Single Room Maternity Care Model: Unit Culture and Healthcare Team Practices

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Abstract

The evidence regarding the effects of a Single Room Maternity Care (SRMC) model on women's childbirth experiences, healthcare providers' workplace satisfaction, and cost outcomes remains equivocal. The research questions for this focused ethnographic study are: how is culture experienced by nurses and other healthcare providers on the SRMC unit, and how do the values, beliefs, and norms of nurses and other healthcare providers on the SRMC unit influence their day-to-day practices of caring for women and their families. The aim of this qualitative focused ethnography was to explore the culture and practices of the healthcare team in a SRMC unit. Twelve healthcare providers were recruited from a Single Room Maternity Care unit located in a Western Canadian hospital. Semi-structured interviews, participant observations, and examination of unit-related documents were conducted between October 2014 and January 2015. Data were analyzed using an approach by Roper and Shapira (2000). Two main themes emerged from the data: creating and maintaining culture and the work family. The participants considered themselves a family, and made collective and conscious efforts to create a unit culture where everyone could feel supported and valued. Unit culture determined the ways members of the healthcare team functioned in their day-to-day practice. Further research is required to explore the relationship between the maternity unit and quality of patient care, as well as the impact of collaborative practices on both providers and recipients of maternal care.

KeyWords: Single room maternity care model, focused ethnography, unit culture, nursing, teamwork

Introduction

During the 1980s in North America, the focus of maternity care began to shift away from a traditional physician and hospital-centered experience toward that of recognizing childbirth as a normal, family-centered experience (Janssen, Klein, Harris, Soolsma, & Seymour, 2000). In order to support family-centered childbirth, a variety of birthing units, such as "home-like" rooms within the hospital unit or adjacent to the hospital unit have been constructed. What makes a single-room maternity care (SRMC) different from the traditional maternity unit is that in a SRMC unit a childbearing woman and her family stay in one room from admission until discharge from the hospital, and the newborn remains with the family at all times (Harris, Farren, Janssen, Klein, & Lee, 2004). This model of care involves continuity of care provider, with all of the Registered Nurses (RNs) being trained in providing antenatal, intrapartum, newborn and postpartum care (Hodnett et al., 2012).

Registered nurses (RNs) are the predominant primary bedside caregivers in hospital maternity units (Carlton, Callister, Christiansen, & Walker, 2009). Nursing interactions (e.g., communication, support, amount of time spent at the bedside) with women and their families during childbirth could be pivotal in a woman's perceptions of her childbirth experience and satisfaction with care (Corbett & Callister, 2000). Understanding the impact SRMC unit culture may have on practices of health care providers may provide directions for policy-makers' decisions about implementing this model of care, and childbearing women and their families' decisions about using it. The Public Health Agency of Canada (2000) supports hospitals moving away from the traditional, multi-transfer models of care, and recommends that all new healthcare facilities that provide maternity care be built to accommodate SRMC units. Yet data about the effect SRMC has on health care providers' workplace satisfaction is equivocal (Bailey & Howe 1993; Bergeron 2001; Grubbs & Cottrell 1996; Harris et al., 2004; Janssen et al., 2000; Janssen et al., 2001, Janssen et al., 2005; Janssen et al., 2006; Morrison & Ludington-Hoe 2012; Olson & Smith 1992; Stolte et al., 1994; Watters & Kristiansen, 1995). Further, qualitative descriptions of the culture and practices on a SRMC unit are absent from the literature. This study contributes to the body of knowledge about SRMC model by describing how the SRMC model impacts upon healthcare providers' practices as they care for women and their families.

Method

The objectives of this study were to describe a SRMC unit. In order to explore how SRMC unit culture impacts healthcare providers' practices, a qualitative study using focused ethnographic (FE) methods was conducted. Within the profession of nursing, there are many undiscovered cultures (Streubert & Carpenter, 2011). According to Roper and Shapira (2000), FE can "reveal the meaningful way nurses think and act within the framework of their lives" (p. 26). FE was used for this study because: a) it has meaningful and useful application in hospital healthcare practices and is often used to determine ways to improve care and care processes; b) it is an efficient way to capture data on a specific topic of importance to clinical specialties; and c) it is suitable to explore specific cultural perspectives held by subgroups of people within a context-specific and problem-focused framework (Higginbottom et al., 2013).

