“What a difference a day makes”

Second trimester termination of pregnancy in the gynaecology ward: a case study

By

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Abstract
The focus of this study are the nurses who care for women undergoing termination of pregnancy in the second trimester. Termination of pregnancy (abortion) is the deliberate ending of a pregnancy. In New Zealand for the year ending December 2015, 13,155 abortions were performed and of these, 553 abortions were performed after the 12th week of pregnancy (second trimester). Changes to how abortions are undertaken has resulted in increased participation by nurses and midwives in the process, where the resulting products of conception often resemble a fully formed foetus. Despite abortion being so widely accessed, little is known about the attitudes, opinions or feelings of the nurses who deliver the care.

The purpose of this study was to explore issues for nurses who provide care for women undergoing second trimester termination of pregnancy in the gynaecology inpatient setting. Case study methodology was used. This study used face to face semi structured interviews and retrospective clinical note review as data collection methods. Themes which were identified in the interviews included: staff experiences and attitudes, strategies for managing demands and challenges, and training and support. The study found that whilst the stance of the nurses who participated in second trimester termination of pregnancy care was largely pro-choice they were not necessarily immune to the stressors associated with the processes of termination of pregnancy, particularly as the gestational age of the pregnancy advances. Support for nurses who work in abortion services is at best haphazard and when compared to the disciplines of palliative care and mental health was found woefully lacking. In addition, education for nurses specific to abortion care was ad-hoc, fragmented and relied mostly on informal peer teaching from other nurses.

The key recommendations emanating from the study were that consideration should be given to developing structures, processes and training to support nurses in their practice with a view to maintaining high quality patient care. Training for staff should be evidence-based, patient centric, planned and a priority and not rely primarily on the good will of colleagues. It is envisaged that the findings of the study will provide a framework with which to build robust support structures for nurses working in this unique area of healthcare.
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The author is grateful to the nurses who participated in the study. Thank you to my gynaecology nursing colleagues who gave their time and shared their thoughts so openly and honestly. Your contributions have enabled me to undertake this work which I hope will make a difference to the nurses and women we care for.

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Thank you to Martine Ribotton, Graphic Designer who so skillfully translated my concept of the journey shared by the women and the nurses into something more roadworthy.

And last but by no means least, to my husband Chris and daughter Maeve. Thank you for your unreserved support, help with finding the right words when I drew a blank, never minding if my study materials seemed to be overtaking our home or that I rarely vacuumed in the last two years. Chris, you were quite right, if it was easy then everyone would be doing it and yes Maeve, it was about the journey.
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Chapter One: Introduction and background

1.0 Introduction

This thesis is about exploring the issues for nurses who care for women undergoing termination of pregnancy in the second trimester (STT). The reason for the study is because it is hard to care for women undergoing STT in the gynaecology ward, because it is ethically challenging, emotionally draining, bureaucratically demanding (in terms of paperwork) and there is little or no training or ongoing education, no formal support in terms of debrief and wellbeing support and more often than not the same nurses are providing the care. Therefore, we need to know what issues arise for nurses so that we can develop structures, processes and training to support them in their practice with a view to maintaining high quality care. Case study methodology was used and face to face, semi-structured interviews were conducted with six registered nurses working in the gynaecology services of a tertiary hospital in New Zealand. The title of the thesis: ‘what a difference a day makes’ is symbolic of time and has significance because the difference of one day in a pregnancy can mean that a woman receives care in either a gynaecology or maternity setting, the difference between a procedure or the delivery of a baby or being called a patient instead of a mother. ‘Twenty-four little hours’ (Adams, 1934). It also means that one day you’re pregnant but the next day you’re not.

