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Voices From the Frontline: A Qualitative Study on Safety Culture Challenges Among Maternity Ward Nurses in A Selected Tertiary Hospital in Zamboanga City

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ABSTRACT

Patient safety culture is critical in maternity care because the condition of mothers and newborns can change rapidly and requires timely, coordinated clinical action. This qualitative phenomenological study explored the lived experiences of maternity ward nurses regarding safety culture in a selected tertiary hospital in Zamboanga City. Fifteen registered nurses with at least two years of maternity-care experience were purposively selected after data saturation was reached. Data were gathered through semi-structured, in-depth interviews supported by field notes and reflexive documentation. The interviews were transcribed verbatim and analyzed using Colaizzi's descriptive phenomenological method. Five major themes emerged: patient safety as a professional responsibility; workload and staffing constraints affecting patient safety; teamwork and communication as foundations of safety; organizational and system barriers to safety culture; and continuous training and institutional support. Nurses emphasized vigilance, early detection of complications, clear endorsements, teamwork, and prompt coordination, while also describing high nurse-patient ratios, multitasking, equipment shortages, and hesitation to report errors because of fear of blame. The study concludes that maternity safety culture depends on both nurses' professional commitment and sustained institutional support. A context-responsive Safety Culture Enhancement Plan is proposed to strengthen staffing, communication, non-punitive reporting, training, resource availability, and workforce well-being.

Keywords: *maternity ward nurses, patient safety culture, phenomenology, nursing practice, safety enhancement plan, Zamboanga City*

INTRODUCTION

Patient safety is a fundamental component of quality maternity care because maternal and neonatal conditions can deteriorate rapidly and require timely, coordinated responses. The World Health Organization (2023) reported that approximately 287,000 women died globally in 2020 from causes related to pregnancy and childbirth, with most deaths occurring in resource-limited settings. In this context, a positive safety culture is not limited to compliance with written protocols; it also reflects the shared values, communication practices, leadership behaviors, and organizational conditions that enable healthcare workers to prevent harm and respond effectively to risk (Agency for Healthcare Research and Quality, 2019; Titi et al., 2021).

Maternity ward nurses occupy a critical frontline position. Their responsibilities include monitoring labor progression, administering medications, assisting during deliveries, providing postpartum and newborn care, and

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communicating clinical changes to the healthcare team. These duties require vigilance and sound judgment, particularly during emergencies. However, nurses may experience excessive workload, inadequate staffing, limited equipment, fragmented communication, and insufficient institutional support. Such conditions can affect bedside monitoring, reporting practices, and the consistency of safety procedures.

International literature has documented recurring safety-culture concerns in maternity and hospital settings. Albalawi et al. (2020) identified persistent challenges related to communication openness and staffing adequacy, while Blaževičienė et al. (2022) emphasized the importance of teamwork and management support in perinatal care. Brás et al. (2023) similarly reported that nurse-midwives' perceptions of maternity safety culture are shaped by organizational support and communication practices. These findings are relevant to resource-constrained contexts where nurses frequently compensate for system limitations through professional commitment and teamwork.

The local experiences of maternity ward nurses in Zamboanga City remain insufficiently documented. Understanding their lived experiences is important because safety-culture interventions should respond to the actual conditions encountered by frontline practitioners. This study therefore explored how maternity ward nurses perceived and experienced safety culture in a selected tertiary hospital, identified the challenges and barriers that hindered safe practice, and developed a Safety Culture Enhancement Plan grounded in their recommendations.

Literature Review

Safety Culture in Maternity Care

Patient safety culture refers to the shared values, beliefs, perceptions, and behaviors that shape how safety is prioritized and practiced within healthcare organizations (Agency for Healthcare Research and Quality, 2019). In maternity care, a strong safety culture is especially important because healthcare teams simultaneously support mothers and newborns during high-risk and time-sensitive clinical situations. Titi et al. (2021) emphasized that maintaining gains in patient safety culture requires continuous attention to organizational practices rather than isolated initiatives.

Safety culture is multidimensional. Alabdullah and Karwowski (2024) noted that hospital safety culture is influenced by teamwork, leadership, reporting practices, staffing conditions, and learning systems. Within maternity settings, Brás et al. (2023) and Blaževičienė et al. (2022) demonstrated that communication, management support, and the ability to raise concerns are essential to the prevention of avoidable harm. These findings support the need to examine safety culture through the voices of nurses who directly experience its strengths and limitations.