Sample and Setting

The study was conducted at a Level II hospital that opened in 2013 in a large city in Western Canada. Staffing and facilities at this birthing unit supported the care of low, moderate and high-risk pregnant women and infants of ≥ 32 weeks' gestation. At the time of the study, the unit operated at full capacity, with women and their families under the care of RNs, obstetricians, and general practitioners. Study information posters containing information about the study and contact information for the researcher were placed in prominent locations within the unit. A brief overview of the study was also presented during the unit staff meetings and shift change meetings.

A purposive sample of 12 healthcare providers (nine RNs, two physicians, and one healthcare aide (HCA)) was recruited. The inclusion criteria were: employed on the unit as a healthcare provider, and being able to provide a detailed knowledge of nuances of care practices on the unit. To attain a more complete understanding of the practices on the unit, RNs with a range of experiences (e.g., labor and delivery, postpartum) were sought ~~out.~~ The past clinical experiences of RN participants included labor and delivery, postpartum, day surgery, public health and paediatrics. Their level of education consisted of one RN having a diploma, two RNs with Master's in Nursing degrees, and the remainder having Bachelor in Nursing degrees. All except one RN (who had postpartum experience) had worked at a labor and delivery units in the past. Three out of nine RNs worked at SRMC units in the past, in both Canada and the US. For all of the participants, the length of employment on the unit ranged from six months to just prior to the opening of the unit in September 2013. Although all persons (employees, patients and their families) who are present on the unit were regarded as part of the culture (Raffin, 2002), nurses were considered key participants for this study. Key participants are the "persons willing to help by explaining the customs and beliefs of the identified cultural group" (Roper & Shapira, 2000, p.77). They are also referred to as key informants, key actors, or consultants. The preliminary informal and formal interviews with the RNs suggested a need to interview other members of the healthcare team (i.e., physicians and healthcare aides) in order to incorporate perspectives from a variety of care providers to develop a fuller description of the unit. The data collection and analysis were completed in 2015.

Data Collection

Face-to-face semi-structured interviews and participant observations were conducted a graduate student researcher. The aim of participant observation was to understand the everyday lives of the participants', and was targeted at collecting information pertaining to the topic under study (Madden, 2010). Participants were observed as they went about their daily work-related activities. During the observations, the researcher questioned the participants about certain activities (e.g., admitting patients to triage and preparing a plan of care) to gain an understanding of the events and cultural experiences on the unit. A total of 75 hours of observation time was spent on-site. All observations occurred over a seven-week period, and varied in length and time. Three to six hour observations were conducted during the day, evening, and night shifts, and included weekdays and weekends to provide a variety of perspectives in order to be more confident in capturing the culture on the unit. Both verbal and non-verbal interactions between the healthcare providers and between the healthcare providers and patients were observed. Specifically, observations were made in the unit hallways, waiting area, reception area, triage, clinic area, operating room, staff lounge, medication and storage rooms, team workroom,

conference room, nursing stations, and patients' rooms (verbal consent was obtained from the patient and family members prior to entering the patient's room).The observations, along with interviews allowed for a rich description of the culture on the unit.

The purpose of the formal, semi-structured interviews was to identify and explore beliefs, values, and norms of the unit, as well as to validate those identified by the researcher during the observations). Informal and formal interviews were used to validate observations, provide direction for future observations, and collect data on non-observable phenomena such as feelings (Roper & Shapira 2000). Interviews can be informal or formal, and usually incorporate open-ended questions (Roper & Shapira, 2000). Informal interviews are unstructured informational exchanges that are not prearranged. This type of interview involves asking questions about an event immediately after it occurs. The purpose of the informal interviews was to identify the range of beliefs about a specific event, and to check the group members' perceptions of the event against the researcher's perception. Formal interviews were semi-structured, and required planning, such as completing an interview guide containing themes or questions relevant to the research question and purpose of the study. Demographic data were collected at the beginning of the interview. The interview questions were adjusted after each interview to allow for emergence of new themes. Interviews began with the same question: "*What is it like to work on this unit?*" Interviews ranged from 30 to 90 minutes, and were digitally recorded to facilitate verbatim transcription for data analysis. All interviews took place at the unit. A total of 24 interviews were conducted. Additionally, 42 unit-related documents, such as policies, procedural documents, vision and mission statement, staffing mix data, maps, and orientation manuals were examined.

Data Analysis

The process of data analysis occurred simultaneously with data collection. Digital recordings of the interviews were transcribed verbatim. Data analysis was performed using the steps outlined by Roper and Shapira (2000): coding of the field notes and interviews; sorting to identify patterns; memoing to identify personal reflections; and generalizing constructs. Interview transcripts and field notes were read and re-read, and coded line-by-line. Codes were compared and contrasted between and across interviews, with other data from observations and field notes, and further developed into categories and themes. Confirmation of data saturation with two members of the researcher's supervisory committee members was achieved through examination of developed codes, categories, and themes.

