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Incidents in the care provided to parturient women and newborns: the perspective of nurses and physicians

Incidentes na assistência das parturientes e recém-nascidos: perspectivas das enfermeiras e médicos

Incidentes en la assistencia de parturientas y recién nacidos: perspectivas de las enfermeras y médicos

Giullia Taldo Rodrigues[1]

Adriana Lenho de Figueiredo Pereira[1]

Priscila da Silva Almeida Pessanha[1]

Lucia Helena Garcia Penna[1]

1. Universidade do Estado do Rio de Janeiro (UERJ). Rio de Janeiro, RJ, Brasil.

Abstract

Objective: to describe the incidents in the care provided to parturient women and newborns, their contributing factors, and preventive measures, from the perspective of nurses and physicians. **Method**: qualitative study conducted in a public maternity hospital in the city of Rio de Janeiro, RJ, Brazil, with a registered Patient Safety Center. Interviews were held with 18 nurses and physicians working at the obstetric center and two nurses from the patient safety center, from February to April of 2019. The Thematic Content Analysis and Patient Safety references were used. **Results**: the main incidents were errors in patient identification, mother and newborn falls, and harmful events caused by inappropriate practices, disrespect and mistreatment of parturient women, lack of incident reporting, insufficient personnel and resources, limited knowledge of the team, and lack of support on the part of management to patient safety actions. Preventive measures are needed to adjust and improve the care structure, process, and management. **Conclusion and implications for practice**: the incidents are errors and harm, the prevention of which requires qualification of the care process and structure, the commitment of professionals and managers to patient safety, and changes in the organizational culture that also encompass coping with institutional obstetric violence.

Keywords: Patient Harm; Parturition; Patient Safety; Organizational Culture**;** Quality of Health Care.

Resumo

Objetivo: descrever os incidentes na assistência das parturientes e recém-nascidos, seus fatores contribuintes e medidas preventivas na perspectiva das enfermeiras e médicos. **Método**: pesquisa qualitativa em maternidade pública do Município do Rio de Janeiro, com Núcleo de Segurança do Paciente registrado. Realizaram-se entrevistas com 18 enfermeiras e médicos atuantes no centro obstétrico e duas enfermeiras integrantes desse Núcleo, de fevereiro a abril de 2019. Utilizaram-se referenciais da Análise de Conteúdo Temática e Segurança do Paciente. **Resultados**: os principais incidentes são erros na identificação dos pacientes, quedas da mãe e do bebê e eventos danosos causados pelas práticas inadequadas; desrespeito e maus-tratos às parturientes; ausência de notificações dos eventos; restrições de pessoal e recursos; limitações no conhecimento da equipe e apoio da gestão às ações de segurança do paciente. As medidas de prevenção são pertinentes às adequações e às melhorias da estrutura e processo de assistência e gerência dos cuidados. **Conclusão e implicações para a prática**: os incidentes são erros e danos, cuja prevenção requer qualificação do processo e estrutura da assistência, comprometimento dos profissionais e gerentes com a segurança das pacientes, e mudanças na cultura organizacional que também abarquem o enfrentamento da violência institucional obstétrica.

Palavras-chave: Dano ao Paciente; Parto; Segurança do Paciente; Cultura Organizacional; Qualidade da Assistência à Saúde.

Resumen

Objetivo: describir incidentes en el cuidado de parturientas y recién nacidos, los factores que contribuyen a ellos y las medidas preventivas para evitarlos, desde la perspectiva de enfermeras y médicos. **Método**: investigación cualitativa en una maternidad pública del municipio de Río de Janeiro que cuenta con un Núcleo de Seguridad del Paciente registrado. Se realizaron entrevistas a 18 enfermeras y médicos que trabajan en el centro obstétrico y dos enfermeras que forman parte del NSP, entre febrero y abril de 2019. Se utilizaron como referencia los aportes del Análisis de Contenido Temático y de Seguridad del Paciente. **Resultados**: los principales incidentes corresponden a errores en la identificación de los pacientes, caídas de la madre y el bebé y eventos dañinos causados por prácticas inadecuadas; falta de respeto y maltrato a las parturientas; ausencia de notificaciones de los eventos; restricciones de personal y recursos; limitaciones en los conocimientos del equipo y en el apoyo a la gestión de las acciones de seguridad del paciente. Las medidas de prevención son relevantes para los ajustes y mejoras en la estructura, el proceso y la gestión de los cuidados. **Conclusión e implicaciones para la práctica**: los incidentes son errores y daños, cuya prevención requiere la evaluación del proceso y la estructura de los cuidados, el compromiso con la seguridad de los pacientes por parte de los profesionales y gestores, además de los cambios en la cultura organizacional, que incluyen el enfrentamiento a la violencia obstétrica institucional.

