

**Connecting with adolescent mothers:
Perspectives of hospital-based perinatal nurses**

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...because [adolescent mothers] don't have the life experiences to lean on, they're very vulnerable. But they have a shell sometimes that makes it a little harder to connect with, but if we can just be open to them, there's a lot of grace underneath.

Preface

The purpose of this preface is to specify the required research ethics board approvals obtained to conduct this research, and to clearly identify my contributions and those of the manuscript (chapter 3) co-authors.

I applied for ethical approval from the University of Ottawa's Health Sciences and Science Research Ethics Board to obtain permission to access and analyze data collected by Dr. Wendy Peterson and her research team between the years 2009 and 2010. Approval was granted in June 2017 and has since been renewed for an additional year (H06-17-25) (Appendix A).

Co-Authorship of “Age does not dictate a person’s ability to be a good mother”:

Perspectives of hospital-based perinatal nurses (Chapter 3)

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As this is my master's thesis research, I conducted the in-depth analysis and interpretation of the data using Interpretive Description. I conducted the literature review and identified my theoretical allegiances to scaffold the study, wrote and revised multiple drafts of the manuscript of which I am the primary author.

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As a thesis committee member, Dr. Barbara Davies, provided guidance regarding the overall design of the thesis. She provided a critical revision of the article and will give final approval of the version to be published.

Abstract

Background: Adolescents are more likely to be dissatisfied with perinatal care than adults.

Adolescents' perspectives of their perinatal care experiences have been explored; however, there are few studies exploring adolescent-friendly inpatient care from nurses' perspectives.

Purpose: To explore adolescent-friendly care from the perspective of hospital-based adolescent-friendly perinatal nurses.

Research Questions: (1) How and why do perinatal nurses in inpatient settings adapt their practice when caring for adolescents? (2) What are the individual nursing behaviours and organizational characteristics of adolescent-friendly care in inpatient perinatal settings, from the perspective of perinatal nurses?

Methods: I report the qualitative component of a mixed methods study. Open-ended interviews were conducted with twenty-seven purposively-sampled expert nurses. Data were analyzed using Interpretive Description.

Findings: Nurses described being mother-friendly to adolescents by being nonjudgmental, forming connections, individualizing care, and employing behavioural strategies that facilitate relationship-building.

Implications: These findings will inform the development of interventions to facilitate connections between nurses and adolescent mothers.

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I am grateful to the twenty-seven nurses who participated in this study and would like to recognize their compassion, kindness, and expertise in caring for mothers and supporting families during the perinatal period.

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Chapter One – Introduction

The purpose of this thesis is to explore the concept of adolescent-friendly care from the perspective of hospital-based intrapartum, postpartum, and neonatal nurses who are considered expert in the provision of care to adolescent mothers. This article-based thesis is organized into four chapters that include one manuscript prepared for peer-review publication. Chapter One provides background information on the medically-associated risks and social challenges of adolescent pregnancy and motherhood and the concept of adolescent-friendly care. Additionally, it introduces the research problem; states the research objective and questions; and describes the relevance of the study. Chapter Two provides a description of the methods of the larger mixed methods study that was conducted and a review of the literature. Given that the data for this study were collected between 2009 and 2010, I conducted an updated review of the published literature related to the experiences of adolescent mothers receiving inpatient perinatal care as part of this thesis. The literature review is a key element of scaffolding any study and verified the continued need to analyze the data and report the findings. Chapter Three is a manuscript prepared for submission to the journal of *Qualitative Health Research* that reports the findings of this thesis research. The thesis concludes with Chapter Four which presents a discussion of how the research findings contribute to the existing literature and explores the implications for nursing practice, policy, education, and research.

In this thesis, I will be using the term ‘adolescent mother’ to encompass mothers who give birth for the first time before or at 19 years of age as per the World Health Organization (WHO) (2004). Additionally, I will refer to women who give birth in their early twenties as ‘young mothers’. The terms ‘adolescent mother’ and ‘young mother’ will be used throughout this thesis because some studies define adolescent motherhood differently than the WHO and include

young (< 25 years) single women in their study samples. The reason for the inclusion of young single women is because this group of women experience many similar challenges to adolescent mothers. Some of these experiences include stigmatization, high risk behaviours, and inadequate social support.

Background

In Canada, approximately 2% (7,858) of newborns are born to adolescent mothers (≤ 19 years old) every year (Statistics Canada, 2018). Adolescence and parenthood are independently challenging stages in life and although some individuals are able to overcome the difficulty of becoming a mother during their teenage years, adolescent mothers are commonly categorized as a population at risk for poor outcomes. Specifically, studies have identified a high prevalence of poor obstetrical, neonatal, social and economic outcomes associated with adolescent motherhood (Fleming et al., 2013; Fleming, O'Driscoll, Becker, & Spitzer, 2015; Gilbert, Jandial, Field, Bigelow, & Danielson, 2004; Paranjothy et al., 2009; WHO, 2004).

Medically-associated risks of adolescent pregnancy and motherhood. Adolescent mothers are at higher risk of some obstetrical complications during pregnancy and the postpartum period (Bakker et al., 2011; Fleming et al., 2013; Fleming et al., 2015). In comparison to adult mothers, adolescents are more likely to experience pregnancy-related conditions such as anemia and postpartum depression (Beers & Hollo, 2009; Cantilino, Barbosa, & Petrubu, 2007; de Vienne, Creveuil, & Dreyfus, 2009; Hudson, Elek, & Campbell-Grossman, 2000; Kingston, Heaman, Fell, & Chalmers, 2012). The infants of adolescent mothers are more likely to be admitted to neonatal intensive care compared to infants of adult mothers (Bakker et al., 2011; da Silva et al., 2003; Fraser, Brockert, & Ward, 1995; Sandal, Erdevi, Oguz, Uras, & Dilmen 2011). In 2011, Sandal and colleagues (2011) conducted a retrospective study in Turkey

where 300 adolescent mothers under 17 years of age and their singleton newborns were enrolled. Approximately 13.6% of newborns required intensive care and of whom, approximately 92.6% were born prematurely. The admission rate of the study population was higher than the overall neonatal intensive care unit admission rate of 9.7% for the participating hospital (Sandal et al., 2011). Additionally, infants born to adolescent mothers are at an increased risk of being stillborn, premature, or small for gestational age; developing behavioural problems; and being involved in accidents during their first year of life (Bakker et al., 2011; Beers & Hollo, 2009; de Vienne et al., 2009; Gilbert et al., 2004; Khashan, Baker, & Kenny, 2010).

Moreover, Fleming et al. (2013) published the findings of a large retrospective population-based cohort study which was conducted in Ontario, Canada and included 551,079 singleton birth records of which 23,992 were adolescent mothers. The researchers found that adolescents are more likely to deliver prematurely and to give birth to infants that are small for gestational age and low birth weight (Fleming et al., 2013). However, this increase in small for gestational age and low birth weight infants among adolescents was no longer present upon adjusting for confounding factors including smoking, parity, median family income, and education. In addition to Fleming et al.'s (2013) research, there are numerous other studies that suggest that smoking and low socioeconomic status are risk factors for these outcomes (Briggs, Hopman, & Jamieson, 2007; Chen et al., 2007; Haiek & Lederman, 1989; Hediger, Scholl, Belsky, Ances, & Salman, 1989). Furthermore, the risk of adolescents delivering low birth weight newborns may be increased due to poor maternal weight gain and poor nutrition (Beeckman, van De Putte, Putman, & Louckx, 2009). The aforementioned factors increase the risk for neonatal mortality and adverse conditions into childhood (WHO, 2006).

In summary, according to Fleming et al. (2013) upon adjusting for confounding factors there is no difference in the rates between adolescent and adult mothers for small for gestational age newborns, low birth weight newborns, preterm birth, and fetal death. In comparison to adults, adolescent mothers actually have lower rates of gestational hypertension, gestational diabetes, antepartum hemorrhage, assisted vaginal delivery, epidural analgesia, caesarean sections. However, they also have lower rates of first trimester prenatal care, breastfeeding, and prenatal class attendance (Fleming et al., 2013). Lastly, although adolescents have higher rates of spontaneous vaginal delivery which is a positive finding, they have higher rates of preterm premature rupture of membranes, emergency caesarean section, delivering a newborn needing intensive care, and very preterm birth in comparison to adult mothers (Fleming et al., 2013).

Social challenges associated with adolescent pregnancy & motherhood. Adolescent childbearing is associated with social and economic challenges. For instance, adolescent mothers tend to have lower educational attainment, employment opportunities, and socioeconomic status than women who begin to have children in their twenties and beyond (Bradley, Cupples, & Irvine, 2002; Hofferth, Reid, & Mott, 2001; Nanchahal, Wellings, Barrett, & Johnson, 2005). Additionally, adolescent mothers have higher rates of rapid repeat pregnancy (i.e., within 2 years) (Barnet, Rapp, DeVoe, & Mullins, 2010), substance use (Cavazos-Rehg et al., 2010; Shaw, Lawlor, & Najman, 2006), and intimate partner violence (Newman & Campbell, 2011). Although adolescent motherhood is associated with poor social and economic outcomes, it is important to recognize that adolescent motherhood does not necessarily cause these poor outcomes. Early motherhood is often a symptom or an outcome of a childhood complicated by adverse childhood experiences and/or economic disadvantage (Hillis et al., 2004; Hotz, McElroy, & Sanders, 1997; Ruedinger & Cox, 2012).

Adverse childhood experiences. Adverse childhood experiences include growing up in a household where there is abuse (i.e., verbal, physical, or sexual), intimate partner violence, substance abuse, mental illness, an incarcerated household member, parental separation or divorce (Hillis et al., 2004). Adolescents who have adverse childhood experiences are more likely to engage in high-risk sexual behaviours including early intercourse and numerous sexual partners (Hillis, Anda, Felitti, Nordenberg, & Marchbanks, 2000). In a large retrospective cohort study of 9,159 women, Hillis et al. (2004) demonstrated a strong positive relationship between the number of childhood adverse events and adolescent pregnancy. Hillis et al.'s (2004) findings are supported by more recent evidence that sexual abuse and neglect during childhood are predictors of pregnancy during adolescence (Garwood, Gerassi, Jonson-Reid, Plax, & Drake, 2015; Noll, Shenk, & Putnam, 2009; Noll & Shenk, 2013). Therefore, it is likely that the poor social outcomes associated with adolescent pregnancy and motherhood are at least partly attributed to these adverse childhood experiences rather than to early childbearing.

Economic disadvantage. Adolescent pregnancy and young motherhood exist across all socioeconomic groups, but it is more likely to occur in young women who come from low socioeconomic upbringings with disadvantaged, single-parent families (Al-Sahab, Heifetz, Tamim, Bohr, & Connolly, 2012; Koniak-Griffin & Turner-Pluta, 2001). The method and use of contraception, the rate of unintended pregnancy, and the decision to continue or terminate an unintended pregnancy are influenced by socioeconomic factors (Abigail & Power, 2008; Biggs, Karasek, & Foster, 2012; Bryant, Nakagawa, Gregorich, & Kuppermann, 2010; Dehlendorf et al., 2011). Furthermore, adolescents from low socioeconomic backgrounds are more likely to choose motherhood (versus pregnancy termination) in comparison to youth from middle class or privileged upbringings (Lee, Clements, Ingham, & Stone, 2004). The aforementioned finding is

driven by different life expectations for individuals from each social group. Adolescents from middle class or privileged upbringings are more likely to choose education and employment over motherhood; however, adolescents from socially-disadvantaged backgrounds may favour motherhood (McLeod, 2001; Rudoe & Thomson, 2009; Tabberer, Hall, Prendergast, & Webster 2000). Thus, the cycle of hardships is not broken as adolescent mothers are more likely to be unemployed and have low income and education in comparison to adult mothers. Moreover, the children of adolescent mothers have a higher probability of becoming parents during their adolescence as well (Jutte et al., 2010).

Accessing perinatal services. Prenatal care can aid in the prevention of perinatal complications and inform women about their well-being and health to ensure a safe and healthy pregnancy. Additionally, adequate prenatal care is protective against fetal and infant deaths (Malabarey, Balayla, Klam, Shrim, & Abenhaim, 2012). There is an underuse of and a delay in accessing perinatal services which is concerning given that adolescents are a high-risk population (Bakker et al., 2011; Fleming et al., 2013; Fleming et al., 2015). Negative attitudes towards health care providers, dissatisfaction with previous provider encounters, and fear of judgment are barriers to accessing health services (Harrison, Clarkin, Rohde, Worth, & Fleming, 2017; Kinsman & Slap, 1992; Peterson, Sword, Charles, & DiCenso, 2007; Teagle & Brindis, 1998).

There is ample research that shows that young mothers experience stigma by perinatal health care providers, thereby, negatively affecting their maternal-newborn experience and their use of pre- and post-natal services (Brady, Brown, Wilson, & Letherby, 2008; Hanna, 2001; Peterson et al., 2007; Whitley & Kirmayer, 2008). Young mothers perceive a difference in the way they are treated by health care providers in comparison to adult mothers (Redwood, Pyer, & Armstrong-Hallam, 2012) and fear judgment from these professionals (Brady et al., 2008). The

stigmatization that takes place in maternal-child settings results in distrust between young mothers and health care providers. The fear of accessing and engaging in maternal-child health services that these mothers experience is concerning as they are often raising their children in the context of social and economic hardships and would benefit from additional supports. The provision of adolescent-friendly perinatal care and strong social support can help to reduce the health inequities that young mothers and their children experience (Peterson et al., 2007; Reszel, Peterson, & Moreau, 2014) as adolescents are more likely to access services and follow recommended health practices that are youth-friendly (WHO, 2002).

Adolescent-friendly care. The adolescent-friendly health care framework, originally described by the WHO (2002), has been used in recent years to improve the provision of various health care services to youth (Goicolea, Coe, San Sebastian, & Hurtig, 2017; Tylee, Haller, Graham, Churchill, & Sancu, 2007). According to the WHO (2012), to be adolescent-friendly, services must meet the dimensions of equity, effectiveness, accessibility, acceptability, and appropriateness of care. Equity means “all adolescents, not just some groups of adolescents, are able to obtain the health services that are available” (p.38) and effective means that “the right health services are provided in the right way, and make a positive contribution to their health” (p.38). The dimensions of accessibility, acceptability, and appropriateness of care relate to how health care is to be provided to adolescents to promote their engagement. Accessibility of health services refers to adolescents being able to obtain the available health services (WHO, 2012). The dimension of accessibility includes the cost of services, the hours of operation of the health service, and that adolescents are informed about the range of services available to them and how they can access and obtain them (WHO, 2012). The degree that adolescents are willing to seek out and request services refers to the acceptability of care which also includes confidentiality,

privacy, and the provision of nonjudgmental care from providers (WHO, 2012). Lastly, the appropriateness of health services refers to adolescents being able to access the health services that they need.

Studies have confirmed that adolescent-friendly care is important as the adolescent assumes an independent role in their health care and decision-making (Daley, 2012). Daley and colleagues explored the expectations that adolescents have of their health care providers (Daley, Polironi, & Sadler, 2017). They identified that communication, privacy and confidentiality, acceptance, nonjudgmental behaviour, equitable treatment, and professionalism were key expectations. A trusting relationship was an essential and central aspect identified from this study (Daley, Polifroni, & Sadler, 2017). Anderson and Lowen (2010) conducted a systematic review to identify health care delivery models that support youth in accessing health and mental health care. These authors described youth as being reluctant to access health services and seek care from their providers regarding substance use, mental health, and reproductive health. It is important to involve youth and their experiences in the planning, delivery, and evaluation of services (Anderson & Lowen, 2010). Moreover, a systematic review conducted by Ambresin et al. identified eight domains as essential to a positive care experience for youth (Ambresin, Bennett, Patton, Sanci, & Sawyer, 2013). These domains included accessibility of health care; clinicians' attitudes, clinical communication, patient-centred care, perceived medical competency, and accessibility of services in an age appropriate environment (Ambresin et al., 2013). Mazur, Brindis, and Decker (2018) conducted a systematic review of studies that involved youth-friendly sexual and reproductive health services with the purpose of assessing how these services are measured worldwide. From this, they identified indicators, from the perspective of researchers, providers, and non-clinical staff, that define and measure youth-friendly sexual and

reproductive health services. They identified three domains as essential and frequently used when assessing the delivery of these services to youth. These domains included accessibility of services, privacy and confidentiality, and staff characteristics and competencies. The domains and dimensions in the aforementioned studies are consistent with the WHO's adolescent-friendly framework (2002, 2012).

Sawyer, Ambresin, Bennett, and Patton (2014) identified a gap in the literature regarding appropriately-developed measurement tools for adolescents and their health care. Upon conducting their research, they found that the quality of health care of adolescents in hospital settings is embedded in patient- and family-centered care (Sawyer et al., 2014). Moreover, positive engagement with health care and the provision of evidence-informed care is essential to being adolescent-friendly. Adolescent-friendly care is an important concept and there is current literature regarding how to engage with and assess adolescents (Goldenring & Rosen, 2004) as well as literature exploring adolescents' experiences of various health care services (Hoopes et al., 2017; Miller, Dowd, Linebarger, Jahnke, & Wickcliffe, 2014; Persson, Hagquist, Michelson, 2017). However, there is limited research exploring the concept of adolescent-friendly care in the perinatal nursing context.

Research Problem

Perinatal nursing involves the collaboration of nurses with women and their families from the preconception period throughout the childbearing year (Perry et al., 2017). The provision of adolescent-friendly care to youth improves their engagement and willingness to access necessary health services (WHO, 2002). Although the Society of Obstetricians and Gynaecologists of Canada (Fleming et al., 2015) has provided clinical practice guidelines for adolescent pregnancy, they are medical in nature and there is minimal discussion regarding the provision of nursing

care for youth specifically in the perinatal context. To engage pregnant youth in prenatal care, some community-based agencies have developed and implemented adolescent-friendly services. For example, pre- and post-natal care for youth should be individualized and the preferred model of care is the ‘one-stop shop’ model. Outreach programs that are adolescent-friendly and that facilitate accessible prenatal care and education may improve perinatal outcomes for adolescent mothers and their children (Fleming, Tu, & Black, 2012). In a matched cohort study conducted by Fleming et al. (2012), youth who were followed in a community-based outreach obstetrical program had higher rates of first trimester visits (76.7% vs. 64%, $P=0.009$), prenatal class attendance (52.8% vs. 30.3%, $P<0.001$), and screening for group B streptococcus ($P=0.01$). Although young mothers in the intervention cohort had significantly higher rates of smoking and substance use than the control cohort, there was not a significant difference in the proportion of premature birth, low birth weight infants, or infants who were small for gestational age (Fleming et al., 2012). However, there was a significantly higher mean gestational age at delivery ($P=0.005$) and higher mean birth weight ($P=0.002$) for the mothers in the intervention group. While public health and other community-based agencies have begun to implement adolescent-friendly obstetrical programs and outreach services, little is known about how to provide adolescent-friendly hospital-based perinatal care.

Adolescent-friendly, hospital-based perinatal nursing care is important since 98% of births in Canada take place in a hospital setting (Statistics Canada, 2016). Although the average inpatient stay for birth is short (2-4 days), it is important that mothers have a good experience during labour, birth, and early postpartum as mothers remember their birth experience and it is essential to their transition to motherhood. Intrapartum, postpartum, and neonatal nurses have an important opportunity to connect and engage with adolescent mothers during the inpatient stay to

teach infant care skills and assess well-being, knowledge, and supports. It is also an opportunity for nurses to educate adolescent mothers on maternal-newborn health and services that are available to them in the community. Nursing care that is adolescent-friendly can potentially improve young mothers' engagement in their own care. By engaging adolescents in their health care, the sensitivity of health services may be improved and services may become more responsive to the needs of youth (WHO, 2002).

Although there is evidence that some perinatal nurses are very good at providing adolescent-friendly care (Peterson et al., 2007), some studies have identified that adolescents have poor inpatient perinatal nursing experiences and they have described feeling judged by nurses (Brady et al., 2008; Brand, Morrison, & Down, 2014; Peterson et al., 2007; Redshaw, Hennegan, & Miller, 2014; Redwood et al., 2012; Whitley & Kirmayer, 2008). These poor experiences have a negative effect on adolescents' maternal-newborn inpatient stay and as a result, their transition to motherhood. The psychosocial experiences (Whitley & Kirmayer, 2008; Yardley, 2008) and the experiences of adolescent mothers accessing health care services have been explored (Robb, McNery, & Hollins Martin, 2013); however, there are few studies specific to the experiences of adolescent mothers in the context of inpatient perinatal care (Peterson et al., 2007).

Research Objective

The objective of this thesis is to explore the concept of adolescent-friendly perinatal care from the perspective of nurses, who were identified as expert in their practice with adolescent mothers, working in hospital-based intrapartum, postpartum, and neonatal intensive care units.

Research Questions

The research questions this study sought to answer are:

1. How and why do perinatal nurses in inpatient settings adapt their practice when caring for adolescents?
2. What are the individual nursing behaviours and organizational characteristics of adolescent-friendly care in inpatient perinatal settings, from the perspective of nurses?

Relevance of Study

The findings from this study will contribute to the generation of knowledge and novel understanding of the adolescent-friendliness of hospital-based perinatal nursing care by exploring and considering the perspective of perinatal nurses. Specifically, these findings have the potential to improve perinatal care by informing the design of interventions and identifying best practices for nursing care and/or supports for adolescent mothers and their families. Excellence in nursing care during the inpatient stage of the continuum of maternal-infant services is essential to promote the health of young mothers and their infants.

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Chapter Two – Methods and Literature Review

This chapter introduces the larger mixed methods study that generated the qualitative data for this thesis and presents a detailed description of the qualitative data collection methods that occurred before my involvement in the study. Subsequently, I situate myself within the research process and describe my role and the methods that I used for the analysis of the qualitative data. As part of the research process, I conducted a review of the published literature relating to the experiences of adolescent mothers receiving inpatient perinatal care. This literature review is in the methodology section of this chapter.

The Mixed Methods Study

Mixed methods research involves the collection and analysis of both qualitative and quantitative data in a study (Creswell, Plano Clark, Gutmann, & Hanson, 2003). Mixed methods research is used when the advantages of qualitative and quantitative research is sought after to answer the research questions (Johnson & Onwuegbuzie, 2004). The purpose of this mixed methods study was to first determine the perceived need of improving inpatient nursing care of adolescent mothers and then to determine how well perinatal units support the provision of adolescent-friendly care from the perspective of hospital-based perinatal nurses. Next, the concept of adolescent-friendly care was to be explored in more depth from the perspective of the expert nurses. The quantitative portion of this study was a key informant survey with perinatal nurses who were identified as expert in the care of adolescent mothers (Peterson, Davies, Rashotte, Salvador, & Trepanier, 2012). These descriptive findings were published in 2012 by Peterson and colleagues. The purpose of this thesis was to describe how perinatal nurses provide adolescent-friendly care and to explore the patterns of those experiences using a qualitative research methodology. Therefore, this thesis will present the findings from the qualitative portion

of this study which involved interviews with the same participants as the quantitative portion. Chapter Four will discuss the findings from this thesis in relation to the quantitative findings and other published literature.

An advisory board was created at the outset of the research study to help determine the recruitment process of expert nurses and to review and provide feedback on the interview guide. The members included an inpatient perinatal unit manager, a hospital-based perinatal nurse educator, a child life specialist, the executive director of an adolescent mother-friendly community-based agency, a manager and a front-line worker from a community-based adolescent prenatal program, and two adolescent mothers.

