep for your records and reference.

Appendix D

Interview Guide

The interview will start with Grand Touring questions with the aim of moving to more specific questions based on what was discovered during participation observation phase of the research study.

1. What is a typical shift like on your labour and delivery unit?
2. What types of things influence your practice on any given shift?
3. What guides your practice in obstetrics?
4. Tell me about your experience on your unit when caring for women with birth plans?
5. What factors on your particular unit help to facilitate the adherence to birth plans?
6. What factors on your particular unit could be a barrier to the adherence of birth plans?

Appendix E

Consent for Interview

TITLE: Birthing Unit Culture: Nurses and Birth Plans

SPONSOR: None

INVESTIGATORS:

Debbie White, RN PhD, Associate Professor and Associate Dean of Research
Faculty of Nursing, University of Calgary
Phone: (403) 333-5555
Email: dwhit@ulcagary.ca

Sandi Sebastian, RN, BScN, MN Student
Faculty of Nursing University of Calgary
Phone: (403) 318-1814
Email: tsseb@shaw.ca

This consent form is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, please ask. Take the time to read this carefully and to understand any accompanying information. You will receive a copy of this form.

BACKGROUND

Childbirth is a powerful life-changing event and has a lasting impact on a woman and her family (Lothian, 2006; Carlton, Clark Callister, & Stoneman, 2005).

Family-centred maternity care guidelines in Canada support women being an active participant in decisions related to their birth experience to ensure individualized care is delivered.
A birth plan outlines a woman's expectations for her birth experience based on her individual knowledge, experience, culture, and belief system. Healthcare providers have a challenging role in striving to adhere to a woman's birth plan while complying with hospital routines and practices.
An important step toward understanding birth plans is examining the labour and delivery nurse's perspective to determine how birth plans are defined and incorporated within their birthing unit culture. Studying unit culture and nurse's ways of knowing within their culture will bring new understanding to the dynamic environment and relationship between a labour and delivery nurse and a childbearing woman.

WHAT IS THE PURPOSE OF THE STUDY?

This purpose of this research project is to explore how birth plans are understood within a birthing unit, and the influences that facilitate or act as barriers to the utilization of birth plans as perceived by labour and delivery nurses.

WHAT WOULD I HAVE TO DO?

As a participant in this study your involvement will include an interview and will take approximately 60 minutes of your time. This interview will take place away from the unit at a time and location mutually agreed upon by the researcher and participant. Written consent for participation in the interview will be obtained. The interview will be digitally recorded and transcribed into text for the researcher to review.

WHAT ARE THE RISKS?

There are no identified risks to participating in this study.

WILL I BENEFIT IF I TAKE PART?

Participating in this study may not directly benefit you, but first-hand knowledge of the facilitators and barriers within the unit culture may help other nurses gain awareness and insight related to birth plans and their use/non-use on this particular unit.

DO I HAVE TO PARTICIPATE?

Participation in the formal interviews is completely voluntary and confidential. You are free to discontinue participation at any time during the study.

WILL I BE PAID FOR PARTICIPATING, OR DO I HAVE TO PAY FOR ANYTHING?

Participants in this study will not be paid. Costs for parking to attend the interview will be reimbursed.

WILL MY RECORDS BE KEPT PRIVATE?

An audio recording of the interview will be made. The interview recording will be transcribed by the student-researcher. This transcript will not contain any information that links the interview with you or the hospital in which you work. Your name and the names of any people or organizations you mention will be deleted or replaced with pseudonyms and any identifying characteristics such as age, gender, and title will be altered.

No personal identifying information will be collected in this study. Only the student researcher, academic supervisors and the University of Calgary Conjoint Health Research Ethics Board will have access to the interview recordings and the transcripts made of the interview. After the research project is completed, the recording will be deleted and any hard copy data will be shredded as will field notes and observation notes. The transcript will be stored electronically, on a password-protected site, for a period of twelve years, and then destroyed.

Quotes from your interview transcript will be used in any writing the student researcher does based on this research. These quotes will be presented in a way that conceals your identity. Should you choose to withdraw from the research, due to how this data is collected, the researcher cannot guarantee that your contributions can be removed.

IF I SUFFER A RESEARCH-RELATED INJURY, WILL I BE COMPENSATED?

In the event that you suffer injury as a result of participating in this research, no compensation will be provided to you by: the University of Calgary, Alberta Health Services – Calgary Zone or the researchers. You still have all your legal rights. Nothing said in this consent form alters your right to seek damages.

SIGNATURES

Your signature on this form indicates that you have understood to your satisfaction the information regarding your participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigators or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time without jeopardizing your health care. If you have further questions concerning matters related to this research, please contact:

Dr. Debbie White (403) 210-9627

If you have any questions concerning your rights as a possible participant in this research, please contact The Director, Office of Medical Bioethics, University of Calgary, at 403-220-7990.

Participant's Name	**Signature and Date**
Investigator/Delegate's Name	**Signature and Date**
Witness' Name	**Signature and Date**

The University of Calgary Conjoint Health Research Ethics Board has approved this research study.

A signed copy of this consent form has been given to you to keep for your records and reference.

Appendix F

Descriptive Labels for Data Coding

(Roper & Shapira, 2000)

Setting: The environment or context
Activities: patterns of behaviour that occur with frequency
Events: rare and infrequent occurrences
Relationships and social structures: patterns of types of bonds between people
General perspectives: The group 's shared understandings
Specific perspectives on the research topics: Individual understanding of the phenomena of interest
Strategies: ways of achieving goals such as problem solving
Process: flow of events; transitioning or changes over time
Meaning: significance and understanding of behaviour
Repeated phrases: regularly occurring comments depicting patterns of thought