Workload, Staffing, and Resource Constraints

Adequate staffing and resources are foundational to patient safety. High patient assignments may divide nurses' attention and reduce the time available for clinical monitoring, documentation, and communication. The effects are particularly important in maternity wards, where subtle changes in maternal or fetal condition may require immediate escalation. The experiences reported by nurses should therefore be understood not simply as individual workload concerns but as organizational conditions with implications for safety.

Nurse well-being is also connected to safe practice. Berdida and Grande (2024) linked safety climate with quality of care and adherence to standard precautions. When staffing shortages, fatigue, and emotional strain remain unaddressed, healthcare workers may find it more difficult to sustain vigilance and consistently apply safety protocols. Resource availability, manageable workloads, and supportive scheduling are therefore integral to a functional safety culture.

Teamwork, Communication, and Reporting Climate

Effective teamwork and communication enable nurses to coordinate patient care, escalate concerns, and prevent errors. Clear shift endorsements are especially important because incomplete information can compromise medication safety, monitoring, and continuity of care. In perinatal settings, Blaževičienė et al. (2022) observed

that teamwork climate and management perceptions are important components of safety culture, while Brás et al. (2023) highlighted the value of communication in maternity care.

A positive reporting climate is equally necessary. Prieto et al. (2021) documented concerns about punitive responses to errors in hospital safety-culture assessments. When healthcare workers fear blame or reprimand, near misses and safety incidents may remain underreported, reducing opportunities for institutional learning. A non-punitive reporting system should therefore encourage transparency, constructive feedback, and improvement-focused responses.

Leadership, Continuous Learning, and Nurse Well-Being

Leadership influences whether safety practices are sustained over time. Nurses require guidance, responsive feedback, adequate resources, and visible institutional commitment. Abu Zaitoun et al. (2023) emphasized that clinical competence contributes to patient safety culture, while Ramos and Abós (2024) underscored the importance of nurses' perspectives in understanding safety conditions in hospital environments.

Continuous professional development is particularly important in maternity care. Regular simulation exercises, refresher training, and competency-based activities allow nurses to rehearse responses to emergencies and strengthen confidence. Patient safety improvement should therefore combine workforce support, learning opportunities, leadership engagement, and practical systems that help nurses translate knowledge into consistent bedside care.

Theoretical and Conceptual Foundations

The study was guided by the integration of three nursing perspectives. Florence Nightingale's Environmental Theory emphasizes the importance of a safe and supportive care environment. Faye Glenn Abdellah's patient-centered typology frames nursing as a problem-solving process that responds to clinical and systemic needs (Abdellah et al., 1960; Alligood, 2022). Madeleine Leininger's Transcultural Nursing Theory highlights culturally congruent care and respectful communication in diverse patient populations (Leininger & McFarland, 2006).

Together, these perspectives support a multidimensional understanding of maternity safety culture. Environmental conditions, professional competence, communication practices, and cultural sensitivity shape how nurses perceive and enact safety in daily practice. Consistent with a subjectivist orientation, the phenomenological approach allowed the study to examine how nurses interpreted these realities through their lived experiences (Aspers & Corte, 2021; Alhazmi & Kaufmann, 2022).

Thematic Framework

The themes were organized into a thematic framework showing that maternity safety culture is shaped by the interaction of professional responsibility, workload conditions, teamwork and communication, organizational barriers, and institutional support. The framework reflects the nurses' view that improved safety outcomes for mothers and newborns require coordinated action at both the individual and organizational levels.