Ethical Considerations

Ethical approval was obtained from the university human research ethics committee. Participants signed informed consent prior to taking part in the study. Participants were informed that their consent was voluntary, and that they could withdraw at any time. The names of the participants and any identifying data were kept confidential, with each participant being assigned a number that was used in organizing the interviews and data analysis, and a record of the participants' names was kept in a separate electronic file on password-protected personal computer.

Rigor

Strategies outlined by Lincoln and Guba (1985) were used to ensure rigor based on credibility, transferability, dependability, and confirmability. The hallmarks of credibility are prolonged engagement, persistent observation, and triangulation (Sterubert & Rinaldi Carpenter, 2011). Adequate time was allowed during data collection to ensure representation of the multiple realities of healthcare providers on the unit. Spending prolonged periods of time with the participants increased the opportunity to assess the accuracy of their statements and my interpretations of these statements (Roper & Shapira, 2000). Triangulation was achieved by using multiple data sources (i.e., observations, interviews, artifact examination) to validate robust conclusions about the data. Members of the researcher's supervisory committee also reviewed the data to ensure accuracy and adequate depth of analysis to help maintain credibility of findings. To increase accuracy of the results, open-ended questions for the interviews were constructed, with the same question being asked several times in different ways. Reflexivity occurred through data collection and analysis. A meticulous audit trail of the research process and explanation of the analytic strategies were employed. Description of the setting allows the reader to appraise the transferability of the findings.

Results

The objectives of the study were to describe the culture of SRMC unit. Values, beliefs and norms of the study participants were strongly tied to the ideologies around the patient and family centered care (PFCC), teamwork, and creating and maintaining culture. What became most apparent from the analysis was the ability of the unit staff to work as a team, and the value they placed on teamwork and collaboration. The participants' beliefs related to the concepts of team and teamwork were remarkably similar, and presented across all interviews. The healthcare team members' ability to provide PFCC was highly valued, and identified as a common goal that underpinned their daily practices on the unit.

Description of the Unit

The selected maternity unit was part of a large acute healthcare facility in Western Canada. The unit had 24 private patient rooms, four triage beds, and was adjacent to an 18-bed neonatal intensive care unit (NICU). There were 987 deliveries for the fiscal year 2013, and 1086 deliveries for the first five months of the fiscal year 2014 (personal communication with nurse manager). Patients labored, delivered, recovered, and received postpartum and newborn care in the same room, unless a caesarean birth was warranted. The unit was shaped as a large letter "L," and divided into three wings. The RN # 3 described the shape of the unit as a "Big Dipper." Prior to the opening of the unit, the staff RNs and management decided to choose the names for the wings. They named them after some of the areas in the province: a park, a river, and the mountain range. The nurse manager explained that the staff enjoyed deciding the names, "to find names that speak to them", and it made the unit feel "like it is their own". The staff had chosen the names that were meaningful to them, and were involved in contributing to the development of the unit in a creative way.

The patients' rooms were clean and bright, with modern furnishings. In each room, the birthing bed, with attachments for medical equipment behind the headboard appeared to take the "center stage" of the room. The bed had a special gynecological mattress that can be adjusted for delivery and recovery, allowing maximal patient comfort. There was a portable workstation next to the bed with a maternal and fetal monitor, computer for electronic charting, and equipment to measure vital signs. There was a flat screen TV mounted on the opposite wall, with a small whiteboard underneath. The whiteboard had "*Welcome to the Unit! You are in room # 9*" written on it, along with a space for the physician, the RN, and the health care aide assigned to the patient, and mother and infant's names. The RN # 8 was observed writing down the names on the board and explaining to the patient: "*Jackie is a health care aide, and she is part of our team*." The RN also added the patient's husband and the older child's names to the board: "*so they will feel included*!"

Obstetricians, family doctors, anesthetists, neonatologists, RNs, and midwives provided healthcare to patients on the unit. Also, there were a variety of medical students and clerks who assisted medical staff in the delivery of patient care. Normally, there were two obstetricians on-call for each shift, and two on-call family doctors who provided labor and delivery care to their (low-risk) maternity patients, one anesthetist on-call, and one neonatologist on-call. Nursing staff consisted of the RNs with experience levels ranging from newly- graduated to experienced (over 25 years of experience) practitioners. All of the RNs underwent an in-depth interviewing process prior to being hired. Most RNs had a previous experience in either labor and delivery or postpartum nursing. Several RNs had worked on SRMC model units in the past, and some had other acute care experiences, such as emergency room. The nurse manager preferred to hire RNs who had labor and delivery background because: *"it is easier to teach the postpartum care piece…the labor and delivery piece is very hard to learn*."

