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A Quality Improvement Project to Improve the Birth Experience of Maternity Clients through Educating Providers on Respectful Maternity Care

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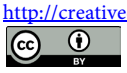

Abstract

Introduction: Disrespect and mistreatment during pregnancy and childbirth has been widely reported. **Objective:** To improve the birth experience of maternity clients through educating maternity providers on Respectful Maternity Care. **Study Design:** Quasi-experimental, Mixed Method research design was used to identify the levels of autonomy and respect maternity clients perceived during their labor and delivery experience. **Participants:** Maternity staff and providers, Maternity clients who were clients of and delivered by delivering providers from Mercy OB/GYN. **Results:** Matched pair t-tests were used to evaluate the staff and providers' knowledge and understanding of respectful maternity practices prior to and following an educational session. Independent 2-sample t-test was utilized to evaluate the maternity clients' perception of respectful care during their labor and delivery process. **Conclusions:** Labor and delivery staff demonstrated an increase in knowledge and understanding of respectful maternity care practices. The increase in the reported levels of autonomy and respect was not statistically significant.

Subject Areas

Maternal-Child Nursing, Women's Health

Keywords

Respectful Maternity Care, Mistreatment or Abuse during Childbirth, Obstetric Violence, Quality Improvement, Person-Centered Care, Maternity or Antepartum or Intrapartum

1. Introduction

The United States is one of the most developed countries in the world. Despite the United States being a high resource country and spending $111 billion annually, approximately twice as much as most other high-income countries on maternity care, the maternal mortality rate in the United States continues to rise [1]. Over the past three decades, pregnancy-related mortality rates have continued to rise, from 7.2 per 100,000 live births in 1987 to 17.3 in 2017 [2]. More disturbing is the pregnancy related mortality ratio when examined based on race or ethnicity. Taylor [3] explains, "Discrimination and bias based on race and gender have pervaded the healthcare experiences of women of color in the United States for centuries." (p. 8) Furthermore, when comparing black women and white women, the risk of experiencing a severe maternal morbidity is 70% greater for black women [3]. A 2019 research study in the United States examined inequity and mistreatment during pregnancy and childbirth [4]. Researchers concluded that mistreatment is experienced more often by women of color, when the birth setting is the hospital environment and is experienced more frequently in those who have socioeconomic or health problems. According to Taylor, women of color have experienced discrimination and unfair treatment by health care providers and report their fears for concerns being ignored, which can be detrimental to maternal outcomes [5].

2. Background and Significance

Researchers estimate up to 30% of women describe their birth experience as "distressing" and "psychologically traumatic" [6]. Recurrent themes identified in literature include maternity clients feeling ignored, feeling their voice is not being heard, feeling that they have been excluded from being a participant in the shared decision-making process during their labor and delivery experience, procedures being performed without consent, and violations of privacy [4] [7]. Obstetric violence, mistreatment, disrespect, and abuse have garnered recent attention from the World Health Organization (WHO), Association of Women's Health, Obstetrics, and Neonatal Nurses (AWHONN), and several other organizations tasked with improving maternal and neonatal outcomes.

A thorough review of current literature revealed that obstetrical violence or mistreatment during pregnancy and childbirth is a significant concern in maternity care. Obstetrical violence, abuse and mistreatment has been documented in research globally, however, very little research has been conducted evaluate the prevalence of mistreatment within the United States. Therefore, this project sought to evaluate the clients' perception of autonomy and respect received during the labor and delivery experience at a community hospital in Western Kentucky, leading to the PICOT question; In a hospital based maternity setting, does educating providers (surgical technicians, registered nurses, midwives and obstetricians) (P) on respectful maternity care practices (I) compared to treatment as usual (C) improve the birth experience of maternity clients (O) over a

seven-month period (T)?

3. Purpose

The purpose of the DNP project was to raise awareness about importance of respectful maternity care. One target of the project was to assess the maternity client's perception of the autonomy and respect they received during their labor and delivery experience. The desire is to be an advocate for respectful maternity care and promote the implementation of respectful maternity care practices to improve the overall experience and outcomes for maternity clients and their families. The ultimate goal is to create a culture of positivity and empowerment that prioritizes the physical, emotional, and psychological well-being of maternity clients, ensuring their choices and autonomy are respected throughout their labor and delivery experience.