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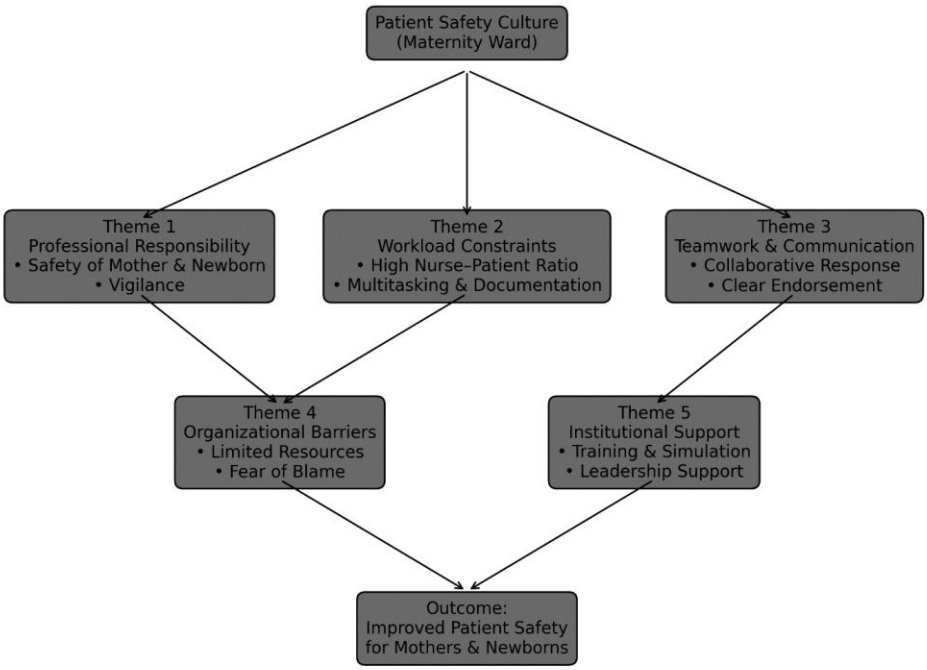

Figure 1. *Thematic framework of patient safety culture in the maternity ward*

METHODS

Research Design

The study employed a qualitative descriptive phenomenological design to explore the lived experiences of maternity ward nurses regarding patient safety culture. Phenomenology was appropriate because it enabled the researcher to describe the shared meaning of participants' experiences and identify the essential structure of the phenomenon (Creswell & Poth, 2018; Polit & Beck, 2021). The researcher practiced bracketing to reduce the influence of prior assumptions and to remain attentive to the participants' narratives.

Research Locale

The study was conducted in a selected tertiary government hospital in Zamboanga City, Philippines. The hospital provided maternity services, including labor and delivery management, postpartum care, and newborn care. The setting was selected because maternity ward nurses routinely managed clinical situations that required continuous monitoring, timely coordination, and adherence to patient safety practices.

Participants and Sampling Technique

Participants were registered nurses assigned to the maternity ward and actively engaged in direct patient care. Purposive, criterion-based sampling was used to recruit nurses who possessed relevant experience and could provide information-rich accounts. Nurses were eligible when they had at least two years of continuous maternity-care experience, were willing to participate, and could articulate their professional experiences. Twenty nurses were initially considered, and interviews continued until saturation was reached at 15 participants. Maximum variation was considered to capture a range of experiences across professional backgrounds and shift assignments.

Research Instrument

A semi-structured interview guide served as the primary research instrument. This format allowed the researcher to ask predetermined questions while using follow-up probes to explore participants' experiences,

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challenges, barriers, and recommendations in greater depth (Nieswiadomy & Bailey, 2018). The guide was reviewed by three subject-matter experts with backgrounds in qualitative research and maternal-health nursing. Field notes and reflexive documentation supplemented the interview data.

Data Gathering Procedure

Approval was obtained from the research adviser, panel members, and the institutional ethics review committee before data collection. Recruitment was facilitated by a gatekeeper, such as the head nurse or unit supervisor, who helped identify eligible participants. Nurses received an explanation of the study and provided written informed consent. Individual interviews were conducted face-to-face in a private setting and lasted approximately 25 to 45 minutes. With permission, the interviews were audio-recorded. Participants could respond in English, Filipino, or a local language, and responses were transcribed verbatim and translated into English when necessary.

Data Analysis

The transcripts were analyzed using Colaizzi's descriptive phenomenological method (Colaizzi, 1978; Morrow et al., 2015). The process involved repeated reading of transcripts, extraction of significant statements, formulation of meanings, clustering of related meanings into themes, development of an exhaustive description, identification of the fundamental structure of the experience, and participant validation through member checking. Trustworthiness was supported through credibility, dependability, transferability, and confirmability procedures, including triangulation, audit trails, reflexive journaling, peer review, and rich contextual descriptions (Lincoln & Guba, 1985).

Ethical Consideration

The study observed informed consent, voluntary participation, privacy, and confidentiality. Participants were informed of their right to withdraw at any time without penalty. Unique codes were used instead of personal identifiers, and identifying information about participants and the hospital unit was protected. Audio recordings, transcripts, and coding documents were stored securely and accessed only for research purposes. The researcher also recognized the possibility of emotional discomfort when participants discussed sensitive workplace experiences and provided appropriate safeguards consistent with the approved protocol.