Each patient care area had various levels of staffing, such as two RNs in triage for four patients; one to one care for the labor and delivery patients; and one to four nursing care for postpartum patients. Staffing schedules were developed to ensure that the staff systematically rotated through different work settings (e.g., labor and delivery, postpartum. Value seemed to be placed on having necessary resources for patient care, but also on ensuring that the resources matched the task. For example, RNs were not required to do non-professional work such as picking up patient care equipment, cleaning the patient rooms, or running blood samples to the laboratory. Multiple support staff were noted on the unit. For example, laboratory technicians drew blood work, unit clerks printed blood work requisitions, and the HCA took blood samples to the laboratory. Service workers were always available to clean rooms between the patients, and frequently were noted in the unit hallways, cleaning the unit and stocking up medical supplies. Thus, the presence of the service workers seemed to optimize the nurses' scope of practice. Presence of the support staff appeared to be one of the factors that influenced unit culture.

In summary, the unit's physical environment, and the people who provided maternity of care, physical layout, and the variety of the healthcare providers created a unique and complex system where women and their families are supported through every stage of the childbirth process.

Unit Culture and Impact on Practice

Overall, two main themes, with four subthemes each emerged from data analysis. Creating and maintaining culture was a theme that included four subthemes: (a) vision and philosophical pillars of care; (b) we need thinkers, we need believers; (c) shared leadership; and (d) recognition of accomplishments. Another identified theme was work family. Within this theme the four subthemes were: (a) everyone works together, everyone plays a part; (b) mutuality and credibility; (c) group identity and connectedness; and (d) unpredictable nature and context of the unit.

Creating and maintaining a unit culture (theme). The unit's vision and mission, hiring new staff for "cultural fit", shared style of leadership and recognition of accomplishments were the factors that strongly influenced the development of the unit culture. Participants described the unit culture as "supportive", "friendly", "encouraging", and "positive". Relations on the unit between the providers were marked by high level of interpersonal trust, as well as relatively low levels of conflict. Expectations of behavior that aligned with the existing unit culture were shared with the newcomers. The RN # 2 commented:

> *The message is: it is a supportive environment, we work as a team and have a positive attitude…this gets re-enforced during every orientation, so everyone says: yes, this is the place where I want to work!*

Vision and philosophical pillars of care (sub-theme). Vision and philosophical pillars of care positively influenced beliefs and values of the healthcare providers working on the unit. The nurse manager was "very intentional" in creating a culture of collaboration and respect on the unit. She recounted a consult with an expert in the field to receive advice on cultural innovation:

> *He* [the expert] *was a big promoter of the team building, and he told us to establish the culture right from the get go, and to keep it simple.*

Respect for the organization and its people was emphasized in the unit's vision statement; the unit was described as a place where employees created a "*welcoming atmosphere where everyone is respected and valued*". Furthermore, participants commented on how the unit's model of care, with its "*patient and family centeredness*", was beneficial for the patients. The model of care was explained by the RN # 3:

> *The patients really enjoy it. They value being able to have their family and support in the room with them. The Single Room Maternity allows our patients to have private rooms, so your family can stay with them, and they can have support throughout the night, unlike at the multi-transfer units that have shared rooms and strict visiting policies.*

An obstetrician # 1 described the importance of the involvement of the patient and the family in the decision-making processes about care:

> *The patient and the support person are part of the team, care decisions are made jointly, and all factors are taken into consideration, it is all about how it sits with the patient and what is best for the patient.*

The overall core value of PFCC was demonstrated in the everyday practices of team members. This value is not unique to the SRMC, and is integral to the nursing practice. The RN # 3 explained how following the PFCC guidelines makes her care more "holistic":

> *My goal is to make it all about the patient and the family…you are not just centered on the event of having the baby, but on the whole change, on the patient and* [emphasized] *the family dynamics.*

The belief and support for involving family in patient care was evident in all interviews and observation data. Visitation was viewed as a part of patient care. RNs encouraged the family's support in the care of the patient in a variety of ways. For example, the RN # 8 explained how she included the family in postpartum teaching:

> *When I teach breastfeeding techniques to postpartum women, they are usually so exhausted from the labor. I include dads as well; I invite them in, so they can remind the moms of this information later. They may not be the ones breastfeeding, but they should be able to do every other aspect of the care and assist mom. The dads usually have a lot of questions, and they listen very attentively.*