3.1. Aims

Two project aims were identified for the project. The first aim was focused on educating the labor and delivery staff on Respectful Maternity Care Principles. The second aim was focused on client satisfaction related to the level of autonomy and respects the client experiences with their delivery provider and with the labor and delivery staff. The project aims were as follows: By March 14, 2023, 100% of the maternal-child department staff and the delivery providers at Mercy OB/GYN will be trained on, and implement the Respectful Maternity Care principles (autonomy, dignity, shared decision making and informed consent, accountability, awareness and mutual respect) to provide safe and equitable care to maternity clients. By June 13, 2023, the percentage of maternity clients who rate their level of autonomy and respect as high will increase 20% above the baseline data collected prior to staff training.

3.2. Objectives

The first goal of the project was to increase the percentage of maternity clients reporting high levels of autonomy and respect in their interactions with their delivery provider and labor and delivery staff by 20% over the baseline data. The objectives to meet goal one were to communicate the project intent to the clients, implement the project survey which utilized the Mother's Autonomy in Decision Making (MADM) [8], Mother's On Respect Index (MORI) [9], and the Mistreatment (MIST) [10] survey tools, and having a response rate of 75%. Although an increase in the percentage of clients reporting high levels of autonomy and respect was witnessed, the percentage fell short of the 20% goal.

The second goal of the project was to increase the staff and provider understanding of Respectful Maternity Care principles. The target was that 85% of providers and staff would demonstrate an improvement of at least 10% on the posttest following the training session, compared to the pretest score prior to the

training session. Staff and providers were encouraged to participate in an Implicit Bias Self-Assessment to identify any unrecognized bias that could impact the care and treatment the maternity client receives. Participation was voluntary as the Implicit Association Test is considered scientific research and it is unethical to force participation [11]. Secondly, the goal was that 100% of providers and labor and delivery staff would participate in the Respectful Maternity Care Training. Third, participants were asked to commit to providing Respectful Maternity Care and sign commitment cards. Signed commitment cards have been displayed in the maternal-child department in view of the clients and family.

4. Synthesis of Evidence

4.1. Appraisal

The Northern Kentucky University Library databases were used to search for relevant publications from the last five years. The Cumulative Index to Nursing and Al-lied Health Literature (CINAHL), Science Direct, and Gale Academic One File were used to search full text, peer reviewed publications written in English from the last five years (2017-2022) with the following search terms: "respectful maternity care", "education or training or knowledge, or awareness", "childbirth", "obstetric violence or 'abuse during childbirth' or 'disrespect and abuse during childbirth'". The initial search term "respectful maternity care" yielded 1,408 results for full text, peer reviewed, English written publications in the last five years. After including the search phrases "education or training or knowledge or awareness", only sixteen articles were excluded. Adding the search terms "obstetric violence" or "abuse during childbirth" or "disrespect and abuse during childbirth", 129 results remained. After reviewing the abstracts, 34 articles were selected for full review. Twelve articles were excluded after review. Only four articles were specifically examining educational methods utilized for training on RMC. Other themes that emerged from the research included raising awareness to improve client experience, patient-centered care, policy and guideline development, and examining disrespectful care from the patient and the provider perspectives. Articles reviewed include five level I systematic reviews, five level VI cross-sectional studies, three mixed methods studies, three qualitative studies, two focus groups, two comparison studies, a case study and a cohort study.

4.2. Weaknesses

Locating quantitative articles on RMC was difficult due to the nature of the topic being researched. The question of autonomy and respect during labor and childbirth is one of the mother's lived experiences, a question in which qualitative data tells the story. An identified inconsistency was in the survey tool used in the research. In several of the articles reviewed a different survey tool was utilized in each study. The Mothers Autonomy in Decision Making (MADM) tool was found to be used over the course of several studies. Additionally, several of the

tools in the reviewed literature had to be translated from its original language into another for use.

4.3. Gaps/Limitations

After an extensive review of current literature, it is evident that there remains a gap in literature. Few studies on RMC have been conducted in the United States in the last five years. Many of the studies conducted on respectful maternity care or obstetrical violence are conducted in underdeveloped countries. Awareness of obstetrical violence or mistreatment during childbirth has gained recent attention. In January 2022, the Association of Women's Health, Obstetrics and Neonatal Nurses (AWHONN) published the Respectful Maternity Care Framework and Evidence-Based Clinical Guideline [12] with a toolkit for implementation of RMC practices.