Palabras clave: Daño al paciente; Parto; Seguridad del Paciente; Cultura Organizacional; Calidad de la Atención de Salud.

Corresponding author:
Adriana Lenho de Figueiredo Pereira.
E-mail: adrianalenho.uerj@gmail.com.

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INTRODUCTION

The World Health Organization (WHO) considers patient safety an essential dimension of the quality of care delivery, intended to reduce harmful incidents associated with health care and improve health indicators. Quality is achieved when the best possible outcomes and experiences are obtained, while patient safety is intended to avoid errors and harm associated with health care as much as possible. Thus, poor quality care corresponds to poor safety and failure to obtain successful outcomes and avoid preventable harm to patients.[1-3]

The assessment of health care quality comprises an analysis of the structure, process, and outcomes of care delivery. The structure includes the resources and material necessary to provide care, the process involves the professionals' care practice, and the outcomes reflect the adequacy level of the care structure and process. Continuous assessment of quality enables fixing mistakes before they happen and result in incidents, thus, act preventively.[3,4]

Note that an incident is a preventable event or circumstance that may or may not harm a patient. A no-harm incident involves reportable circumstances, which are any event, situation, or process with significant potential to harm, such as communication failure, inadequate personnel, and deficient equipment maintenance. When an incident is detected before reaching a patient, it is called a near miss. Finally, harmful incidents or adverse events (AE) necessarily cause some physical, psychological, or social harm to patients.[4,5] The prevalence of AE in obstetrical care units is estimated between 1% and 4%.[3,4]

The search for quality and appropriate care provided to childbirth is essential to decrease maternal mortality. The promotion of safe maternity based on quaternary prevention, that is, without iatrogenesis or harm, is a promising approach in decreasing morbidity and mortality and improving the satisfaction of women with care delivery.[6]

Brazil has established policies and programs in this direction, such as the creation in 2013 of the *Programa Nacional de Segurança do Paciente (PNSP)* [Patient Safety National Program] to promote advancements in the quality and safety of the health care delivered to the population. Thus, all health services were required to implement a Patient Safety Center (PSC) to promote and support patient safety institutional actions.[3,5]

After the creation of the Patient Safety National Program, the ANVISA (Brazilian Regulatory Agency) of the Ministry of Health, released in 2014 a reference document for maternal and neonatal healthcare services, aiming to address the specificities of the health field, advancing in the prevention of adverse outcomes accruing from the healthcare process, and improving health indicators of this segment of the population.[6]

Despite these governmental actions, inadequate practices remain, negatively impacting the quality and safety of care delivery and maternal and neonatal outcomes. The rates of C-sections and unnecessary interventions in vaginal deliveries remain high, negatively impacting maternal mortality in Brazil.[7,8]

In addition to these challenges, it was verified that 2% of 10,000 puerperal women received no-harm care, while the prevalence of preventable incidents, such as episiotomy, was high (87.7%), along with C-sections (55.4%), and the hospitalization of infants born at term in Intensive Neonatal Care Units (NICU) (7.7%), revealing there is an urgent need to improve the safety and quality of maternal care.[6,8]

Given these problems associated with the safety and quality of childbirth care and programmatic actions to decrease harmful incidents among women and their children, the following question guided this study: what are the incidents in the care provided to parturient women and newborns, their factors, and preventive measures, from the perspective of nurses and physicians?