Setting

The data collection phase of the study took place between 2009 and 2010 within four individual hospital sites of three health care institutions within one large metropolitan city in Ontario, Canada. The organizational diversity and philosophies of each hospital site were expected to contribute to our understanding of adolescent-friendly perinatal nursing care. A table describing the participating hospital sites and their perinatal units is attached as Appendix B. According to the Better Outcomes Registry & Network of Ontario (2011), at the time of data collection, approximately 2% (223) of births at these four sites were to adolescent mothers. Ethics approvals were obtained from the University of Ottawa and each institution's Research Ethics Board and annual renewals were obtained as required (Appendices Ca, b, c, & d).

Participants and Recruitment

A purposive sampling technique was employed to recruit nurses and maximize the richness of the data as is commensurate with the research method (Patton, 1990). Frontline staff nurses were eligible to participate in an interview if they were employed at one of the

participating hospitals on a perinatal unit, had experience providing nursing care to adolescent mothers, were considered expert in providing adolescent-friendly care, and could converse easily in either English or French.

A notice (Appendices Da, b, c) was posted in each unit to inform staff of the research study. Two recruiting strategies were employed. First, clinical leaders (i.e., unit managers, clinical educators, clinical nurse specialists, or advanced practice nurses from each participating hospital's perinatal units) were contacted by each hospital's site investigator or a research assistant (RA). The leaders were asked to identify four to six nurses who were considered to be expert in the provision of care to adolescent mothers and could contribute valuable information. Leaders then asked these nurses for their consent to be contacted by the RA to learn more about the study. The intention was to recruit two to four nurses from each of the eight participating units (for a total of 18-20 participants) and one perinatal manager, clinical educator, or advanced practice nurse from each unit or group of units (four to eight participants). Second, upon completion of each interview, the RA asked participants to identify nursing peers who they considered to be expert and skilled in the care of adolescent mothers. Participants were recruited until two to four nurses from each unit had participated in an interview.

In total, 34 nurses were invited to participate in an interview and 27 agreed to take part in the study. Seven declined due to their schedules or because they felt that they did not have enough experience caring for adolescent mothers. The nurses were employed in birthing units (n=6), mother-baby units (n=6), neonatal intensive care units (n=10), or cross-trained in all three units (n=5). The majority of nurses were baccalaureate-prepared (n=14) with the remainder holding a college diploma (n=11) and some holding a Master's level of education (n=2). The

nurses were all female; the number of years working as a nurse ranged from four to 38; and the average length of time working in their current perinatal unit was 10.8 years.

Data Collection

The collection of data took place between February 2009 and June 2010 and was conducted by three RAs. The time and place of data collection were agreed upon between the participant and the RA. These meetings were conducted in private offices at the nurses' places of employment or at the nurses' choice of setting that was mutually negotiated.

Written informed consent (Appendices Ea, b, & c), which was offered in both French and English, was obtained by a fluently-bilingual RA at the beginning of the data collection.

Participating nurses were first asked to complete an orally-administered, 30-minute survey (Appendices Fa & b) prior to engaging in the qualitative interview process. The survey consisted of: eight demographic questions, two Likert-type scale questions relating to self-perception and peer skill level in adolescent-friendly care, two Likert-type scale questions relating to self and peer knowledge of community resources for adolescent mothers, and 11 yes/no questions about unit-level factors that may contribute to nurses' capacity to provide adolescent-friendly care (Davies & Edwards, 2009; Davies et al., 2006). The findings from this survey were published by Peterson et al. (2012).

The RA then conducted a face-to-face, audio-recorded interview with participants using a semi-structured interview guide (Appendices Ga & b) with open-ended questions to explore the nurses' perceptions of adolescent-friendly nursing care, how the nurses adapted and tailored their care for adolescent mothers, and the barriers and facilitators to providing adolescent-friendly care. The interview guide was drafted and reviewed by the advisory board and the revised English interview guide was pilot tested with two birthing unit, two mother-baby, and two

neonatal nurses (n=6). Final revisions were made to the English guide based on this pilot testing. Translation of the interview guide into French followed this pilot testing process. As a result of concurrent preliminary data analysis during data collection, minor adjustments were made to the interview questions throughout data collection to better facilitate the attainment of rich and thick data. Specifically, if a participant introduced an issue or thought that was previously mentioned by one or more participants, the RA prompted the participant to explore that particular idea or thought in more depth and detail.

The interviews ranged between 18 and 67 minutes in length. Three interviews were conducted in French. Following each interview, the RA documented their impressions, thoughts, and observations in the form of field notes and also included questions that might require follow-up in subsequent interviews. All audio-recordings were transcribed verbatim following each interview by a professional transcriptionist who signed a confidentiality agreement (Appendix H) and all transcripts were de-identified at that time. As a result, the participants' names and any information that could identify the specific hospital site, health care institution, patients and families, and staff members were removed from the transcripts and each participant was assigned a numerical code. All transcripts were verified for accuracy by the RA.

Protection of Human Rights

The transcribed audio-recordings were de-identified and the consent forms, demographic forms, audio-recordings, electronic transcripts, and paper transcripts are stored in separate locked cabinets in the principal investigator/thesis supervisor's locked office. The digitally-based audio-recordings are stored in this office on a password-protected computer. Only the principal investigator of the mixed methods study (W. Peterson, thesis supervisor) and one co-investigator (J. Rashotte, thesis committee member) had access to the de-identified transcripts. The master

files, audio recordings, and transcripts will be destroyed 15 years after the completion of the study, as stated in the approved ethics board certificates.

My Role in the Research

I joined the research team in August 2017 as an outsider to the mixed methods study. I was not involved in the data collection process, nor was I involved with the data analysis or findings derived from the quantitative data. I came into the master's program with an interest in the provision of perinatal care to marginalized women and wanted to explore research within this topic from the perspective of nurses. My decision to explore research relating to pregnant and parenting adolescents is not based on any personal experience with adolescent pregnancy, nor is it based on my own experiences of marginalization. My interest in exploring research relating to this population stemmed from my professional work experience as a Level III Neonatal Intensive Care Unit nurse and my interest in marginalized women and their access to perinatal health care. As a neonatal nurse for nearly four years, I have observed inconsistencies in the delivery of adolescent and mother-friendly care in perinatal settings. I desire a better understanding of the experiences of adolescent mothers in this setting and how to improve their satisfaction with care. Considering that I am a neonatal nurse, I am interested in the care provided to the mothers as they will be the individuals bringing their infants home and their experiences are instrumental in forming their perspectives about accessing health care services and connecting with care providers for their own and their family's health care needs.

The data collection for this study occurred between 2009 and 2010 and there was a delay in completing the qualitative data analysis and publication. However, recent interactions that I have experienced with perinatal nurses at conferences and health care professionals and adolescent mothers from community-based agencies have confirmed that negative attitudes remain present within perinatal health care settings.

Research Proposal

I developed and wrote a research proposal that was submitted to my thesis committee for their review. The purpose of this proposal was to describe the study and outline the procedures that I would conduct with regard to the analysis of the data. The committee approved the proposal and subsequently, I applied for ethics approval to access the data for analysis and publication purposes in partial fulfilment of my master's thesis.

Methodology

Interpretive description. Interpretive description is a method of qualitative research inquiry that was developed by Thorne, Reimer Kirkham, and MacDonald-Emes (1997) to meet the unique demands of researchers in the nursing discipline and to move beyond adherence to specific methodologies such as phenomenology, grounded theory, and ethnography (Thorne, 2016). Thorne et al. (1997) identified that there were limitations in both the traditional (quantitative) science and qualitative research traditions and thus, developed a non-categorical qualitative research approach to interpretive description. Aligned with a constructivist and naturalistic orientation to inquiry, this approach has the potential to generate an interpretive description. This interpretive description has the potential to inform clinical understanding by capturing themes and patterns within subjective perception (Thorne, 2016) when used to explore human health experience and phenomenon (Thorne et al., 1997), for example, adolescent-friendly perinatal nursing care. According to Thorne (2016), interpretive description is “a means by which to name and clearly reference the kind of well-founded organizing logic that applied researchers have always been striving toward” (p.39). Interpretive description is an inductive analytic approach that has the potential to develop nursing knowledge and create an understanding of clinical phenomena to yield implications (Thorne, 2016).

Theoretical scaffolding. Thorne coined the term theoretical scaffolding to describe “the initial position from which you will build out your design plan” (2016, p.59). The researcher is instrumental in the investigation and the interpretation of the study findings and reflection is essential for the researcher to identify and acknowledge who they are, what they represent, and what they are trying to accomplish (Thorne, 2016). The purpose of scaffolding is to foreground the study and the essential elements of this process include conducting a literature review and identifying theoretical allegiances.

The literature review is the first element of scaffolding a study as it allows the writer to recognize and draw conclusions about the topic in relation to the research problem (Thorne, 2016, p.60). The literature review is instrumental in the research process and explains the current research regarding the topic and the “nature of the inquiries upon which we have come to that knowledge” (Thorne, 2016, p.68). Moreover, upon the completion of the literature review the researcher’s theoretical allegiances must be identified and acknowledged. Thus, the identification of the theoretical allegiances is the second element of scaffolding. The process occurs by the researcher recognizing what they are bringing into their study (Thorne, 2016, p.60).

Literature review. The purpose of this section is to review the published literature related to the experiences of adolescent mothers’ receiving inpatient perinatal care. The literature review’s purpose was twofold: (1) to update the review undertaken at the time of the development of the research proposal for the mixed methods study, and (2) to ensure that the initial gap that had driven the study still existed as evident in the literature. This section begins with a brief description of the search strategy, followed by the critical analysis and synthesis of the body of literature.

The literature review is a narrative review of published materials regarding a given topic (Grant & Booth, 2009; Green, Johnson, & Adams, 2006). English and French articles were searched without any limits on the year of publication or the location of the study. Additionally, both qualitative and quantitative studies were considered and included. A search of the Cumulative Index for Nursing and Allied Health (CINAHL), Scopus, and PubMed databases were undertaken without year limitations. In October 2018, the search was updated to include the most recent publications and research studies. The key words for the search included adolescent pregnancy, teenage pregnancy, adolescent mothers, teenage mothers, young mothers, nurse attitudes, nurse behaviours, perinatal care, maternal-newborn care, adolescent-friendly care, youth-friendly care, health services, health care, maternal experiences, and maternal satisfaction. The detailed search strategy can be found in Appendix I.

Adolescent mothers have described the quality of their nursing care as dependent on the relationship-building skills of individual nurses and the degree of adolescent-friendliness of hospitals. Unfortunately, they have reported feeling judged by nurses, which has had a negative effect on their maternal-newborn hospital experience and the transition to motherhood (Brady, Brown, Wilson, & Letherby, 2008; Brand, Morrison, & Down, 2014; Peterson, Sword, Charles, & DiCenso, 2007; Redwood, Pyer, & Armstrong-Hallam, 2012; Whitley & Kirmayer, 2008). For example, young mothers who sense nurses' judgment may decline all nursing care or leave the hospital before they are ready for discharge (Peterson et al., 2007). Declining nursing care and leaving the hospital early are problematic as new mothers can benefit from health and social supports that are available in hospital (Peterson et al., 2012).

In the case of adolescent mothers, studies have indicated that improvement is needed in the provision of hospital-based perinatal care (Peterson & DiCenso, 2002; Peterson et al., 2007)

and when nurses fail to engage adolescent mothers, mothers are not as likely to receive the supports that they need (Peterson et al., 2007). Nonjudgmental perinatal nursing care is essential since adolescents may decline nursing care if negative attitudes are present from the nursing staff (Peterson et al., 2007).

Peterson and colleagues (2007) conducted a study using a transcendental phenomenological approach to describe adolescent mothers' experiences of inpatient postpartum nursing care. These mothers described their experiences as satisfactory when nursing care was friendly, patient, respectful, or understanding of the individual needs of each mother. Specifically, adolescent mothers were satisfied with their care when nurses shared information about themselves, were calm, demonstrated confidence in the mother, spoke to adolescents in the same way they spoke to adults, and when nurses could anticipate the unstated needs of mothers. These findings are supported by the research of Harrison et al. in which pregnant and parenting youth identified that health encounters were viewed as positive when they featured mutual respect, support, open communication, and nonjudgmental attitudes (Harrison, Clarkin, Rohde, Worth, & Fleming, 2017). In contrast, care experiences were described as unsatisfactory and negative when adolescent mothers perceived their nurses to be too serious, rushed, judgmental, or misunderstanding of the individual needs of each mother (Peterson et al., 2007). Adolescent mothers have identified the need to improve the adolescent-friendliness of inpatient perinatal nursing care (Peterson & DiCenso, 2002; Peterson et al., 2007). Moreover, it has been identified that positive interpersonal relations greatly influence the maternal-newborn inpatient stay (Johansson, Oleni, & Fridlund, 2002; Lin, 1996; Peterson et al., 2007; Wilde, Starrin, Larsson, & Larsson, 1993). Furthermore, in a study conducted by Redshaw, Hennegan, and Miller (2014) to

explore the experiences of young mothers with labour and delivery, the young women reported poor interpersonal care and thus, a poor care experience.

Findings from the Peterson et al. (2012) quantitative survey identified that perinatal nurses described their intrapartum and postpartum peers as having varying abilities in the provision of adolescent-friendly care. Additionally, judgment and other negative attitudes of some perinatal nurses influence the care that they provide to adolescent mothers (Peterson et al., 2012). The findings from this study of nurses' perspectives are important because they support the findings from studies with adolescent mothers. Both nurses and adolescent mothers describe how young mothers are negatively judged by some health care providers (Peterson et al., 2007; Redshaw, Hennegan, & Miller, 2014; Redshaw, Miller, & Hennegan, 2014; Robb et al., 2013; Whitley & Kirmayer, 2008). Redshaw, Hennegan, and Miller (2014) conducted a study to compare the labour and birth experiences of younger women (<20 years old) and woman older than 20 years. In regards to interpersonal relations, fewer younger mothers reported having a positive perinatal experience in comparison to older mothers (Redshaw, Hennegan, and Miller, 2014). Younger mothers were less likely to have had one care provider throughout their labour and birth (69% versus 76%); feel as though they received respectful care (74% versus 89%); feel as though their decisions (70% versus 85%) and privacy (76% versus 98%) were respected; and to feel as though they were spoken to in a manner which they could understand (71% versus 89%) (Redshaw, Hennegan, and Miller, 2014). However, when young mothers sensed support and positive relations from care providers they described feeling positive about their labour and birth experience (Redshaw, Miller, & Hennegan, 2014). It is important to recognize and acknowledge that health professionals are in a powerful position to influence birth and early mothering experiences of adolescents and to assist their transition to motherhood.

Other studies have explored adolescent pregnancy and motherhood from the perspective of health professionals such as midwives and nurses working in public health (Fredriksen, Lyberg, & Severinsson, 2012) and the community (Norris et al., 2016). Fredriksen and colleagues' qualitative study (2012) took place in Norway and involved multistage focus group interviews that were conducted with six participants including five midwives and one public health nurse. The purpose of this study was to describe their perceptions of their experiences of caring for young women during pregnancy and early motherhood (Fredriksen et al., 2012). Fredriksen et al. reported their findings as being aligned and consistent with other studies which found that "being a good midwife" was attributed to behaviours and characteristics such as compassion, kindness, support, knowledge, and good communication (Lyberg & Severinsson, 2010; Nicholls & Webb, 2006). Moreover, these participants described the importance of long-term relationships between the health care professional and the mother as it enhanced their self-esteem and helped to prepare them for their new role as a mother (Fredriksen et al., 2012).

Norris and colleagues conducted a qualitative study in the United States and the purpose of the research was to describe the establishment and maintenance of relationships between nurses and first-time pregnant, poor teenagers and their families (Norris, Howell, Wydeven, & Kunes-Connell, 2009). Six nurses participated in a year-long series of monthly focus groups. These nurses had experience working in long-term relationships with a diverse and vulnerable group of women in a community setting. The authors used a grounded theory methodology and found that "partnering" was essential to the development of nurse-mother long-term relationships (Norris et al., 2009). Three key strategies to engage mothers were described by the nurse participants. These strategies included courting the client, monitoring the progress of the relationship, and focusing on the client (Norris et al., 2009).

Both studies by Fredriksen et al. (2012) and Norris et al. (2016) identify the importance of interpersonal relations between young mothers and midwives, public health nurses, and nurses working in the community setting. Peterson et al.'s (2012) study is the only study found that explores the topic from the perspective of hospital-based perinatal nurses. Therefore, the knowledge gap remains regarding adolescent-friendly perinatal care, particularly as it relates to the perinatal period in hospital-based settings and what nurses perceive as adolescent-friendly care and how to provide it. By examining this knowledge gap from the perspective of nurses, who are identified as expert in caring for adolescent mothers, interventions may be developed to address and improve the provision of adolescent-friendly perinatal care by all nurses.

To improve outcomes for the maternal-newborn dyad, it is crucial that high quality perinatal care that is adolescent-friendly is provided. Analysis of the qualitative interview data collected from the nurses surveyed by Peterson et al. (2012) will contribute an in-depth understanding of the nature of adolescent-friendly perinatal nursing care, the development of expertise, and the factors that influence the provision of adolescent-friendly care.

Theoretical allegiances. This element of scaffolding the study involves locating the researcher's theoretical allegiances, locating oneself within a discipline, and locating one's personal relationship to the concept being explored (Thorne, 2016). In qualitative research studies, the investigator greatly influences the data collected and the end-result of the analysis and therefore, it is critical to engage in reflexive analysis to identify the influence of the investigator on the research process (Finlay, 2002). Reflexive analysis exposes and 'outs' the investigator, which leaves him or her vulnerable to scrutiny and criticism while increasing the integrity of the research (Finlay, 2002). Therefore, before describing the data analysis process, it

is imperative to situate myself and consider my social position and how this may have an influence on the research process and the future results.

I used a constructivist lens to explore the concept of adolescent-friendly perinatal care from the perspective of nurses who are expert in the care of adolescent mothers. The constructivist lens allows the researcher to explore the experiences of participants to discover the multiple, socially-constructed views of reality that exist and gain an understanding of “what is” regarding the experiences (Appleton & King, 1997; Guba & Lincoln, 1982).

According to Appleton and King (1997), the ontology and epistemology of the constructivist paradigm are dynamically interwoven and are to be considered in tandem as these philosophical foundations guide the inquiry. Constructivism uses a natural setting for data collection and the researcher interacts with the participants to construct knowledge and explore the multiple views of reality that exist regarding the phenomenon of interest (Appleton & King, 1997; Guba & Lincoln, 1982). Constructivist researchers must acknowledge and recognize that their own experiences, assumptions, and biases impact their interpretation of data; therefore, they must immerse themselves into the research (Creswell, 2009; Mills, Bonner, & Francis, 2006). The personal background of the researcher is an inevitable part of the data collection and analysis (Appleton & King, 1997; Guba & Lincoln, 1982; Stratton, 1997). Knowledge is inductively generated into a pattern of meaning due to this intersubjectivity amongst the researcher and the participants (Dzurec, 1989; Horsfall, 1995; Weaver & Olson, 2006).

The constructivist paradigm assumes a relativist ontological position meaning that the world consists of multiple realities that are individually and subjectively perceived and influenced by context (Guba & Lincoln, 1994). A relativist believes that ‘truth’ and ‘reality’ must be individually explored and understood “as relative to a specific conceptual scheme,

theoretical framework, paradigm, form of life, society, or culture” (Bernstein, 1983, p.8). To summarize, the development of knowledge cannot be translated into a universal truth as the world is composed of multiple realities that are impacted by context (Mills et al., 2006; von Glasersfeld, 1984).

According to Appleton and King (1997) and Guba and Lincoln (1994), the methodology of constructivism involves a hermeneutic and dialectic approach as proposed by the ontology and epistemology. The paradigm involves the interpretation and understanding of multiple views of reality and the construction of many truths. The constructivist lens has a significant impact on nursing research as it allows researchers to explore the lived experiences and the multiple realities of participants regarding human interactions and other phenomena (Horsfall, 1995).

The constructivist lens allows the researcher to explore the experiences of nurses who care for adolescent mothers in perinatal settings as this lens facilitates the discovery of the multiple views of reality that exist while permitting the researcher to gain an understanding of the many truths regarding the topic (Appleton & King, 1997; Guba & Lincoln, 1982). The researcher interacts with nurses to make their voices and concerns visible regarding their lived experiences through the dialectic approach (Benner, 1994). For instance, this lens may uncover experiences of nurses who have personal or family histories of adolescent pregnancy. According to Weaver and Olson (2006), the knowledge that is developed using the constructivist paradigm would be lost with the use of an alternate lens. By using a constructivist lens to explore the topic of discussion, the researcher is able to explore the experiences of nurses.

A relativist approach was implemented to explore the topic of adolescent-friendly perinatal care. Using the ontological and epistemological underpinnings, data collected were interpreted to construct knowledge that is related to (1) how and why perinatal nurses in inpatient

settings adapt their practice when caring for adolescent mothers and (2) the individual nursing behaviours and organizational characteristics of adolescent-friendly care in inpatient perinatal settings.

Ethics

I prepared and submitted an ethics application to the University of Ottawa's Health Sciences and Science Research Ethics Board to request permission to access and review the data that had been collected between 2009 and 2010. Ethics approval was granted prior to accessing the data (Appendix A). Additionally, the privacy and confidentiality of the participants were maintained and protected at all times and a confidentiality form, provided by the principal investigator, was signed. Once, I received permission to have access to and analyze the data, the principal investigator reviewed the transcript and field note data to ensure that they were completely de-identified prior to giving me access.

Data Analysis

Prior to beginning the analysis, I engaged in journaling to reflect on the ideas that I have regarding adolescent-friendly perinatal care. The purpose of tracking reflections is to "acknowledge and document the nature and substance of the ideas you hold about the phenomenon you are studying before you enter the field" (Thorne, 2016, p.119). I also maintained this reflexive journal to document and record the analytic decisions that were made and to maintain an audit trail (Thorne et al., 1997; Thorne, 2016). The following paragraphs will describe my analysis process as guided by Thorne et al.'s interpretive description approach (1997).

As I was not involved in the collection of the data, it was essential that I come to know the data (Thorne, 2016). According to Thorne (2016), "knowing your data means dwelling in it

repeatedly and purposefully and developing a relationship with it” (p.167). Therefore, I first conducted a preliminary reading of each transcript in its entirety and listened to the audio-recording of the interview. The purpose of listening to the audio-recordings and this reading of the transcripts simultaneously was to: (1) fully immerse myself in the data and (2) gather initial thoughts and impressions. Additionally, listening to the audio-recordings while reading the interview transcripts allowed me to develop a “feel” for my participants and their stories (p.167). At this point in time, I also reviewed the field notes that were recorded by the RAs to provide additional context. From this initial step, I documented notes in the margins of each printed transcript. This initial phase of data analysis was instrumental to the analysis process as it was my time to react to the data and moreover, to ascertain what terms used by the participants attracted my attention so that I could give greater consideration to them in subsequent readings (Thorne, 2016).

Secondly, I re-read each transcript and identified passages from each interview that answered each specific research question. Therefore, this step of analysis was essential to “sorting and organizing” the data (Thorne, 2016, p.163). During this reading of the transcripts, I analyzed the readings on an individual level, meaning that I did not compare them to one another. To manage the analysis of the data with this step, I maintained Microsoft Word files of the transcripts and used a combination of colour-coding and highlighting to identify thematic similarities and the insertion of comments with marginal memos and notes (Thorne, 2016). To ensure that premature identification of themes and sub-themes did not occur, passages that were deemed “quotable” or that appeared to have significant importance were managed as a “special kind of data” and were “flagged and harvested” in my analysis journal (Thorne, 2016, p.163).