Additionally, when reviewing literature regarding educational interventions regarding abuse in healthcare, the studies have also taken place outside of the United States. The studies that were specific to educating staff on RMC were conducted in Sweden and Sri Lanka. Dhakal, *et al.* [13], recently published a mixed-method systematic review exploring the effectiveness of education interventions to promote RMC. According to the review, Dhakal, *et al.* (2021) [14] could not identify tools of sufficient quality to measure the impact of continuing professional development interventions or pre-registration education on clinicians' and/or students' understanding, attitudes, or practices in relation to RMC. [14] However, the need for RMC education interventions was emphasized in high- income countries as well as in mid-and-lower-income countries.

5. Concepts and Theoretical Frameworks

The theoretical framework chosen to guide the RMC project was Hildegard Peplau's Interpersonal Relations Theory. In Peplau's Interpersonal Relations Theory, the emphasis has been placed on the patients' experience and how the experience is shaped by the nurse-patient relationship [15] Hagerty, *et al.* [15] explain that according to this theory, "nursing is defined as an interpersonal, therapeutic process that takes place when professionals, specifically educated to be nurses, engage in therapeutic relationships with people who are in need of health services" (p. 161). The theory is comprised of three phases; orientation, working, and termination. In the orientation phase, the nurse meets the patient, learns essential information about the patient including their needs and priorities, treats the patient with respect, and begins to build trust. The majority of the nurse-patient relationship occurs during the working phase when the nurses are spending a great deal of time with the patient. During the working phase, patients begin to accept the nurse as an educator and resource. The nurse assesses the needs of the patient, provides education to the patient, and contributes to the plan of care. The final stage is the termination phase where discharge planning commonly occurs [15]. The theory corresponds well with the maternity client and their labor nurse.

6. Project Design

The DNP project design fell under the description of a quasi-experimental study as defined by Ambroggio, *et al.* (2018) [16]. This is due to the methodology of an outcome being recorded prior to an intervention, the intervention, in this case an educational session and implementation of RMC, is them implemented, and finally after the intervention has been implemented, the outcome is recorded.

6.1. Organization

A convenience sampling method was utilized to recruit participants. Inclusion criteria for maternity participants include maternity clients who were clients of the Mercy OB/GYN practice and who were experienced a live birth at Mercy Health Lourdes by a practicing provider from Mercy OB/GYN, consisting of two obstetricians and two midwives, and returned to the Mercy OB/GYN practice for their 2-week postpartum visit. Clients from providers outside the Mercy OB/GYN practice, clients who did not follow up at Mercy OB/GYN for their two-week postpartum visit, and women who experienced a pregnancy loss were excluded.

Convenience sampling was also utilized to recruit staff participants. Registered nurses and surgical technicians of the Mercy Health Lourdes birthing center, along with one obstetrician from Mercy OB/GYN practice, participated in the educational training on Respectful Maternity Care principles.

6.2. Implementation

The quality improvement project was conducted in the maternity department of Mercy Health Lourdes, a non-profit hospital in western Kentucky, part of the Mercy Health System, and the outpatient obstetrics and gynecology practice Mercy OB/GYN. The maternity unit was a 16-bed unit comprised of seven postpartum rooms, three labor, delivery and recovery (LDR) rooms, three triage bays, and three multifunction rooms used for overflow of labor or postpartum clients. The nursery was a well newborn nursery, also licensed as a level 2 nursery with 4 level 2 beds. The questionnaire concerning their labor and delivery experience was administered at Mercy OB/GYN at their two-week postpartum visit.

The quality improvement project consisted of three phases: a 90-day pre-implementation phase, a 30-day implementation phase and 90-day post-implementation phase. During the pre-implementation phase, data was collected to determine a baseline score of the maternity clients' level of autonomy, respect and satisfaction with their birth experience. A questionnaire was developed utilizing the Mothers Autonomy in Decision Making (MADM) tool [8], the Mothers on Respect Index tool (MORI) [9], and the Mistreatment Index (MIST) [10] and open ended questions adapted from Afulani, *et al.* [17] examining the maternity client's perception of autonomy, respect, and shared decision-making in their labor and delivery process. Permission to utilize the MADM, MORI and

MIST tools was secured from Birth Place Labs. The project proposal was submitted to the Internal Review Board of Mercy Health Lourdes and to the Internal Review Board of Northern Kentucky University. A paper copy of the questionnaire was provided to the maternity clients at their two-week postpartum visit at Mercy OB/GYN.