RESULTS AND DISCUSSION

Overview of the Emergent Themes

The thematic analysis revealed five interconnected themes that described how maternity ward nurses experienced patient safety culture. The findings showed that safe care depended on nurses' vigilance and professional accountability, but the ability to sustain these practices was shaped by workload, communication, available resources, reporting climate, leadership, and opportunities for continuous learning. Table 1 summarizes the themes and their corresponding subthemes.

Table 1. *Emergent Themes and Subthemes*

Major Theme	Subthemes
Patient safety as a professional responsibility	Ensuring the safety of mother and newborn; vigilance and early detection of complications
Workload and staffing constraints affecting patient safety	High nurse-patient ratio; multitasking and documentation burden
Teamwork and communication as foundations of safety	Collaborative response to safety issues; importance of clear endorsement and communication
Organizational and system barriers to safety culture	Limited resources and equipment; fear of blame and reporting hesitation
Continuous training and institutional support	Need for regular training and simulation; leadership support and workforce well-being

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Patient Safety as a Professional Responsibility

Participants consistently described patient safety as a fundamental nursing responsibility. Their accounts emphasized continuous monitoring, adherence to protocols, medication accuracy, and attentiveness to changes in maternal and newborn condition. One nurse explained, “For me, patient safety culture means ginagawa namin lahat para masigurado na safe si mother and baby from admission until discharge” (P1). Another participant stressed that the patient's status can change rapidly during labor and therefore requires close monitoring (P2).

The nurses' narratives indicate that safety culture begins with professional accountability but extends beyond individual competence. Vigilance and early detection are essential in maternity settings because delayed responses may increase risk. This finding is consistent with the patient-centered and problem-solving orientation of Abdellah's framework and with literature emphasizing clinical competence as a contributor to safety culture (Abu Zaitoun et al., 2023).

Workload and Staffing Constraints Affecting Patient Safety

Heavy workload and staffing limitations were prominent challenges. Nurses described situations in which several patients required simultaneous attention, resulting in divided focus and possible delays in monitoring. One participant stated, “Kapag kulang ang staff, divided ang attention namin which may affect close monitoring” (P11). Another observed that high patient assignments limit the frequency of observation (P13).

Participants also described the burden of multitasking. Direct patient care was performed alongside documentation and coordination responsibilities. Although documentation supports continuity and accountability, excessive paperwork may reduce time for bedside care. These experiences reinforce the importance of staffing systems that recognize the intensity and unpredictability of maternity care and support the well-being of nurses (Berdida & Grande, 2024).

Teamwork and Communication as Foundations of Safety

Teamwork emerged as an important protective factor. Nurses described how rapid communication and task delegation helped them manage urgent concerns. A participant explained, “Kapag may potential safety issue, we immediately inform the charge nurse and coordinate with the physician while assisting each other” (P1). Another emphasized that rapid coordination and task delegation were essential during critical situations (P15).

Clear endorsements were also necessary to avoid omissions and errors. One participant reported that incomplete information about a patient allergy almost caused a medication error (P3). These accounts demonstrate that communication is not merely an interpersonal preference but a safety mechanism. Standardized handover practices, daily briefings, and clear escalation procedures can strengthen continuity of care, consistent with previous maternity safety-culture research (Blaževičienė et al., 2022; Brás et al., 2023).

Organizational and System Barriers to Safety Culture

Participants identified limited equipment and supplies as barriers to consistent patient monitoring. One nurse described having only two blood-pressure apparatuses and one oxygen-saturation probe for a high number of patients (P4). Others noted that unavailable equipment and limited emergency resources could delay care. These statements show that nurses' commitment to safety must be matched by adequate institutional resources.

The findings also revealed hesitation to report errors because of fear of blame. A participant stated, “I witnessed hesitation in reporting medication error because staff feared punishment” (P14). Another described how issues may be discussed privately before formal reporting (P14). This finding is consistent with literature showing that punitive responses can discourage transparency and reduce opportunities for organizational learning (Prieto et al., 2021; Alabdullah & Karwowski, 2024).

Continuous Training and Institutional Support

Nurses emphasized the importance of regular training, emergency drills, and simulation-based learning. One participant noted that training was available but simulation opportunities remained limited (P2), while another recommended regular emergency drills (P7). Refresher programs can enhance preparedness for maternal hemorrhage, fetal distress, and neonatal complications by allowing nurses to rehearse coordinated responses in a controlled setting.