A retrospective review of clinical records from 12 women who had undergone a second trimester termination of pregnancy in the gynaecology ward within the past 12 months and review of guidelines, policy and legislation about second trimester termination of pregnancy was conducted. Additionally, the content of a learning package developed to provide nursing staff with contemporary and theoretical information relating to the care of women undergoing the STT procedure was scrutinised to see if it met their needs and those of their patients. This study revealed that whilst the stance of the nurses who participated in second trimester termination of pregnancy care was largely pro-choice they were not necessarily immune to the stressors associated with the processes of termination of pregnancy, particularly as the gestational age of the pregnancy advances. In addition, there was a lack of support for the nurses in term of wellbeing support, disparities in how patient care was
allocated and gaps in provision of skills, knowledge and training for the nurses who provided care.

In this chapter I will explore termination of pregnancy worldwide and in the New Zealand context, the notion of care, nurses’ education, skills and knowledge of termination of pregnancy, termination procedures and professional responsibilities. An outline of the thesis content will be presented.

1.1 Abortion in New Zealand

Abortion is the deliberate ending of a pregnancy (Cook, 2015) and throughout the centuries and in all cultures women have ingested substances believed to bring about an abortion. In the Western world some of the most popular have been concoctions made from the following plants: Pennyroyal, Savin-oil of Juniper, Black Cohosh, Blue Cohosh, Queen Anne’s Lace, Aloes, Tansy, Parsley (apiol) and in New Zealand: Supplejack root, Flax root, Toetoe leaves, Poroporo leaves and berries from Te Mahoe. In the 2013 film White Lies a traditional Māori healer used native plants to induce abortion/birth (Abortion Law Reform Association of New Zealand, 2014).

In 2008, around 44 million women worldwide voluntarily terminated their pregnancy (abortion) which equates to an abortion rate of 28 per 1,000 women aged 15 – 44 (World Health Organisation, 2012). In New Zealand for the year ending December 2015, 13,155 abortions were performed (14.2 per 1,000 women aged 15 – 44) and of these, 553 abortions were performed after the 12th week of pregnancy (second trimester). This equates to 4.2% of the total induced abortions undertaken in New Zealand (Statistics New Zealand, 2016). In the study setting approximately 95 second trimester terminations occur annually. Access to termination of pregnancy is available via a woman’s general practitioner, family planning clinic or termination of pregnancy service for women who meet specific criteria. The Ministry of Health provides healthcare to New Zealanders through District Health Boards (DHBs) by making available funding to the DHBs and specifying the services that they must deliver. In relation to abortion DHBs are required to provide termination of pregnancy services for those women who meet the criteria provided by the Crimes Act 1961 (Ministry of Justice, 2015) and the Contraception, Sterilisation and Abortion Act 1977
(Ministry of Justice, 2013). Abortion is free in New Zealand to any pregnant person eligible for funded healthcare.

Induction of labour using a prostaglandin analogue is the preferred method of termination for women presenting in the second trimester in New Zealand in the public health sector, as in the United Kingdom (Rose, Shand & Simmons, 2006). As compared to surgical termination of pregnancy, which is performed by a doctor in the first trimester, care of women undergoing medical induction of labour is New Zealand, is predominantly provided by nurses and midwives. This care includes administration of the pharmacological agents, analgesics and antiemetic, monitoring of the progress of labour and care of the foetus and woman following delivery.

