

This assignment is going to reflect upon different events I have experienced while on placement in my employment as a maternity support worker in a local hospital. As a maternity support worker, I was working under the guidance of a registered midwife in providing care, help and support to women and their babies with their families (RCM, 2016). I have chosen to use my employment as my placement as perhaps it would give me a different perspective and allow me to view it more objectively. Open University (2019) describes reflection as a way of assessing yourself, how you study and the way you work. Reflection in healthcare can be described as a process in which health care workers can consider their encounters, both negative and positive ones, to enable them to learn from that experience and guide improvements in their future practice (NMC, 2019). Reflection can be one of the most important sources of improving the way you work, by amalgamating theory and practice greater knowledge, understanding and learning is gained (Muller, 2015) and, as Dewey (1916, cited in Rolfe *et al.*, 2001) points out 'we learn from doing and seeing what becomes of our actions'.

For me to reflect efficiently, I have investigated and considered the different models of reflection and theories. According to Rolfe *et al* (2001), a theory is a method of sequencing knowledge, in a useful framework that explains and describes. Many models could be used to reflect, however, as Gibbs (1998) educational framework divides reflection into six various categories, I believe this provides the most appropriate structure for someone like myself, who is not familiar with reflection, and is the model I have chosen to use for this assignment. It could, however, be argued that as this model separates the experience into distinct categories, it does not provide a holistic approach to maternity care which aims to provide a 'woman-centered approach' (RCM, 2014)

For me to use these events in this essay, pseudonyms will be used throughout to ensure confidentiality and privacy is maintained. Following NHS Code of Practice, disclosure of any information that could enable the identification of a patient, must not be shared unless the patient has consented or there is a legal reason for doing so (DOH, 2003).

Event 1

The first event I have decided to reflect on was chosen as it was an experience I will not forget and, through reflection, I feel this will aid me in becoming more professional in terms of best practice and having a clearer understanding of personal and professional boundaries.

Ms A was in the final stages of pregnancy. She was admitted to the antenatal ward for induction of labour due to being currently sectioned under the Mental Health Act (1983) for drug-induced psychosis. Before admittance, she had presented in accident and emergency having taken a heroin overdose and was requesting an inhaler. Her behaviour was erratic, which led to her being sectioned. Throughout her hospital admission, she was on anti-psychotic medication. Ms A was known to me as she grew up on the same estate that I did. However, she was taken into care in adolescence. We recognised each other, and initially, Ms A was chatty towards me asking me to make her a cup of tea and sharing with me that she only discovered the pregnancy at 26 weeks' gestation. Ms A always had to be supervised by two mental health workers. Ms A had two previous children removed from her care, and this baby was also going to be removed.

When Ms A became in 'established labour' (WHO, 2018), she was transferred to the labour ward for delivery. While in labour, the two mental health workers were stood in the doorway of the delivery room. Ms A had a normal delivery; however, the baby was born with a noticeable abnormality. Following delivery Ms, A transferred with the baby to the postnatal ward, awaiting a court order to be granted to remove the baby from her care. While on the postnatal ward she was allocated a side room for privacy, however, she still had to be supervised by two mental health workers and also a social worker who all sat in the room with her. However, Ms A was very hostile towards and did not trust the social worker. When she needed to leave the ward to have a cigarette accompanied by the mental health staff, she would bring her baby to the maternity staff office to be cared for. On one of these occasions, I had just come on duty, and when she returned to collect her baby, I congratulated her and stated that her baby was gorgeous. At this point, Ms A attitude towards me changed where she did not reply, gave me an unpleasant look and took her baby back to her room.

Ms A cared effectively for her baby for five days while waiting for a court order to be approved. However, she became paranoid that the medical staff and especially the social worker wanted to harm her or her baby. This paranoia caused her to believe that the baby milk provided by the hospital would be poisoned and therefore, she arranged to have her own milk brought in. Also, she believed medication given would be tampered with, and therefore midwives had to open the sealed medication in front of her. On occasions, Ms A appeared to deny the baby was hers saying 'my baby wouldn't look like that' referring to the abnormality. Five days after delivering her baby, a

court order was granted, and the baby was removed from her care, and Ms A was transferred back to the mental health ward under the section.