During the implementation phase, the maternity providers attended a training session on respectful maternity care and principles to be implemented. The RMC training included a presentation demonstrating the status of maternity care in the United States, the impact of trauma, and the components of RMC. Staff participants received guidance on implementing RMC based on the evidence-based recommendation presented in the Respectful Maternity Care Framework and evidence-based Clinical Practice Guideline published by AWHONN in 2022. During the final portion of the training, participants were presented with two client scenarios in which participants were asked to determine if the client received respectful care, and if not, what changes could be implemented to ensure the client receives respectful care. In the post-implementation phase, data was collected to compare to the baseline data collected prior to the training session. A pre- and post-test measurement tool was developed to assess the maternity staff and provider knowledge and understanding of respectful maternity care principles prior to and following the educational intervention. The educational session was presented using a PowerPoint presentation and a period of discussion to work through case scenarios.

6.3. Data Collection

The DNP project was a Quality Improvement project with a goal of improving maternity client satisfaction in the areas of autonomy and respect during their labor and delivery process. The Quality Improvement project used the Plan-Do-Study-Act (PDSA) design. Pre/post measures were used to measure outcomes for both the staff and client portions of the project. A pretest was used to assess staff and provider baseline knowledge and understanding of Respectful Maternity Care (RMC). Training sessions were then held where staff and providers were educated on RMC principles and the AWHONN evidence-based recommendations for implementing RMC.

Maternity clients were offered a paper survey when they arrived for their postpartum follow up visit. Surveys completed between November 13, 2022 and February 11, 2023 were used as a baseline for the percentage of maternity clients reporting high levels of autonomy and respect during their labor and delivery experience. The staff training sessions were held between February 12, 2023 and March 11, 2023. To prevent crossover from surveys collected and training, surveys collected between February 12, 2023 and March 11, 2023 were excluded. Surveys completed between March 12, 2023 and June 13, 2023 were used to calculate the percentage of maternity clients reporting high levels of autonomy and respect during their labor and delivery experience.

In quasi-experimental designed studies, pre and posttest methods are utilized to assess the effect of an intervention on a group of participants. The pretest assessed the staff participants' knowledge and understanding of respectful maternity care prior to the training session. Following the training session, participants completed a posttest to assess the knowledge and understanding gained from the training. A Matched Pairs t-test was conducted to evaluate the staff and providers' knowledge and understanding of respectful maternity practices prior to and following an educational session. Each participant created a unique code to link the pretest and posttest. No identifiable information was collected from the participant. The scores from the pretest and posttest were entered into an excel spreadsheet and provided to the Burkhardt Consulting Center for analysis. The computer used to enter the scores in to the excel spreadsheet is password protected.

Independent 2-sample t-tests were utilized to evaluate the maternity clients' perception of respectful care during their labor and delivery process. Independent 2-sample t-tests are used to compare the means of two independent groups to determine if there is a significant difference between the two. The study involved clients who gave birth prior to and following the intervention making the samples two independent samples and deeming this method appropriate. A paper questionnaire was provided to the client by the front desk personnel during check in at the two-week follow up visit. Once the survey was completed, the front desk personnel collected the survey and placed it in a secure, locked drawer. The surveys were collected on a weekly basis and entered the data in to the excel spread. The paper questionnaires were maintained in a secure, locked office unit through the project completion. The survey results were sent to the Burkhardt Consulting Center for analysis.

7. Data Analysis and Results

There were two groups being surveyed, staff and clients, and each are reported separately. Forty staff members completed both the pre and posttests following the RMC training. Only staff members completing both the pre and posttest were included in the data analysis. The staff sample consisted of one physician (2.5%), 29 registered nurses (72.5%) and 10 surgical technicians (25%) (**Table 1**). Thirty-nine staff (97.5%) identified as white and one staff member (2.5%) identified as other. Demographics were summarized using mean/standard deviation. Demographics for staff participants were as follows: mean age in years 40.13 (sd 12.65), mean years practicing in role (registered nurse, surgical technician, or physician) 13.50 (sd 10.87), mean years of experience in maternity care 8.42 (sd 7.60) and mean length of time employed at Mercy Health Lourdes 7.70 years (sd 9.48) (**Table 2**). A Matched Pairs T-test was conducted to compare the pre and posttest scores. There was evidence of an increase in the average scores from the pretest to the posttest ($T = 3.29$, p-value = 0.002). The average posttest score was estimated to be between 0.308 and 1.292 points higher than the pretest

Table 1. Staff role and ethnicity.