In my experience the viewpoint taken by my nursing colleagues who work in gynaecology is that while they are mostly pro-choice they are certainly not unaffected by providing termination of pregnancy care, and this is particularly so when the pregnancy is advanced. In 2009 Abortion Law Reform Association President Margaret Sparrow said staffing abortion services in New Zealand generally did not pose problems, although those for the second trimester were more difficult. Sparrow reportedly said a lot of those nurses are quite happy to be involved in early abortions but with the increasing gestation they do find it difficult (Johnston, 2009). Dr Sparrow said this was because of the greater development of the foetus, rather than having a complete moral objection to abortion (Johnston, 2009). It is my experience in my area of practice, that support for nurses who work in abortion services is at best haphazard and when compared to the disciplines of palliative care and mental health is found to be woefully lacking. In New Zealand, as elsewhere, hospital staff are reluctant to perform second trimester abortions (Life Information, 2011). In 2001 Dr Michael Laney, then Clinical Director of Gynaecology Services at Christchurch Women's Hospital, sent a letter to Christchurch and Canterbury GPs, advising of problems with late referrals: A higher than acceptable percentage of patients are being referred late, when the pregnancy is quite advanced. These women are more difficult to operate on, and some are too advanced and require prostaglandin termination of pregnancy (PGTOPS). This is an unpleasant procedure for staff and patients alike. As a result of the increased number of PGTOPS that we are being asked to carry out, we are losing competent and highly regarded nursing staff. They find that they cannot cope with
these PGTOPS, particularly when done for non-medical reasons. Although this letter is over 10 years old and rates of termination of pregnancy are reducing (Statistics New Zealand, 2015), the fact remains that we continue to lose nursing staff from the gynaecology service because they find it difficult dealing with the termination of pregnancy procedure, particularly in the second trimester. The Abortion Supervisory Committee’s Report for 2005, admitted to continuing concerns about workforce recruitment and retention. Late mid-trimester medical termination of pregnancy with mifepristone followed by the prostaglandin misoprostol is now the most commonly used methods in six of the larger units in New Zealand. The experience of these units is very positive and both client and provider satisfaction are anecdotally reported (Abortion Supervisory Committee, 2009).

Whilst the introduction of medical termination of pregnancy is considered preferable for the patient in terms of reducing risks associated with a surgical procedure and a speedier return to normality, it is important that caring for nurses should be considered as important as caring for patients. I felt it was valuable to understand what ‘care’ meant, in terms of what it means for me as a person, as a nurse and as a researcher.

1.2 Care

Care is defined as the provision of what is necessary for the health, welfare, maintenance, and protection of someone or something (Oxford University Press, 2016) and as effort made to do something correctly, safely, or without causing damage; things that are done to keep someone healthy, safe, etc.; things that are done to keep something in good condition (Merriam-Webster, 2016). So how does this differ from nursing care? The Nursing Council of New Zealand (2012b) states that ‘nurses utilise nursing knowledge and nursing judgement to assess health needs and provide care, and to advise and support people to manage their health’. As a nurse my goal is to provide safe, timely and patient centred care to the best of my ability (scope). In response to the second Mid Staffordshire Foundation Trust report Ann Hemingway, a senior lecturer public health, School of Health and Social Care, Bournemouth University wrote, “the nursing profession should reflect on how it views care. How we
care should be dominated not by knowledge but an understanding of others’ feelings, experiences and stories. Nurses need to care by head, hands and heart, integrating technical and practical knowledge with understanding” (Hemingway, 2013, p. 16). She urged nurses to re-examine their philosophy of care and move beyond the notion of patient-centered care to develop a compassionate, humanising approach and I wholeheartedly agree.

Defining care in the context of my research initially felt quite challenging and I spent some time pondering on this until suddenly, it became very clear. I think it is as simple as caring enough to want my study to make a positive difference in the lives of my nursing colleagues and the women they care for.