When I first saw Ms A, given the fact I knew of her personally, I was quite taken aback by the extent of her mental health problems and the effect this had on how she appeared. My initial feeling was that she might object to my involvement in her care, and questioned would she feel that I would breach confidentiality or judge her? According to Hooks (2015), pregnant women that are drug users are afraid to attend healthcare settings due to fear of the attitudes of staff members and the feelings of being judged or treated in a different way to others. I could not help but feel initial upset that, yet another child had been conceived when her others had been taken into care. However, I felt sorry for her as I knew her life had changed in adolescence through her involvement with drugs and her drug use worsened following the removal of her first child.

Furthermore, I felt that being under the surveillance of the mental health workers was an invasion of her privacy, especially during her labour. I felt that by allowing Ms A to bond with her baby for five days was extremely cruel when it was known a court order was being sought and it was predetermined that the baby would be taken into care due to her lifestyle and poor mental health. While deep down, I knew that removing the baby would be the best decision, I could not help but feel emotional and compare it as a mother myself.

On evaluating this experience, I felt that it was both a positive experience in that I was reminded of the need to maintain confidentiality (DOH, 2003). It was also a useful reminder of the contentious situation it can be when dealing with patients that you know. According to the Royal College of Nurses (RCN, 2020), knowing somebody on a personal level may be a valid reason for staff to withdraw from caring for them. Therefore, it may have been better to have alerted the midwife in charge this patient was known to me and asked not to be involved in her care. This would have prevented me from feeling emotional and crossing any professional boundaries. This experience was good as it enabled me to gain a better understanding of the value and need of mothers spending time with their new-born babies whatever the situation. Crenshaw (2007) argues that mothers and their babies have a shared physical and emotional need for closeness and on reflection, my initial views of it being cruel to have changed. Arguably, it was positive that the baby was being removed and cared for by experienced foster carers who would be able to meet

the baby's needs. The birth mother, due to her mental health issues and drug dependency, would be unable to do so (Messina *et al.*, 2015; Strand *et al.*, 2015). As the patient's baby was being taken into care when looking at the situation from a different perspective, it may have been better for me not to have congratulated the patient and positively commented on the baby. I could have simply asked her how she was or maybe just smiled.

It is a concern for health care staff working with vulnerable patients, and this event has highlighted to me the importance of safeguarding policies. While I always found it to be very invasive that Ms A had to be supervised, I understand that maintaining the safety of the patient, her baby and the staff around her was paramount (Social Services and Wellbeing (Wales) Act, 2014; Mental Capacity Act, 2005). Mainly due to her behaviour being so unpredictable in psychosis.

Ms A's behaviour towards me initially was friendly, which was possibly due to recognising me. She showed this by sharing information with me about the pregnancy or perhaps may have been seeking acceptance for her pregnancy. Her attitude may have changed after birth because she knew she had to come to terms with having her baby taken away from her, and therefore, all staff involved may have been viewed with disdain. According to Cooper (2012), it is important not to take the presented behaviour to heart as it very often represents a response to the role you are working in or what you represent as opposed to a personal issue with you. Perhaps, due to baby's abnormalities, she did not want to hear positive remarks either about giving birth or her baby and felt she was being patronised or judged inappropriately as her baby was being removed (Calder, 2016). Ms A's statement that the baby was not hers could, in fact, have been due to her psychosis. Also, she may have been in denial that the child had an abnormality possibly caused by her drug dependency. As according to Mind (2020), a person with psychosis interprets real life differently to others and is suggested a person loses contact with the real world. On the other hand, it could be the way her mind was coming to terms with the loss of her baby due to the forthcoming removal into care.