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Leadership support and workforce well-being were also important. Participants valued supervisory guidance but identified gaps in emotional support, staffing assistance, and rest periods. These findings indicate that safety culture requires institutional systems that support both professional competence and the psychological well-being of nurses. The hospital should therefore combine training initiatives with leadership engagement, manageable workloads, and non-punitive reporting mechanisms.

Representative Statements Across Themes

Table 2. *Selected Participant Statements Supporting the Themes*

Theme	Code	Representative Statement
Professional responsibility	P4	As nurses, responsibility namin na siguraduhin na tama ang medications at procedures para hindi magkamali.
Vigilance	P6	Observation at monitoring ang pinaka-important, especially kapag sabay-sabay ang labor patients.
Staffing constraints	P6	Main challenge talaga is staffing shortage and physical exhaustion.
Documentation burden	P10	Aside from direct patient care, marami kaming documentation and coordination responsibilities.
Teamwork	P6	Kapag may safety issue, we immediately call the doctor and inform charge nurse while assisting each other.
Communication	P1	Proper endorsement greatly affects patient safety.
Resources	P12	Insufficient equipment and space limitations.
Reporting climate	P14	Blame culture affects transparency.
Training	P10	We receive training, pero mas effective sana kung may regular simulation drills.
Leadership support	P11	Leadership provides guidance but emotional support programs are limited.

Proposed Safety Culture Enhancement Plan

Based on the themes, a Safety Culture Enhancement Plan was developed to address the interconnected challenges experienced by maternity ward nurses. The plan prioritizes feasible organizational actions that may strengthen daily practice, reduce preventable risks, and support continuous improvement.

Table 3. *Proposed Safety Culture Enhancement Plan*

Focus Area	Priority Actions	Timeline	Expected Outcome
Staffing and workload	Review nurse-patient assignments; adjust shift schedules; monitor workload distribution; consider additional staffing or float-nurse support.	3-6 months	Reduced fatigue and improved patient monitoring.
Communication and teamwork	Conduct daily briefings and endorsements; standardize handover and escalation procedures; promote teamwork activities.	Monthly / ongoing	Improved coordination and reduced communication-related errors.
Safety reporting system	Implement a confidential and non-punitive reporting process; encourage near-miss reporting; provide constructive feedback.	2-4 months	Increased reporting, transparency, and organizational learning.
Training and development	Conduct regular workshops, emergency drills, simulation activities, and competency assessments.	Quarterly	Improved clinical preparedness and emergency response.
Resources and equipment	Perform inventory checks; promptly replace faulty tools; prioritize essential maternity-monitoring equipment.	Ongoing	Improved availability of resources for timely care.
Emotional and psychological support	Provide debriefing, counseling referrals, rest-period support, and workforce well-being activities.	Monthly / ongoing	Reduced stress and improved staff morale.

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CONCLUSION

Maternity ward nurses in the selected tertiary hospital demonstrated a strong commitment to patient safety through vigilance, protocol adherence, early detection of complications, and coordinated responses to clinical concerns. Their experiences also revealed that professional commitment alone cannot fully address safety risks. High nurse-patient ratios, multitasking, documentation demands, limited equipment, fragmented communication, and fear of blame can hinder consistent safe practice. Teamwork, clear endorsements, continuous simulation-based training, supportive leadership, adequate resources, and a non-punitive reporting environment are therefore essential. The study contributes a context-responsive understanding of maternity safety culture and provides a practical Safety Culture Enhancement Plan grounded in the voices of frontline nurses.

Recommendations

Hospital administrators should review staffing patterns and workload distribution in the maternity ward, prioritize the availability of essential monitoring equipment, and establish a confidential and non-punitive safety-reporting process. Supervisors should provide timely feedback and encourage reporting of near misses as opportunities for learning rather than blame.

Nursing managers and educators should institutionalize regular emergency drills, simulation-based activities, competency assessments, and standardized handover practices. These interventions should be complemented by debriefing activities and workforce well-being support, particularly after stressful clinical events.

Future research may examine patient safety culture in other hospital departments and healthcare facilities using quantitative or mixed-methods designs. Studies involving nurses, midwives, physicians, administrators, and patients may provide a broader understanding of how organizational conditions influence maternity safety outcomes.

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