This study's objective was to describe incidents in the care provided to parturient women and newborns, their contributing factors, and preventive measures according to nurses and physicians.

METHOD

This qualitative and descriptive study was conducted in a large-sized public maternity hospital in the city of Rio de Janeiro, RJ, Brazil. It is a referral facility for habitual-risk pregnant women and those with associated morbidity, providing care to more than 5,000 births/year, according to the institution's systematized birth data.

This facility was selected because it is listed in the ANVISA website among the health services that have a Patient Safety Center (PSC) and also because it has obstetric nurses assisting normal childbirths. The PSC in this maternity service was created in the second semester of 2016 but was not regularly functioning at the time of data collection, i.e., from February to April 2019.

The study's participants were nurses and physicians working in the facility's Obstetrical Center (OC) and PSC. The following inclusion criteria were adopted: being a nurse or physician providing care to parturient women in the OC and/or be a member of the PSC team. Professionals working for six months or less in these sectors were excluded.

To recruit the nurses and physicians, two members of the research team explained the study's objectives to the heads of the facility and the OC before data collection. This oral explanation was provided at the time of data collection, and whenever necessary, to encourage adherence of these workers to the study.

The professionals were intentionally selected according to their involvement or leadership role in the care provided in the OC and/or actions within the PSC. The proportional representativeness between the OC teams was considered, first recruiting those who have worked longer for the institution, and verifying their availability to grant an interview in the work environment.

After providing clarification of the study's objectives to each worker selected, inclusion and exclusion criteria were verified. Some participants asked to schedule a time in advance, and no one refused the interview. Interviews were individually held during breaks from work, in a private area in the hospital's premises, or the staff's meeting room.

A semi-structured script was used to characterize the participants' professional profile, and six open questions addressed the actions developed within the PSC; the reasons for the occurrence of incidents in childbirth care; the types of harm caused to women and babies at the time of delivery; incident reporting on the part of the team; and preventive measures and actions necessary to provide safe care to women and babies.

The primary author, member of the research team, was previously trained to conduct the interviews, which were supervised by a more experienced Ph.D. researcher, who checked the recorded interviews and respective transcriptions. Afterward, the analysis *per se* was conducted according to Thematic Content Analysis (TCA) proposed by Lawrence Bardin.[9]

In the TCA's pre-analysis, each report was transcribed, organized, and read with floating attention to identify the excerpts pertinent to the study's purposes. Subsequently, the material was explored by grouping units of meaning according to the semantic equivalence of codes, from which thematic categories emerged. When new codes or themes ceased to emerge from this stage of the analysis, the interviews were interrupted. Two members of the research team, not participating in the collection of data, checked these steps. Finally, the results were treated according to interferences and interpretations,[9] guided by the Patient Safety concepts and assumptions applied to the care provided to labor and childbirth.

This study complied with ethical principles and was approved by the Institutional Review Board at the State University of Rio de Janeiro (Opinion report No. 2.533.376 and CAAE No. 81896117.0.0000.5282). All the participants signed free and informed consent forms and were identified according to their profession, sector, and order in which Interviews (I) were provided, for instance, OC Nurse, I1; OC Physician, I2; PSC Nurse, I3; and so on.

RESULTS

Of the 20 participants, 12 nurses working in the OC composed a group of six nurses providing general nursing care and six obstetrical nurses responsible for providing care to labor and normal childbirth. These workers are aged between 24 and 51 years old and had worked from one to 25 years in the maternity hospital, with an average of 6.9 years; most were women. Of the six physicians working in the OC, most were male, four were obstetricians, and two were pediatricians. These workers are aged between 27 and 68 years old, working from 1.5 to 27 years, 10.4 years on average.

The two nurses working in the PSC since its creation are women aged 41 and 42 years old and specialists in the field of Public Health; one is also a specialist in Patient Safety. These professionals have worked in the facility for seven and 16 years.

Two categories emerged from the TCA and are described as follows: safety incidents and factors that contribute to their occurrence among parturient women and newborns, and measures to prevent incidents in the care provided to labor and childbirth.