While Ms A's mistrust of the social worker may also have been as a result of her mental health. However, it could also be due to her own experiences of being in the care system when she was younger, leading to suspicion and mistrust of social workers (Davies, 2015; Calder, 2016). Bowlby (1969) points out that a sign of an attachment disorder, perhaps because a person was in care as a

child and not able to form a secure attachment, is a reluctance to seek help from others and a general mistrust of those in authority. Also, the fact that her own children had been previously removed from her care indicates social services involvement which could perhaps have increased her mistrust. Furthermore, Calder (2016) argues that families that have had personal involvement in the 'child protection system' are more likely to experience poor mental health and substance abuse. Perhaps this could explain why her drug use worsened after the removal of her first child.

Although I had emotional reactions to the situation, as a mother myself it is hard to imagine what it feels like to have a child removed. I found it particularly difficult to separate my professionalism to that of just being a mum. According to Jeffery (2016), cognitive empathy is being able to recognise and appreciate another person's feelings and viewpoint objectively. I was unable to display cognitive empathy which is a skill I need to develop to enable me to separate my personal feelings of sympathy and compassion. Cognitive empathy would have enabled me to understand the experiences of this mother without arousing a personal emotional comeback. I found that it was hard to switch off what had happened and was not something I could leave at work and dwelled on it at home afterwards. It may have been better for me to have asked for a debriefing at the end of the day, so I did not take my feelings home with me. According to Vaithilingham *et al* (2008), a debriefing is an effective way of lessening the emotional impacts that staff can experience following an adverse incident.

On analysis, my views of allowing Ms A to care for and bond with her baby while awaiting court somewhat altered. I initially considered it to be cruel. However, it could be looked at in a similar way to that of a bereaved mum who finds having their stillborn baby with them for a few days gives the most valuable memories and helps them to cope with the loss. Adoptions Together (2015) agree with this and point out that by enabling mothers to have the opportunity to spend time with their babies after delivery allows them to process the removal more effectively in the future.

Reflecting on this scenario helped me recognise and take account of the need in the future for diplomacy when speaking to vulnerable mothers, especially in sensitive situations where they are losing their baby. It has been useful to develop my knowledge and understanding of the need for mothers to spend time and care for their baby even when the baby is being taken into care. Also, it was good for me to understand the need to learn the skill of cognitive empathy to enable me to

separate my personal feelings from my professional behaviour. Furthermore, it has highlighted that I need to be mindful when I am working with people, I know of what I say and maintaining professional behaviours. I now believe that I have a better understanding of mental health issues and substance misuse and the underpinning factors.

In future, I will endeavour to be more careful or cautious about what I say to a mother whose baby is being taken into care. I am aware that I need to be more diplomatic in the comments that I make. In future, if a patient comes to the ward that I am familiar with I will arrange with the midwife in charge if possible, for me to not have any involvement in her care to prevent any difficulties arising. I need to become more resilient in situations like this as I am likely to come across similar situations again and take on board the need to develop my cognitive empathy by attending further training and arranging to complete online courses to aid this.

Event 2

The next event I have chosen to reflect on was chosen because it was an embarrassing and uncomfortable experience where I felt unskilled and inadequate.

The chosen incident occurred during a busy shift working on the labour ward. In the maternity department, we have four different areas to work, antenatal ward, postnatal ward, midwifery-led unit and labour ward. During my time working for the department, I had never been allocated to work on labour ward before and was unfamiliar with the role, however, due to staff shortages this shift, I had to. On two previous occasions, when attending my annual personal development meeting with my manager, knowing I will be required to work in the labour ward, I had requested training in this area. However, this did not materialise. I received handover from my colleague and was made aware that all rooms on the ward were currently full of women in labour. I was given a quick talk through the basics of what I needed to do and left to get on with it. Not long into my shift, the emergency buzzer went off. I ran to assist, along with other colleagues and I was told: "can you get the reg – fetal brady in room 1". The "reg" being the obstetric registrar and "fetal brady" meaning bradycardia which is when the heart rate of the baby is abnormally low and is a potential indicator that the baby is distressed and may require urgent delivery (Carvalho, 2014).