1.3 Positioning myself in the research

The setting for the study is a 27 bed gynaecology inpatient ward of a New Zealand tertiary hospital which provides care for women with gynaecological anomalies. Gynaecology is the area of medicine that involves the treatment of women’s diseases, especially those of the reproductive organs including surgery for gynaecological cancer, miscarriage, surgery resulting in cessation of fertility, investigation of dysfunctional bleeding, genito-urinary conditions and gynaecology related abdominal pain. The service also provides assessment and treatment for women with ongoing pregnancies up to 20 weeks gestation and postnatal women and their infants, admitted for treatment of breast, wound or uterine infections. Termination of pregnancy services are offered in the gynaecology inpatient setting for women in the second trimester (13 - 20 completed weeks of pregnancy) following diagnosis of foetal demise or foetal abnormality after referral from the regional Foetal Maternal Medicine (FMM) service, and for those who present for elective termination of a pregnancy between 13 and 20 completed weeks. Termination of pregnancy for women under 13 weeks occurs at an outpatient facility which operates under the jurisdiction of women’s health but is situated elsewhere on the hospital campus. After 20 completed weeks gestation women referred from FMM are admitted to the maternity setting where care is provided by midwives in a specially designed suite that can accommodate both the woman and her support people/family in a less clinical setting.
My interest in this area began in 2009 when I commenced my role as nurse educator in the gynaecology service. Prior to this I had worked in a variety of nursing and midwifery settings both in New Zealand and overseas but the last 20 years has been spent in the women’s health setting and specifically gynaecology operating theatre, postnatal ward and general practice. As a nurse I had worked in healthcare settings where surgical termination of pregnancy under 12 weeks had occurred and as a midwife I had been involved in inductions of labour at term when they were obstetrically indicated but I had never been involved in termination of pregnancy in the second trimester. During my orientation period to the educator role I had the opportunity to work alongside nurses providing care for women undergoing second trimester termination (STT) of pregnancy in the gynaecology inpatient ward. I was intrigued as to how the nurses were able to simultaneously care for up to four other women during the eight-hour shift, particularly when the patients had a variety of diagnoses including STT. This practice is not in line with recommendations from the Abortion Supervisory Committee (ASC) which states that it is in the interests of all women and their support people to separate women undergoing abortion – for whatever reason – from women whose pregnancies are being preserved, birthing or post-natal women, and babies (ASC, 2005).

All the patients in the gynaecology setting have unique and complex health needs requiring the nurse to possess a myriad of skills if she is to provide patient-centred, holistic care in line with the New Zealand registered nurse scope of practice. These skills or competencies include demonstrating professional responsibility, management of nursing care, interpersonal relationships and interprofessional health care and quality improvement (Nursing Council of New Zealand, 2007). In addition, I had observed what appeared to be a disparity in the time nurses spent in the room with the patients undergoing STT, depending on their reason for the STT; with elective STT women generally receiving less face to face time than those referred from FMM who were generally well supported, and usually had the additional presence of family. Staff seeking employment within the gynaecology service are informed that nurses employed to work in gynaecology are expected to provide care to these patients, however I observed that not all staff did or would provide care. Specific questions regarding willingness to participate in abortion are asked during interviews for potential staff such as “Do you have any objection to participating in terminations of
pregnancy/abortions?” Perhaps they did not fully appreciate what participation meant in the clinical setting? One new member of staff I spoke to in November 2014 revealed that she did not realise that she would be required to administer medication “to start the abortion” but thought she would be caring for women following surgical abortion. In her mind this would release her from any responsibility of having being involved in the abortion process as she was only providing care to a post-operative patient (personal communication, November 2014). It seemed to be the same nurses were regularly caring for women undergoing STT and they were not necessarily the nurses who had worked in this setting for the longest time who by virtue of longevity would be considered the most experienced. Whilst all women received appropriate physical nursing care my perception was that the allocation of compassion was not always evenly distributed and I wondered why this was. Although I was no stranger to gynaecology my role as nurse educator was new and I was therefore in a position to utilise the naïve enquirer approach and so I asked questions. They mostly began with why?

1.4 Nurse preparation for working in abortion care

When I commenced my nurse educator role there was no specific training pathway for gynaecology nursing staff, in labour and birth and I was concerned that nursing staff did not have access to adequate education to prepare them to provide safe and compassionate care for women undergoing STT in the inpatient setting, particularly those new to the specialty. Whilst some gynaecology nurses had also trained as midwives, the majority of nurses held single registration. A midwifery perspective is relevant in the care of women undergoing medical abortion – particularly mid-trimester – though care can be in the hands of adequately trained and supervised registered nurses (Abortion Supervisory Committee, 2005).