Safety incidents and factors that contribute to their occurrence among parturient women and newborns

The nurses and physicians characterize the incidents as errors or failures occurring during the care provided to women and their children at the time of labor and childbirth, being related to falls; a failure in patient identification; medication or prescription errors, and a lack of or incomplete care records, as the following reports show.

> *[...] I think that the main incident refers to the fall of babies and mothers, the most common really* (OC Nurse, I12)
>
> *[...] I don't recall experiencing it here, but I've heard about change of medications and of a patient who fell from the gurney [...].* (OC Physician, I10)
>
> *[...] Incident is a matter of patient identification; sometimes patients are not properly identified [...]. There has been the prescription of a patient that was changed by the one of another patient [...].* (OC Nurse, I14)
>
> *[...] I recall a recent situation in which there was a mistake in recording vaccination, a baby was vaccinated on one day and received another [dose] on the following day* (PSC Nurse, I16)

Harmful incidents or AE among women and newborns were characterized as physical harm, mainly accruing from inappropriate knowledge and professional behavior and practice, such as unnecessary or poorly indicated obstetric interventions or maneuvers that cause traumatic injuries, and sometimes result in severe outcomes for mothers or babies.

> *[...] I think negligence is the main factor, but, sometimes, it's lack of information on the part of the workers.* (OC Physician, I9)
>
> *[...] There is an excess of interventions with women [...]. Harm is caused to the baby; I believe that it is related to the administration of oxytocin and maneuvers performed during delivery* (OC Nurse, I3)
>
> *[...] I guess that it is lack of quality of care, basically. Sometimes, women are left waiting when the facility is full [...], so, some harm and incident may occur.* (OC Nurse, I5)

In addition to these incidents, the reports highlight situations of obstetrical institutional violence women experience during labor and which may cause emotional or physical harm, as the nurses and physician report.

> *[...] It is falls and obstetric violence [...]. It is obstetric violence when workers apply the Kristeller's maneuver, for instance, and the baby has a clavicle fracture or injury of the [brachial] plexus.* (OC Nurse, I13)

> *[...] What happens is what's called obstetric violence. We realize some workers are unaware of humanized childbirth and say things we consider violent to parturient women* (OC Nurse, I18)

> *[...] So, you may experience all kinds of harm: harm to the perineum and emotional harm, and also harm to newborns depending on the inappropriate practices performed at the time of childbirth.* (OC Physician, I6)

Some participants characterize the women's social and clinical problems as incidents, being related to maternal associated risks and complications, such as morbidities before pregnancy, lack of access to prenatal care, and lack of a social support network.

> *[...] Harm includes risks associated to labor [...] laceration, pressure "peak", patient decompensation [...], arrest disorders, failure of uterine nervi-motor power [...]. Some patients do not have a companion [...], and when they do, the family is poorly structured [...], and there are those women who don't even attend prenatal care [...].* (OC Physician, I4)

> *[...] In reality, there are varied reasons for a patient's complication such as preeclampsia, diabetes, and comorbidities associated with the pregnancy. [...] The most complicated issue is not having a maternal ICU (within the maternity facility) to compensate these patients.* (OC Physician, I2)

From the workers' perspective, the deficiencies in the service's structure and process corroborate to the occurrence of incidents such as the interruption of the PSC activities; absence of protocols, surveillance, and reporting of incidents; deficiencies in terms of professional qualification, insufficient human resources, and equipment.

> *[...] I think there is a lack of a specific work to better instruct people for these errors not to occur [...], protocol as well as training the staff is important.* (OC Physician, I10)

> *[...] our PCP beds [Prepartum, Childbirth and Postpartum] are almost all broken, the wheelchairs are old, and [...] it increases the risk of accidents and patient falls.* (OC Nurse, I12)

> *[...] I noticed difficulties in developing actions [within the PSC] because we were unable to ensure that people really focus on this.* (PSC Nurse, I16)

> *[...] At the moment, we do not have specific actions within the PSC [...], but there was an effective action in the implementation of the correct patient identification protocol.* (PSC Nurse, I17)

In addition to these organizational limitations, the nurses' and physicians' reports express limited knowledge regarding patient safety and a lack of knowledge regarding the facility's PSC and incidents as reportable events.