I ran to the office to make the call but was unable to locate the telephone number, there was nobody around for me to ask so I had to run back to the room and explain I could not find the phone number to which the midwife in charge sternly replied in a raised voice 'you bleep them!' I returned to the office quickly looking through the noticeboards for the bleep number aware that I was wasting crucial time when a colleague came into the room and informed me of the bleep number. Having responded to my bleep, the obstetric registrar quickly arrived on labour ward and made the decision to take the woman to theatre for an emergency caesarean section.

I was then asked to bring a catheter to the room for the midwife to insert, unaware there were different types of catheters I just grabbed the first one I saw and took that. The midwife appeared to be panicking when I returned and again responded firmly and in a raised voice "try again it's the wrong one". I then replaced with the correct catheter and the woman was taken to theatre for caesarean section. When they arrived in theatre, I heard the midwife in charge then shout that there was no Cardiotocograph machine in there. A cardiotocograph machine is used to monitor the heartbeat of the baby and the contractions of the uterus (Bass *et al.*, 2012). I quickly went to get one and returned with it and said 'I am so sorry – It's my first time here' to which she just rolled her eyes, received the machine and walked off. I was unaware that it was part of my role to ensure there was a monitor in the room the moment the decision was made to go to the theatre. The mother was then delivered of a healthy baby, and both were doing well.

At the time, my initial thoughts were that the patient and other midwives and doctors could hear all of this and would be thinking I was incompetent. As the midwife in charge did not appear to be supportive towards me, I was thinking I am not going to be able to do this and wanted my shift to end for me to be able to go home. At one point, I recall myself briefly thinking of a reason I could use as an excuse for me to go off duty. I felt emotional, humiliated and incompetent and was aware of the reddening of my face. However, I determinedly thought I must continue my shift. I felt anger towards the midwife in charge for speaking to me the way she did and moreover, for not being more considerate after explaining it was my first time on the labour ward. I felt remorseful for the patient for having to witness the incident and felt that my incompetence had delayed her getting to the theatre which could have led to an unimaginable, devastating outcome (Mishra *et al.*, 2017; Goodman *et al.*, 2017).

Following the experience, my feelings were still that of incompetence and embarrassment. Another midwife approached me and asked how I was. She advised me I was not the first person to have felt like this when working with this person and assured me that I was doing a great job given the circumstances of having not worked there before or had any proper training. On reflection, this provided me with a somewhat sense of feeling supported and reassurance that other colleagues were not thinking I was inept. *Mikkola et al* (2018) state that having support from colleagues can aid in learning and development. Had the midwife been more supportive and understanding this opportunity would have assisted my professional development through familiarisation with labour ward requirements.

When evaluating this experience, I feel that I should have spoken up at the beginning of the shift and made everyone aware that I had not worked there before. This may possibly have prevented the midwife from being unsupportive towards me, and she may have been more understanding. It would have allowed me to be more confident, knowing that I had the support of all colleagues on that shift (*Mikkola et al.*, 2018). I was aware I did not have the experience or knowledge of labour ward expectations. However, after receiving a handover and a quick overview of the basics, this benefitted me as I was able to get some form of knowledge which I was able to learn from and take forward. It was positive that I was able to continue working this shift as I feel I will be able to learn from this and the mistakes that were made. It was good that despite these unfortunate mistakes that the mother and baby did not suffer any adverse consequences.

In analysing the situation, this experience has highlighted the need for me to be more proactive in my learning and development. *Rehnstrom and Dahlborg-Lyckhage* (2016) point out that by being proactive, problems can be anticipated and prevented. Therefore, I should have kept asking for training and not left it until my next annual review before raising the issue again. I could have used quiet times on my ward as an opportunity to ask if I could shadow the staff on the labour ward to familiarise myself.

If the emergency numbers for contacting Doctors had been clearly displayed, this would have helped me and reduced the delay in me finding the correct number. Now that I know the numbers, I have recorded them in the back my diary should I need to call or bleep them again.