Lastly, I interpreted the collected data to formulate broader themes and sub-themes that were characteristic of the data. For this step, I used NVivo™ to further manage the data. Similarities and differences amongst the participants noted and considered. Since interview transcripts can be interpreted in different ways as there are multiple meanings to the text and the interpretation is influenced by the researcher's personal experiences, the principal investigator and thesis supervisor (WP) and a committee member (JR) were involved in the data analysis process (Polit & Beck, 2012). This strategy helped to minimize misinterpretations of the data and build a comprehensive understanding of the phenomena. WP and JR had undertaken a preliminary analysis of the data in 2010 and therefore, I reviewed, considered, and reflected on their analysis notes to ensure that valuable findings were not lost. Using my analysis notes, a concept map was developed to identify and demonstrate how the themes and sub-themes were inter-related. This concept map was further developed through diagrams and discussions with the thesis committee. At this point, the transcripts were reviewed again to ensure that there were no misinterpretations and to ensure that context was considered.

Methodological Trustworthiness

Interpretive description allows researchers to explore a human subjective experience (Thorne, 2016). According to Thorne (2016), "an appreciation for the credibility of qualitative research...extends beyond mere consideration of adherence to the methodological rules and toward examination of the much more complex question of what meaning can be made of the research findings" (p.233). Qualitative credibility was ensured through multiple measures. I wrote comprehensive notes after reading and re-reading each interview transcript to document my impressions and reflections (Thorne et al., 1997). Investigator triangulation was used in the study to minimize biased interpretations of the data as WP and JR were involved in the data

analysis (Polit & Beck, 2012). When WP and JR initially began the analysis in 2010, they documented their initial impressions and reflections and logged their decisions, all of which began an audit trail. I reviewed these notes and reflections made by WP and JR upon completing my own analysis to ensure that valuable information was not lost. I also applied the final coding structure to the entire data set using NVivo™ to ensure the parts reflected the meanings within the whole. The audit trail was maintained and includes data analysis meeting minutes, my reflection journal, and the transcripts with my initial thoughts and impressions (Thorne et al., 1997). The purpose of the audit trail is to track my logical reasoning and all decisional processes that were made throughout the study (Thorne, 2016). Across all these analysis steps, approximately eight hours of committee meetings were held to complete analysis activities and I met with my thesis supervisor on a weekly basis to discuss the analysis and my interpretation of the findings. Furthermore, in February 2018, I shared a summary of preliminary study findings with perinatal care providers at the Canadian National Perinatal Research Meeting in Banff, Alberta. In October 2018, I presented the findings of my thesis with nurses at the Canadian Association of Perinatal and Women's Health conference in Ottawa, Ontario and qualitative health researchers at the International Qualitative Health Research conference in Halifax, Nova Scotia. Many providers confirmed they had similar experiences, thoughts, and concerns about adolescent-friendly care within their working environments. These activities support the methodological trustworthiness of this study and strengthen the findings (Polit & Beck, 2012).

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Chapter Three – Manuscript

“Age does not dictate a person’s ability to be a good mother”:

Perspectives of hospital based perinatal nurses

This chapter is an unpublished manuscript formatted for submission to Qualitative Health Research. This journal does not have a word or page count limit. If possible, manuscripts are to be less than 30 pages; however, longer manuscripts, if exceptional, are considered.

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Abstract

Adolescent mothers are more likely to be dissatisfied with their perinatal nursing care than adult mothers. The purpose of this Interpretive Descriptive study was to explore adolescent-friendly care from the perspective of hospital-based perinatal nurses. Twenty-seven interviews were conducted with nurses with expertise in caring for adolescent mothers. Open-ended questions were used to determine how nurses adapted care for adolescents, how nurses learned to provide adolescent-friendly care, and the barriers and facilitators to providing care. Nurses described two main goals: 1) delivering a positive experience and 2) ensuring safety. They accomplished these goals by being nonjudgmental, forming a connection, and individualizing nursing care. The nurses described being mother-friendly, regardless of maternal age, and employing strategies to facilitate establishing the nurse-adolescent mother therapeutic relationship. This research contributes to our understanding of how hospital-based perinatal nurses engage and support adolescents.

Keywords: adolescent mothers, adolescent-friendly care, inpatient nursing care, perinatal nursing, intrapartum care, postpartum care, neonatal care, interpretive description

Introduction

Approximately 2% (7,858) of infants are born to adolescents (≤ 19 years old) yearly in Canada (Statistics Canada, 2018). These dyads are identified as at-risk because of the prevalence of challenging life circumstances and some poor maternal and infant health outcomes associated with adolescent motherhood. For instance, compared to adult mothers, adolescents have higher rates of smoking, substance use, low education, low income; emergency caesarean sections, very preterm birth; infants requiring intensive care (Fleming et al., 2013); and postpartum depression (Cantilino, Barbosa, & Petrubu, 2007; Hudson, Elek, & Campbell-Grossman, 2000). Adolescents are less likely than adult mothers to intend to breastfeed (80.3% vs. 90.1%) and attend prenatal care appointments (73.5% vs. 85.5%) (Fleming et al., 2013).

Some community-based agencies have implemented adolescent-friendly services to engage youth in prenatal care (World Health Organization [WHO], 2012). Outreach programs that facilitate accessible prenatal care may improve perinatal outcomes for adolescents and their children. For example, adolescents in outreach obstetrical programs gave birth to infants with higher gestational ages ($P=0.005$) and birth weights ($P=0.002$) (Fleming, Tu, & Black, 2012). Adolescent-friendly services have been implemented in the community; however, little is known about adolescent-friendly hospital-based perinatal care.

In Canada, approximately 98% of pregnant women are admitted to hospitals for childbirth (Statistics Canada, 2016). The hospital stay is an opportunity for perinatal nurses to engage with, assess, and teach young mothers about important topics such as breastfeeding and postpartum depression. Adolescents have described the quality of their inpatient perinatal care as dependent on the relationship-building skills of individual nurses. They have identified that some nurses are more skilled in establishing therapeutic relationships than others, thus influencing adolescents' engagement in care and self-esteem. Adolescents respond to friendly, respectful

nursing care by identifying health, learning, and social needs (Peterson, Sword, Charles, & DiCenso, 2007). Unfortunately, adolescents have described judgment from nurses, negatively influencing their transition to motherhood (Brady, Brown, Wilson, & Letherby, 2008; Peterson et al., 2007). These mothers may decline care or leave the hospital prior to discharge if they experience judgment (Peterson et al., 2007). This missed care, “any aspect of required nursing care that is omitted (either in part or in whole) or delayed” (Kalisch, Landstrom, & Hinshaw, 2009, p.1510), is problematic as new mothers benefit from nursing support and care.

Peterson et al. (2012) published the quantitative results of a mixed methods study that sought to determine whether hospital-based adolescent-friendly perinatal nurses identified a need to improve the care of adolescents. Nurses completed a key informant survey and identified their peers as having varying abilities in the provision of adolescent-friendly care and that quality of care is negatively influenced when nurses hold poor attitudes toward adolescents (Peterson, Davies, Rashotte, Salvador, & Trepanier, 2012). Moreover, these key informants identified the need to improve the nursing care of adolescent mothers. These findings support evidence describing the perinatal experience from adolescents’ perspectives (Harrison, Clarkin, Rohde, Worth, & Fleming, 2017; Peterson et al., 2007).

This article’s aim is to report the findings of the qualitative component of Peterson et al.’s (2012) mixed methods study. The objectives were to describe: (1) how and why perinatal nurses in inpatient settings adapt their practice when caring for adolescents; and (2) the individual nursing behaviours and organizational characteristics of adolescent-friendly care in inpatient perinatal settings.

Methods

Study Design

Interpretive description was selected as the methodology for the qualitative component of the mixed methods study as it aligns with constructivism and naturalistic inquiry. The aim of interpretive description is to generate knowledge to inform clinical understanding (Thorne, 2016).

Setting and Sample

Between 2009 and 2010, data collection occurred in three hospitals (four sites) in one city in Ontario. At the time of recruitment, 2% (223) of the 9,400 births from all sites were to adolescents (Better Outcomes Registry & Network, 2011). Sites diverse with respect to patient population, size, internal resources for youth and context of care were selected. All perinatal units (birthing (n=3), postpartum (n=3), and neonatal (n=3)) at the four sites participated and purposive sampling was used to recruit nurses (Patton, 1990). Nurses were eligible to participate if employed at one of the participating hospitals on a perinatal unit and were considered adolescent-friendly.

A research assistant contacted clinical leaders (e.g., nurse educators, unit managers, clinical nurse specialists) and asked them to identify four to six adolescent-friendly nurses from their units. These leaders obtained consent from nurses to be contacted by the research assistant to learn about the study. Additionally, these nurses were asked to identify peers who were expert in adolescent-friendly perinatal care. Participants were recruited until two to four nurses from each unit had participated in an interview. The research assistant obtained written informed consent from each nurse prior to the beginning of the interview.

In total, 34 nurses were invited to participate and 27 agreed to take part in the study; seven declined due to their schedules or felt that they did not have enough experience caring for

adolescents. All participants agreed that they were skilled in the perinatal care of adolescents (Peterson et al., 2012). Table 1 summarizes the participant characteristics at data collection:

Table 1

Participant Characteristics (N=27)

Characteristics		Number (%)	Median (range)
Professional license	Registered nurse	26 (96)	
	Registered practical nurse	1 (4)	
Education (highest level)	Master's degree	2 (7)	
	Undergraduate degree	14 (52)	
	College diploma	11 (41)	
Unit of employment	Birthing unit	6 (22)	
	Postpartum unit	6 (22)	
	Neonatal unit	10 (37)	
	All three units	5 (19)	
Current position	Clinical educator	7 (26)	
	Staff nurse	20 (74)	
Nursing experience (years)	Total lifetime	19	(4 - 38)
	In current perinatal unit	10.8	(< 1 - 25)

Data Collection

Interviews were conducted to collect in-depth data to contribute to our understanding of hospital-based perinatal nurses' perspectives of adolescent-friendly care (Creswell, Plano Clark, Gutmann, & Hanson, 2003). A semi-structured interview guide (Table 2) was used to conduct face-to-face, audio-recorded interviews. The English interview guide was pilot-tested with birthing unit, postpartum, and neonatal nurses (n=6) and minor revisions were made. Following this process, the interview guide was translated into French. Interviews ranged from 18-67 minutes. Following each interview, the research assistant documented their impressions,

thoughts, and observations and noted questions that required follow-up in subsequent interviews with the other participants.

Table 2

Interview Questions

1. Tell me a story about caring for an adolescent mother that you felt went well.
2. Tell me a story about caring for an adolescent mother that you felt did not go well.
3. Please explain how you care for a mother when she is an adolescent?
4. How did you learn to care for adolescent mothers?
5. Based on your experiences, how would you describe adolescent-friendly nursing care?
6. What helps you to provide adolescent-friendly care?
7. What makes it more difficult to provide adolescent-friendly care?
8. Tell me why some nurses have difficulty caring for adolescent mothers?

Ethics

For the large mixed methods study, ethics approval was obtained by the University of Ottawa's and each individual organization's research ethics boards. In 2017, the University of Ottawa's research ethics board permitted the first author access to the data.

Data Analysis

The inductive approach to data analysis employed by the authors follows the method described by Thorne, Reimer Kirkham, and MacDonald-Emes (1997). The purpose of interpretive description is to capture "...themes and patterns within subjective perceptions and [generate] an interpretive description capable of informing clinical understanding" (Thorne, Reimer Kirkham, & O'Flynn-Magee, 2004, p.3). Interpretive description can develop nursing knowledge when used to explore health experiences, for instance adolescent motherhood (Thorne et al, 1997).

The second and third authors had initiated a preliminary analysis of the data in 2010. However, to “know” the data and develop a “feel” for the participants and their stories, the first author (AQ) began by fully immersing herself into the data by conducting multiple readings of each transcript, listening to the audio-recordings, and reviewing the field notes (Thorne, 2016, p.167). After each initial reading, thoughts and impressions were documented. Each transcript was then re-read and the “sorting and organizing” of the data occurred as passages that answered the research questions were identified (Thorne, 2016, p.163). The data were interpreted to formulate broader themes and sub-themes. NVivo™ was used to manage the data. It was only after the first author had formulated themes and sub-themes that she reviewed and reflected on the preliminary 2010 analysis notes. During the analysis process, AQ and WP met weekly and all authors met for a total of eight hours to discuss the interpretation of data and the findings. These processes strengthened the findings and improved the comprehensive understanding (Polit & Beck, 2012).

Findings

This vignette is one nurse’s story of caring for an adolescent mother. This story provides: (a) an example of the life circumstances and vulnerability of some adolescents; and (b) an understanding of the compassionate work that nurses must be skilled in to establish relationships.

A young adolescent, who already had one child who her parents helped care for, found herself pregnant again upon returning to school. When her second baby was born, he was very sick. Mom had mental health struggles, denied the pregnancy, did not seek prenatal care, and used substances. As a result, many members of the health care team judged this young lady before even establishing a relationship with her. I really felt for her. She was a lost kid and really touched me. A few of us volunteered to be her primary nurses so that continuity could be maintained – it was hard. We had to be careful who we assigned to her because some individuals

were not as sensitive as others. I saw a young girl who was scared and yet once she was supported and her needs were cared for, she was very attentive and loving towards her baby. Her family stepped up and took care of her. The feelings of the staff changed over time. At first, there was a lot of chatter in the unit about this baby and mom, but as time went by, people started to see how she had transitioned and triumphed. We had faith that she could do it. She showed us that she wanted to do it, and we got the family home together.

Adolescent-friendly nurses were found to be expert in the relational aspect of caring for adolescent mothers as they embodied a philosophy of care that is being mother-friendly, regardless of age and other life circumstances. Therefore, ‘being mother-friendly’ was conceptualized as an overarching theme. Three main themes were derived from the data and included ‘being nonjudgmental’, ‘forming a connection’, and ‘individualizing nursing care’. These themes enabled nurses to accomplish their goals of nursing care which they strived to achieve for all mothers, regardless of age. The first goal was to ensure that mothers had a positive perinatal experience and the second goal was to ensure that mothers were capable of safely caring for their newborn by discharge.

Goals of Perinatal Nursing Care

Delivering a positive experience. Nurses described the importance of mothers having a positive experience, the first goal of perinatal nursing care. The nurses demonstrated through their narratives that they genuinely cared about mothers and wanted to make a difference in their lives as new mothers. As one nurse explained: *“My goal is to give people a positive experience, no matter what the reason is that they came to the hospital”*. Another nurse explained the importance of a positive experience when she stated: *“Nurses care about what they do, are passionate about what they do, and want to make a difference. In their hearts, [they] want all*

women who come here to leave feeling good about their experience”. A positive perinatal experience was enabled when nurses were nonjudgmental, formed a connection with mothers, and individualized nursing care. The provision of nursing care while employing certain behavioural strategies was believed to positively influence the experiences of mothers.

Ensuring safety. The second goal of nursing care was to ensure that mothers were able to safely care for their newborns by discharge. One nurse explained that nurses were “*looking not just at the aspect of care while [mothers are] here, but what's long-term*” and consistently asking “*...what are their supports at home? Is baby going to be safe? Is mom going to be safe*”? The nurses described achieving this goal by recognizing and addressing learning needs of parents. Although these nurses emphasized the importance of providing family-centered care, they identified that their focus was on ensuring that the mother was able to safely care for the newborn upon discharge home.

Being Mother-Friendly: Treating All Mothers the Same

One nurse was intrigued when presented with the term adolescent-friendly and responded: “*Adolescent-friendly, hmm, quite a word... I don't think it's any more adolescent-friendly than it is 'mother-friendly'*”. Nurses described adolescent-friendly care as no different from the care that they delivered to other mothers. Maternal age was described as only one indicator of the potential need for extra effort in establishing a therapeutic relationship and that support and maturity were more influential than age alone. Therefore, nurses preferred to describe care as mother-friendly because they “*meet people where they are [at]*”.

Treating all mothers the same revealed a philosophy of nursing care. Nurses described providing care in a friendly manner to all mothers. When asked how her care differed depending on maternal age, this nurse explained that she “*treat[s] them like every other mother in the unit*”

because “*they’re a mother first...regardless of what your life experience[s][are] you’re a mum and I’m going to support you in that and respect that title for you*”. The nurses revealed a sameness to the care that they provided to all mothers. Nurses qualified this notion by describing the need to provide equitable care, given that mothers of any age may require a greater effort from nurses to establish a therapeutic relationship. One nurse explained: “*Their experiences are real. Their pain is real. Everything is the same as you would treat anyone else. They just have a more difficult story, and they can be more challenging*” and that “*they don’t deserve less just because their life may be a little more chaotic than the normal*”.

It is not that the nurses treat all mothers equally, but they described providing equitable care by putting forth more effort in establishing therapeutic relationships with mothers who are more challenging to engage. Although some nurses attributed expertise with adolescents to treating them in the same way that they care for all mothers, they recognized that adolescents need additional supports and teaching. One nurse articulated this nicely when she stated: “*treat them as adults but with understanding that they don’t have enough years under their belt to have experiences they need*”.

Learning to be mother-friendly. Some nurses in this study explained that they did not learn to provide adolescent-friendly care. The following nurse could not explicitly identify how she developed expertise in caring for adolescents: “*It’s a gut feeling a lot of the time. I can’t really think of any formal teaching that I’ve had, other than my experience(s)*”.

Learning through positive role model emulation. Some nurses explained that they learned to care for adolescents by “*mentoring; it’s watching other people do it*” and having role models in their units who were “*very good with these mums*”. The nurses explained that seeing “*what worked and what didn’t work with a mum*” helped them learn to care for and engage with

these mothers. The presence of staff that were role models facilitated adolescent-friendly care since they “*look upon caring for adolescents as something that's really cool to do and a challenge and really rise to the occasion to make the care exceptional...adolescents are leaving feeling empowered and with their baby feeling strong as mothers*”.

Learning through being self-reflective. Although these nurses described mentoring as having contributed to their knowledge of caring for adolescents, they explained that it was their reflection on these experiences that resulted in learning. Nurses described that by reflecting on their experiences, both personal and professional, their adolescent-friendliness developed and evolved. “*Reflecting on our own personal beliefs and values is a huge skill, [helping us] to know our own limitations, our own judgments*”.

Although some nurses articulated that significant life or clinical experiences contributed to their expertise, it was their ability to reflect on these experiences and subsequently learn from them that mattered. This process of learning to be mother-friendly, and hence adolescent-friendly, was described by one nurse who spoke about what she had learned from her own experiences as a mother of teenagers who “*made choices for themselves that pulled me into a world that I never thought I would ever experience...those experiences have really helped me open up and understand. Now when I see a teenager, I have such compassion*”. She demonstrated that she reflected on her experiences and as a result, her clinical practice was influenced because of the alteration in her evolving beliefs.

Being Nonjudgmental

“*The most important [adolescent-friendly behaviour] would be for [nurses] to be empathetic and nonjudgmental...age does not dictate a person's ability to be a good mother*”.

The nurses emphasized the importance of being respectful and having acceptance for mothers of

all ages and backgrounds. Being nonjudgmental was strongly evident in the nurses' stories in which they remained open to life circumstances, personal choices, and family dynamics. Mothers of all ages with vulnerabilities can experience judgment and stigma from providers.

Don't be judgmental. Just [be] non-biased. Give them the same care you would give every other family. It's not just teen moms that get judged; it's families that come in that are low income – you see a bit of that judgment and stigmatism apply to those cases as well. I became a nurse to take care of people and regardless of what this person's life is like or who they are on the outside, I'm here to [take] care of [them].

Many nurses described that having a child was a personal choice. For example, one nurse explained: *“You have to be nonjudgmental, that's really important. It's not my life, it's their life; it's their choices. My opinion doesn't matter”*. Nurses described the importance of wholeheartedly accepting and supporting mothers and their decisions: *“I can't decide if you're 13 and wanted [to] get pregnant...You can't change these decisions. What you can do is improve on it for them, or try to help them cope with it in the best way possible”*. Being nonjudgmental requires nurses to move beyond the judgment of each mother's choices regarding pregnancy within complex contexts and focus on the goals of perinatal nursing and their philosophy of nursing care.

Getting past the judgment. The nurses admitted that they make judgments about mothers. However, they acknowledged their biased reactions, described having reflected upon them, and actively worked at being nonjudgmental by engaging in activities that help them to move past the judgments. One such strategy, was to shift focus away from prejudicial and stereotypical issues to thoughts of the individual's needs as a new mother. To identify and meet mothers' individual needs, nurses focus on a relational ethic of care, which necessitates forming

a connection to build trust so that they can get to know the adolescent: *“I think that I’m fairly tolerant, nonjudgmental, open. I try not to personalize it. I try and step out of my feelings and just focus on the mum”*.

The nurses’ narratives also demonstrated nonjudgmental attitudes toward their colleagues who struggled to provide adolescent-friendly care. This nurse, who was cross-trained in all three units, recognized the uniqueness of her colleagues, similar to the uniqueness of mothers, and acknowledged that *“everybody brings their own baggage to the table, as a nurse”*. Some nurses had difficulty remaining respectful and nonjudgmental because of this ‘baggage’; however, regardless of *“whatever experience we’ve had, we try to be professional”*. This nurse elaborated that *“we all bring our values and beliefs to work with us”* and that some individuals, including herself, had a *“hard line”* about what they were able to move past or not. This figurative ‘hard line’ was described as the boundary at which one’s values and beliefs influenced their practice and may create challenging situations. It is because of this ‘hard line’ that some nurses cannot remain nonjudgmental.

Forming a Connection

Nurses described the hospital stay as a key time to assess mothers’ infant care skills, well-being, knowledge, and supports. It is through nurses’ nonjudgmental and respectful attitudes that adolescents can engage with nurses and form a connection. Nurses described challenges connecting with adolescents due to their limited life experiences and previous poor health care provider interactions. Although extra effort was often required to connect with adolescents, nurses emphasized that extra effort could also be required for any new mother.

Many nurses described the importance of establishing a rapport with adolescents (and their families) as they considered this connection to be essential to the therapeutic relationship. Yet, they also described the challenges they could encounter when attempting to connect.

[B]ecause [adolescents] don't have the life experiences to lean on, they're very vulnerable. But they have a shell sometimes that makes it a little harder to connect with, but if we can just be open to them, there's a lot of grace underneath.

The shell to which this nurse referred manifests in a variety of behaviours. Some adolescents and/or their family members enacted in a way that made forming a connection challenging, and sometimes impossible, despite efforts made by adolescent-friendly nurses. Some behaviours identified were associated with alterations to the adolescents' physical appearance, which seemed to reinforce the social stigma that was often associated with adolescent mothers, such as the display of multiple piercings and tattoos and clothing choices. Other behaviours were associated with attitudes that could include swearing, use of threatening- or intimidation-like actions, or rule-breaking such as disappearing from the unit, smoking, and substance use.

However, the nurses also provided examples of behaviours in which adolescents and/or their families engaged and facilitated the nurse-mother therapeutic relationship. These behaviours contradicted the biases that stigmatize adolescents. For example, adolescents who displayed inquisitiveness and eagerness to participate in the care of the newborn, were perceived as less resistant to forming a connection. Additionally, familial involvement and nurturing support extended toward their daughter, as well as the adolescent's higher levels of maternal maturity and developmental level were factors perceived as positive influences in forming

connections. Nurses stated that when these factors were present and combined with compassionate nursing, a therapeutic relationship could more easily form.