> *[...] The main action I know is patient identification [...], but also not leaving the baby on the bed and having a baby crib to accommodate him.* (OC Nurse, I5)

> *[...] So... I've never been introduced to the Patient Safety Center here* (OC Nurse, I.20)

> *[...] I don't know, but if there is (incident reporting) I'm not aware of because it never happened to me, so, I've not even tried to learn about it.* (OC Physician, I7)

Improvement in the process and structure to prevent incidents in the care provided to labor and childbirth.

Incident preventive measures, from the perspective of nurses and physicians, involve improving the care provided to parturient women and their children, such as adapting care through the use of best practices and qualifying care and team communication.

> *[...] I think that preventive measures mainly focus on the quality of care [...]. So, it is observing the golden hour and performing the auscultation correctly, as recommended by the WHO.* (OC Nurse, I5)

> *[...] Best practices are interconnected with safety [...]. So, preventive measures include welcoming and identifying women; proper recording [...]; proper flow regarding the line of care; and communication between workers to be successful in the care provided.* (OC Nurse, I20)

> *I guess that guidance is the main thing, providing good guidance to mothers and the team [...]. Not only preventing incidents, but also promoting health during prenatal care [...], explaining how labor takes place [...] and care provided to the mother, baby, and later with the pediatrician [...] and so on.* (OC Physician, I4)

In addition to these measures, the participants also consider that the prevention of incidents demands improvements in the process and structure of care delivery, such as the qualification of workers; communication protocol; a qualified work process; women-centered care; incidence surveillance; management involved with patient safety; PSC functioning; appropriate resources; equipment maintenance; and personnel that is sufficient to meet the demand of care.

> *[...] Having more resources, medications, exams, and workers in the institution, [...] understanding the protagonism of women, and the presence of companions [...], we need to work effective communication, it is urgent to have a communication protocol, but we need an operating Center, you know.* (OC Nurse, I15)

[...] Preventive measures are of a personal nature; workers need to keep updated, with a continuous habit of studying and seeking the literature and attending congresses. (OC Physician, I6)

[...] I think that working with indicators is important because they show what managers need to look at to improve the work process [...] and reduce harm. (PSC Nurse, I16)

[...] Training the team and reflecting about the practice [...] focusing on patient-centered care [...], but the management needs an agenda that gives priority, involving all the managers of this service. (PSC Nurse, I17)

DISCUSSION

The errors and adverse events are one of the greatest challenges faced in health systems worldwide. It is estimated what one in every ten patients experience an AE during hospital care, most of which are preventable. Harmful events prolong hospital stay and may lead to death.[10]

The accumulated incidence of AE in 41 maternity hospitals in Spain is estimated at 3.6%, the causes of which were surgical interventions or procedures (59.4%), and administration of medication (12.5%). These harmful events prolonged hospital stay and caused readmission among 13.3% of the women, though they did not cause severe maternal morbidity or death.[11]

Most of the incidents reported in a Brazilian public maternity facility originated from obstetrical clinical care (45.8%), prepartum (19.3%), and NICU (15.1%) in the period from 2017 to 2019. The incident most frequently reported was errors in the identification of women (27%) and neonates (18.4%), followed by the omission of care or medication dose (16.9%); falls among newborns (15.3%) and women (10.8%), and lack of hospital material (8.4%).[12] These types of incidents were also highlighted by the nurses and physicians interviewed in this study.