Coinciding with my arrival in 2009 the gynaecology service adopted the Dedicated Education Unit (DEU) model of clinical teaching and learning. This collaborative partnership between a tertiary education provider and the local DHB allows practice areas to provide a more supportive clinical learning and teaching environment for nursing students on clinical placements. This change to ways of working coincided with the advent of the Nursing Entry To Practice Programme (NetP),
a nation-wide initiative underpinned by Health Workforce New Zealand and the Nursing Council of New Zealand, which resulted in a steady influx of newly registered nurses to the gynaecology service and increased numbers of second and third year nursing and midwifery students completing clinical placements in the gynaecology setting. Unlike the historical hospital based training (up to 1987) the current New Zealand undergraduate nursing programme does not include an obstetric component and therefore most students and many registered nurses have no theoretical knowledge or practical experience of supporting women during labour and birth.

At the same time our aging nursing workforce means that several nurses were either reducing their hours of work or retiring, resulting in a shift in skill mix ratio and loss of institutional knowledge. Turnover of nursing staff in the study setting was historically low with a stable workforce where many nurses had been practicing in the specialty for over 20 years. Training of new staff in STT patient care was consistently being provided by a few experienced (predominantly older, hospital trained) nurses who had ‘learnt on the job’ over several years. Mentorship from experienced colleagues and structured opportunities for reflection on ethical issues enable the nurses to develop security in their professional roles and feel confident in their personal life situation (Andersson, Gemzell-Danielsson & Christensson, 2014).

Some nurses identified themselves as conscientious objectors to abortion and refused to participate in care of these patients whilst other nurses would either willingly or reluctantly provide care. The nurse assigned to care for a patient undergoing pregnancy termination is forced to confront their own beliefs head-on, and her decision to care for or refuse to care for the patient affects staff unity, influences staffing decisions and challenges the ethical concept of duty (Marek, 2004). There is a likelihood that some staff have had first-hand experience with pregnancy or foetal loss which may affect their world view and attitude to abortion. At least one-third of women will have had an abortion by the time they reach the age of 45 years (Royal College of Obstetricians and Gynaecologists, 2011) and overall, about 12 -15% of clinically recognised pregnancies end in miscarriage with the frequency increasing with rising maternal age (Mehta & Pattanayak, 2013).

The nurses who were willing to provide STT care were sometimes doing so several times a week and this resulted in nurses self-reporting burnout, utilising sick
leave entitlements on days when procedures were scheduled, eventual avoidance of participation in STT procedures and in some instances choosing to transfer to another, unrelated healthcare service. The service had received complaints from patients, families and nursing colleagues about the perceived lack of care and attention from some nursing staff which was of concern. A study by Wolkomir and Powers (2007) found that staff managed women undergoing abortion on a continuum from investment to detachment depending on the circumstances of the individual woman. Exploration of the health professional’s own value system and honesty about personal issues and beliefs that might influence client management is always advisable in abortion service provision (Abortion Supervisory Committee, 2005). It was not only the procedure itself that the nurses found challenging but the processes that supported it, particularly in terms of documentation.

1.5 Documentation

The legal requirements in terms of documentation associated with the STT procedure are extensive, particularly if registration of birth or post-mortem is required. Incomplete or incorrect documentation may result in delays to cremation or burial and significant distress for family. With advanced gestational age there is the possibility of a liveborn foetus and besides the emotional and ethical difficulties for the patient, their partners and staff, a delivery of a foetus with signs of life has legal implications (Paul, Lichtenberg, Borgatta, Grimes, Stubblefeld & Creinin, 2009). New Zealand observes the World Health Organisation definition of a live birth as ‘the complete expulsion or extraction from its mother of a production of conception, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached; each product of such birth is considered liveborn’ (World Health Organisation, 2012). This requires both the birth and death to be registered as by law, both parents of a child born in New Zealand must jointly notify Births, Deaths and Marriages, as soon as is reasonably practicable after the birth (deemed by the Registrar-General as generally being within two months of the birth) (Department of
Internal Affairs, 2014). This likely contributes further stress to the woman’s experience and requires the nurse to complete additional documentation.