Even though the midwife was not particularly pleasant, and appeared to raise her voice at me, I understand that in emergency situations, the midwife requires a clear voice to effectively convey information. England & Morgan (2012) point out that midwives need to communicate clearly, directly and firmly. However, by not specifying the exact type of catheter that was required, her communication was not clear. Furthermore, assuming I knew about the bleep system and how to prepare the theatre for a caesarean section meant she did not effectively direct me. O'Daniel and Rosenstein (2008) stress that the safety of patients is at risk if there is poor communication between staff. I realise that the midwife did not know this was my first time working on the labour ward, and if she had, then she may have been more supportive and specified what I needed to do. This also highlighted to me that my communication was not as effective as Dyer and Dyer (2019) point out, not voicing my concerns is a contributory factor in poor communication. I should have spoken up to ensure all staff were aware I was inexperienced. I was required to work on the labour ward, and when I arrived, everyone was busy, which made it difficult for me to discuss my lack of experience. Furthermore, at the time I did not feel there was any point in raising this as staff shortages meant there was no other option, however, on reflection had I have mentioned it staff attitudes may have been different.

The overall outcome has had its benefits as it has allowed me to gain some experience in an area I had never worked. Ideally, I should not have been put in this position and should have received training on the ward procedures before working there. However, when there are staff shortages, it is expected that you work where you are needed. It has allowed me to acknowledge that on occasions where I feel I cannot continue, I proved that I can. By continuing my shift to the best of my ability, it enabled me to complete the work I was familiar with successfully, and the work I was not familiar with, I have gained some insight into. Furthermore, it has enabled me to voice the need for me to have further training in this area and become more proactive in my development. This embarrassing situation may have been avoided if I had stated upfront that I had no previous labour ward experience.

To address the things I have identified from this reflection, in future if I am asked to work in an unfamiliar ward, I will tell the midwife in charge as soon as I begin my shift that I have not previously had experience working there. I will explain that I need to know specifically what is needed to enable me to carry out instructions efficiently, especially when emergencies arise. I will

ask if I can spend further time on the labour ward to enable me to be familiar with the requirements. I will become more proactive and utilise any opportunities on quiet shifts to shadow staff on the labour ward. Going forward, I have started to compile A4 laminates with important numbers on, to be displayed near the phone in each working area.

Event 3

The final incident I have chosen to reflect on is when working on the antenatal ward. It was a very busy shift, and I was asked to chaperone a Doctor who would be performing a speculum examination on a woman who had presented with suspected ruptured membranes. The doctor was currently seeing another patient in the adjacent bed who needed a cannula sited, so I proceeded to get all the required equipment in readiness for him to perform the procedure. I observed that after the doctor had sited the cannula in the patient, he did not wash his hands before coming in to see the patient who needed a speculum examination. I knew this was wrong; however, I did not feel confident enough to tell him. I was considering a way that I could best tell him, however, by the time I had decided the best way to approach this, he had already started his procedure. Therefore, I did not say anything to him and left him to continue performing the procedure. I later told the senior midwife who thanked me and addressed the situation with the doctor. However, she told me that I should have reminded the doctor myself. The doctor apologised and stated that he had not realised his omission due to being so busy and stated he would be more vigilant in future.

Observing this made me feel uncomfortable because I knew how crucial handwashing is, even though surgical gloves were used. I felt especially concerned and knew I should have spoken up but lacked the confidence to do so. I felt inferior to the doctor and therefore, unable to challenge him. I felt annoyed with the doctor as he could be cross infecting patients and putting everyone at risk and angry with myself for not speaking up. Furthermore, I felt that I was partly responsible should any harm come to the patient because of this.

