Maternity safety - Thematic analyses of stakeholder meetings

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Background: Adverse outcomes in maternity care prompted our group to host a series of stakeholder meetings to define the key issues facing maternity safety and to inform our focus for research as the Midlands Maternity Safety Research Centre.

Methods: Advertisements for stakeholders were placed through the RCOG, RCM, as well as through personal and professional contacts. Three stakeholder meetings were held over a period of 1 year. The first delineated the conditions of interest, the second refined the tools stakeholders felt could improve patient safety and the third, provided a progress update.

Results: Stakeholders comprised of obstetricians (2-3/ meeting), neonatologists (1-2 per meeting), an obstetric physician and members of the public (3-4 per meeting) [Total 6-9 per meeting]. The first stakeholder meeting concluded that conditions pertinent for prioritisation included maternal mental health, venous thromboembolism and medications management. Panel members felt strongly that technology was not being used optimally and discussed tools currently used. At the second meeting, we presented decision support tools within electronic maternity records for mental health and VTE. Panel members commented on the accuracy and usability of VTE risk assessment. There was a perception that the patient was not an active participant in their maternity notes. The panel felt that it was important to explore usability. At the final meeting, we outlined the protocols for evaluating maternity notes as an entity and discussed its evaluation for mental health.

Conclusions: Stakeholder meetings prioritised mental health, VTE and electronic maternity notes for further evaluation for patient safety and the themes included: Interoperability (between neonatal and maternity, maternity-GP settings and maternity-other specialities), Customisability, Usability (both from the patient and clinician perspectives), Digital literacy and the impact of digital poverty. Suggestions for improvement with regards to medicines management included an alert system that could be transferred to the GP setting and inform/ advice about childhood vaccination schedules

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ABSTRACT

Adverse outcomes in maternity prompted our group to host a series of stakeholder meetings to define the key issues facing maternity safety and to inform our focus for research as the Maternal health theme of the Midlands Patient Safety Research Collaboration.

METHODS: Advertisements for stakeholders were placed through the RCOG, RCM, as well as through personal and professional contacts. Three stakeholder meetings were held over a period of 1 year. The first delineated the conditions of interest, the second refined the tools stakeholders felt could improve patient safety and the third, provided a progress update.

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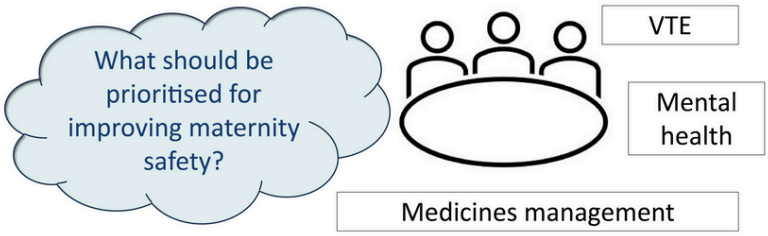
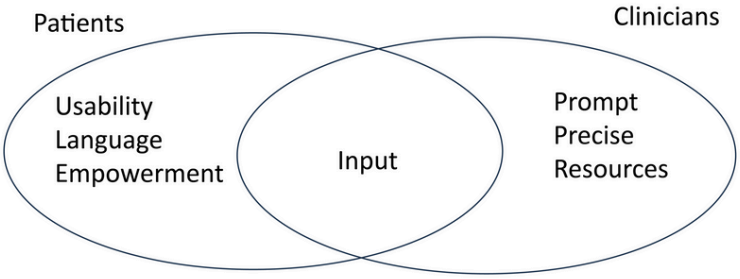
CONCLUSIONS: Stakeholder meetings prioritised mental health, VTE and electronic maternity notes for further evaluation for patient safety and the themes included: Interoperability (between neonatal and maternity, maternity-GP settings and maternity-other specialities), Customisability, Usability (both from the patient and clinician perspectives), Digital literacy and the impact of digital poverty. Suggestions for improvement with regards to medicines management included an alert system that could be transferred to the GP setting and inform/ provide advice about childhood vaccination schedules.



Stakeholders felt that decision support should incorporate:

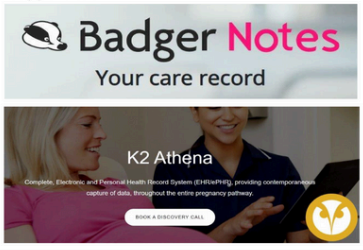


Stakeholders' responses about their knowledge of decision support:

Most were able to describe the decision support tools embedded within their local electronic maternity record, but some were unaware or felt that these were limited.

Electronic maternity notes

Since 2015, there has been a drive to increase the use of electronic maternity notes and a number of these exist. Stakeholders felt that there was an opportunity therefore, to evaluate their use with regards to improving patient safety. The Tommy's app for example is a decision support tool



Follow up actions following stakeholder reviews

The three stakeholder meetings were informative, and we designed:

1. A protocol to undertake a qualitative study of patients and clinicians' views about the use of electronic maternity notes and the use of prompts to support decision making.
2. A protocol to evaluate current clinical practice with regards to maternal mental health within the context of risk assessment, prompts and escalation.

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Scan this and tell me what you think about electronic maternity notes!

This QR code will take you to MentiMeter where you can list 3 things about electronic maternity notes and how it can improve patient safety.

This QR code will take you to MentiMeter where you can vote about whether electronic maternity notes can be used to improve patient safety

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