Variable/Levels	
Role	Count (%)
MD	1 (2.5%)
RN	29 (72.5%)
ST	10 (25.0%)
Race/Ethnicity	
White	39 (97.5%)
Other	1 (2.5%)

Table 2. Staff age and experience.

Variable/Level	Mean	Standard Deviation	5-number summary
Age (years)	40.13	12.65	23.00-29.00-39.00-48.50-65.00
Years Practicing in Role	13.5	10.87	1.50-4.25-13.50-18.75-44.00
Years of Experience in OB	8.42	7.60	0.00-2.63-5.00-15.75-27.0-
Length of time employeed at facility	7.70	9.48	0.06-1.50-3.75-12.75-43.00

score with a confidence interval of 95%. Of the n = 40 staff surveyed, 27 (67.5%) showed an increase in score, 7 (17.5%) showed a decrease in score, and 6 (15%) showed no change in the score between the pretest and the posttest.

Client surveys were apportioned into two groups, pre and post implementation. During the pre-implementation period, 173 clients were offered the survey and 69 clients completed the survey for a response rate of 39.8%. During the post-implementation period, 111 clients were offered the survey and 32 clients completed the survey for a response rate of 28.8%. The overall response rate for the pre-implementation and post-implementation periods was 35.6%. Pre and post implementation differences were assessed using independent two-sample T-tests. Additionally, the scale scores were assessed related to the delivery providers separately from the labor and delivery staff. Outcome variables include the Mothers Autonomy in Decision Making (MADM) and Mother's on Respect Index (MORI) scores. Demographics were summarized using mean/standard deviation for quantitative variable and percentages for categorical variables. The pre-implementation group (n = 60) consisted primarily of white women 20 - 29 years of age, married, with some college education (**Table 3**). The post-implementation group (n = 28) were primarily white women, age 20 - 29, married with at least some college education.

Client outcomes related to delivery providers show no evidence of pre/post differences for the MADM or MORI scores and subscores (sections A, B, and C) (**Table 4**). The autonomy level from the MADM was examined as high, moderate, low or very low. Examination with a chi-square test shows no evidence of

Table 3. Client demographics.

Variable/Level	Client Demographics		
	Variable/Level	Precount (%)	Postcount(%)
Age Range			
	15 - 19	4 (6.67%)	2 (7.41%)
	20 - 29	39 (65.00%)	16 (59.26%)
	30 - 39	16 (26.67%)	9 (33.33%)
	40 - 49	1 (1.67%)	0 (0.00%)
Marital Status			
	Never Married	15 (25.42%)	7 (25.93%)
	Married	42 (71.19%)	19 (70.37%)
	Separated	1 (1.69%)	0 (0.00%)
	Divorced	1 (1.69 %)	1 (3.70%)
Highest Level of Education			
	High School or GED	16 (26.67%)	4 (14.81%)
	Some College	24 (40.00%)	7 (25.93%)
	Associates	7 (11.67%)	2 (7.41%)
	Bachelors	10 (16.67%)	9 (33.33%)
	Masters	3 (5.00%)	3 (11.11%)
	Doctorate	0 (0.00%)	2 (7.41%)
Race/Ethnicity			
	Black	2 (3.33%)	1 (3.70%)
	White	57 (95.00%)	26 (96.30%)
	White/American Indian	1 (1.67%)	0 (0.00%)
Pregnancies over 20 Weeks Gestation			
	1	27 (45%)	11 (40.74%)
	2	22 (36.67%)	12 (44.44%)
	3	9 (15.00%)	3 (11.11%)
	4	2 (3.33%)	1 (3.70%)

Table 4. Client outcomes related to delivery providers.