We need thinkers, we need believers (sub-theme). Clinical competence, although highly valued by the team members, was only one single component of successful clinical performance. Working harmoniously with others was key to building a cohesive team. Hiring staff who exemplified unit values also served to reinforce the organization and unit culture. The nurse manager used a behavior-descriptive interview style with focused questions to solicit information about how the candidates have handled certain situations in the past, and noted that in the potential employees "*some clinical skills can be developed, but personality must fit*". The desired "culture-fit" was based on the following characteristics: "*team players, patient and family focused, and are able to think about the bigger picture*". The nurse manager was very intentional when hiring new staff to ensure the match between the organizational vision and unit vision:

> *We do not want people who are naysayers and say that it* [model of care] *will never work, we want people who are innovative…we have people who worked 15 years in the labor and delivery units, but have not worked a day in postpartum, but the reason it works for them is because they are innovative thinkers, they are believers…*

Shared leadership (sub-theme). Relational structures and solution-based processes on the unit were established to intentionally facilitate engagement of the staff, and to foster ownership of the workplace. Staff and management co-created solutions to issues and concerns on the unit. The nurse manager shared:

> *The only way we succeed is if we work together. The management goes to the front staff and says: so, this is not working, what can we do, what are your suggestions, you are the expert, you are working the front line. I want staff to be responsible, I want to give them power to say how they want the change to be. The front staff needs to identify what changes are important to them, and the management will help to make changes happen.*

Participants explained that the atmosphere on the unit allowed for the discussion of the problems, and opportunity for timely feedback. Respect between the nurse manager and other nurses were noted during the observations and interviews. Staff felt like they can go to the manager for advice

and support, and that the manager would "*back them up".*

One example of shared leadership was the establishment of strategies necessary for staff to prevent and resolve intra-group conflicts. The nurse manager did not view her job as "*fixing things*" on the unit, but rather to equip staff with skills to manage the conflicts. Preventing and resolving conflicts on the unit was named as "*getting out of the swamp*". Across all of the interviews there was a stated value for "*not being swampy*". The nurse manager explained:

> *We want to make sure that our environment stays positive, so when we see gossiping or bullying we are going to call it. How are we going to call each other out? In a very safe way. We would use safe words: you are just getting a little "swampy" here, maybe you want to back up…So we find that there is a humorous tone to it, so people do not get offended, and say: oh yes, maybe I am getting a little "swampy."*

Recognition and celebration of accomplishments (sub-theme). Employees who embraced values of collaboration, teamwork, respect, and patient and family focused practices were recognized and rewarded. This was an important factor in creating and maintaining positive unit culture. Healthcare team members developed a very personalized approach to celebrating each other's accomplishments. The obstetrician # 2 explained:

> *We would write in a card: you are doing a good job, we love working with you, we love your positive attitude. This little gratitude cards re-enforce kindness and supportiveness in the subtle way.*

The healthcare aide also spoke about expressions of gratitude to one another: "*Nurses appreciate us, they give us notes of appreciation, and they also tell us straight up when they appreciate us, they would come and say: thanks for all your help."*

Overall, the ability of staff to work as a team, and the value they placed on teamwork and collaboration were reflected in participants' interviews and observations. The unit culture was represented through the beliefs, values, and norms shared by people on the unit, and modelled by the leadership. The positive culture on the unit influenced the ways members of the healthcare team functioned in their daily practices.

Work family (theme). The unit culture of shared accountability and responsibility impacted care delivery, and participants felt mutually supported which enabled them to successfully carry out their daily practices. Participants described the unit as a place where every person, every single member of the team is important. When asked to describe their co-workers, several participants responded: "we are family, a work family". The RN # 1 shared: "I like coming to work every day…my co-workers are happy to be here, so this is a good environment to work in. It makes a difference if you like who work with, all of the girls are pretty close at work and outside of work". Similar sentiments were repeated in most of the formal and informal interviews with the staff RNs, healthcare aides, and physicians.