The nurses articulated that having time and patience were essential elements for building trust with adolescents, so that they could let their guards down enough to enable nurses to get to know their unique needs and the best ways to meet these needs. The nurses described that adolescents often required them to “*prove*” themselves: “*I think [adolescents are] more on their guard and you have to prove to them that you're on their side before they let you into their little circle*”. Many nurses discussed the importance of establishing trust with adolescents: “*It's important for the nurses to try and get to know the adolescent as well as she can and establish trust early so that she can support her*”. Another nurse explained: “*You just need to be patient; you know, sometimes you need to just sit in the room with them quietly and with nobody talking*”. She then added, “*We just have to be willing to communicate with them on their level and have lots of time for them*”.

Being assigned to the same patient over a period of time was described by the nurses as a facilitator to mother-friendly and adolescent-friendly care as it provided an ongoing opportunity to develop a therapeutic relationship with adolescents and their families. Continuity of carer, with the provision of time it offers, enabled the nurse to perform a more holistic assessment of their patients’ support and what is needed.

[B]eing that a lot of the babies that we see in the NICU are there long-term, we have the ability to have that time to get to know the parents, again regardless of age. For adolescent-friendly care, that time allows the nurses to get to know mom or dad or the support system and really get to know who or what they can do to help them to get to a point where they're able to care independently for the baby and take them home.

Some nurses described an association between their ability to establish a therapeutic relationship combined with a true desire to form that connection. One nurse explained that *“knowing how to connect with that mom sometimes just requires patience and the experience of having built relationships with several moms over several years [because then] you can go into it with a little bit more confidence”*. She elaborated on this relational aspect of care by explaining that to be an adolescent-friendly nurse, a true desire to form a connection needed to be combined with one’s experiential learning of caring for adolescents: *“You are not just coming in here to do your job and get out; you truly want to build a relationship with that family [to] meet [their] needs”*.

Being compassionate. The nurses emphasized the importance of having compassion for mothers and its role in the development of a therapeutic relationship. One birthing unit nurse described compassion in caring for an adolescent mother when she stated: *“This little gal really opened up well. She talked; there was eye contact; there was touch between myself and her, between her mum. It was a very warm and very accepting environment that she laboured and delivered in”*.

One nurse explained that she felt that *“it’s important for me to tell them, ‘you can succeed. This is not an ending. This is a beginning’. You don’t need to be told, ‘You shouldn’t have been pregnant in the first place’. You need to be told, ‘what you’re doing is brave”*. This nurse’s compassion was evident as she described empowering adolescents. Treating individuals with compassion and facilitating a positive experience amidst vulnerabilities and suffering, recognized as common amongst adolescents, was described by this birthing unit nurse:

A nurse that’s giving you information, is positive, holding your hand, and says, “look, I’ll stay with you, I’ll be here, I’ll tell you if something’s wrong” makes a big difference than

somebody who just leaves you there on a cold table by yourself and doesn't explain anything. It makes a difference—more so for people who are already vulnerable.

When asked about caring for and supporting adolescents, one nurse explained that “*extra special kindness is the medicine that I give: I just really want to be super kind to them so that they will be open and receptive when I want to take care of them or teach them something*”. This “*special kindness*” was common amongst nurses who described the generosity of spirit that many adolescent-friendly nurses embodied. Nurses referred to adolescent-friendly care as compassionate, generous, respectful, nurturing and being “*open, nonjudgmental, and really coming from your heart*”.

Being friendly. Nurses described having friendly interpersonal relations with adolescent mothers as a behavioural strategy to build trust, which was needed to establish a therapeutic relationship. One nurse described that “*getting [adolescents] to talk about their life by asking them questions about school and friends and what they do outside of their home and what their interests are, tends to make them more trusting*”. Being able to build trust was perceived as a crucial component of adolescent-friendly care. When asked to describe adolescent-friendly care, this nurse focused on trust

I think adolescent-friendly is care that opens the door for adolescents to trust and to feel supported and that they can express their needs in whatever way they feel they need to with their healthcare provider. So that there isn't a barrier between the adolescent and the healthcare provider, there's flexibility, trust, openness, respectfulness where the adolescent doesn't feel judged and feels that she can be open.

Taking risks. Many nurses described the need to engage in risk-taking behaviours to facilitate the building of a trusting relationship with adolescents. These risks included such

actions as bending some organization- and unit-based policies, pushing their own boundaries and level of comfort with confronting negative adolescent behaviours and setting acceptable limits, and heightening the timing and types of nursing care approaches they employed to engage the mother. The nurses explained that to be able to take risks, one must be confident in one's own nursing knowledge and critical judgment, with a willingness to bear the consequences of risk-taking. One nurse provided an example of risk-taking as "*[having] to ask those hard questions*" in relation to substance use during the perinatal period. She described that although it is challenging to do, it is important to be patient and honest with adolescents by "*[taking] the time to sit down with them and talk about it openly...if it's been disclosed a few times, then you know they're willing to talk about it*". She acknowledged that the risk of asking the hard questions may only pay off depending on how the nurse "*come[s] across and how you can get them to open up*". Being honest, considered to be a form of risk-taking within the context of caring for adolescents with trust issues, was a common behavioural strategy of being adolescent-friendly. The nurses recognized the importance of being able to ask the hard questions and to be honest and upfront, yet supportive, in the way that they responded due to adolescent mothers' vulnerabilities.

[I]t's a very scary world out there, and if somebody doesn't try to support you in a positive way—because I think a lot [of the reason] these people are pregnant at 13 or [in their] teenage years is because [of a] lack of support—because of that, you need to be that much more there for them and to be honest and upfront with them.

The nurses acknowledged that when caring for adolescents, it was important to "*pick your battles, because you're not going to win them all*". One nurse provided the example of encouraging adolescents to consider breastfeeding, quitting smoking, and returning to school.

Maybe you're not going to win all three of those. Pick the one that you think most likely...If she's not going to quit smoking hell or high water – maybe you can get her to breastfeed. Maybe that's the one that you work on. You find where you think she's most responsive and try to get her to see that as a better choice.

Another nurse described the care of adolescents as “*need[ing] an extra bit more creativeness. It's more creative care and trying to break down the barrier*”. This notion of creative care was supported by other nurses who provided examples of taking risks by creatively interpreting the rules and policies. These nurses disregarded criticism from their peers, thus risking their relationships with their colleagues who had negative attitudes towards adolescents. However, these nurses took calculated risks with their practice and were able to distinguish when to do so and when not.

Advocating for mothers. Being an advocate for mothers required that nurses foster interdisciplinary teamwork. One nurse explained how teamwork helps her to be adolescent-friendly:

[T]eamwork helps. Social work, I like to get involved as soon as I can... I use the whole team as much as I can, depending on where [the mother] is in her labour...you treat them the same as you would anyone else; if I notice that she might be put on the back burner, I'll definitely advocate and get the whole team to come see her.

The availability and accessibility of an interdisciplinary team, with positive attitudes towards adolescent mothers, was described as a facilitator to adolescent-friendly care. One nurse described the importance of “*having a good strong adequate support network for them before they deliver... social work is available for them, the nutritionist is available for them, triage is available for them if they have a concern or a problem*”. This nurse elaborated that involving the

entire health care team promoted the holistic view of health for the adolescent which is essential for these vulnerable mothers: *“You know, constant assessment of their emotional and psychological needs during the whole process, not just that 12 hours that we have them for. Access to care, that's it”*.

Just as the interdisciplinary team can have positive influences on adolescent-friendly care, negative attitudes or outlooks of individual team members can pose a barrier to care and make being an advocate more challenging. One nurse described the impact of the business-oriented nature of some providers and the lack of holistic care: *“There are a few [providers] that you kind of think it's unfortunate that these girls get paired up with them. They are very business-oriented. They're very matter-of-fact. They don't consider it their job to do any of the social work stuff”*.

Many nurses explained that their units had limited adolescent-specific teaching resources regarding the labour, birth, and delivery process and community resources. This lack of resources made it more challenging for nurses to advocate for adolescent mothers in their discharge teaching and to connect them with a support network upon being discharged home.

[T]here's no resources at hand that can point us to where we can give this information to the mums easily...that would help - having more resources on the unit that we could provide the mums, or even to provide us so we can have a better follow-up in the community...I'm really not aware of what's out there for these mums once they leave.

Individualizing Nursing Care

“Every situation is different, so I don't say because she's young she's not going to do this...I approach every client differently”. The participants described individualizing nursing care for all mothers as essential to recognizing and being sensitive to the unique needs and

situation of each mother. Although the nurses described their philosophy of care as providing the same care for all mothers, they adapted the strategies they use to connect with mothers to each situation and the needs of the mother, her infant, and the entire family.

The uniqueness of each mother is evident when considering adolescents and their development. Adolescent mothers of various ages “*are at different developmental stage[s] so it is important to assess and recognize what stage they’re at and to meet your care to those needs*”. Many nurses asserted that age does not determine maturity or parenting abilities because “*...some adolescent moms are more mature than adult moms and some of the adolescents are more interested and engaged than other parents...care has to be adapted in the situation*”.

Being adaptable. Virtually every nurse described the importance of adapting care to meet the individual needs of each mother and her situation while remaining nonjudgmental and respectful in the care approach. One nurse explained that “*if you are the type of person that is able to very quickly see beyond age, socio-economic status, or certain demographic information [and] to be able to very quickly get to know that mother as an individual [then] that enhances your ability to really cater the care to meet her needs, and her role as a Mom*”. One neonatal nurse stated that being adaptable was a facilitator to adolescent-friendly care. Although she described the importance of adapting adolescents’ care, she argued that this was not unique to maternal age.

You adapt your care, your care plan, and all of the teaching. You may find a very mature adolescent that you can chat with straight-up with a specialist and not have a problem, and you may end up with an adult who’s got some emotional or psychological situations where they’re at a level of an adolescent, and you have to adapt to that.

Being flexible. Demonstrating flexibility was described by the nurses as essential to their nursing care, specifically to adolescents. One nurse stated the following: “*How do I describe adolescent-friendly nursing care? It has to be quite a bit more flexible when it comes to dealing with adolescent mothers than older mothers*”. The behavioural strategy of being flexible and adapting care was supported by the following nurse:

[T]o provide good care nurses have to be able to be flexible, like to meet people where they're at learning needs wise or support needs wise and help them along to where they know they need to be. When we say who provides good care, who provides bad care, I think it's nurses that are able to meet people where they are and be supportive in the teaching that needs to happen versus some that are more rigid.

When asked about policies that may influence adolescent-friendly care, the majority of nurses identified the visitation policy. This policy was a barrier as it restricted the number of visitors that a mother could have at a given time. The nurses recognized that social support was essential for adolescent mothers; therefore, flexibility regarding the number of visitors was common amongst the participants. One nurse explained that “*...if they wanted their three best friends and their mother with them for [the labour and birth], then that's what they wanted. And sometimes that requires some negotiation with your [charge nurse] and asking them to trust you to police that*”.

Summary of Findings

Figure 1 demonstrates the overarching theme of being mother-friendly. Nurses are mother-friendly by being nonjudgmental, forming a connection, and individualizing nursing care. As a result of this mother-friendliness, nurses are enabled to achieve their goals of care which include delivering a positive experience and ensuring safety. Additionally, the nurses were

asked to describe how they learned to be mother-friendly; they attributed their expertise to having positive role models/mentors and being self-reflective on these experiences as well as on other professional and personal experiences. Figure 2 demonstrates the barriers and facilitators to adolescent-friendly nursing care.

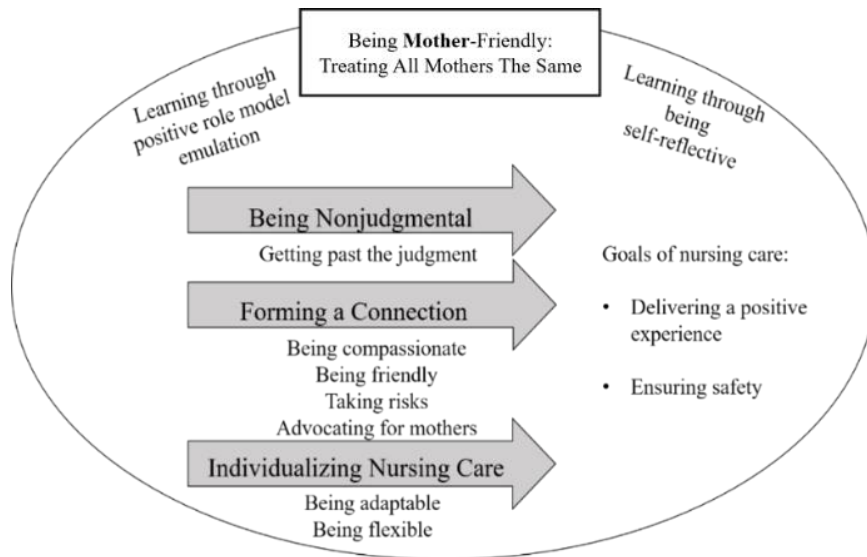


Figure 1. Themes of Adolescent-Friendly Care

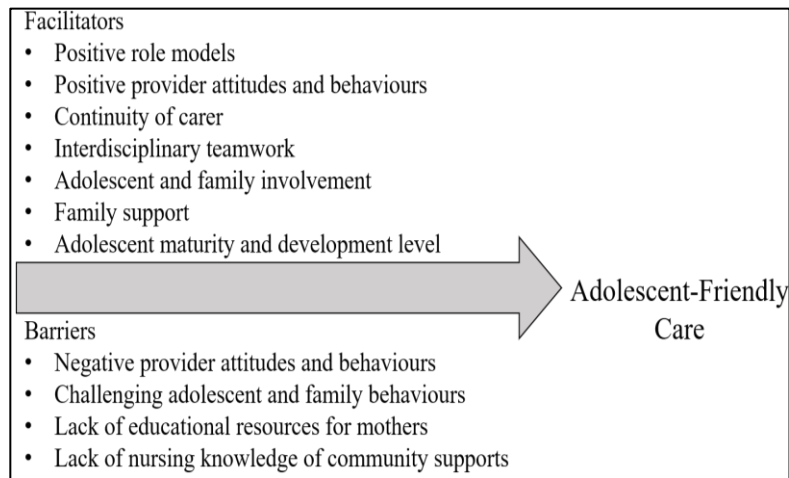


Figure 2. Barriers and Facilitators of Adolescent-Friendly Care

Discussion

Adolescent-friendly perinatal care was described as being mother-friendly; that is, the nurses identified that regardless of vulnerabilities, such as young age and life circumstances, they

treat all mothers the same. Being mother-friendly is the philosophy of care that is embodied by adolescent-friendly nurses and because of this, these nurses are perceived to excel at caring for and connecting with adolescent mothers. As a result of this philosophy, nurses treat adolescents in the same way as other mothers, but have the understanding that adolescents are more vulnerable due to limited life experiences.

Interestingly, this finding is congruent with the adolescents' perspective as adolescent mothers have identified that they want to be treated as a new mother instead of an adolescent with an infant (Low et al., 2003; Peterson et al., 2007). Adolescents expect their nursing care to be similar to the care of other new mothers because they do not consider their needs to be any different (Peterson et al., 2007). This demonstrates the uniqueness of the inpatient perinatal nursing context as mothers and nurses alike have described adolescent-friendly care as being the same as the care delivered to other mothers. In other health contexts, adolescent-friendly care is delivered in a different way such as with shortened wait times, with or without appointment, and with swift referrals to improve the acceptability of health care (WHO, 2002). Although treating all mothers the same was an overarching theme amongst the nurses' narratives, they described providing equitable rather than equal care to mothers. Care is considered equitable as nurses identified putting forth more effort in therapeutic relationships when it is more challenging to connect.

Societal stigma and negative health care provider attitudes are a barrier to adolescents accessing health services (Burgess, Fu, & Van Ryn, 2004; Escarce, 2005). There is ample evidence that when adolescent mothers sense judgment and/or disrespect, they may decline nursing care or leave the hospital before discharge (Peterson et al., 2007). The nurses in this study identified that they were able to remain respectful by placing their own personal values and

beliefs aside when delivering nursing care. Patients have described key elements of respect as including empathy, care, autonomy, provision of information, recognition of individuality, dignity, and attention to needs into nursing care (Dickert & Kass, 2009). Interestingly, in relation to the concept of adolescent-friendly and thus mother-friendly care, the themes that were derived from the interview data align with these elements. For example, the nurses described the importance of compassion and having empathy, connecting with mothers, remaining non-judgmental, and individualizing nursing care.

The nurses ultimately described a relational ethic of care, that is, the situation of ethical action in a relationship (Bergum & Dossetor, 2005), as their philosophy of nursing care. Relational ethics regards the manner in which individuals engage and connect with one another and Austin (2008) describes that being open to all individuals and their life circumstances is essential to ethical action. This description of relational ethics is therefore, easily applicable to the provision of adolescent-friendly perinatal nursing care. Mutual respect, open communication and dialogue, engagement, and an interdependent environment are core concepts in relational ethics and were mentioned in the participants' descriptions of adolescent-friendly and mother-friendly care.

According to adolescents, adolescent-friendly nurses are skilled in the relational aspect of nursing care (Harrison et al., 2017; Peterson et al., 2007). Caring and the therapeutic relationship is central to nursing care and greatly contributes to the health and well-being of patients (Benner & Wrubel, 1989). The purpose of the therapeutic relationship is to meet the health care needs of the patient, and the nurses in this study described the importance of building trust to form a connection with adolescent mothers. Nurses described the ability to form a connection with adolescents as essential to being able to provide individualized care. The nurse-patient

therapeutic relationship enables nurses to plan, deliver and evaluate care in an individualized, person-centered manner (Gordon, 2006).

The nurses in this study described individualizing the care that they provided to all mothers. Adolescent-friendly and hence mother-friendly care was described as maternal, patient-centered care that is provided in a respectful, nonjudgmental, and relationship-centered manner. Perinatal nursing care was described by the nurses as needing to be mother-friendly, specifically in the case of adolescents. Nurses described that this approach develops from a foundation of respect and responsibility.

Implications and Recommendations

Individual nurses can improve the inpatient perinatal experience of adolescent mothers (Peterson et al., 2007). Although adolescent-friendly training is a recommendation for all health care providers (WHO, 2002), the nurses in this study could not identify any adolescent-friendly training that they had received and they described learning to be mother-friendly by reflecting on their own personal and professional experiences. Perinatal units can foster learning to be mother-friendly amongst their interdisciplinary team by (1) providing workshops where the stories of adolescent parents or parents with other vulnerabilities are shared to foster reflection, (2) providing opportunities for mentorship of students and nurses who have identified the need to improve their interactions with mothers with vulnerabilities, and (3) conducting debriefing sessions of more challenging cases to foster reflection (Johns, 2002).

Moreover, to promote mother-friendliness at the individual level, it is recommended that perinatal health care providers receive training in and employ trauma-informed care (Harris & Fallot, 2001). A trauma-informed care approach is recommended because there is a strong relationship between adolescent pregnancy and trauma such as abuse, intimate partner violence,

substance use, and mental illness (Hillis et al., 2004). The nurses did not explicitly state that they employed a trauma-informed approach to the care of adolescent mothers; however, in their narratives, they shared stories of adolescents who had experienced trauma thus they described the importance of delivering care in a sensitive and supportive manner.

At the unit level, mother-friendliness can be promoted in two ways. First, it is recommended that perinatal units employ a liaison nurse to keep in-hospital nurses informed and up-to-date about community-based resources and referral programs. The nurses in this study identified the need for education and information regarding community resources and supports as they had limited knowledge of the programs available for adolescent mothers. The liaison nurse is an effective way of creating links between hospitals and community programs in various health care settings (Hofmeyer & Clare, 1999; Jowett & Armitage, 1988). The liaison role has potential to support the referral process for adolescent mothers to community-based programs in the postpartum period upon discharge from hospital. Second, continuity of carer was identified as a facilitator to mother-friendly care and nurses recommended that perinatal units implement a primary nursing model of care. There is evidence that relational continuity has been associated with a positive birth experience (Mattila et al., 2014), the feeling of safety during labour (de Jonge, Stuijt, Eijke, & Westerman, 2014), and breastfeeding (Wan, Hu, Thobaben, Hou, & Yin, 2011).

This study has made novel contributions to the evidence regarding adolescent-friendly care from the perspective of hospital-based perinatal nurses. The findings support the need for future research to design and test interventions to: (1) promote self-reflection amongst perinatal nurses and (2) improve hospital-based perinatal nursing care through the reduction of health care

provider stigma and the betterment of attitudes to facilitate connecting with and engaging mothers from vulnerable populations.

Strengths and Limitations

A study strength is the number of interviews conducted and the richness of the data collected from expert adolescent-friendly nurses. Although the first author did not collect the data, she became fully immersed through re-reading the data collected and listening to audio-recordings. The original research members involved in data collection and the initial analysis remained involved.

The data collection for this study occurred between 2009 and 2010 and there was a delay in completing analysis and publication. However, key stakeholders and adolescents from community-based agencies have confirmed that negative health care provider attitudes towards adolescent mothers continue to negatively impact the quality of perinatal care that adolescents receive (B. MacKillop, personal communication, October 3, 2018; Harrison et al., 2017). Additionally, the study findings were presented at three conferences and many health care providers shared similar experiences and thoughts about adolescent-friendly care thus supporting the study's trustworthiness (Polit & Beck, 2012).

Conclusion

The expert nurses participating in this study embody a philosophy of providing the same care for each mother regardless of age and life circumstances. However, these nurses use various strategies to form connections with mothers who initially resist engaging with health care providers. The therapeutic relationship permits nurses to more accurately assess mothers with vulnerabilities and to individualize care in order to more effectively meet the needs of each mother and family. Our findings describe: (1) how and why perinatal nurses adapt their practice when caring for adolescents and (2) the individual nursing behaviours and organizational

characteristics of adolescent-friendly care in inpatient perinatal settings. The findings of this study complement the quantitative research published by Peterson et al. (2012) by providing greater depth to our understanding of expertise in the nursing care of adolescent mothers.

Peterson et al.'s (2012) key informant survey results raised the question: Are some nurses expert in the care of adolescent mothers because they are expert in the care of all mothers? This study has revealed that nurses who are expert in the care of adolescents are expert in this care as they embody a philosophy of care that is being mother-friendly, regardless of age and life circumstances.

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Chapter Four – Discussion

The findings from the interviews with these expert perinatal nurses contribute evidence of nurses embodying a philosophy of care that is being mother-friendly and the importance of connecting with adolescent mothers to ensure a positive perinatal experience. The purpose of this chapter is to situate the findings, presented in Chapter Three, in the literature. Additionally, the implications and recommendations for nursing practice, policy, education, and research will be explored followed by a discussion of the strengths and limitations of the study.

According to the World Health Organization (WHO) (2012), adolescent-friendly care is necessary to improve access to health services that are required to protect and improve the health and well-being of adolescents. The WHO (2002) identifies that there are several barriers for adolescents requesting and obtaining health care services. These barriers are related to the appropriateness, accessibility, acceptability, effectiveness, and equity of health care services (WHO, 2002). This study aimed to describe the concept of adolescent-friendly care from the perspective of intrapartum, postpartum, and neonatal nurses with expertise in caring for adolescent mothers. The findings from the study revealed that hospital-based perinatal nurses provide adolescent-friendly care by caring for adolescents in the same manner as they care for all other mothers; that is, they treat mothers respectfully, regardless of age and life experiences. Their mother-friendly approach enables these nurses to build trust and establish therapeutic relationships with all mothers, even those who are more challenging to engage with. This connection permits these nurses to provide an individualized approach to care based on the needs of the mother, infant, and family. This discussion will situate these findings within the current literature and is organized according to adolescent-friendly care as being: (1) mother-friendly, (2) respectful and nonjudgmental, (3) relational, and (4) self-reflective.