It was a bad practice that I did not challenge the doctor when I observed he had not washed his hands. Laurel (2016) points out that healthcare staff that do not voice their concerns when knowing something is wrong are not communicating effectively. Ineffective communication is one of the most common causes of adverse outcomes in healthcare and is a major factor in the high number of preventable deaths that occur each year. Okuyama *et al* (2014) agree with this, and further states

that healthcare workers should speak up before patient safety is compromised to enable the opportunity to rectify. However, by reporting the incident to the Senior Midwife, it has ensured that the doctor was made aware of it. It was good that she followed this up immediately with the doctor and that he acknowledged that he should have washed his hands, apologised and assured he would ensure he always did so in the future. Schmidt (2011) points out that many healthcare workers tend to voice their concerns with colleagues as opposed to speaking directly with the person concerned; this suggests that healthcare workers like myself lack confidence in speaking out. On a positive note, thankfully, no harm came to the patient.

On reflection, my analysis of this situation is that although this incident should not have happened, my response to it should have been more assertive; especially when knowing that hand hygiene is the most effective way of reducing the spread of germs and viruses (WHO, 2009), and particularly given that we are currently amid COVID-19 pandemic where handwashing is paramount in reducing the spread (WHO, 2020). According to Ratna (2019), healthcare staff must communicate effectively to ensure patient care and safety is not compromised and, in acknowledging this, I am aware that my communication skills were not effective. I should have spoken directly to the doctor about it, but I felt challenged as I lacked the confidence to confront somebody in a higher position than me. Samuel *et al* (2015) state that a hierarchal culture within healthcare settings could stop less experienced staff from voicing their concerns. However, the qualified midwife felt more able to address this issue, and this has left me feeling more confident that this doctor would learn from this and not behave in this way again.

This incident has taught me how quickly and easily a patient's safety and wellbeing can potentially be compromised, and it has highlighted how important effective communication and being assertive with colleagues when working in a healthcare setting is. My inability to challenge the doctor directly, and have the courage of my convictions, has shown me that this is an area I need to work on. As Gentile (2010) would term it, I need to build up my 'moral muscle'. However, I did fulfil my duty under health and safety by reporting this to the midwife in charge.

In future, I will try to be more confident in speaking up, especially when I know things are wrong. Alternatively, using body language as a prompt to discreetly communicate a message of their

omission may be a better way of conveying this. I will look into assertiveness training and practice this in my everyday life.

In conclusion, this reflection has allowed me to look at my practice from a more objective stance. I have learned a lot about myself and have found this empowering. The incidents that I have described and reflected on using the Gibbs (1998) model of reflection have enabled me to look in detail and from different angles at the incidents. This has developed my professional understanding and knowledge. By using Gibbs (1998) reflective cycle as a model for reflection it has enabled me to consider the emotional aspects of a situation. This has helped me to understand my reactions in certain circumstances and gain a better understanding of myself, to make changes in choices of what I say and do in the future. My overall reflection on my placement experience and in writing this assignment has encouraged me to carry out and read academic research to understand better the importance of reflection in all environments. Through developing my reflective practice, it has helped me to value that looking back at a situation enables me to reflect less emotionally, and this assists me in finding less subjective and better outcomes. The experience that I had of being spoken to sharply by the midwife has made me critically consider my own behaviour and how this may have affected her attitude. This reflection has also highlighted my need to consider how best to develop my communication skills, as this is something that was highlighted in all three scenarios and suggests that this is something I need to work on in future.

References

- Adoptions Together (2018). *Will You Spend Time With Your Baby In The Hospital? Adoption & You*. Adoptions Together. Available at:
<<https://www.adoptionstogether.org/blog/2018/05/04/will-you-spend-time-with-your-baby-in-the-hospital/>> (Accessed 8 May 2020).
- Bass, L., Walpole, C. and Folwell, J (2012). *Monitoring In Labour*. Uhcw.nhs.uk. Available at:
<https://www.uhcw.nhs.uk/clientfiles/files/Monitoring_in_labour_UHCW_patient_information.pdf> (Accessed 28 May 2020).
- Bowlby J (1969). Attachment. Attachment and loss: Vol. 1. Loss. New York: Basic Books.