In response to an organisational trend for efficiency and to avoid the potential for error, omission and duplication, evidence of care is recorded on a multi-disciplinary care plan (MCP) dependant on whether the STT procedure is a Prostaglandin Termination of Pregnancy (PGTOP) or Induction of Labour (IOL) for foetal demise or foetal abnormality. The procedures are in essence identical however it was deemed essential to moderate the language used in each pathway, for example in the IOL pathway the word baby is used throughout, whereas in the PGTOP pathway the term is foetus.

The pathways were designed as both a guide and prompt for the nurses and doctors and intended as a sequential and accurate record of care provision. As tasks were completed (admission procedure, consent for care confirmed, administration of medication) and milestones (rupture of membranes, delivery of baby/foetus and placenta) reached, the nurse ticked a box and signed to indicate completion. A perceived benefit of this was that the nurse taking over patient care could quickly elicit what had occurred in the preceding shift as the intention was that no aspects of care would be omitted or duplicated.

Information about legislation relating to abortion services in New Zealand, the second trimester termination of pregnancy procedure, professional responsibilities and scope of practice pertinent to nursing is provided for background and context.

1.6 Second trimester termination of pregnancy procedure

After 12 weeks a pregnancy is terminated by inducing labour and the foetus is delivered vaginally. The development of simple, highly effective drug regimens for abortion has transformed abortion care in the past 30 years (Lohr, Fjerstad, DeSilva & Lyus, 2014). Second trimester termination of pregnancy with mifepristone (Mifegyne®) followed by the prostaglandin misoprostol (Cytotec®) are now the most commonly used methods in six of the larger units in New Zealand (Abortion Law Reform Association of New Zealand, 2014). Mifepristone (also known as RU486) is a synthetic steroid which blocks the hormone progesterone that is needed for a
pregnancy to continue. It has been used in France for termination of pregnancies since 1989 and in August 2001 the Ministry of Health gave consent for mifepristone to be used in New Zealand for four indications: early medical termination of pregnancy, priming the cervix before a surgical termination, second trimester medical termination of pregnancy and induction of labour for foetal death in utero (Abortion Law Reform Association of New Zealand, 2014). Misoprostol is a synthetic prostaglandin which has a direct effect on the uterus and cervix, causing contractions and cervical dilatation. Whilst the primary function of misoprostol is to inhibit gastric acid secretions and mucosal protection it is utilised in this case as an abortifacient, and used in first and second trimester termination of pregnancy (Abortion Supervisory Committee, 2005). When mifepristone is combined with misoprostol it provides a medical alternative to surgical termination of intra-uterine pregnancy. Benefits of this method are that the interval between the administration of the prostaglandin and delivery of the products of conception is shortened from an average of 15.8 hours to 6.8 hours which reduces the psychological stress on both the women and the staff. In addition, the amount of prostaglandin required is reduced and the cost of the procedure is reduced, despite the added cost of mifepristone (Abortion Supervisory Committee, 2005). Misoprostol can be used alone but is less effective (Lohr et al., 2014).

Abortions between 13 and 20 weeks are usually performed over two days, however some women do not wish to wait the 36 – 48 hour period for misoprostol administration. This is often in the case of foetal demise or foetal abnormality. In other situations, the women do not meet the criteria: being in telephone contact, have private transport arrangements and live within 60 minutes of the hospital. In these instances, mifepristone is given orally as soon as the decision has been made for the procedure and they then commence the course of misoprostol. Evidence shows that there is likely to be a synergistic effect, no matter what the interval is between mifepristone and misoprostol and so it is recommended to give both medications (Abortion Supervisory Committee, 2005).