The correct identification of patients is essential in preventing incidents and improving patient safety. Another Brazilian public maternity hospital verified that 10% of the admitted women were exposed to a potential risk of errors because their first and last names were identical. One Brazilian hospital estimated a rate of 7.8% of incorrect identification of babies in its neonatal unit. Thus, institutional and professional competencies should be developed to improve the use of effective identification bracelets, including the active participation of mothers and their companions.[13]

Patient falls are the most frequently reported incident in British hospitals, the average rate of which is 6.63 falls/1,000 days of occupied beds with a frequency from 30% to 50% of physical injuries and from 1% to 3% of fractures, especially among elderly individuals.[14] Among newborns, from 1.6 to 4.4 falls/10,000 births are estimated in American hospitals, in which maternal fatigue is the main contributing factor, followed by hospital equipment such as hospital beds and cribs. The nurses and physicians interviewed here also mentioned that these events are frequent. In addition to the risks posed to the health of newborns, from minor injuries to death, falls cause emotional distress and dissatisfaction among mothers, as well as feelings of guilt and fear of reprimands or lawsuits on the part of workers.[15]

In addition to these negative repercussions, severe adverse events during labor and childbirth may have a catastrophic and lasting effect on the lives of mothers or children. It is estimated that 5% of the pregnant women experienced problems in the quality of care provided to labor and childbirth in American hospitals, most of which were associated with professional errors (87%) and, therefore, are classified as preventable incidents.[16]

Despite the severe injuries or traumas caused in the organic system of patients being associated with AE, the nurses and physicians consider that a lack of respect and mistreatment are behaviors associated with institutional violence and cause emotional and physical harm during labor. A negative experience during labor may have profound debilitating effects on women's self-esteem and mental health; contributing to the risk of postpartum depression and posttraumatic stress disorder, impacting maternal attachment and bonding, in addition to affecting subsequent reproductive decisions, such as giving up having another child, postponing a future pregnancy, fearing normal childbirth, and having a preference for a C-section in the next pregnancy.[1,17]

Therefore, debates and studies on patient safety need to address disrespectful and potentially iatrogenic behaviors, attitudes, and practices among parturient women and newborns. The nurses and physicians suggest that there are a potential correlation and synergetic effects between institutional violence and safety patient problems.

Institutional violence during labor is a critical problem in Brazilian obstetrical care and other countries. One study with 2,138 American women verified that one in every six women experience disrespect and mistreatment, such as loss of autonomy; screams, reprimands, or threats on the part of workers; and a perception of being ignored and having their requests for help disregarded. Mistreatment reports are more frequently reported when childbirth occurs in a hospital than in the women's home or in a normal childbirth center, as well as more frequent among indigenous, Latin and Afro-descendent women compared to Caucasians.[18]

Therefore, pregnant women are exposed to risk and harm accruing from inappropriate, disrespectful, discriminatory, and iatrogenic care, which demands that the promotion of respectful maternal care, based on human rights, focused on people's dignity be a priority as well as on the need to include sensitive and reliable indicators to measure abuse and mistreatment during labor, in order to enable changes in unsafe healthcare contexts, practices, and culture and related to violence against women.[6,8]

Given this challenging context, policies have been proposed to promote a positive safety culture in health.[5,8] The organizational culture is a critical factor in advancing the intended improvements, considering there is a tendency to accept the cultural standards established in health care. The culture in the organizations is expressed as "this is the way it is done" and "what one chooses to tolerate," thus, it is correlated with the results expected to be achieved.[19]

Patient safety is related to organizational culture as it promotes team engagement, favors relevant changes, and recognize care as a complex adaptive system that results from different processes and implicated actors. Therefore, positive patient safety culture values correct and successful outcomes, learning with errors, participation in the resolution of failures in the care process, and active collaboration in improvement actions.[16,19]

From this perspective, safety and quality contemplate essential components such as evidence-based clinical guidelines and standardized verification lists; efficient communication processes and change of responsibility between workers for continuing patient care; engaged, cooperative, and respectful teamwork; continuous education and professional qualification, including simulations; and commitment on the part of managers with safety and quality improvement actions within the institution. The nurses and physicians mentioned most of these components to be necessary measures to prevent incidents.[3,16,20]

In addition to expressing understanding of these essential components, the nurses and physicians reported limitations and restrictions in the maternity hospital's care process and structure that hinder the prevention of incidents, such as discontinuity of the PSC activities, lack of reporting and monitoring of incidents; lack of safety protocols; insufficient human and material resources; and limited professional knowledge; while associations were also wrongly established between maternal morbidities and incidents.