Variable/Level	Two-Sample t-Test and CI		One Sample 95% CI's	
	t-Value (P-value)	95% CI for Difference	PRE	POST
MADM	−0.70 (0.491)	−3.94 to 1.93	38.37 to 40.71	35.82 to 41.25
Section A Score	1.83 (0.071)	−0.20 to 4.79	35.21 to 39.31	38.07 to 41.04
Section B Score	−0.35 (0.730)	−2.359 to 1.669	22.18 to 23.99	20.92 to 24.57
Section C Score	−0.50 (0.619)	−1.720 to 1.037	16.00 to 17.27	15.06 to 17.53
MORI Overall	0.80 (0.425)	−2.60 to 6.07	74.42 to 79.51	75.22 to 82.30

association (chi-square = 0.329, p-value = 0.556). The level of respect was examined as high/moderate low and again, there was no evidence of association (chi-square = 0.667, p-value = 0.414).

Client outcomes related to labor and delivery staff show no evidence of pre/post difference in the five variables except for the section A score (Table 5). In section A, there was evidence of an increase in average score between 0.25 and 5.21 units. The autonomy level was examined from MADM as high/moderate/low/very low using a chi-square test. There was no evidence of association (chi-square = 1.394, p-value = 0.498). The level of respect was examined as high/moderate low and again showed no evidence of association (chi-square = 3.926, p-value = 0.140).

Clients also answered questions regarding mistreatment during the labor and delivery experience (Table 6). In the pre-implementation period, there were zero reports of personal information being shared without consent, physical privacy violations or experiences of physical abuse. There were 2 reports (3.3%) of being scolded or shouted at, 1 report (1.7%) of treatment either being without or being forced to accept unwanted treatment, 1 report (1.7% of being threatened by a healthcare provider, and 4 reports (6.7%) of requests for help being ignored. In the post-implementation period, there were zero reports of personal information being shared without consent, being threatened by a healthcare provider, or experiencing physical abuse. There were 2 reports (7.1%) of the physical privacy

Table 5. Client outcome related to labor & delivery staff.

Variable/Level	Two-Sample t-Test and CI		One Sample 95% CI's	
	t-Value (P-value)	95% CI for Difference	PRE	POST
MADM	0.04 (0.969)	−3.59 to 3.73	35.05 to 39.02	33.97 to 40.25
Section A Score	2.20 (0.031)	0.25 to 5.21	35.34 to 39.12	38.29 to 41.64
Section B Score	0.72 (0.478)	−1.32 to 2.78	21.20 to 23.74	21.55 to 24.85
Section C Score	0.78 (0.440)	−1.045 to 2.365	14.96 to 17.00	15.24 to 18.04
MORI Overall	1.69 (0.097)	−0.76 to 8.90	72.42 to 78.40	75.58 to 83.38

Table 6. Mistreatment during labor and delivery experience.

Question	Proportion of Yes Answers—PRE	Proportion of Yes Answers—POST
Personal Info Shared without Consent	0 (0%)	0 (0%)
Physical Privacy Violated	0 (0%)	2 (7.1%)
Scolded or Shouted at	2 (3.3%)	1 (3.6%)
Treatment Withheld or Forced to Accept	1 (1.7%)	2 (7.1%)
Threatened by Healthcare Provider	1 (1.7%)	0 (0%)
Ignored, Request for Help Ignored	4 (6.7%)	1 (3.6%)
Experienced Physical Abuse	0 (0%)	0 (0%)

being violated, 2 reports (7.1%) of treatment being withheld or being forced to accept unwanted treatment, 1 report (3.6%) of being scolded or shouted at, and 1 report (3.6%) of request for help being ignored. Statistical analysis and interpretations were completed with the assistance of the Northern Kentucky University Burkhardt Consulting Center (Highland Heights, KY).

Clients were also given the opportunity to give written feedback to eight open-ended questions adapted from Afulani, *et al.* [17]. The first question was "Please explain how the doctors, nurses, and other staff at the hospital treated you with respect." The common themes identified in the answer to this question were that the nurses were kind, listened, explained what they were doing, answered questions, asked for client opinions, and did not talk down to clients. The second question asked was "Were you asked for permission or consent from the doctors, nurses, or other staff at the hospital before procedures were performed on you? Please explain or provide examples." Overwhelming, clients answered they were asked for permission or consent prior to cervical exams, infant medication administration, epidural placement, and administration of Pitocin. One client noted being asked permission for a student nurse to observe labor. Two clients reported not being asked permission before procedures, one being placement of a fetal scalp electrode and one being administration of Pitocin.