- Calder, M (2016). *Risk in Child Protection Assessment Challenges and Frameworks for Practice*. London: Jessica Kingsley Publishers.
- Carvalho, J (2014). Primary bradycardia: keys and pitfalls in diagnosis. *Ultrasound in Obstetrics & Gynecology*, 44(2), pp.125-130.
- Cooper, F (2012). *Professional Boundaries in Social Work and Social Care*. London: Jessica Kingsley Publishers.
- Crenshaw, J (2007). Care Practice #6: No Separation of Mother and Baby, With Unlimited Opportunities for Breastfeeding. *The Journal of Perinatal Education*, 16(3), pp.39-43.
- Davies, H (2015). *Understanding Children's Personal Lives and Relationships*. Basingstoke: Palgrave Macmillan
- DOH (2003). *Confidentiality NHS Code Of Practice*. Assets.publishing.service.gov.uk. Available at:
<https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/200146/Confidentiality_-_NHS_Code_of_Practice.pdf> (Accessed 24 May 2020).
- Dyer, G. and Dyer, J (2019). *How to Support High Performing Teams and the Culture to Support Them*. New Jersey: John Wiley and Son, Inc.
- England, C. and Morgan, R (2012). *Communication Skills For Midwives*. Maidenhead: Open University Press.
- Gentile, M (2010) *Giving Voice to Values: How to Speak Your Mind When You Know What's Right*. Michigan: Yale University Press
- Gibbs, G (1998) *Learning by doing: A guide to teaching and learning methods*. Further Education Unit. Oxford: Oxford Polytechnic.
- Goodman, D., Srofenyoh, E., Olufolabi, A., Kim, S. and Owen, M (2017). The third delay: understanding waiting time for obstetric referrals at a large regional hospital in Ghana. *BMC Pregnancy and Childbirth*, 17(1).
- Hooks, C (2020). *Paranoid Or Persecuted? The Stigmatisation Of Pregnant Drug Users: A Literature Review*. Arro.anglia.ac.uk. Available at:
<https://arro.anglia.ac.uk/700038/8/Hooks_2015.pdf> (Accessed 7 May 2020).

- Jeffrey, D (2016). Empathy, sympathy and compassion in healthcare: Is there a problem? Is there a difference? Does it matter?. *Journal of the Royal Society of Medicine*, 109(12), pp.446-452.
- Laurel, N (2016). Speak up for patient safety. *Nursing Critical Care*, 11(6), p.4.
- Mental Capacity Act (2005). c.9. Available at:
<http://www.legislation.gov.uk/ukpga/2005/9/section/4A>
- Mental Health Act (1983). c.20. Available at:
<http://www.legislation.gov.uk/ukpga/1983/20/contents>
- Messina, N., Calhoun, S., Conner, E. and Miller, M (2015). Improving the outcomes of children affected by parental substance abuse: a review of randomized controlled trials. *Substance Abuse and Rehabilitation*, 6, pp.15-24.
- Mikkola, L., Suutala, E. and Parviainen, H (2018). Social support in the workplace for physicians in specialization training. *Medical Education Online*, 23(1), p.1435114.
- Mind (2020). *About Psychosis*. Mind.org.uk. Available at:
 <<https://www.mind.org.uk/information-support/types-of-mental-health-problems/psychosis/about-psychosis/>> (Accessed 26 May 2020).
- Mishra, N., Gupta, R. and Singh, N (2017). Decision Delivery Interval in Emergency and Urgent Caesarean Sections: Need to Reconsider the Recommendations?. *The Journal of Obstetrics and Gynecology of India*, 68(1), pp.20-26.
- Muller, G (2015). Reflective Practice to Connect Theory and Practice; Working and Studying Concurrently. *Procedia Computer Science*, 44, pp.679-688.
- NMC, (2019). *Regulators Unite To Support Reflective Practice Across Health And Care*. Nmc.org.uk. Available at: <<https://www.nmc.org.uk/news/press-releases/joint-statement-reflective-practice/>> (Accessed 1 May 2020).
- O'Daniel, M. and Rosenstein, A (2008). Professional Communication and Team Collaboration. In: Hughes, R. *Patient Safety and Quality an Evidence-based Handbook for Nurses*. Rockville, MD: Agency for Healthcare Research and Quality.
- Okuyama, A., Wagner, C. and Bijnen, B (2014). Speaking up for patient safety by hospital-based health care professionals: a literature review. *BMC Health Services Research*, 14(1).