Therefore, the perspectives of the nurses and physicians indicate that the PSC was not effectively implemented in the facility. Despite this restrictive factor, the activities initially developed by the PSC were capable of sensitizing or mobilizing the team for the first patient safety goal, the correct identification of women and babies, and the activities may also have aroused their perception regarding the need to advance the organizational culture and individual and collective competencies toward patient safety.

The fact the PSC was not operative until the completion of this study may have hindered the creation of an incident reporting system, without which, preventive measures are not facilitated. On the other hand, the insufficient resources and equipment reported by the interviewers may be a consequence of the chronic underfunding of Brazilian public health system,[6,21] which is a microstructural factor that limits the effectiveness of programmatic goals on safety and quality of maternal and neonatal care, such as those recommended by the Patient Safety National Program.

Another critical issue, from the perspective of these workers, is that the PSC activities are not a priority in the local management's agenda. This limitation indicates there is a need to enlarge the strategies to qualify and sensitize managers of maternity hospitals, considering that changes depend on the engagement of all those involved, including representatives of the users of health services, social and women movements.[9] These strategies may favor the understanding of affective, cognitive, attitudinal, and cultural dynamics of individuals and the logic present in the context of the implementation of safety actions, such as structures, processes, behaviors, practices and political-organizational values of these social spaces of health care.[16,22]

Finally, note that the results presented here should be interpreted with caution due to this study's limitations. These results comprise the perspectives of a particular group of nurses and physicians and do not represent the diversity of contexts and points of view concerning the safety of care delivered to labor and childbirth at the local and national spheres. These results, however, are expected to contribute to the debate concerning the challenges faced in the prevention of incidents and necessary advancement of care and research, including the use of more comprehensive and participatory methods that contemplate other contexts, settings, and perspectives of maternal and neonatal multi-professional teams.

CONCLUSIONS AND IMPLICATIONS FOR PRACTICE

The main incidents reported by the nurses and physicians are identification errors, falls, and harm caused to women and babies. Physical and emotional harm is caused by the inadequate process and structure of the care provided to parturient women and newborns, as well as those related to the following contributing factors: 1) the use of inadequate practices and professionals' violent behavior; 2) the institution's inactive PSC and lack of safety protocols, incident notification, and monitoring; 3) insufficient personnel, resources, and equipment maintenance; and 4) limited knowledge on the part of the team and lack of support to safety actions and PSC.

Given these inadequacies, preventive measures were proposed, including improvement in the care process and structure and changes in the organizational culture given the correlation established between safety incidents and institutional obstetric violence caused to women during labor and childbirth.

This correlation may indicate additional complexity when addressing the safety of patients in hospitals providing obstetric care, which includes gender inequities related to disrespectful behavior and mistreatment of pregnant women in care settings. We suggest that processes intended to promote a change of organizational culture in maternity hospitals address safety problems together with challenges posed by institutional violence in order to improve the effectiveness of health policies and local initiatives intended to improve the quality and safety of care provided to labor and childbirth.

AUTHOR'S CONTRIBUTIONS

Study design. Adriana Lenho de Figueiredo Pereira.

Data collection. Adriana Lenho de Figueiredo Pereira. Giullia Taldo Rodrigues.

Data analysis. Adriana Lenho de Figueiredo Pereira. Giullia Taldo Rodrigues.

Results interpretation. Adriana Lenho de Figueiredo Pereira. Priscila da Silva Almeida Pessanha. Lucia Helena Garcia Penna.

Written and critical review. Approval of the manuscript's final version. Responsibility for all the aspects concerning the content and integrity of the published article. Adriana Lenho

de Figueiredo Pereira. Giullia Taldo Rodrigues. Priscila da Silva Almeida Pessanha. Lucia Helena Garcia Penna.

ASSOCIATE EDITOR

Ana Luiza de Oliveira Carvalho

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