Everyone works together, everyone plays a part (sub-theme). Collaboration was an expectation that guided the behaviors of the healthcare team. The RN # 3 spoke of collaboration as interactions and relationships between various professionals:

> *Your co-worker nurses, charge nurse, educators, managers, OR team, healthcare aides,*

> *housekeepers, everyone has to be a part of the team, to make it function, to make it work. Here, everyone works together, and everyone does their part.*

The lack of hierarchy on the unit was obvious. Healthcare team members viewed one another as open to communication and approachable. The RN # 7 assured that all RNS on the unit are "*all equal here, you do not feel like you must curtsy to the doctors"*. The healthcare aide confirmed: "*you never feel like the bottom of the totem pole here".* Participants identified shared decision-making and communication as essential components of collaborative practice on the unit. No single individual was held responsible for all the aspects of the patient's care, and team members had confidence in each other. Staff had a very global way of defining the team, which was not restricted to their primary work group such as RNs or physicians. The obstetrician # 2 stated:

> *The work on the unit is never done in isolation, you cannot work on the maternity unit and be the sole person there, you can only function as part of a team…obstetricians and nurses, healthcare aids, anesthesiologists, everyone seems to jive very well.*

The RN # 3 spoke of communication as "*key*" to a well-functioning team. For example, the "closed-loop communication" was used to avoid breakdowns in communication:

> *Say you are a healthcare aide, and I asked you to do a set of vitals on my patient. I would want you to say: I will do a set of vitals on the patient, and will report to you what they are. This way, I know that you heard me.*

Mutuality and credibility (sub-theme). An environment of mutual understanding, respect, and trust, shared by physicians and nurses alike, reflected the culture on the unit and influenced practices of the healthcare providers. Expectations of the collaborative practice also shaped the unit culture. One example of observed cultural activity was the change of shift meeting. Three shift change meetings were observed. The change of shift meeting is a social interaction between the night and day shift nurses and healthcare aides. This meeting required planning, especially by the charge nurse giving information about the past shift. This event provided an opportunity to observe and analyze interactions between staff on the incoming and off going shifts. The exchanged information was practical, such as details about patients and care plans, and in addition, nurses learned and appreciated each other's expertise. For instance, if a high-risk patient (e.g., with a twin or breech pregnancy) was expected in the unit, the charge RN assigned the care of the patient to the nurse who had the most experience with this type of patient. If staffing permitted, a newly hired RN would be buddied on the same assignment to provide learning opportunities. The change of shift meeting served as one source of information regarding the beliefs, values, and norms of the RNs and healthcare aides caring for patients.

Obstetricians also emphasized the importance of practicing collaboratively, and acknowledged unit RNs' competencies in patient care. The obstetrician # 1 said:

> *We trust them because they know their stuff cold. They are very good clinical nurses, and this is something you don't always get.*

However, they understood that developing trusting relationships also took time. The obstetrician # 2 noted that:

> *You need the time to get to know the nurse. With new nurses coming in it takes time to*

develop trust, it builds over time.

An RN # 5 explained how trust provided her with a sense of safety in her practice:

> *The unit can become acute very quickly, so you need to know that you can count on people in crisis situation.*

Participants valued their experience and skills. RNs demonstrated their credibility by attending educational programs to improve their practice and to keep their knowledge up-to-date. One of the junior RNs (RN # 1) reflected on how she tapped into her co-workers' knowledge and expertise:

> *Because my background is labor and delivery, postpartum is not a strength of mine…when I need advice about the postpartum patient, I go to some nurses who have strong background in both labor and delivery and postpartum and say: this is what is happening, what do you think? There is never any judgement. People are open and approachable; we are all learners here*

Group identity and connectedness (sub-theme). Underpinning the belief in teamwork was a strong commitment to the co-workers, and feelings of pride, ownership, and emotional investment to the daily practices on the unit. The RN # 1 said:

> *We were new, we came to this new place together, we realized early on: we are going to create our own way, because we are different than the other sites…we had to come up with ways of doing it ourselves, and that has really brought everyone together.*

Several participants mentioned socializing as an important aspect of teamwork and "work family" on the unit. Relationships with each other were identified as rewarding, and were central to people's experiences of working on the unit. The RN # 7 expressed this idea by explaining that:

> *We have become friends, and when you work with people you have personal relationships with, you do not want to let them down.*

Learning about different aspects of the maternity care was an important step in building effective work relationships. Working on the unit involved blending of labor and delivery and postpartum roles, and the RNs had to be knowledgeable and comfortable in both sets of skills. Having a clear understanding of each other's contribution to patient care lead to respect and positive attitude between RNs, obstetricians, and health care aides. The RN # 2 explained:

> *If you look at other sites, labor and delivery nurses and postpartum nurses do not get along, despite everyone's best efforts. They blame each other for patient's issues, and neither unit appreciates what the other is doing. Here, we do it all. So, we totally get where the others are coming from. What helps us to avoid a conflict is that we see what the other side do, and we can see the whole picture better.*