Adolescent-Friendly Care as Mother-Friendly

Adolescent-friendly perinatal care was described by the nurses in this study as being mother-friendly; that is, they identified that they treat mothers the same, regardless of vulnerabilities such as young age and complex life circumstances. This finding is congruent with the adolescents' desires given that there is evidence in the literature that adolescent mothers want to be treated as a new mother instead of an adolescent with an infant (Peterson, Sword, Charles, & DiCenso, 2007). Adolescent mothers have identified feeling disrespected by and frustrated with health care providers when they are treated as a child instead of as an adult (Low, Martin, Sampsell, Guthrie, & Oakley, 2003; Peterson et al., 2007; Yardley, 2008). In Peterson et al.'s qualitative study (2007), adolescent mothers identified that they expected their nursing care to be similar to the care of other new mothers because they did not consider their needs to be any different. Because the mothers in Peterson et al.'s study preferred to be treated as a new mother, they would describe themselves as such rather than as a young or adolescent mother (2007). In this sense, the inpatient perinatal nursing context is unique since adolescent-friendly services in other health-care contexts involve care being delivered in a different way or in an altered setting to meet the needs of the adolescent-aged population. For instance, in certain contexts, adolescent-friendly services are offered with short wait times, with or without appointment, and with swift referrals to improve the acceptability of health care. Examples of these contexts include community-based clinics, mental health services, and sexual health clinics (WHO, 2012). According to a systematic review conducted by the WHO, actions taken to make health care services friendly to adolescents in developing countries resulted in the increased use of these services by the adolescent population (Dick et al., 2006).

According to the WHO (2002, 2012), adolescents encounter barriers in health care that relate to the appropriateness, accessibility, acceptability, effectiveness, and equity of health services. The nurses in this study described providing equitable care as they put forth more effort in establishing therapeutic relationships with mothers who are more difficult to connect with and engage. Equity is defined by the Canadian Nurses Association's Code of Ethics (CNA) (2017) as, "the fulfillment of each individual's needs as well as the individual's opportunity to reach full potential as a human being" (p.21); health equity occurs "when everyone has an opportunity to reach their full potential, and no one is disadvantaged from achieving this potential because of their social position or other socially determined circumstances" (p.21). It can be argued that the dimensions of adolescent-friendly care as per the WHO (2012) have been met by nurses providing mother-friendly care within the context of a one-on-one relationship with adolescent mothers in the perinatal context. For instance, demonstrating respect, being nonjudgmental, and individualizing nursing care can be viewed as bettering the acceptability of care, while forming a connection with all mothers can be viewed as providing equitable care as nurses put forth extra effort with some mothers to build trust and establish a therapeutic relationship. The nurses described this extra effort as often required to connect with and engage adolescent mothers and mothers with other vulnerabilities such as mental illness, substance use, and low income. However, the nurses provided behavioural strategies that they employ in their nursing care to engage mothers. These behavioural strategies included getting past the judgment, being compassionate, being friendly, taking risks, advocating for mothers, being adaptable, and being flexible. The National Institute for Health and Clinical Excellence reported that patients value the therapeutic relationship and partnership that is formed when in hospital (2012, 2014).

Moreover, there were numerous consistencies between this study's findings and the results from studies that explored the perinatal experience from the perspectives of adolescent mothers. The nurses in this study identified that they provide respectful and nonjudgmental care to form a connection with mothers which then enables them to individualize nursing care to meet the unique needs of each mother. Time and patience were described by the nurses as essential to their ability to connect with and engage mothers and to be able to be mother-friendly. In Peterson et al.'s (2007) study, adolescent mothers identified being satisfied with their perinatal experience when nursing care was delivered in a friendly and patient manner that was responsive to their individual needs. Furthermore, adolescents have described adolescent-friendly nurses as respectful, nonjudgmental, and supportive (Harrison, Clarkin, Rohde, Worth, & Fleming, 2017).

For the nurses in this study, being mother-friendly is their philosophy of care. As an outcome of the embodiment of their philosophy, these nurses are perceived to excel at caring for and connecting with mothers with all types of vulnerabilities. According to Benner and Wrubel, the act of caring for one another is central to nursing practice as it enables the possibility of giving and receiving help and promotes the development of a trusting relationship (1989). The nurses described providing nonjudgmental perinatal care in a patient-centered and friendly manner where all mothers are empowered, supported, and respected.

Adolescent-Friendly Care as Respectful and Nonjudgmental

The nurses in this study were asked to describe both the individual nurse behaviours and the organizational characteristics that influenced the provision of good quality perinatal care to adolescent mothers. In both instances, the majority of nurses discussed the influence of the attitudes of individual nurses or the interdisciplinary team. Occasionally, the nurses explicitly discussed the presence of societal stigma associated with adolescent mothers as influential to

their care as well. Therefore, the following paragraphs will discuss the importance of respectful attitudes and moral behaviour in the health care setting.

Nurses are expected to, “practice with compassion and respect for the inherent dignity, worth, and unique attributes of every person” (American Nurses Association, 2015, provision 1). Negative attitudes arising from the societal stigma and assumptions about adolescent mothers, may act as a barrier to adolescents accessing services and can affect the care provided (Burgess, Fu, & Van Ryn, 2004; Escarce, 2005). In the case of adolescent motherhood, it has been identified that when judgment or disrespect is sensed, adolescent mothers may decline all nursing care or leave the hospital before they are ready for discharge (Peterson et al., 2007).

Beach, Duggan, Cassel, and Geller (2007) have developed an account of respect “as recognition of the unconditional value of patients as persons” (p.692) and have suggested that respect in the medical setting needs to be both cognitive and behavioural. For instance, cognitive respect occurs when the provider believes in the value of a patient whereas behavioural respect occurs based on the action of this belief. The concepts of cognitive and behavioural respect were not specifically articulated by the nurses in this study. However, they did describe the importance of demonstrating respect by being unconditionally accepting and putting their values and beliefs aside to provide the best possible care for their patients. For example, the nurses recognized that although they may make judgments about mothers in their care, they are capable of moving past the judgment and remaining respectful.

Respect is an essential concept to the provision of care in all health care settings and, in a study conducted by Dickert and Kass (2009), patients described respect as incorporating empathy, care, autonomy, provision of information, recognition of individuality, dignity and attention to needs into nursing care. Interestingly, in relation to the concept of mother-friendly

care, the themes that were derived from the interview data align with these elements. For example, the nurses described the importance of remaining nonjudgmental, having compassion and empathy, forming a connection, and individualizing care to meet mothers' unique needs.

Adolescent-Friendly Care as Relational

The nurses in this study ultimately described a relational ethic of care, that is the situation of ethical action in a relationship (Austin, Bergum, & Dossetor, 2003; Bergum & Dossetor, 2005), as their philosophy of nursing care. Relational ethics regard the manner in which individuals engage and connect with one another and Austin (2008) describes that being open to all individuals and their life situations and circumstances, is essential to ethical action. As a result, this description of relational ethics is easily applicable to the provision of adolescent-friendly perinatal nursing care. Mutual respect, open communication and dialogue, engagement, and an interdependent environment are core concepts in relational ethics and are concepts mentioned in the descriptions of mother-friendly care by the expert nurses in this study.

Adolescent mothers have described adolescent-friendly nurses as those who are skilled in establishing a connection with mothers and their families. Moreover, the nurses in this study described compassion as an essential component of fostering the formation of genuine connections and engaging mothers in self- and infant-care. Compassion is recognized as a core value and ethical responsibility for registered nurses, and compassionate care is provided when there is understanding and caring from the nurse in regards to one's health care needs (CNA, 2017). Adolescent mothers can be a hard-to-reach and vulnerable group and as a result, nurses have an important role to support their transition to motherhood by caring for them, educating them, and providing them with valuable resources.

The therapeutic relationship between the nurse and the patient is at the centre of nursing, thereby, greatly contributing to the health and well-being of patients (College of Nurses of Ontario [CNO], 2006). The purpose of the therapeutic relationship is to meet the health care needs of the patient and its importance to health care delivery, patient experience, and health outcomes has been well established as evidenced by its inclusion in nursing theories (Peplau, 1952; Travelbee, 1971). The nurses in this study described the importance of building trust to establish a therapeutic relationship and form a connection with adolescent mothers. They described the ability to form a connection with adolescent mothers as essential to being able to engage these mothers in their health and to provide individualized care. This finding is supported by Gordon (2006) and Weinberg (2006) who describe the nurse-patient relationship as enabling for the nurse to plan, evaluate, and deliver care.

According to the Registered Nurses Association of Ontario's (RNAO) Best Practice Guideline on *Patient-Centered Care and Family-Centered Care* (2015), care is focused on the whole person as a unique individual. The lens of patient-centered and family-centered care promotes understanding amongst providers regarding the individual's life circumstances and history, health experiences, and family presence (RNAO, 2015). Person- and family-centered approaches to care have the potential to develop partnerships between individuals and their health care providers, thus improving satisfaction and achieving quality outcomes (Baker, 2014; Bridges et al., 2013; McCormack & McCance, 2006). Mother-friendly care is essentially maternal, patient-centered care that is provided in a respectful, nonjudgmental, and relationship-centered manner as described by the nurses in this study. Perinatal nursing care is described by the nurses as needing to be mother-friendly in the case of adolescents. Many nurses described

that this approach to care develops from a foundation of respect for all mothers and a sense of responsibility for each maternal-child dyad.

Adolescent-Friendly Care as Self-reflective

Some nurses perceived that an individual does not learn to be adolescent-friendly; rather, it is an internal way of being since they treat all mothers the same. However, other nurses described that they developed expertise in caring for adolescent mothers through personal and professional experiences and through the reflection of these events. A few examples of these experiences include having children at a young age, having family members with vulnerabilities, being mentored by an adolescent-friendly nurse, or certain professional encounters that have remained engrained in their memory. According to Benner, Tanner, and Chesla (1996), it is likely that expertise is developed from the combination of experience and self-reflective practice. This evidence is supported by research from Morrison and Symes (2011) that found that extensive experience does not necessarily result in nurses becoming expert. However, the act of reflecting in nursing is known to enhance the development of skills and professional competencies in clinical practice. According to Parrish and Crookes (2014), nurses who engage in reflective practice promote flexible, individualized, and holistic approaches to care; are skilled in problem solving; and are more aware of their professional competence. As a result, reflection is recognized as a critical nursing skill, as evidenced by its incorporation into the CNO's Quality Assurance Program (2018) and the CNA's Code of Ethics (2017, p.5). The CNA calls for nurses to reflect on practice, specifically with regard to the quality of interactions with others (2017).

The powerful process of self-reflection can serve as a foundation for meaningful nursing practice and may even be transformational as individuals are able to learn and develop through their own experiences (Johns, 2010). According to Mezirow (1990), transformational learning

may occur in adults as a result of reflection as it leads to the recognition of assumptions, communication with the self, and action based on the identification of the issue. Although none of the nurses in this study articulated that the process of learning to be mother-friendly was necessarily transformational for them, they described the process as being based on the reflection of their professional and personal experiences. Some of the nurses recommended that perinatal units identify mother-friendly role models to act as mentors for novice nurses and nurses who have identified the need to improve their interactions with adolescent mothers. According to Johns (2010), guided reflection is a process of learning and development assisted by a guide and that can create insight into the development of one's own nursing practice and, thereby, the improvement of the quality of their care (Johns, 2010).

Implications and Recommendations

The study findings have implications for nursing practice, policy, education, and research. These implications will be described below and recommendations will be discussed.

Nursing practice. From this study, there are two main implications for nursing practice and they include (1) employing a trauma-informed and strength-based approach to nursing care in the perinatal context for adolescent mothers and (2) employing a liaison nurse to keep in-hospital nurses informed and up-to-date about community-based resources and referral programs. These recommendations will be elaborated on below.

Individual nurses can inherently impact the quality of the inpatient perinatal experience for adolescent mothers (Peterson et al., 2007). The nurses in this study described providing care in a way that was understanding to the needs of adolescent mothers as they recognized the possibility of trauma in their lives. Moreover, although it was not articulated as such, the nurses described providing a trauma-informed approach to care by being sensitive and supportive with

their care approach. According to Harris and Fallot (2001), trauma-informed care involves nurses being sensitive and mindful of the possibility of past or present trauma and by being aware of the individual's experiences, care can be provided in a more holistic and integrated manner. To be trauma-informed, nurses must understand the influence of violence and trauma on victims (Harris & Fallot, 2001; Elliott, Bjelajac, Fallot, Markoff, & Reed, 2005). Evidence has shown that adverse (or traumatic) events in childhood are predictors of adolescent pregnancy (Garwood, Gerassi, Jonson-Reid, Plax, & Drake, 2015; Hillis et al., 2004; Noll, Shenk, & Putnam, 2009; Noll & Shenk, 2013). Examples of adverse events resulting in trauma include abuse (i.e., verbal, physical, or sexual), substance abuse, and mental illness. Given the evidence of the relationship between trauma and adolescent pregnancy, all adolescent mothers should be cared for as if they may have experienced trauma (Elliott et al., 2005). A main principle of trauma-informed care is that care is provided in a safe, respectful, and accepting atmosphere. This principle is consistent with the findings from this study as the nurses emphasized respectful and nonjudgmental attitudes to deliver a positive perinatal experience for adolescent mothers. Therefore, a recommendation for nursing practice is for all perinatal nurses to receive specific training in trauma-informed care in the form of in-services, education days, and conferences.

Moreover, it is recommended that trauma-informed care is paired with a strength-based approach to nursing care. A strength-based approach to nursing care, consistent with the RNAO's (2010) Best Practice Guideline on *Enhancing Healthy Adolescent Development*, is imperative for adolescent mothers as there is ample evidence that they experience intense fear, judgment, stigma, and other negative attitudes when accessing health care (Brady, Brown, Wilson, & Letherby, 2008; Hanna, 2001; Harrison et al., 2017; Peterson et al., 2007; Redshaw, Hennegan, & Miller, 2014; Redshaw, Miller, & Hennegan, 2014; Robb, McInery, & Hollins

Martin, 2013). The strength-based approach empowers adolescents to reach their full potential as mothers while in a supportive and safe environment.

Furthermore, the perinatal hospital stay is a period of transition for adolescents to adjust to the maternal role and to gain knowledge about caring for the infant and herself postpartum. This period presents as an opportunity for nurses to engage with, assess, and teach young mothers. In Canada, the average length of the maternal-newborn inpatient stay is approximately 48 hours (Canadian Institute for Health Information, 2017). As this stay is generally brief and adolescents are often hard-to-reach and engage once discharged home, it is important for inpatient perinatal nurses to provide referrals to community-based programs. By referring mothers to appropriate services upon discharge, continuity of care from the hospital to the community is achieved (Ministry of Health and Long-Term Care [MOHLTC], 2012).

Public health services such as Ontario's Healthy Growth and Development program support at-risk women in their new roles as mothers by providing a telephone call and offering a home visit as needed, shortly after discharge. Adolescent mothers can benefit from this public health referral as these programs offer support and information following childbirth (MOHLTC, 2012). Although in this study, some nurses identified the importance of the public health nurse in the postpartum period upon discharge home, many nurses were unaware of other community supports that cater to the needs of adolescent mothers. Hospital-based perinatal nurses have identified that they have limited knowledge of community resources and referral programs for adolescent mothers (Peterson, Davies, Rashotte, Salvador, & Trepanier, 2012). This is concerning given that adolescent mothers can benefit from being referred to community programs to provide them with support and other resources upon discharge from hospital.

For nurses to make referrals from the hospital to the community, they must have an awareness of the available programs and supports and an appreciation of the services offered (Edwards, Davies, Ploeg, Virani, & Skelly, 2007). Therefore, it is recommended that the referral process for adolescent mothers be facilitated by the formation of partnerships between perinatal units and community programs to better inform nurses about the available resources. In order to keep hospital-based nurses informed and up-to-date about community resources, employing a liaison nurse is recommended to link community-based agencies and inpatient perinatal units. The role of the liaison nurse is to improve communication between the hospital-based providers and community services in order to foster support for individuals in need. The liaison nurse role has been employed and researched in the context of mental health, chronic diseases and disabilities, and intensive care (Manderson, McMurray, Piraino, & Stolee, 2012; Wand & Shaecken, 2006; Wild, 2014). In the context of mental health, patient satisfaction levels improved with the implementation of liaison services (Gillette, Bucknell, & Meegan, 1996). The effectiveness of the liaison role in the context of mental health care is evident (Callaghan, Eales, Coates, Bowers, & Bunker, 2002; Summers & Happell, 2003); however, there is less known about the liaison nurse role and integrated service delivery in the maternity and child-family health contexts (Olley et al., 2016; Schmied et al., 2010). Olley et al. (2016) employed a qualitative interpretive study to explore the liaison role in child and family health services and found that the liaison nurse has three main roles: (1) building links between hospital-based providers and community-based agencies, (2) providing support to individuals and families when awaiting the transition from the hospital to the community, and (3) supporting hospital-based providers and providing education to them. Liaison roles have the potential foster the communication of information and facilitation of the transition of care from the hospital to the

community for mothers and families with greater, more complex needs (Schmied et al., 2010). These connections may enable hospital-based providers to make appropriate referrals for vulnerable families upon their discharge from hospital.

Nursing policy. The nurses in this study identified continuity of carer as a key organizational factor that influenced the provision of good quality nursing care. There is evidence that younger mothers are less likely to have one care provider throughout their labour and birth in comparison to older mothers (Redshaw, Hennegan, and Miller, 2014). Therefore, it is recommended that perinatal policies be developed to promote this continuity within the hospital context. Moreover, it is recommended that perinatal units implement a policy addressing this continuity for all mothers, regardless of age, since having relational continuity has been associated with a positive birth experience (Dahlberg & Aune, 2013; Wiegers, 2009) and the feeling of safety during labour (de Jonge, Stuijt, Eijke, & Westerman, 2014). There is evidence that discontinuity of carer can lead to inconsistency in health advice and the loss of valuable health information (Evers et al., 2010). A recommendation for nursing policy would be for organizations to enhance continuity of carer by employing a primary nursing model of care.

Additionally, there is evidence that patients are more satisfied with their care when delivery is based on the primary nursing model of care (Mattila et al., 2014). This is relevant in the perinatal nursing context as mothers tend to be more satisfied with care during pregnancy, during labour and delivery, postpartum, after discharge, and during follow-up when cared for by a primary nurse (Shields et al., 1998; Spurgeon, Hicks, & Barwell, 2001; Wan, Hu, Thobaben, Hou, & Yin, 2011). Furthermore, primary nursing has benefits for maternal attitudes towards breastfeeding as mothers who are cared for by a primary nurse or their own midwife are more likely to breastfeed in hospital and six weeks postpartum (Wan et al., 2011). Along with the

beneficial effects that primary nursing has for women during pregnancy, labour and delivery, and postpartum, this model of nursing care also contributes to an increased sense of job control and autonomy for nurses (Mattila et al., 2014).

There is a need for organizational support in the perinatal setting to improve health care provider attitudes and skill level in caring for adolescent mothers and mothers with other vulnerabilities. One recommendation to achieve this improvement, as it would better the mother-friendliness of perinatal units, would be the implementation of a formal policy of assigning mother-friendly nurses to provide primary nursing care for mothers with vulnerabilities. This recommendation is supported by the key informant survey results from the Peterson et al. study published in 2012.

Nursing education. The nurses in this study did not report ever receiving any formal training in the provision of adolescent-friendly care. They identified that reflecting on their own professional and personal experiences was an essential component of how they learned to care for adolescents, and mothers of all ages. Interestingly, these nurses were all considered expert in being adolescent-friendly, despite never receiving formal adolescent-friendly training which is a recommendation from the WHO (2002). This suggests that self-reflection can be powerful for professional development and it is a tool that enables nurses to develop their practice thus, improving the quality of their nursing care (Johns, 1995, 2010; Parish & Crookes, 2014). A recommendation for nursing education is the sharing of narratives and/or stories of adolescent parents or other ethical situations during courses, workshops, and conferences for nursing students and/or novice nurses. This sharing exercise can be used to facilitate the guided reflection of personal beliefs, biases, and judgments. Guided reflection is a process in which a practitioner is assisted and supported by a mentor to reflect on clinical practice and one's self

(Johns, 2010). This process has the potential to provide meaningful insights into the development of one's self and one's professional competencies as the presence of the guiding mentor can enhance the learning potential of reflection (Johns, 2004).

Additionally, nurses who have identified a need to improve their interactions with adolescent mothers or mothers with other vulnerabilities should be assigned a mother-friendly mentor with expertise to learn from. Specifically, it is recommended that student and/or novice nurses be paired with mentors who can be role models for the relational component of nursing care, in addition to other nursing skills, during undergraduate clinical practicums and hospital orientations.

Nursing research. There is ample research exploring the experiences of adolescents in accessing perinatal health care services and this study makes a novel contribution to the literature regarding adolescent-friendly care from the perspective of perinatal nurses. This study supports the need for research that tests the effectiveness of interventions designed to promote self-reflection amongst nurses since there is an important need to improve health care providers' skill in developing therapeutic relationships with adolescent mothers. Additionally, there is a need for future research to include the design of an intervention to improve hospital-based nursing care through the reduction of health care provider stigma and the betterment of attitudes to facilitate connecting with and engaging mothers from more vulnerable groups.

Study Strengths and Limitations

Twenty-seven interviews were conducted with nurses that were purposefully sampled and the hospital sites were selected based on their organizational diversity. Therefore, the multitude of interviews conducted and the richness of the data is a strength of this study as the findings have contributed to our understanding of adolescent-friendly perinatal nursing care. Although I

did not collect the data, I became fully immersed and came to “know” the data (Thorne, 2016, p.167) by reading and re-reading the transcripts, listening to the audio-recordings, and reviewing field notes that were created upon data collection between 2009 and 2010. Additionally, the thesis committee members were involved in the larger mixed methods study and my proposal development. Two members (WP and JR) were involved in the data collection and the initial analysis of the data. I reviewed their analysis notes upon completing the third step of my analysis process in NVivo™ and the committee was consulted throughout the study to ensure that valuable information was not lost.

It is acknowledged that the data collection for this study occurred between 2009 and 2010 and there was a delay in completing analysis and publication. However, key informants, including care providers and adolescent mothers from community-based agencies, have informed the authors that negative attitudes remain present within perinatal health care settings and that this research remains applicable and highly relevant. Furthermore, the findings from this study were shared at two national perinatal conferences and one international health research conference and attendees provided feedback that the findings were relevant and resonated with them in their perinatal health care settings.

Summary

The purpose of this study was to explore adolescent-friendly care from the perspective of hospital-based intrapartum, postpartum, and neonatal nurses who were identified as expert in their practice with adolescent mothers. Specifically, the research questions sought to determine the individual nursing behaviours and organizational characteristics of adolescent-friendly care and to determine how and why perinatal nurses adapt their care to adolescent mothers in inpatient perinatal settings. Demonstrating respect and remaining nonjudgmental, forming a

connection, and individualizing nursing care were found to be essential to the care of all mothers as described by the expert perinatal nurses in this study. However, the nurses identified specific behaviours that enabled them to be adolescent-friendly. For instance, to demonstrate respect and remain nonjudgmental, nurses recognized that they may have judgments; however, they describe getting past the judgment by being self-aware and recognizing their own biases. To better connect and engage adolescent mothers, nurses described employing the following behavioural strategies: getting past the judgment, being compassionate, being friendly, taking risks, and advocating for mothers. Lastly, the nurses described the importance of being adaptable and flexible to be able to individualize care for each mother.