The third questions asked, "How were you involved in making decision about your care at the facility?" Most clients reported feeling that they were able to make decisions or that they had been given options and were allowed to choose. One client reported, "I really had to self-advocate. If I were younger and less self-confident, this would have been hard. As it was, I found it tiring and discouraging." The fourth question was "During your labor and delivery experience, were you able to be in the position of your choice? Please explain." This question had the largest variation of questions. Ten clients stated that they were not able to be in the position of their choice because they were having cesarean deliveries and were not laboring. Three clients reported not being able to be in the position of their choosing.

The fifth question asked, "Where you able to have the support persons that you desired stay with you during your labor and birth?" The majority of clients reported being able to have their support persons of choice with them. A handful were not able to have their support persons with them either due to Covid regulations or because of delivering via cesarean delivery. The sixth question asked, "How was your pain controlled? Do you feel the doctors and nurses did everything they could to control your pain?" Three clients reported opting to have an unmedicated delivery. Two clients reported the epidural not working or the epidural running out. One client voiced being in a great deal of pain and not being treated effectively by her primary nurse and another nurse obtaining a stronger medication. Nearly all of the clients reported pain being well controlled.

The seventh question was, "In what ways do you feel that you could completely trust the doctors, nurses, or other staff at the facility regarding your care?" Some of the responses included, "I was never made to feel less than and I

was always listened to", "they made me feel more than safe and comfortable in their care", "I felt comfortable telling them anything. They were never judgmental", and "they proved they were good with my first two, my third pregnancy was a no-brainer". Two clients reported feeling that it depended on the nurse that was caring for them. One client expressed feeling as if she did not receive the care she expected after transfer to postpartum care. The final open-ended question was "What could your doctor, midwives, or nurses have done to improve your experience?" While most of the clients surveyed reporting having a positive experience and nothing could have been done to improve their experience, there were several that mentioned improvements could be made in the postpartum area such as more education regarding postpartum and newborn care, more assistance after delivery, and more warning prior to fundal exams.

8. Relationship of Results to Framework, Aims and Objectives

The framework provides the theoretical and conceptual foundation for the project. Peplau's Interpersonal Relations Theory corresponds well with the relationship between the client and nurse as the client is in labor and delivery for a brief period of time. During the orientation phase of the relationship, the nurse learns the client's preferences for their labor experience. In the working phase, the client and nurse work together to have a labor and delivery experience where the client feels respected and positive outcomes are achieved. During the termination phase, discharge planning occurs. Once a maternity client gives birth and the recovery criteria to be discharged to postpartum has been met, the working phase is considered complete, the relationship terminated, and the client is discharged to the care of the postpartum nurse.

As previously noted, in Peplau's Interpersonal Relations Theory, the emphasis has been placed on the patients' experience and how the experience is shaped by the nurse-patient relationship. During the pre-implementation phase of the project, more than 80% of clients reported high levels of autonomy and more than 78% reported high levels of respect with their delivery provider during their labor and delivery process. Regarding the labor and delivery staff, 75% of clients reported experiencing high levels of autonomy and 65% of clients reported experiencing high levels of respect during their labor and delivery experience. The baseline levels of respect and autonomy were higher than the author anticipated and therefore made the goal of increasing levels by 20% following implementation of respectful maternity care practices unrealistic. Although the author did note an increase in the percentage of clients reporting high levels of autonomy and respect following the training sessions, the increase was not statistically significant.

A pre/posttest was administered to evaluation staff knowledge and understanding of RMC. Over 67% of staff had an increase of 10% or greater in the posttest score. During the training sessions, staff were given client scenarios and were able to identify examples of disrespect or abuse. Through discussion, staff

identified small practice changes that could be implemented with ease that would provide more respectful care. This included a change in the verbiage being used when preparing to perform a procedure with the client.