Unpredictable nature and context of the unit (sub-theme). Working as a team resulted in collective support and relief, which meant that staff could continue working in an acute, fast-paced environment without feeling burnt-out. Again, the concept of work family was

evident in how members of the team readily offered and accepted help with patient care, listened attentively and communicated respectfully to each other. As stated by the RN # 8:

> *You are dealing with complicated things, you need to feel supported, then there is less stress. I think there is a strength in numbers, you can accomplish more and give better care when you are not overwhelmed, or scared, or stressed. Working as a team helps. The patients get better care, and the nurses are less stressed, people are happier when you work as a team. Burn-out is a very real risk factor in maternity care, because the unit is a high-intensity, high acuity, and high volume, and it can wear on people. Because of the supportive environment, people still see the acuity and stress, but burn-out is minimized…*

The participants described unit activity as unpredictable, fluctuating in both volume and acuity. RNs often felt that they had to "*keep on their toes*" and "*watch and wait*". It was noted that: "*you just never know what might come bursting through the door the next minute*". For instance, one RN "*liked"* the unpredictability of the unit, and described it as a way to keep her job exciting. The RN # 5 said:

> *I like having variety and excitement. I like coming in and going with the flow, I find if you are doing the same thing day in and day out…you get bored.*

As a team, unit members supported each other in addressing patient care cases. As a result, staff appeared to have better endurance and resilience. The RN # 1 said:

> W*hen I started working on the unit, I was nervous. But there was a lot of support, everyone was so good to bounce ideas off, and when I got my first labor, everyone helped me. Little things really help you out when you are new, and take the stress out of your work.*

Participants enacted their roles as members of a "work family" through functioning as a cohesive team, where each other's professional knowledge and contributions to patient care were respected and valued. The feelings of mutual support and trust, shared by physicians, nurses and healthcare aides alike, also created conditions that further enhanced collaborative practices on the unit.

Discussion

This ethnographic study describes how culture of the SRMC unit impacts healthcare providers' daily practices as they look after childbearing women and their families. Two main themes emerged from the data collection: *creating and maintaining culture* (subthemes included *vision and philosophical pillars of care*; *we need thinkers, we need believers*; *shared leadership;* and *recognition of accomplishments*), and the *work family* (subthemes included *everyone works together, everyone plays a part*; *mutuality and credibility*; *group identity and connectedness*; and *unpredictable nature and context of the unit*). The culture of the unit was largely based on teamwork and collaboration, and shaped the ways for staff to work collectively towards goals around patient-centered care, and problem-solving. Participant portrayal of expectations, attitudes, norms, and values provided a rich description of expected

behavioral patterns and signified the prevailing culture of a "work family". Culture is critical in developing and preserving levels of dedication among employees (O'Reilly, 1989). Reinforcing shared values and purposes is a helpful way to keep a team working together (Ashoori et al., 2014). The actions of the nurse manager that influenced the development of the unit culture were provided as an example of shaping the desired culture on the unit. While not unique to the SRMC model, some of these intentional actions were: consultations with experts in team building and cultural innovation, development of unit vision and mission statements, providing opportunities for collective problem-solving, and celebration of accomplishments. Further, the nurse manager used a descriptive-behavioral style of interviewing to carefully select new employees to ensure an appropriate culture fit. Person-culture fit has been linked to individual commitment, and workplace satisfaction (Carlstrom & Ekman, 2012), because hiring staff that "fitted" with the culture allowed for staff's easier adjustment to the unit culture.

Workplace culture influences how healthcare providers function in their day-to-day practices (Arundell, Mannix, Sheehan, & Peters, 2017). When nurses think about changing their profession, they state the workplace culture as one of the common reasons to leave the workplace (Wei, Sewell, Woody, & Rose, 2018). Management style has been reported to be a key variable in predicting the turnover rates of nurses and the quality of patient care (Leveck & Jones, 1996). A recent Finnish study found that young and newly graduated nurses especially need support from their managers in order to feel committed to their workplace (Kurjenluoma et al., 2017). Further, the leadership style of nurse managers influences nurses' satisfaction with the workplace (Morsiani, Bagnasco, & Sasso, 2017). Black and Westwood (2004) reported that when shared leadership was employed on the hospital unit, it fostered trust, cohesiveness, and communication, and conflict resolution amongst the members of the healthcare team. Findings from the present study support previous research that suggests shared leadership is an appropriate way to lead team-based healthcare structures, as the nature of healthcare requires collaboration. Teamwork was viewed by participants as key to working synchronously and exchanging patient care information and knowledge between different professions (e.g., RNs, physicians, lactation consultants, pharmacists). Similar to other research, this study showed that teamwork and collaborative practice created successful working conditions for healthcare team members in the acute, unpredictable context of a maternity care unit (Berridge et al. 2010; Hua et al., 2012; Hutter & Diehl, 2011). The present study identified effective communications between staff in various professional groups (e.g., nurses, physicians) that served to support efficient patient care, and promoted positive professional relationships. Transparent interactions, and effective communication are known to be necessary to create successful teamwork (Berlin, 2014). In maternity care, failure to communicate effectively may result in erroneous exchange of patient-related information between care providers and can cause medical errors, contributing to the adverse effects in the maternal and perinatal health (Hua et al., 2012; Lewis, 2007).