In the quantitative component of this large mixed methods study, conducted by Peterson et al. (2012), the key informants raised the question: Are some nurses expert in the care of adolescent mothers because they are expert in the care of all mothers? The findings of this thesis, the qualitative component of the large mixed methods study, revealed that adolescent-friendly nurses are experts in caring for adolescent mothers as they are mother-friendly, regardless of age, background, and life circumstances. These findings have identified the need for better practice in the nursing care of adolescent mothers as excellence in nursing care during the inpatient perinatal stay is essential to promote the health of adolescent mothers and their infants.

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Appendix A: Research Ethics Board Approval for Secondary Review of Data

File Number: H06-17-25

Date (mm/dd/yyyy): 06/12/2017



Université d'Ottawa **University of Ottawa**
 Bureau d'éthique et d'intégrité de la recherche Office of Research Ethics and Integrity

Ethics Approval Notice
Health Sciences and Science REB

Principal Investigator / Supervisor / Co-investigator(s) / Student(s)

First Name	Last Name	Affiliation	Role
Wendy	Peterson	Health Sciences / Nursing	Supervisor
Ashley	Desrosiers	Health Sciences / Nursing	Student Researcher
Barbara	Davies	Health Sciences / Nursing	Other Collaborator
Judy	Rashotte	Health Sciences / Nursing	Other Collaborator

File Number: H06-17-25**Type of Project:** Master's Thesis – Secondary Use of Data**Title:** Caring for adolescent mothers: Perspectives of hospital-based perinatal nurses

Approval Date (mm/dd/yyyy)	Expiry Date (mm/dd/yyyy)	Approval Type
06/12/2017	06/11/2018	Approval

Special Conditions / Comments:
 N/A

1

File Number: H06-17-25

Date (mm/dd/yyyy): 06/12/2017



Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

This is to confirm that the University of Ottawa Research Ethics Board identified above, which operates in accordance with the Tri-Council Policy Statement (2010) and other applicable laws and regulations in Ontario, has examined and approved the ethics application for the above named research project. Ethics approval is valid for the period indicated above and subject to the conditions listed in the section entitled "Special Conditions / Comments".

During the course of the project, the protocol may not be modified without prior written approval from the REB except when necessary to remove participants from immediate endangerment or when the modification(s) pertain to only administrative or logistical components of the project (e.g., change of telephone number). Investigators must also promptly alert the REB of any changes which increase the risk to participant(s), any changes which considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project and safety of the participant(s). Modifications to the project, including consent and recruitment documentation, should be submitted to the Ethics Office for approval using the "Modification to research project" form available at: <https://research.uottawa.ca/ethics/forms>.

Please submit an annual report to the Ethics Office four weeks before the above-referenced expiry date to request a renewal of this ethics approval. To close the file, a final report must be submitted. These documents can be found at: <https://research.uottawa.ca/ethics/forms>.

If you have any questions, please do not hesitate to contact the Ethics Office at extension 5387 or by e-mail at: ethics@uOttawa.ca.

Signature:

Protocol Officer for Ethics in Research
For Chair of the Health Sciences and Sciences REB

File Number: H06-17-25

Date (mm/dd/yyyy): 10/04/2018



Université d'Ottawa **University of Ottawa**
 Bureau d'éthique et d'intégrité de la recherche Office of Research Ethics and Integrity

Ethics Approval Notice
Health Sciences and Science REB

Principal Investigator / Supervisor / Co-investigator(s) / Student(s)

<u>First Name</u>	<u>Last Name</u>	<u>Affiliation</u>	<u>Role</u>
Wendy	Peterson	Health Sciences / Nursing	Supervisor
Ashley	Desrosiers	Health Sciences / Nursing	Student Researcher
Barbara	Davies	Health Sciences / Nursing	Other Collaborator
Judy	Rashotte	Health Sciences / Nursing	Other Collaborator

File Number: H06-17-25

Type of Project: Master's Thesis

Title: Caring for adolescent mothers: Perspectives of hospital-based perinatal nurses

Renewal Date (mm/dd/yyyy)	Expiry Date (mm/dd/yyyy)	Approval Type
06/12/2018	06/11/2019	Renewal

Special Conditions / Comments:
 N/A

File Number: H06-17-25

Date (mm/dd/yyyy): 10/04/2018



Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

This is to confirm that the University of Ottawa Research Ethics Board identified above, which operates in accordance with the Tri-Council Policy Statement (2010) and other applicable laws and regulations in Ontario, has examined and approved the ethics application for the above named research project. Ethics approval is valid for the period indicated above and subject to the conditions listed in the section entitled "Special Conditions / Comments".

During the course of the project, the protocol may not be modified without prior written approval from the REB except when necessary to remove participants from immediate endangerment or when the modification(s) pertain to only administrative or logistical components of the project (e.g., change of telephone number). Investigators must also promptly alert the REB of any changes which increase the risk to participant(s), any changes which considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project and safety of the participant(s). Modifications to the project, including consent and recruitment documentation, should be submitted to the Ethics Office for approval using the "Modification to research project" form available at: <https://research.uottawa.ca/ethics/forms>.

Please submit an annual report to the Ethics Office four weeks before the above-referenced expiry date to request a renewal of this ethics approval. To close the file, a final report must be submitted. These documents can be found at: <https://research.uottawa.ca/ethics/forms>.

If you have any questions, please do not hesitate to contact the Ethics Office at extension 5387 or by e-mail at: ethics@uOttawa.ca.

Signature:

Research Ethics Coordinator

For Director of the Office of Research Ethics and Integrity

Appendix B: Description of Participating Hospital Sites and their Perinatal Units

Characteristics	Hospital Site 1	Hospital Site 2	Hospital Site 3	Hospital Site 4
Inpatient beds	482	438	167	421
Client population	Adult	Adult	Pediatric	Adult
	Regional referral center	Regional referral center	Regional referral center	Local community
Perinatal services				
Births/year	3363	3389	n/a	2541
Births to adolescents/year	129	46	n/a	47
Level of obstetrical care	High risk	Moderate risk	n/a	Low risk ^a
Level of neonatal care	All gestational ages	≥32 weeks	All gestational ages	≥34 weeks gestation
<p>Note. Better Outcomes Registry and Network (2011) ^a Only hospital site with single room maternity care (i.e. labor, birth, recovery & postpartum in same room), and midwifery care at the time of the study.</p>				

Source: Peterson, W.E., Davies, B., Rashotte, J., Salvador, A., & Trepanier, M.J. (2012). Hospital-based perinatal nurses identify the need to improve nursing care of adolescent mothers. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 41(3), 358-368. doi:10.1111/j.1552-6909.2012.01369.x

Appendix C(a) – Research Ethics Board Certificate (University of Ottawa)

Université d'Ottawa University of Ottawa

Service de subventions de recherche et d'éthologie Research Grants and Ethics Services

November 5, 2008

Wendy Peterson
School of Nursing
Faculty of Health Sciences
University of Ottawa
451 Smyth
Ottawa ON K1H8M5

RE: Adolescent-friendly Health Services: What can Perinatal Nurses and Hospitals provide? (H 07-08-01)

Dear Doctor Peterson and colleagues,

You will find enclosed the Health Sciences and Science REB ethical clearance for the abovementioned study.

During the course of the study, any modifications to the protocol or forms may not be initiated without prior written approval from the REB. You must also promptly notify the REB of any adverse events that may occur.

This certificate of ethical clearance is valid until November 5, 2009. Please submit an annual status report to the Protocol Officer in November 2009 to either close the file or request a renewal of ethics approval. This document can be found at:

http://web9.uottawa.ca/services/rgessrd/ethics/application_dwn.asp

A copy of this approval will be sent to research services, if necessary.

If you have any questions, you may contact the undersigned at the number [REDACTED]

Sincerely yours,

[REDACTED]

[REDACTED]
Interim Assistant Director, Ethics
For [REDACTED], Chair of the Health Sciences and Science REB



Université d'Ottawa University of Ottawa

Service de subventions de recherche et déontologie Research Grants and Ethics Services

HEALTH SCIENCES AND SCIENCE RESEARCH ETHICS BOARD

CERTIFICATE OF ETHICAL APPROVAL

This is to certify that the University of Ottawa Health Sciences and Science Research Ethics Board has examined the application for ethical approval of the research project entitled **Adolescent-friendly Health Services: What can Perinatal Nurses and Hospitals provide? (H 07-08-01)** submitted by Doctor Wendy Peterson of the School of Nursing at the University of Ottawa [REDACTED] and colleagues.

The Board found that this research project met appropriate ethical standards as outlined in the Tri-Council Policy Statement and in the Procedures of the University of Ottawa Research Ethics Boards, and accordingly gave it a Category 1a (approval). This certification is valid one year from the date indicated below.

[REDACTED]

November 5, 2008

Date

[REDACTED]
Interim Assistant Director, Ethics
For [REDACTED] Chair of the
Health Sciences and Science REB

File Number: H07-08-01

Date (mm/dd/yyyy): 06/01/2010



Université d'Ottawa **University of Ottawa**
 Service de subventions de recherche et d'éthologie Research Grants and Ethics Services

Ethics Approval Notice
Health Sciences and Science REB

Principal Investigator / Supervisor / Co-investigator(s) / Student(s)

<u>First Name</u>	<u>Last Name</u>	<u>Affiliation</u>	<u>Role</u>
Wendy	Peterson	Health Sciences / Nursingy	Principal Investigator
Barbara	Davies	Health Sciences / Nursingy	Co-investigator
Ann	Mitchell	Others / Others	Co-investigator
Judy	Rashotte	Health Sciences / Nursingy	Co-investigator
Ann	Salvador	Others / Others	Co-investigator
Marie-Josée	Trépanier	Others / Others	Co-investigator

File Number: H07-08-01**Type of Project:** Professor**Title:** Adolescent-friendly Health Services: What can Perinatal Nurses and Hospitals Provide?

Renewal Date (mm/dd/yyyy)	Expiry Date (mm/dd/yyyy)	Approval Type
11/05/2010	11/04/2010	Ia

(Ia: Approval, Ib: Approval for initial stage only)**Special Conditions / Comments:**

N/A

File Number: H07-08-01

Date (mm/dd/yyyy): 06/01/2010



Université d'Ottawa **University of Ottawa**
 Service de subventions de recherche et d'éthologie Research Grants and Ethics Services

This is to confirm that the University of Ottawa Research Ethics Board identified above, which operates in accordance with the Tri-Council Policy Statement and other applicable laws and regulations in Ontario, has examined and approved the application for ethical approval for the above named research project as of the Ethics Approval Date indicated for the period above and subject to the conditions listed the section above entitled "Special Conditions / Comments".

During the course of the study the protocol may not be modified without prior written approval from the REB except when necessary to remove subjects from immediate endangerment or when the modification(s) pertain to only administrative or logistical components of the study (e.g. change of telephone number). Investigators must also promptly alert the REB of any changes which increase the risk to participant(s), any changes which considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project and safety of the participant(s). Modifications to the project, information/consent documentation, and/or recruitment documentation, should be submitted to this office for approval using the "Modification to research project" form available at:
http://www.rges.uottawa.ca/ethics/application_dwn.asp

Please submit an annual status report to the Protocol Officer 4 weeks before the above-referenced expiry date to either close the file or request a renewal of ethics approval. This document can be found at:
http://www.rges.uottawa.ca/ethics/application_dwn.asp

If you have any questions, please do not hesitate to contact the Ethics Office at extension 5841 or by e-mail at: ethics@uOttawa.ca.

Signature:

Protocol Officer for Ethics in Research
 For Chair of the Sciences and Health Sciences REB

2

550, rue Cumberland 550 Cumberland Street
 Ottawa (Ontario) K1N 6N5 Canada Ottawa, Ontario K1N 6N5 Canada
 (613) 562-5841 • Téléc./Fax (613) 562-5338
<http://www.rges.uottawa.ca> <http://www.srd.uottawa.ca>

Appendix C(b) – Research Ethics Board Certificate (Hospital 1)



Monday, April 12, 2010

Dr. Wendy Peterson
University of Ottawa
School of Nursing
Faculty of Health Sciences
451 Smyth Road
Ottawa, ON K1H 8M5

Dear Dr. Peterson:

RE: Protocol# - 2008517-01H Adolescent-Friendly Health Services: What Can Perinatal Nurses and Hospitals Provide?

Renewal Expiry Date - Monday, April 11, 2011

Thank you for your letter of March 25, 2010 enclosing the revised renewal report and consent forms as well as the signature and TCPS certificate for Ms. Ann Mitchell. The file has been updated to include Ann Mitchell as a Co-Investigator. [REDACTED] has been removed.

I am pleased to inform you that your Annual Renewal Request (listed above), the Revised English and French Consent Form – Interview, Version 2, dated March 25, 2010, and the Revised English and French Consent Form – Focus Group, Version 2, dated March 25, 2010, were reviewed by the [REDACTED] and are approved. No changes, amendments or addenda may be made in the protocol or the consent form without the [REDACTED] review and approval.

Renewal is valid for a period of one year. The validation date should be indicated on the bottom of all consent forms and information sheets (see attached copy). Approximately one month prior to that time, a single renewal form should be sent to the [REDACTED] office.

The Tri-Council Policy Statement requires a greater involvement of the [REDACTED] in studies over the course of their execution. As well, you must inform the Board of adverse events encountered during the study, here or elsewhere, or of significant new information which becomes available after the Board review, either of which may impinge on the ethics of continuing the study. The [REDACTED] will review the new information to determine if the protocol should be modified, discontinued, or should continue as originally approved.

Yours sincerely,

[REDACTED signature]

Chairman

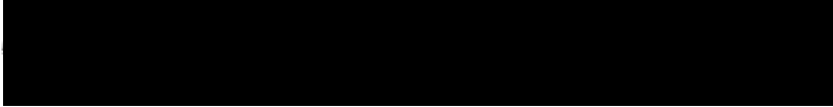
[REDACTED name]

Encl.

/km

[REDACTED enclosure area]

Appendix C(c) – Research Ethics Board Certificate (Hospital 2)



RESEARCH ETHICS BOARD APPROVAL – EXPEDITED REVIEW

Principal Investigator: Dr. Judy Rashotte/Dr. Wendy Peterson

Proposal Number: #08/75X

Protocol Title: Adolescent-friendly health services: What can Perinatal nurses and hospitals provide?

Department or PSU: Nursing Research

Approval date: November 24, 2008

Valid Until: November 23, 2009

Documents reviewed and approved: Research protocol submitted July 21, 2008

This is to notify you that the [redacted] Research Ethics Board has granted approval to the above named research study on the date noted above. Your project was reviewed under the expedited stream, which is reserved for projects that involve no more than minimal risk to human subjects.

During the course of the research, no deviations from, or changes to, the protocol or consent form may be initiated without prior written approval from the REB. Further, investigators are asked to report the following to the REB:

- Proposed changes to the study procedures (including the recruitment strategy, inclusion criteria, etc.);
- Concerns or issues that arise in conducting the research;
- Changes to the consent documents and advertisement notices;
- Changes to the investigators who assume responsibility for the study; &
- An annual report.

Wishing you success in your project.



Chair, Research Ethics Board

CG/sneh 24/11/2008

c.c. [redacted] Administration

This is an official document. Please retain the original for your file version 11/2003



RECEIVED FEB 08 2010



REPORTING FORM – ANNUAL RENEWAL

Please submit and original and one copy of the signed and completed form, including attachments as required.

REB PROTOCOL NUMBER:	#08/75X	SPONSOR'S PROTOCOL NUMBER:	NA	COST CENTRE	NA
PROTOCOL TITLE:	Adolescent-Friendly Health Services: What Can Perinatal Nurses and Hospitals Provide?				
PRIMARY INVESTIGATOR:	Judy Rashotte, RN, PhD	Telephone:	[REDACTED]		
		Email:	[REDACTED]		
HAVE ANY OF THE CO-INVESTIGATORS BEEN ADDED OR REMOVED SINCE THE LAST APPROVAL? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
IF YES, PLEASE SPECIFY NAMES BELOW:					
SECONDARY CO-INVESTIGATORS (use supplementary pages as required)					
NAME:	DIVISION OR PSU:	TELEPHONE:	EMAIL:		
[REDACTED]					
Current Status: <input checked="" type="checkbox"/> Actively Recruiting <input type="checkbox"/> Closed to Accrual <input type="checkbox"/> Permanently Closed <input type="checkbox"/> Temporarily Closed If study will be re-activated, a major modification must be submitted to the REB for full Board review at the regularly scheduled deadlines (see page 4 of the REB Procedures and Application Forms).					
Date enrolment commenced locally:		Feb. 5, 2009 – recruitment began			
		1st data collection – Feb. 10, 2009			
		1 st data collection @ [REDACTED] – Mar. 12, 2009			
If study is closed, indicate the date of the last patient enrolled locally:		n/a			
Projected date of study completion:		Data collection will be completed by December 31, 2010.			
Number of potential subjects approached for study participation locally since last approval:		Contacted 36 individuals (all sites)			
Number of subjects (patients) recruited locally since last approval:		22 (4 from [REDACTED])			

REPORTING FORM – ANNUAL RENEWAL

Has there been any departure from the approved protocol procedures (please describe below):	
Inclusion/Exclusion Criteria <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Source of subject (patient) population? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Other? Please describe:	
<p>Has an amendment/major modification been submitted to the REB for review of these changes?</p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, date approved: _____</p> <p>If an amendment has been approved, indicate the date of the Health Canada Non-Objection Letter in relation to the Amendment/Version # above (please attach a copy to ensure our records are accurate). When a Health Canada Non-Objection Letter is required for an amendment, please submit two copies for the Chair to acknowledge receipt (one copy will be returned to the Primary [REDACTED] Site Investigator or Research Coordinator).</p>	
<p>A copy of last approved Consent Form must be appended to this report.</p> <p>Has the consent form been modified since last approval? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has the REB been informed of these changes? <input checked="" type="checkbox"/> Yes – with this renewal. A modified consent form is attached to this renewal (new co-investigator's name) <input type="checkbox"/> No If yes, indicate date approved: _____</p>	
<p>Has any unexpected side effects, adverse events, or findings been noted since last approval? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Has the REB been informed of these? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate date approved: _____</p> <p>Have these SAEs been reviewed by the DSMB since last annual approval. If yes, please append the DSMB report to this submission. Any recommended protocol revisions made by the DMSB must be submitted separately for protocol amendments. See Major Modification submission form, page 46.</p>	
<p>Has any information appeared in the literature, or evolved from this or other similar ongoing studies (including interim analyses), since the date of last approval that might affect the perception of the risks and benefits of the study?</p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If yes, provide this information and your assessment of it in the section on progress of the study). Has the [REDACTED] REB been informed of these? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicated date submitted: _____</p>	

Continued on the following page

- Please attach all revised documents (consent and assent forms, recruitment notices, etc.) with changes appearing in bolded text).

Signature of Primary Site Investigator: [Redacted]	Date: February 8, 2010
---	---------------------------

Please forward to:

[Redacted] Administrative Assistant
Research Ethics Board



[Redacted] Research Ethics Board - APPROVAL
Chair's Signature: [Redacted]
Date: February 9, 2010

Appendix C(d) – Research Ethics Board Certificate (Hospital 3)

[REDACTED]

[REDACTED]

Le 21 avril 2009

Dre Wendy Peterson
Assistant Professor
School of Nursing, Faculty of Health Sciences
University of Ottawa
451 Smyth Road, Room [REDACTED]
Ottawa, ON K1H 5M8

OBJET: «Adolescent-friendly Health Services: What Can Perinatal Nurses and Hospitals Provide?»

Docteure,

La présente est pour vous informer de la décision du Comité de recherche de [REDACTED] en ce qui a trait à votre projet de recherche cité en rubrique. Le projet est approuvé par le Comité de recherche.

Vous pouvez discuter des modalités de fonctionnement de ce projet avec [REDACTED] de la Direction des affaires universitaires au [REDACTED]. Si jamais vous anticipez des changements significatifs au présent projet de recherche, vous devez communiquer avec [REDACTED] avant d'effectuer les changements.

Nous vous remercions de l'intérêt que vous portez à la recherche au sein de [REDACTED] et nous vous souhaitons le succès dans votre étude.

Veillez agréer, Docteure Peterson, l'assurance de nos meilleurs sentiments.

[REDACTED]

Président

[REDACTED]

c.c.

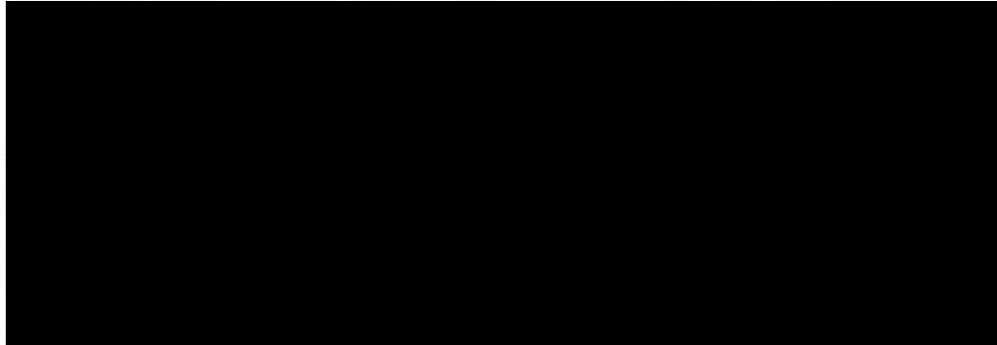
[REDACTED]

[REDACTED]

3.6 Adolescent-Friendly Health Services: What Can Perinatal Nurses and Hospitals Provide?

Principal Investigator: Ms. Wendy Peterson, RN, PhD
Assistant Professor, Faculty of Health Sciences,
University of Ottawa

ANNEXE I





July 14th, 2010

Dr Wendy Peterson
Assistant Professor
School of Nursing, Faculty of Health Sciences
University of Ottawa
451 Smyth Road, Room [REDACTED]
Ottawa, (ON) K1H 5M8

SUBJECT: Adolescent-friendly Health Services: What Can Perinatal Nurses and Hospitals Provide?

Doctor,

The [REDACTED] Research Committee has received the following documents which you sent by email on July 8th, 2010:

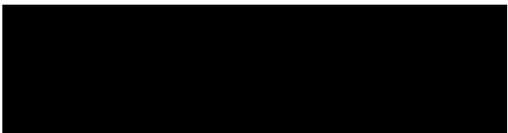
- An up-to-date Ethics Approval from the [REDACTED]
- An up-to-date Ethics Approval from [REDACTED]
- An Ethics Approval from [REDACTED]

You have met the requirements of the [REDACTED] Research Committee and we are pleased to inform you that the above-mentioned research project has been given an approval for a period of one year.

If you would like to discuss the matter further please contact [REDACTED] Scientific Director at [REDACTED]. Please contact the Research Committee in advance if any significant modifications are made to your research protocol in the future.