- Open University (2019). *Self reflection | Unison*. Available at:
<http://www.open.ac.uk/choose/unison/develop/my-skills/self-reflection> (Accessed 01 May 2020).
- Ratna, H (2019). *The Importance Of Effective Communication In Healthcare Practice*. Harvardpublichealthreview.org. Available at: <http://harvardpublichealthreview.org/wp-content/uploads/2019/09/Vol-23_Effective-Communication-in-Healthcare_HPHR.pdf> (Accessed 26 May 2020).
- RCM (2014). *High Quality Midwifery Care*. Rcm.org.uk. Available at:
 <<https://www.rcm.org.uk/media/2354/high-quality-midwifery-care.pdf>> (Accessed 28 May 2020).
- RCM (2016). *The Roles And Responsibilities Of Msws*. Rcm.org.uk. Available at:
 <<https://www.rcm.org.uk/media/2338/role-responsibilities-maternity-support-workers.pdf>> (Accessed 3 May 2020).
- RCN (2020). *Refusal To Treat | Advice Guides | Royal College Of Nursing*. The Royal College of Nursing. Available at: <<https://www.rcn.org.uk/get-help/rcn-advice/refusal-to-treat>> (Accessed 26 May 2020).
- Rehnström, K. and Dahlborg-Lyckhage, E (2016). Proactive Interventions. *SAGE Open*, 6(3), p.215824401665808.
- Rolfe, G., Freshwater, D. and Jasper, M (2001). *Critical Reflection For Nursing And The Helping Professions*. Basingstoke: Palgrave.
- Samuel, R., Shuen, A., Dendle, C., Kotsanas, D., Scott, C. and Stuart, R (2012). Hierarchy and Hand Hygiene: Would Medical Students Speak Up to Prevent Hospital-Acquired Infection?. *Infection Control & Hospital Epidemiology*, 33(8), pp.861-863.
- Schmidt, B (2011). *The Silent Treatment: Why Safety Tools And Checklists Aren'T Enough - Patient Safety & Quality Healthcare*. Patient Safety & Quality Healthcare. Available at:
 <<https://www.psqh.com/analysis/the-silent-treatment-why-safety-tools-and-checklists-arent-enough/>> (Accessed 23 May 2020).
- Social Services and Wellbeing (Wales) Act (2014). c.7. Available at:
<http://www.legislation.gov.uk/anaw/2014/4/part/7>
- Strand, J., Boström, P. and Grip, K (2019). Parents' Descriptions of How Their Psychosis Affects Parenting. *Journal of Child and Family Studies*, 29(3), pp.620-631.

Vaithilingam, N., Jain, S. and Davies, D (2008). Helping the helpers: debriefing following an adverse incident. *The Obstetrician & Gynaecologist*, 10(4), pp.251-256.

WHO (2009). *WHO Guidelines On Hand Hygiene In Health Care: A Summary*. Who.int.

Available at: <https://www.who.int/gpsc/5may/tools/who_guidelines-handhygiene_summary.pdf> (Accessed 26 May 2020).

WHO (2018). *WHO Recommendation On Definitions Of The Latent And Active First Stages Of Labour | RHL*. Extranet.who.int. Available at:

<<https://extranet.who.int/rhl/topics/preconception-pregnancy-childbirth-and-postpartum-care/care-during-childbirth/care-during-labour-1st-stage/who-recommendation-definitions-latent-and-active-first-stages-labour-0>> (Accessed 6 May 2020).

WHO (2020). *WHO SAVE LIVES: CLEAN YOUR HANDS IN THE CONTEXT OF COVID-19*.

Who.int. Available at: <https://www.who.int/infection-prevention/campaigns/clean-hands/WHO_HH-Community-Campaign_finalv3.pdf?ua=1> (Accessed 26 May 2020).