The participants noted that inter-professional communication practices on the unit were friendly, positive and respectful, both during emergencies and low-acuity situations. Poor relationships between the RNs and physicians can impede communication and collaboration (Chang et al., 2009). In a recent Australian study, both new and experienced midwives identified negative workplace culture as a barrier to providing quality care to women and their families (Catling, Reid, Hunter, 2017). Vertical hierarchy is another common barrier to

effective communication and collaboration (Sutcliffe et al., 2004), and has been found to contribute to compromised patient care due to delayed recognition and responses to changes in patients' health status (Berridge et al., 2010). In contrast to this finding, participants on the unit described staff interactions as positive and inclusive. Furthermore, no role conflicts or interpersonal power struggles were observed or reported by the participants.

For study participants, being able to work in an atmosphere of mutual support and trust provided an opportunity to recognize each other's contributions to patient care, and enhance each other's skills. Understanding each other's contribution to patient care has been reported as one of the factors that led to respect and a positive attitude between co-workers (Quinlan & Robertson, 2010). These findings are similar to research on inter-professional learning opportunities within established teams, where team members learned about one another's perspectives and practices as a way to improve collaboration and teamwork (Freeth et al., 2008). Because the SRMC unit offered care to women in various stages of childbirth, working on the unit involved blending of the labor and delivery and postpartum roles. Hence, the team members had to possess labor and delivery, as well as postpartum care skills, in addition to understanding unique contributions to care from other providers. Learning about different aspects of maternity care appeared as an important step in building effective work relationships.

Staff were bound together by shared cultural expectations, and norms that directed individual and group behaviors. Appreciation from each other had a motivating effect. Participants felt it was a privilege to be part of such a high performing team. These findings are similar to research by Wheelan (2010), which demonstrated that appreciation was a driving force to motivate further positive efforts in the workplace. In a recent study of the Icelandic nurses, the motivation of nurses by the management was instrumental in creating organizational commitment towards patients and colleagues (Halldorsdottir, Einarsdottir, & Edvardsson, 2018). Specific to the SRMC unit, Grubbs and Cottrell (1996) noted that the appreciation for the staff working on a newly opened SRMC unit encouraged nurses' commitment to the patients care and workplace.

Implications for Nursing Practice

Nursing management succeeded in developing a collaborative agenda amongst members of the group to benefit patient care, and to create a positive working environment. The members of the team had shared values, such as to meet the needs of women and their families, and a desire to collaborate and learn. The findings of this study contribute to an understanding of the important role that the unit culture plays in affecting behaviors of the members of a cultural group. If one was attempting to open a SRMC unit, it seems that support from nursing management, having adequate staff development resources, providing rewards and recognition, and ample ancillary support for the nurses may be critical for success. The nurse managers are encouraged to create a positive workplace culture on the unit, by creating a clear vision for the unit, and by motivating staff though appreciation and rewards. Specifically, having a vision for the unit that individuals can "own" may help to translate the unit vision into the employees' personal vision. This may make it easier for staff to support and achieve the desire outcomes of the organization, such as teamwork, positive working environment, collaboration and patient and family-centered care. It is also important that nurse managers create opportunities to celebrate

staff achievements as means of creating strong teams. A multitude of factors such as unit history, group memberships, relationships between group members, managerial and institutional support, care model and nature and context of practice determine the culture of the birthing unit. The complexity of this picture reinforces the importance of investigating how unit culture shapes practices of the healthcare providers working on the unit.

Conclusion

This study describes how culture on the SRMC plays role in shaping healthcare providers day-to-day practices and beliefs. Constructing a SRMC unit is more than development of physical space; it is about the climate and culture that exist within this built environment. Therefore, it is necessary to understand how the unit culture influences healthcare providers' practices. This was the first study to explore how the culture of the SRMC unit influences healthcare providers' practices. To further understand the impact of SRMC model on care providers, a comparative study of SRMC and traditional maternity care is needed.

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