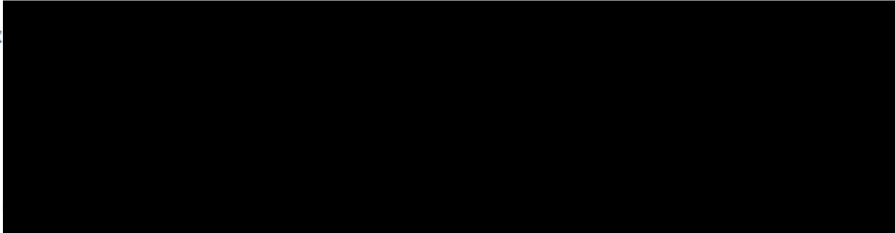
We thank you for your interest in research at [REDACTED]. We wish you success in this venture.

Sincerely yours

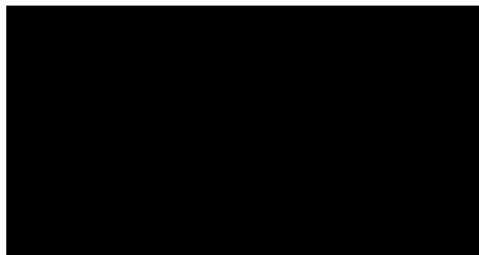


Associate Vice-president, Research and scientific director

CC :



Appendix D(a): Information Notice of Study (Hospital 1)



Study Notice

Nurses, physicians and social workers:

You may be invited to participate in a study called

"Adolescent-friendly health services: What can perinatal nurses and hospitals provide?"

We are conducting interviews and focus groups with staff at

four [redacted] hospitals that provide perinatal services.

We are interested in learning about how to best care for adolescent mothers and their families.

For more information about this study, please contact:

[redacted] Research Assistant, at [redacted]

[redacted] Research Assistant, [redacted]

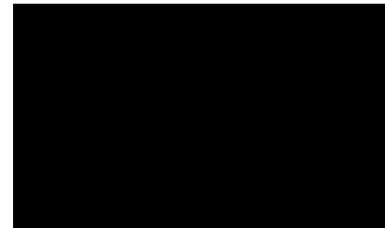
or

Wendy Peterson, Assistant Professor, School of Nursing, University of Ottawa



This research study has been approved by the [redacted] Ethics Board.

Appendix D(b): Information Notice of Study (Hospital 2)



Study Notice

Nurses, physicians and social workers:

You may be invited to participate in a study called

"Adolescent-friendly health services: What can perinatal nurses and hospitals provide?"

We are conducting interviews and focus groups with staff at

four [redacted] hospitals that provide perinatal services.

We are interested in learning about how to best care for adolescent mothers and their families.

For more information about this study, please contact:

[redacted], Research Assistant, at [redacted]

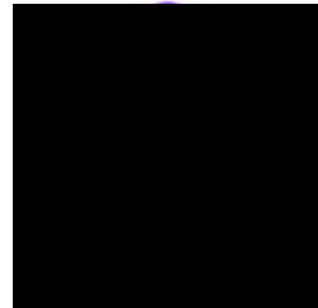
[redacted] Research Assistant, at [redacted]

or

Wendy Peterson, Assistant Professor, School of Nursing, University of Ottawa



This research study has been approved by the [redacted] Ethics Board.

Appendix D(c): Information Notice of Study (Hospital 3)**Avis de l'étude**

Infirmières, médecins et travailleurs sociaux

Vous pourriez être appelé à participer à une étude intitulée:

*Les services de santé adaptés aux adolescentes : Que peuvent offrir
les hôpitaux et le personnel infirmier en périnatalité ?*

Nous procédons à des entrevues et des groupes cibles avec le
personnel de quatre hôpitaux de la région [redacted] qui dispensent des
services de santé périnataux.

Nous désirons apprendre comment fournir de meilleurs soins auprès des
mères adolescentes et de leur famille.

Pour plus d'information sur cette étude, SVP communiquer avec:

[redacted] Assistante de recherche au [redacted]

OU

Wendy Peterson, Professeure adjointe, École des sciences infirmières, Université d'Ottawa au [redacted]
[redacted]

Appendix E(a): REB Approved Consent form from 2009-2010 (Hospital 1)

Study title: Adolescent-friendly health services: What can perinatal nurses and hospitals provide?

Investigators:

Wendy Peterson (Principal investigator), Assistant Professor, School of Nursing,
University of Ottawa
Telephone: [REDACTED]

Barbara Davies, Associate Professor, School of Nursing, University of Ottawa

Carolyn Kennelly, Corporate Clinical Director, Obstetrics, Gynecology & Newborn Care,
The Ottawa Hospital

Judy Rashotte, Director, Nursing Research & Knowledge Transfer Consultant,
Children's Hospital of Eastern Ontario

Ann Salvador, Director, Family Birthing Centre, Hopital M^ontfort

Marie-Josée Trépanier, Clinical Nurse Specialist, Professional Practice, Hopital M^ontfort

1. Invitation to participate:

I am being asked to participate in the above mentioned study because I work in an inpatient perinatal unit at one of the four participating sites and I have experience caring for adolescent mothers.

2. Introduction/Background:

The provision of adolescent-friendly care is well recognized as a strategy to engage youth in health promoting behaviours. This study will contribute knowledge about how to provide adolescent-friendly care in perinatal inpatient settings. The researchers are conducting interviews and focus groups with approximately 70 perinatal staff employed at [REDACTED]
[REDACTED]

3. Purpose of study:

The purpose of this study is to learn how nurses and hospitals can adapt their inpatient perinatal services to be adolescent-friendly.

4. Description of the study activities:

I am being asked to participate in an interview (focus group). If I agree to participate,

- I will be interviewed by a member of the research team (I will participate in a focus group with 7-9 other nurses, led by a member of the research team)
- The interview (focus group) will take place in a private room at my place of work, or in an alternate location of my choice, and at a time that is convenient to me (convenient for most participants).
- During the interview (focus group), I will be asked to speak about my experiences and thoughts about caring for adolescent mothers

- The interview (focus group) will be tape recorded as a record for the research team. The tape will be destroyed 15 years after completion of the study.

5. Length of time:

The interview will take approximately 1 to 1 ½ hours to complete. (The focus group will take approximately 1 to 2 hours).

6. Possible risks and discomforts:

There are no major risks associated with participating in this study.

- There is the possibility that my manager/supervisor will determine that I have agreed or declined to participate in this study.
- I may feel uncomfortable answering some questions. I can decline to answer any question or stop the interview at any time.

7. Benefits:

I will not benefit directly from participating in this research. However, this research may contribute to the improvement of services available to help adolescent parents.

8. Withdrawal from the study:

My participation in this study is completely voluntary. I am free to decline to participate and if I choose to participate, I can withdraw at any time for any reason. I can also decline to answer any questions that I do not wish to answer. If I decide not to take part or to leave the study this will not affect my employment.

9. Compensation:

After the interview (focus group), I will be given:

- A \$20.00 gift certificate as thanks for my participation, and
- A \$30.00 honorarium if I participated in an interview or focus group during my personal time (not during my paid work hours).

10. The use, disclosure and protection of information collected for this study:

- [in focus group consent only] I agree to respect the confidentiality of the focus group and I will not disclose our discussions to others within the workplace.
- The information gathered from me will only be used for the purpose this of research.
- The tape-recordings and transcripts will be kept in Wendy Peterson's locked office at the School of Nursing, University of Ottawa until 15 years after completion of the study. After 15 years, the study's paper files will be shredded in confidential waste and electronic files will be deleted.
- The only people who will have access to the tape-recordings are Wendy Peterson, Barbara Davies, RAs and the transcriptionists.
- My name will be removed from the transcripts and replaced with a numerical code. Research team members and graduate students assisting with the study will have access to the transcripts but not to the tape-recordings.
- The [REDACTED] Research Ethics Board and the [REDACTED] Research Institute may review the study records for audit purposes.

- Reports of this study may include quotes of what I have said. My name will not be used in any reports. However, because the community of inpatient perinatal staff in [REDACTED] is small, my anonymity cannot be guaranteed.

11. Questions:

If I have any questions about taking part in this study, I can:

- Telephone the principal investigator, Wendy Peterson [REDACTED]
- Meet with the co-investigator who is in charge of the study at [name of hospital]. That person is: Site investigator's name and phone number

Talk to someone who is not involved with the study, but can advise me on my rights as a participant in a research study. This person can be reached through the:

Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550
Cumberland Street, Room 159, Ottawa, ON K1N 6N5, tel: 613-562-5841 or
ethics@uottawa.ca

OR

[REDACTED]

I, _____ the undersigned, agree to participate in the above research study. The study has been explained to me. I have read this 3 page consent form and had the opportunity to ask questions about my involvement and to receive additional details that I wanted to know about the study. I understand that by accepting to participate, I am in no way waiving my right to withdraw from the study at any time.

I will be given a copy of this signed consent form.

I agree to participate in this study.

Research participant's name (printed)

Research participant's signature

Date

Investigator / Delegate's name (printed)

Investigator / delegate's signature

Date

Appendix E(b): REB Approved Consent Form from 2009-2010 (Hospital 2)**Consent Form (Interview)**

Study title: Adolescent-friendly health services: What can perinatal nurses and hospitals provide?

Investigators:

Wendy Peterson (Principal investigator), Assistant Professor, School of Nursing, University of Ottawa

Telephone: [REDACTED]

Barbara Davies, Associate Professor, School of Nursing, University of Ottawa

Ann Mitchell, Corporate Clinical Director, Obstetrics, Gynecology & Newborn Care, The Ottawa Hospital

Judy Rashotte, Director, Nursing Research & Knowledge Transfer Consultant, Children's Hospital of Eastern Ontario

Ann Salvador, Director, Family Birthing Centre, Hopital M^ontfort

Marie-Josée Trépanier, Clinical Nurse Specialist, Professional Practice, Hopital M^ontfort

1. Invitation to participate:

I am being asked to participate in the above mentioned study because I work in an inpatient perinatal unit at one of the four participating sites and I have experience caring for adolescent mothers.

2. Introduction/Background:

The provision of adolescent-friendly care is well recognized as a strategy to engage youth in health promoting behaviours. This study will contribute knowledge about how to provide adolescent-friendly care in perinatal inpatient settings. The researchers are conducting interviews and focus groups with approximately 70 perinatal staff employed at [REDACTED]

3. Purpose of study:

The purpose of this study is to learn how nurses and hospitals can adapt their inpatient perinatal services to be adolescent-friendly.

4. Description of the study activities:

I am being asked to participate in an interview. If I agree to participate,

- I will be interviewed by a member of the research team.
- The interview will take place in a private room at my place of work, or in an alternate location of my choice, and at a time that is convenient to me.

- During the interview, I will be asked to speak about my experiences and thoughts about caring for adolescent mothers
- The interview will be tape recorded as a record for the research team. The tape will be destroyed 15 years after completion of the study.

5. Length of time:

The interview will take approximately 1 to 1 ½ hours to complete.

6. Possible risks and discomforts:

There are no major risks associated with participating in this study.

- There is the possibility that my manager/supervisor will determine that I have agreed or declined to participate in this study.
- I may feel uncomfortable answering some questions. I can decline to answer any question or stop the interview at any time.

7. Benefits:

I will not benefit directly from participating in this research. However this research may contribute to the improvement of services available to help adolescent parents.

8. Withdrawal from the study:

My participation in this study is completely voluntary. I am free to decline to participate and if I choose to participate, I can withdraw at any time for any reason. I can also decline to answer any questions that I do not wish to answer. If I decide not to take part or to leave the study this will not affect my employment.

9. Compensation:

After the interview (focus group), I will be given:

- A \$20.00 gift certificate as thanks for my participation, and
- A \$30.00 honorarium if I participated in an interview during my personal time (not during my paid work hours).

10. The use, disclosure and protection of information collected for this study:

- The information gathered from me will only be used for the purpose this of research.
- The tape-recordings and transcripts will be kept in Wendy Peterson's locked office at the School of Nursing, University of Ottawa until 15 years after completion of the study. After 15 years, the study's paper files will be shredded in confidential waste and electronic files will be deleted.
- The only people who will have access to the tape-recordings are Wendy Peterson, Barbara Davies, research assistants and the transcriptionists.

- My name will be removed from the transcripts and replaced with a numerical code. Research team members and graduate students assisting with the study will have access to the transcripts but not to the tape-recordings.
- [REDACTED]
- Reports of this study may include quotes of what I have said. My name will not be used in any reports. However, because the community of inpatient perinatal staff in Ottawa is small, my anonymity cannot be guaranteed.

11. Questions:

If I have any questions about taking part in this study, I can:

- Telephone the principal investigator, Wendy Peterson [REDACTED]
- Meet with the co-investigator who is in charge of the study at [REDACTED] That person is: Judy Rashotte [REDACTED]
- Talk to someone who is not involved with the study, but can advise me on my rights as a participant in a research study. This person can be reached through the:
Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 159, Ottawa, ON K1N 6N5, tel: 613-562-5841 or ethics@uottawa.ca

I, _____ the undersigned, agree to participate in the above research study. The study has been explained to me. I have read this 4 page consent form and had the opportunity to ask questions about my involvement and to receive additional details that I wanted to know about the study. I understand that by accepting to participate, I am in no way waiving my right to withdraw from the study at any time.

There are two copies of this consent form and one is for me to keep. I have been given a copy of this form.

I agree to participate in this study.

Research participant's name (printed)

Research participant's signature

Date

Investigator / Delegate's name (printed)

Investigator / delegate's signature

Date

This study has been reviewed and approved by the [REDACTED] Research Ethics Board is a committee of the hospital that includes individuals from different professional backgrounds. The Board reviews all human research that takes place at the hospital. Its goal is to ensure the protection of the rights and welfare of people participating in research. The Board's work is not intended to replace a parent or child's judgment about what decisions and choices are best for them. You may contact the Chair of the Research Ethics Board, for information regarding patient's rights in research studies at [REDACTED] although this person cannot provide any health-related information about the study.

Appendix E(c): REB Approved Consent Form from 2009-2010 (Hospital 3)**Formulaire de consentement – Entrevue**

Titre de l'étude : Des services de santé adaptés aux adolescentes : Que peuvent offrir les hôpitaux et le personnel infirmier en périnatalité ?

Chercheuses :

Wendy Peterson (chercheuse principale), professeure adjointe, École des sciences infirmières, Université d'Ottawa [redacted]

Barbara Davies, professeure agrégée, École des sciences infirmières, Université d'Ottawa

Ann Mitchell, directrice générale des services cliniques, Unité d'obstétrique, de gynécologie et des soins du nouveau-né, Hôpital d'Ottawa

Judy Rashotte, directrice de la recherche en sciences infirmières et consultante en transfert des connaissances, Hôpital pour enfants de l'Est de l'Ontario

Ann Salvador, directrice, Centre familial des naissances, Hôpital Montfort

Marie-Josée Trépanier, infirmière clinicienne spécialisée à la pratique professionnelle, Hôpital Montfort

1. Invitation à participer

On m'invite à participer à cette étude en raison a) de mon travail dans une unité de soins périnataux dans un des quatre sites de l'étude et b) de mon expérience auprès de mères adolescentes.

2. Introduction / Fondements

Prodiguer des soins adaptés aux adolescentes est une stratégie bien reconnue qui incite les jeunes à adopter des comportements favorables à leur santé. Cette étude alimentera les connaissances sur la façon d'adapter les soins aux adolescentes en milieu hospitalier périnatal. À cette fin, les chercheuses comptent mener des entrevues individuelles et des discussions pour groupes de consultation visant quelque 70 employés en périnatalité à [redacted]

3. But de l'étude

L'étude vise à dévoiler comment le personnel infirmier et les hôpitaux peuvent adapter leurs services périnataux hospitaliers aux besoins des adolescentes.

4. Activités liées à l'étude

On m'invite à participer à une entrevue. Si j'accepte de participer,

- Je passerai en entrevue avec un membre de l'équipe de recherche
- l'entrevue aura lieu dans une salle privée à mon lieu de travail ou dans un autre endroit de mon choix, à un moment qui me convient;
- on me demandera de parler de mon expérience et de mes idées en ce qui concerne les soins prodigués aux mères adolescentes;
- l'entrevue sera enregistrée pour les archives de l'équipe de recherche, mais l'enregistrement sera détruit 15 ans après la fin de l'étude.

5. Durée de l'entrevue

L'entrevue personnelle sera de 60 à 90 minutes.

6. Risques et inconfort possibles

La participation à cette étude ne comporte aucun risque important.

- Il se peut que la personne dont je relève signale que j'ai accepté ou refusé de participer à l'étude.
- Certaines des questions pourraient me mettre mal à l'aise. Je peux refuser de répondre à n'importe quelle question et mettre fin à l'entrevue en tout temps.

7. Avantages

Je ne retire aucun avantage direct de ma participation à cette recherche. Toutefois, les résultats de celle-ci pourraient améliorer les services offerts aux parents adolescents.

8. Retrait de l'étude

Ma participation à l'étude est complètement volontaire. Je peux refuser d'y participer et, si j'y prends part, je peux m'en retirer en tout temps et pour n'importe quelle raison. Je peux aussi refuser de répondre à n'importe quelle question. Si je refuse de participer ou si je me retire, cela n'aura aucune répercussion sur mon emploi.

9. Rémunération

Après l'entrevue, je recevrai

- un chèque-cadeau de 20 \$ en remerciement de ma participation, et
- des honoraires de 30 \$ si j'ai participé à une entrevue pendant mes heures de loisir et non pendant mes heures de travail rémunérées.

10. Utilisation, divulgation et protection de l'information recueillie pendant l'étude :

- L'information que je fournis sera utilisée strictement aux fins de cette recherche.
- L'enregistrement et les transcriptions seront conservés sous clé dans le bureau de Wendy Peterson à l'École des sciences infirmières de l'Université d'Ottawa pendant 15 ans après l'étude. Après cette période, les dossiers papier de l'étude seront déchiquetés dans un endroit confidentiel, et les dossiers électroniques seront effacés.
- Les seules personnes qui auront accès aux enregistrements sont Wendy Peterson, Barbara Davies, les assistants de recherche et les transcripteurs.
- Mon nom sera retiré des transcriptions et remplacé par un code numérique. Les membres de l'équipe de recherche et les étudiants diplômés engagés pour l'étude auront accès aux transcriptions, mais pas aux enregistrements.
- Le Conseil de recherche et d'éthique (Research Ethics Board) [redacted] peuvent analyser les archives de l'étude aux fins de vérification déontologique.

- Les rapports de l'étude pourraient citer mes opinions, mais mon nom n'apparaîtra dans aucun rapport. Toutefois, vu le petit nombre de personnes travaillant en périnatalité hospitalière à Ottawa, l'équipe de recherche ne peut garantir mon anonymat.

11. Questions

Si j'ai des questions liées à ma participation, je peux :

- Téléphoner à la chercheuse principale, [REDACTED]
- Rencontrer les co-chercheuses chargées de l'étude à [REDACTED] il s'agit de : [REDACTED] et [REDACTED]
- parler à une personne non rattachée à l'étude, mais capable de m'informer de mes droits à titre de participant ou participante. Je peux contacter cette personne par l'entremise du :
 - Responsable de la déontologie en recherche, Université d'Ottawa, pavillon Tabaret, bureau 159 (550, rue Cumberland, Ottawa, ON K1N 6N5); 613-562-5841 ou ethics@uottawa.ca
 - Conseil d'éthique en recherches de [REDACTED]

Je, _____, la personne soussignée, accepte de participer à la recherche décrite ci-dessus. On m'a expliqué la nature de l'étude, et j'ai lu le formulaire de consentement de trois pages. J'ai aussi eu l'occasion de poser des questions au sujet de ma participation et de recevoir d'autres renseignements à propos de l'étude. Je comprends que le fait d'accepter de participer à l'étude ne m'empêche aucunement de m'en retirer plus tard.

On me remettra une copie de ce formulaire de consentement pour mes dossiers.

J'accepte de participer à cette étude.

Participant ou participante (en caractères d'imprimerie)

Signature du participant ou de la participante

Date

Chercheuse/ personne déléguée (en caractères d'imprimerie)

Signature de la chercheuse ou de la personne déléguée

Date

Appendix F(a): Mixed Methods Study Questionnaire (English)**Part 2: Structured questions (interviewer administered)**Part 2a: Characteristics of participants

1. How many years have you been in nursing? _____ years
 2. How long have you been employed at this hospital? _____ years
 3. How long have you been working in this unit? _____ years
 4. Would you describe your employment as Full Time, Part Time or Casual?
 Full-time
 Part-time
 Casual
 5. Which professional license do you currently hold with the College of Nurses of Ontario or other professional college? (check both if both are applicable).
 RN
 RPN
 Other professional license, please specify _____
 Not licensed
 6. What is your highest level of education?
 Diploma
 Baccalaureate degree
 Masters degree
 Doctorate degree
 Other: specify _____
 7. Are you studying presently? (Please explain) _____
 8. What is your current position and do you have other work experience in nursing?
-

9. On a scale from 1 to 10 where 1 is beginner and 10 is expert:
How would you describe your skill at caring for adolescent mothers?

I don't know

1	2	3	4	5	6	7	8	9	10
beginner									expert

Please explain your rating.

10. On a scale from 1 to 10 where 1 is not knowledgeable at all and 10 is extremely knowledgeable:

How knowledgeable are you about the resources for adolescent mothers in the community?

I don't know

1	2	3	4	5	6	7	8	9	10
not at all knowledgable									extremely knowledgable

Part 2 b: Internal hospital resources for youth

11. Has your unit/hospital provided educational sessions related to adolescent mothers?

Yes

No

If yes, when did this/these educational session related to adolescent mothers occur?

Over 2 years ago

1-2 years ago

Less than a year ago

During orientation _____ years ago

12. Are there funds provided by your hospital to attend educational sessions/conferences related to adolescent mothers?

Yes

No

Don't know

13. If an educational session about adolescent mothers was offered during your shift, would your workload permit you to attend?

- No please explain: _____
- Yes
- Only if offered as a 'lunch and learn' (when break is covered by another nurse)

14. Have you received any other information regarding the care of adolescent mothers?

- No
- Yes In what form? (and from where: circle 'work' or 'other')
- Email from work / or other: _____
- Poster at work / or other: _____
- Bulletin / newsletter from work / or other: _____
- Journal article at work / or other: _____
- Conference at work / or other: _____
- Coursework at work / or other: _____
- Other _____

When did you receive this information?

- Over 2 years ago
- 1-2 years ago
- Less than a year ago
- During orientation _____ years ago

15. Are there resources in your hospital that are specific for adolescent mothers?
(ie: adolescent specific services; adolescent antenatal clinic)

- Yes (Please explain)
- No
- Don't know

16. Are these services used (consulted) on a regular basis by staff?

- Yes (Please explain)
- No (Please explain)
- Don't know

17. Are there resources outside of your hospital that are specific for adolescent mothers & used on a regular basis by hospital staff?

- Yes (Please explain)
- No (Please explain)
- Don't know

Part 2c): Organizational (unit / hospital) factors that may influence care:

18. On a scale from 1 to 10 where 1 is beginner and 10 is expert:

How would you describe the skill of other nurses on this unit at caring for adolescent mothers?

- I don't know

1	2	3	4	5	6	7	8	9	10
beginner									expert

Please explain your rating.

19. On a scale from 1 to 10 where 1 is not knowledgeable at all and 10 is extremely knowledgeable:

How knowledgeable are the other nurses on this unit about the resources for adolescent mothers in the community?