8.1. Project Strengths

The staff of the birthing center were receptive to the RMC training session. After attending the training, the birthing center staff identified minor changes that could be made in practice to increase the level of autonomy and respect the client feels during their labor and delivery process. The birthing center staff comprised of 10 surgical technicians, 33 registered nurses, 1 nurse manager and 1 nurse educator. Ten surgical technicians, 31 registered nurses, 1 nurse manager, 1 nurse educator, and 1 obstetrician participated in the training sessions. Neither of the nurse midwives attended the training. Two registered nurses and 1 obstetrician were on medical leave at the time the project was implemented and therefore did not participate in the training. Of the 47 staff and providers available to participate in the training, 41 attended the training in full for a participation rate of 87.2%. Birthing center staff and the delivery providers attending the training session were asked to complete a pretest and posttest to evaluate the effectiveness of the training session. Overall, out of the nurses, surgical technicians, and physicians who completed the pretest, attended the training, and completed the posttest, 67.5% saw an improvement by 10% or greater following the training.

8.2. Project Limitations

There were several limitations identified in the project. The first limitation was a lack of diversity in the client population. There were very few women of color who opted to complete the survey. While people of color are in the minority in the region, the representation in the project was much less than the population. The second limitation was the response rate. Despite the information sheet being provided to clients while in the hospital, the response rate was not as high as the project manager would have liked. Overall, the response rate for survey completion was approximately 35.6%. The third limitation was concerning the clients being offered the survey at their postpartum visit. The project manager instructed the front desk personnel to offer the survey to clients when they returned for their two-week visit and to refrain from administering the survey to women at the six-week visit. However, in the second month of the post-implementation period when the project manager questioned the front desk personnel about the low number of women returning for two-week follow-up visits, some women with complications had been scheduled follow-up for one-week following delivery and surveys were not offered to those women.

9. Recommendations and Implications for Future Practice

The goals and objectives identified and set for this project were unrealistic and

out of reach. For future projects, the setting of goals would be less ambitious. Additionally, collaborative efforts will take place with the unit nurse educator and unit nurse manager to incorporate training sessions into the unit orientation and mandatory unit education to ensure that all staff receive the training. Collaboration is also occurring with the nurse manager and risk manager to develop a process to continue to administer the survey to postpartum surveys in the month following their delivery without requiring the Mercy OB/GYN staff to be responsible for survey administration.

The findings of this project are important to the development of policies related to respectful maternity care and client autonomy. Collaboration with the nurse manager, nurse educator and providers is essential to develop policies that promote client equity and inclusion, access to language services for English as a second language or non-English clients, and a process for debriefing to ensure clients receive culturally competent and respectful maternity care.

Additionally, the training could be extended to other disciplines such as anesthesia and respiratory therapy who work closely with the maternity department. The Association of Women's Health, Obstetrics, and Neonatal Nurses (AWHONN) suggests that all employees in contact with maternity clients, such as environmental services or dietary, be included in the RMC training [8]. A change that has been recently implemented in the maternity department is the requirement of nurses to participate in bedside report. The RMC training in conjunction with bedside report may also increase the client's perception of autonomy and respect.

As noted in the qualitative data, several clients expressed disappointment in their postpartum care. While the project's focus was the autonomy and respect experienced by the client during the labor and delivery experience, the concerns by the clients cannot be ignored. It is speculated this is due, in part, to the variation in staffing ratios in labor and delivery versus the staffing ratios in postpartum and nursery. For clients in active labor, the nurse-to-patient ratio is 1:1 allowing the labor nurse to be present at the bedside and provide their undivided attention and individualized care to the client. However, once the client is transferred to the postpartum department, the nurse-to-patient ratio is 1:6 - 8. The variation in staffing guidelines could be communicated to the client during the bedside report handoff between the labor nurse and the postpartum nurse. The communication could be scripted to ensure that the client understands that staff will be monitoring vital signs and providing pain management on a regular basis, assisting with breastfeeding, assisting with personal hygiene, and addressing any questions posed by the client, however, it is not always possible to have a nurse present in the room at all times. Communicating this to the clients can help to define expectations while ensuring all clients receive the best possible care.

10. Dissemination Plan and Rationales

Upon completion of the project, the preliminary findings of the project were

shared with the OB unit manager, OB nurse educator, as well as the project manager's preceptor and practice mentor. Initial findings were communicated via face-to-face communication; however, a presentation has been prepared and shared with nursing leadership and with the birthing center staff in the upcoming staff departmental meeting. Project findings were presented to the DNP committee in July 2023. Data may also be shared with the Chief Nursing Officer at the facility as well as with any interested nursing leaders of any obstetrical units in the health system in order to develop policies for educating obstetrical staff and delivery providers about Respectful Maternity Care principles.

Conflicts of Interest

The author declares no conflicts of interest.

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