- I don't know

1	2	3	4	5	6	7	8	9	10
not at all knowledgable									extremely knowledgable

20. Have there been any changes in policies or procedures related to the care of adolescent mothers at your workplace ?

- Yes (Please describe, including when they took place)
- No
- I don't know

21. In your unit are there strong role models or champions for excellence in nursing care of adolescent mothers?
- Yes
- No
- Please explain**
22. In your unit, does the formal structure/process of providing care of adolescent mothers differ from adult mothers? (examples of formal structure / process are care plans, care pathways, policies)
- Yes (Please explain)
- No (Would that be helpful)
- Don't know
23. Regarding nursing assignment, on your unit, are there specific nurses assigned to adolescent mothers
- Yes (Please explain)
- No (Should it be considered? Yes /No. Please explain)
- Don't know
24. In your unit, does the informal structure/process of providing care of adolescent mothers differ from adult mothers? (examples of informal structure / process include the tradition within the unit, what usually happens, unwritten practices)
- Yes (Please explain)
- No
- Don't know
25. What are the key organizational policies that have an impact on the care of adolescent mothers?
- Visiting policies
- Smoking policy
- Length of stay policy
- Referral to public health policy
- Child protection reporting policy
- Other please explain: _____

Don't know

Are there **any other comments** you would like to make that might help us understand the factors that influence the nursing care of adolescent mothers?

Would you recommend other nurses/managers/clinical educators/nurse specialist or interprofessional colleague that would be good participants to be interviewed for this study?

Are there any documents, such as care plan that you could leave us to have more information on the documentation that is used on a regular basis by nurses on your unit.

THANK YOU SO MUCH FOR YOUR TIME!

Appendix F(b): Mixed Methods Study Questionnaire (French)**Partie 2: Questions à réponse courte / choix multiples**Partie 2a : Profil de la personne interviewée

1. Depuis combien d'années travaillez-vous en soins infirmiers? _____ ans
2. Depuis combien d'années travaillez-vous à cet hôpital? _____ ans
3. Depuis combien d'années travaillez-vous dans cette unité? _____ ans
4. Votre emploi est-il à temps plein, à temps partiel ou occasionnel (d'appel)?
 - Temps plein
 - Temps partiel
 - Occasionnel / d'appel
5. Quel permis professionnel possédez-vous de l'Ordre des infirmières et infirmiers de l'Ontario ou d'un autre ordre professionnel? (Cochez les deux, s'il y a lieu.)
 - Infirmière autorisée (IA)
 - Infirmière auxiliaire autorisée (IAA)
 - Autre permis professionnel (Précisez) : _____
 - Aucun permis professionnel
6. Quel est votre plus haut niveau d'études?
 - Diplôme collégial
 - Baccalauréat
 - Maîtrise
 - Doctorat
 - Autre (Précisez) : _____
7. Suivez-vous un programme d'études en ce moment?
Pouvez-vous préciser, S.V.P.? : _____
8. Quel est votre poste actuel? Avez-vous d'autres expériences de travail en soins infirmiers? :

9. Sur une échelle de 1 à 10, où 1 représente « niveau novice » et 10 « niveau expert », comment décririez-vous votre capacité de fournir des soins aux mères adolescentes?
 - Je ne sais pas

1 2 3 4 5 6 7 8 9 10

Novice

Expert

Comment expliquez-vous votre évaluation?

10. Sur une échelle de 1 à 10, où 1 représente « aucune connaissance » et 10 « connaissance approfondie », dans quelle mesure connaissez-vous les ressources offertes aux mères adolescentes dans la communauté?

Je ne sais pas

1	2	3	4	5	6	7	8	9	10
Aucune connaissance									Connaissance approfondie

Partie 2 b : Ressources internes de l'hôpital pour les jeunes

11. Est-ce que votre unité/hôpital a déjà offert des séances de formation sur les soins aux mères adolescentes?

Oui

Non

Si oui, les formations remontent à quand?

plus de 2 ans

entre 1 et 3 ans

moins d'un an

12. Est-ce que votre hôpital alloue des fonds pour vous permettre d'assister aux séances de formation ou aux conférences sur les soins aux mères adolescentes?

Oui

Non

Je ne sais pas

13. Si une séance de formation sur les mères adolescentes était offerte pendant votre quart de travail, pourriez-vous y assister?

Non (Pouvez-vous expliquer, S.V.P.?) _____

Oui

Seulement si elle a lieu comme « séance du midi » (et quelqu'un me remplace pendant ma pause)

14. Avez-vous reçu d'autres informations au sujet des soins aux mères adolescentes?

Non

- Oui; de quelle façon et par quelle source (encerclez « travail » ou « autre » et précisez, S.V.P.)?
- Courriel du travail / autre : _____
 - Affiche au travail / autre : _____
 - Communiqué ou bulletin d'information au travail / autre : _____
 - Article d'un journal au travail / autre : _____
 - Conférence au travail / autre : _____
 - Cours au travail / autre: _____
 - Autre façon : _____

Si oui, quand avez-vous reçu cette information?

- Il y a plus de 2 ans
- Il y a entre 1 et 2 ans
- Il y a moins d'un an.
- Pendant mon orientation, il y a _____ an(s)

15. Y a-t-il des ressources dans votre hôpital qui sont offertes spécifiquement aux mères adolescentes (p. ex., une clinique anténatale)

- Oui (lesquelles?) _____
- Non
- Je ne sais pas

16. Y a-t-il des services utilisés (consultés) régulièrement par le personnel?

- Oui (lesquels?) _____
- Non (Pouvez-vous expliquer?) _____
- Je ne sais pas

17. Y a-t-il des ressources à l'extérieur de votre hôpital qui sont offertes spécifiquement aux mères adolescentes et qui sont utilisées régulièrement par le personnel de l'hôpital?

- Oui (lesquelles?) _____
- Non (Pouvez-vous expliquer?) _____
- Je ne sais pas

Partie 2c) : Facteurs organisationnels (unité/hôpital) qui peuvent influencer les soins

18. Sur une échelle de 1 à 10, où 1 représente « niveau novice » et 10 « niveau expert », comment décririez-vous la capacité des autres infirmières ou infirmiers de votre unité à fournir des soins aux mères adolescentes?

Je ne sais pas

1	2	3	4	5	6	7	8	9	10
Novice								Expert	

Comment expliquez-vous votre évaluation?

19. Sur une échelle de 1 à 10, où 1 représente « aucune connaissance » et 10 « connaissance approfondie », évaluez celle des autres infirmières et infirmiers de votre unité en ce qui concerne les ressources pour mères adolescentes dans la communauté?

Je ne sais pas

1	2	3	4	5	6	7	8	9	10
Aucune connaissance								Connaissance approfondie	

20. Les politiques ou procédures qui visent la prestation des soins aux mères adolescentes ont-elles changé dans votre milieu de travail?

Oui (Décrivez les changements et précisez quand ils ont eu lieu.)

Non

Je ne sais pas

21. Y a-t-il des modèles ou des champions pour la prestation de soins de qualité aux mères adolescentes dans votre unité?

Oui

Non (Pouvez-vous expliquer pourquoi?) :

22. Est-ce que la structure formelle ou le cadre de la prestation des soins offerts aux mères adolescentes diffère de celui des mères adultes dans votre unité?
(Exemples : plans de soins, plans cliniques, politiques)

Oui (Pouvez-vous expliquer pourquoi?) : _____

Non

Je ne sais pas

23. Dans votre unité, est-ce qu'on affecte certains membres du personnel infirmier spécifiquement aux mères adolescentes?

Oui (Pouvez-vous expliquer pourquoi?) : _____

Non (Faut-il le considérer? Expliquez votre réponse.)

Je ne sais pas

24. Est-ce que la structure *informelle* ou le cadre de prestation des soins aux adolescentes diffère de ce qui se fait pour les mères adultes dans votre unité?
(Exemples : culture de l'unité, routine de l'unité, pratiques non prescrites)

Oui (Expliquez pourquoi) : _____

Non

Je ne sais pas

25. Quelles sont les politiques organisationnelles qui ont un impact sur la prestation des soins aux mères adolescentes?

Politique sur les visites

Politique sur le tabagisme

Politique sur la durée du séjour à l'hôpital

Politique sur le renvoi à la santé publique

Politique sur la déclaration à la Société d'aide à l'enfance

Autre (préciser) : _____

Je ne sais pas

Recommanderiez-vous d'autres infirmières/gestionnaires cliniques/éducatrices/infirmières cliniciennes spécialisées ou des collègues interprofessionnels pour cette étude?

Y a-t-il des documents, comme un plan de soins ou un cheminement clinique, que vous utilisez couramment dans votre unité? Si oui, nous aimerions en recevoir un exemplaire.

Appendix G(a): Mixed Methods Study Interview Guide (English)

Thank you for agreeing to participate in this interview. As you know, you were identified by a colleague as a nurse with expertise in caring for adolescent mothers. We are very interested in talking with you. We would like to know about how you care for adolescent mothers and about the characteristics of the people you work with, your unit, or hospital have hindered or facilitated your care of adolescent mothers.

You may not know all the answers to the questions, but we feel you still will provide us with valuable information. We want to know what you and other nurses actually do, not what they are supposed to do. We are not evaluating you, so there are no right or wrong answers. We will not judge your responses and all the information that you give us will be confidential. We really need you to be honest. Do you feel comfortable and in a location that is private enough? Do you have any questions regarding your participation in this interview at this point? (pause..)

Please feel free to ask questions at anytime during the interview.

Now, I will turn on the tape recorder and will ask you some open-ended questions.

Qualitative interview questions (audio-recorded)

1. Please explain how you care for a mother when she is an adolescent?
Probes:
 - a) tell me about a specific adolescent mother that you have cared for, as an example.
 - b) how does your care of an adolescent mother differ from adult mothers? Tell me about why it is necessary to adapt your care for adolescents.
2. How did you learn to care for adolescent mothers?
Probe:
 - a) tell me about the skills / qualities of care that are essential for the provision of good care to adolescent mothers?
3. Based on your experiences, how would you describe adolescent-friendly nursing care?
Probes:
 - a) individual nurse and unit/hospital levels
4. What helps you to provide adolescent-friendly care?
Probe:

- a) what characteristics / policies of your unit / hospital help you to provide adolescent-friendly care?
5. What makes it more difficult to provide adolescent-friendly care?
Probe:
- a) what characteristics / policies of your unit / hospital make it difficult for you to provide adolescent-friendly care?
6. Tell me why some nurses have difficulty caring for adolescent mothers?

Are there **any other comments** you would like to make that might help us understand the factors that influence the nursing care of adolescent mothers?

Thank you for your thoughtful answers to my questions. Now, I will turn off the recorder.

Appendix G(b): Mixed Methods Study Interview Guide (French)

Guide d'entrevue pour infirmières

Merci d'avoir accepté de participer à cette entrevue. Comme vous le savez, des collègues nous ont signalé que vous aviez de l'expertise dans la prestation de soins aux mères adolescentes. Par « expertise », on veut dire une personne qui *s'intéresse* aux soins pour mères adolescentes et qui les donne efficacement. Nous sommes donc très intéressées de discuter avec vous, surtout pour en savoir plus sur deux choses : d'abord, la façon dont vous prenez soin des mères adolescentes; ensuite, les caractéristiques de vos collègues, de votre unité ou de votre hôpital qui facilitent votre travail auprès des mères adolescentes, ou qui y nuisent.

Vous ne pourrez peut-être pas répondre à toutes les questions, mais tout ce que vous partagerez avec nous contribuera énormément. Notez que nous voulons savoir ce que vous et vos collègues faites *réellement*, pas ce que vous *devriez* faire. Nous ne sommes pas en train de vous évaluer; il n'y a pas de bonnes ou de mauvaises réponses. Nous ne jugeons rien, et tout ce que vous dites reste confidentiel. Nous comptons donc vraiment sur votre honnêteté. Êtes-vous à l'aise dans ce local? Est-il assez privé?

Avez-vous des questions à propos de votre participation jusqu'à présent? (Pause...)

N'hésitez pas à poser des questions à tout moment de l'entrevue.

Questions ouvertes (enregistrées)

1. Racontez-moi une situation où vous avez pris soin d'une mère adolescente et que le tout s'était bien déroulé d'après vous.
2. Racontez-moi une situation où vous avez pris soin d'une mère adolescente et que le tout ne s'est pas bien déroulé d'après vous.

Explorer : implication de la Société de l'Aide à l'enfance, abus de drogues, plusieurs grossesses (y compris avortements ou autres enfants), partenaire difficile, visites difficiles, patiente donne son bébé en adoption

3. Dites-moi comment votre prise en charge des mères adolescentes diffère de votre prise en charge des mères adultes?

Explorer : Dites-moi pourquoi vous devez adapter vos soins auprès des mères adolescentes?

4. Dites-moi comment votre prise en charge des mères adolescentes ressemble à votre prise en charge des mères adultes?

5. Comment avez-vous appris à prodiguer des soins aux mères adolescentes?

Explorer :

- Parlez-moi des habiletés ou des qualités essentielles dans la prestation des soins aux mères adolescentes?
- Parlez-moi des expériences personnelles que vous avez vécues et qui, selon vous, vous aident à bien soigner les mères adolescentes.

6. Pensez à votre expérience et décrivez-moi ce que c'est des soins de santé adaptés aux adolescentes.

Explorer :

- Fondez-vous sur l'expérience au niveau du personnel infirmier, de l'unité, de l'hôpital ou des liens dans la communauté.
- Dites-moi pourquoi, selon vous, on vous a reconnue comme une infirmière qui offre des soins de santé bien adaptés aux adolescentes?

7. Dans votre unité, est-ce qu'on voit et traite les mères adolescentes de façon positive ou négative? (Les infirmières parlent-elles des mères adolescentes? Existe-t-il un esprit ou une culture d'équipe/d'unité qui appuie l'excellence dans la prestation des soins aux mères adolescentes?)

Expliquez votre réponse.

8. Dans votre organisation, est-ce qu'on voit et traite les mères adolescentes de façon positive ou négative? Est-ce qu'on parle des mères adolescentes? Est-ce qu'il y a une culture ou une philosophie qui préconise l'excellence dans la prestation des soins aux mères adolescentes?

Expliquez votre réponse et donnez des exemples.

9. Qu'est-ce qui vous aide à offrir des soins de santé bien adaptés aux adolescentes?

Explorer :

- Quelles sont les qualités de vos collègues qui vous aident à offrir des soins de santé bien adaptés aux adolescentes?
- Quelles sont les caractéristiques/politiques de votre unité qui vous aident à offrir des soins de santé bien adaptés aux adolescentes?
- Quelles sont les caractéristiques/politiques de votre hôpital qui vous aident à offrir des soins de santé bien adaptés aux adolescentes?

10. Quels sont les obstacles qui nuisent à vos efforts de fournir des soins de santé bien adaptés aux adolescentes?

Explorer :

Quelles caractéristiques ou politiques de votre unité/hôpital viennent nuire à la prestation des soins bien adaptés aux adolescentes?

11. Pourquoi certaines infirmières ont-elles du mal à soigner les mères adolescentes?

Explorer : Dans d'autres études, les mères adolescentes ont dit avoir l'impression que certains professionnels de la santé ont une attitude négative à leur égard. Qu'en pensez-vous?

12. Qu'est-ce votre unité (ou votre hôpital) peut faire pour améliorer la prestation des soins aux adolescentes?

Avez-vous des commentaires ou des suggestions pour nous aider à mieux comprendre les facteurs qui influencent les soins infirmiers dispensés aux mères adolescentes?

C'est la fin de l'entrevue. Merci d'avoir participé et d'avoir offert des réponses franches et éclairantes.

Appendix H: Transcriptionist Confidentiality Agreement**Université d'Ottawa . University of Ottawa**

Faculté des sciences de la santé Faculty of Health Sciences
 École des sciences infirmières School of Nursing

**Adolescent-friendly health services:
 What can perinatal nurses and hospitals provide?**

Confidentiality Agreement

In order to maintain the anonymity and confidentiality of the people who participate in this research study and to meet the ethical requirements of the study, I understand that anyone collecting data and working with raw data collected for this study is required to sign a confidentiality agreement. This includes research team members, research staff, graduate and post-doctoral students, research interns, language interpreters and audio-tape transcribers.

I, _____ agree to keep the information contained within the tapes, audio files, transcripts and questionnaires for the above research strictly confidential. If I am involved in collecting data, I also agree to respect the privacy of participants by keeping my conversations with them confidential. Keeping information confidential means that I will not relate or discuss any segment of this information to another person who is not a research team member directly involved in the data analysis. The purpose of discussing this information with research team members will be limited to clarification and data analysis.

Signature: _____ Date: _____

Signature of Principal Investigator: _____

Date: _____

Appendix I: Literature Review Search Strategy

Research Questions:

(1) How and why do perinatal nurses in inpatient settings adapt their practice when caring for adolescents?

(2) What are the individual nursing behaviours and organizational characteristics of adolescent-friendly care in inpatient perinatal settings, from the perspective of nurses?

A search strategy was developed to identify the most relevant and current literature. This involved searching for literature based around concepts of young motherhood, nurse attitudes/behaviours, maternal care, and woman-centered care. Alternative terms for these concepts were identified:

1. Adolescent motherhood	2. Nurse attitudes/behaviours	3. Maternal care	4. Woman-centered care	5. Maternal satisfaction
Adolescent mother*	Nurse attitudes	Maternal care	Adolescent-friendly care	Patient satisfaction
Adolescent pregnancy	Nurse behaviours	Maternal-newborn care	Youth-friendly care	Client satisfaction
Teen* mother*	Nurse stigma	Maternal newborn care	Woman-centered care	Satisfaction
Teen* pregnancy	Nurse judgment	Perinatal care	Woman-friendly care	Maternal experience
Young mother*	Nurse support	Postpartum care	Mother-centered care	Maternal experience
Young parent*		Post-partum care	Mother-friendly care	Client experience
Early childbearing		Obstetric* care	Person-centered care	Experience
Early motherhood			Person-friendly care	
			Client-centered care	
			Client-friendly care	

To enter these concepts into databases, the following search strings were used:

1. Adolescent motherhood and Nurse attitudes/behaviours – 1 and 2
 (“Adolescent mother*” OR “Adolescent pregnancy” OR “Teen* mother*” OR “Teen* pregnancy” OR “Young mother*” OR “Young parent*” OR “Early childbearing” OR “Early motherhood” AND “Nurse attitudes” OR “Nurse behaviours” OR “Nurse stigma” OR “Nurse judgment” OR “Nurse support”)
2. Adolescent motherhood and Maternal care – 1 and 3
 (“Adolescent mother*” OR “Adolescent pregnancy” OR “Teen* mother*” OR “Teen* pregnancy” OR “Young mother*” OR “Young parent*” OR “Early childbearing” OR “Early motherhood” AND “Maternal care” OR “Maternal-newborn care” OR “Maternal newborn care” OR “Perinatal care” OR “Postpartum care” OR “Post-partum care” OR “Obstetric* care”)
3. Adolescent motherhood and Woman-centred care – 1 and 4
 (“Adolescent mother*” OR “Adolescent pregnancy” OR “Teen* mother*” OR “Teen* pregnancy” OR “Young mother*” OR “Young parent” OR “Early childbearing” OR “Early motherhood” AND “Adolescent-friendly care” OR “Youth-friendly care” OR “Woman-centered care” OR “Woman-friendly care” OR “Mother-centered care” OR “Mother-friendly care” OR “Person-centered care” OR “Person-friendly care” OR “Client-centered care” OR “Client-friendly care”)
4. Nurse attitudes and Maternal care – 2 and 3
 (“Nurse attitudes” OR “Nurse behaviours” OR “Nurse stigma” OR “Nurse judgment” OR “Nurse support” AND “Maternal care” OR “Maternal-newborn care” OR “Maternal newborn care” OR “Perinatal care” OR “Postpartum care” OR “Post-partum care” OR “Obstetric* care”)
5. Nurse attitudes/behaviours and Woman-centered care – 2 and 4
 (“Nurse attitudes” OR “Nurse behaviours” OR “Nurse stigma” OR “Nurse judgment” OR “Nurse support” AND “Adolescent-friendly care” OR “Youth-friendly care” OR “Woman-centered care” OR “Woman-friendly care” OR “Mother-centered care” OR “Mother-friendly care” OR “Person-centered care” OR “Person-friendly care” OR “Client-centered care” OR “Client-friendly care”)
6. Maternal care and Woman-centered care – 3 and 4
 (“Maternal care” OR “Maternal-newborn care” OR “Maternal newborn care” OR “Perinatal care” OR “Postpartum care” OR “Post-partum care” OR “Obstetric* care” AND “Adolescent-friendly care” OR “Youth-friendly care” OR “Woman-centered care” OR “Woman-friendly care” OR “Mother-centered care” OR “Mother-friendly care” OR “Person-centered care” OR “Person-friendly care” OR “Client-centered care” OR “Client-friendly care”)

7. Adolescent motherhood and Nurse attitudes and Maternal care and Woman-centered care – 1, 2, and 3 and 4

(“Adolescent mother*” OR “Adolescent pregnancy” OR “Teen* mother*” OR “Teen* pregnancy” OR “Young mother*” OR “Young parent*” OR “Early childbearing” OR “Early motherhood” AND “Nurse attitudes” OR “Nurse behaviours” OR “Nurse stigma” OR “Nurse judgment” OR “Nurse support” AND “Maternal care” OR “Maternal-newborn care” OR “Maternal newborn care” OR “Perinatal care” OR “Postpartum care” OR “Post-partum care” OR “Obstetric* care” AND “Adolescent-friendly care” OR “Youth-friendly care” OR Woman-centered care” OR “Woman-friendly care” OR “Mother-centered care” OR Mother-friendly care” OR “Person-centered care” OR “Person-friendly care” OR “Client-centered care” OR “Client-friendly care”)

8. Adolescent motherhood and Nurse attitudes/behaviours and Maternal care and Maternal satisfaction

(“Adolescent mother*” OR “Adolescent pregnancy” OR “Teen* mother*” OR “Teen* pregnancy” OR “Young mother*” OR “Young parent*” OR “Early childbearing” OR “Early motherhood” AND “Nurse attitudes” OR “Nurse behaviours” OR “Nurse stigma” OR “Nurse judgment” OR “Nurse support” AND “Maternal care” OR “Maternal-newborn care” OR “Maternal newborn care” OR “Perinatal care” OR “Postpartum care” OR “Post-partum care” OR “Obstetric* care” AND “Maternal satisfaction” OR “Patient satisfaction” OR “Client satisfaction” OR “Satisfaction”)

9. Adolescent motherhood and Nurse attitudes/behaviours and Maternal care and Maternal experience/satisfaction

(“Adolescent mother*” OR “Adolescent pregnancy” OR “Teen* mother*” OR “Teen* pregnancy” OR “Young mother*” OR “Young parent*” OR “Early childbearing” OR “Early motherhood” AND “Nurse attitudes” OR “Nurse behaviours” OR “Nurse stigma” OR “Nurse judgment” OR “Nurse support” AND “Maternal care” OR “Maternal-newborn care” OR “Maternal newborn care” OR “Perinatal care” OR “Postpartum care” OR “Post-partum care” OR “Obstetric* care” AND “Maternal experience” OR “Patient experience” OR “Client experience” OR “Experience” OR “Maternal satisfaction” OR “Patient satisfaction” OR “Client Satisfaction” OR “Satisfaction”)

The following databases were searched without any date restrictions:

- CINAHL
- PubMed (Medline)

In addition to the aforementioned database searches, bibliographies of the reference lists of relevant articles were searched and articles were identified through “hand searching” and key informants. Literature that were included/excluded are as follows:

- Inclusion: qualitative, observational, and cohort studies; narratives; quantitative studies; literature reviews; systematic reviews; guidelines
- Exclusion: editorials, commentaries, reviews