On day one the woman is admitted to the gynaecology ward with her support person/s. The nurse confirms that consent forms and Mifepristone (Mifegyne®)/Misoprostol Information form are complete. An initial nursing assessment of temperature, pulse, blood pressure, weight and allergy status is undertaken and the nurse discusses the plan of care with the woman. Documentation
of care is on a multi-disciplinary care plan specific to whether the STT procedure is a Prostaglandin Termination of Pregnancy (PGTOP) or Induction of Labour (IOL) for foetal demise or foetal abnormality. Mifepristone 200mg is prescribed by the doctor and is given orally by a nurse as per the medication regimen. The woman remains in the unit for one hour and is observed for effects that may include: nausea, vomiting, pain, chills, dizziness and abdominal cramping. During this time the nurse discusses the role of the support person during the procedure, options for aftercare of the foetus/baby and placenta which include: hospital cremation, private cremation or burial. In addition, a discussion about contraception post-partum occurs. The woman is discharged with instructions to contact the ward immediately if she has any concerns, such as bleeding or pain or in an emergency she is advised to contact emergency services.

The woman returns to the ward 36 – 48 hours later, receives misoprostol 800mcg vaginally by a nurse then lies flat for one hour. It is not necessarily the same nurse she met previously. Thereafter misoprostol 400mcg is administered orally every three hours until delivery of the baby or foetus, up to a maximum of five doses. Most women will require one vaginal and one oral dose of misoprostol and 97% of women will have completed the process within 15 hours from the first misoprostol tablet (Abortion Supervisory Committee, 2005). Nursing care during this time includes administration of analgesia, antiemetic, assessment of vaginal blood loss, vital signs and emotional encouragement and support. Following delivery of the baby or foetus an intramuscular injection of Syntocinon® is administered to induce contraction of the uterus and facilitate delivery of the placenta, which controls bleeding. Once vaginal bleeding has settled the woman is encouraged to mobilise, pass urine, shower and dress and most women are ready for discharge four hours following delivery. All women, whether a foetal demise, miscarriage, foetal abnormality or PGTOP, are given an opportunity to view the foetus/baby and receive a karakia or blessing from the chaplain or Maori Health Worker. Photos and footprints are offered for miscarriage, foetal demise or foetal abnormality. If the baby, foetus or products of conception is to undergo laboratory testing or post mortem examination additional documentation by both the woman, medical staff and nurses is required.
1.7 Skills, Knowledge and Training

A Self Learning Package (PGTOP/IOL SLP) was created in 2013 in response to an incident whereby a woman complained about the standard of care around a STT procedure. The corrective action plan required a review of skills, knowledge and training for nursing staff. This was timely as I had been thinking about how I would do this as no documented training strategy existed which demonstrated that staff were both confident and competent in provision of second trimester termination of pregnancy care (STT). The package was structured according to the organisation’s self-learning package education framework and included learning aims and objectives which were linked to written and practical assessment and evaluation components. The primary aim was to provide contemporary information to nurses who work in gynaecology services, on accepted practice, professional responsibilities and legislation specific to the provision of care for women presenting for PGTOP/IOL in the second trimester. The specific objectives identified were that on completion of the SLP the healthcare professional will be able to;

1. Provide necessary care and information and ensure patient safety;
2. Communicate with the patient in a way which reduces anxiety and instils confidence;
3. Anticipate and identify potential problems associated with the procedure and the remedial action to be taken;
4. Be aware of comprehensive documentation relating to the procedure.

As the nurse educator on the gynaecology ward, I made contact with two nurse educators nationally who were employed in similar abortion services requesting access to their educational resources and this was willingly shared. The document was informed by national abortion legislation; The Contraception, Sterilisation, and Abortion Act 1977 (Ministry of Justice, 2013), Health and Disability Code of Health and Disability Services Consumers’ Rights (Health and Disability Commissioner, 2012) and abortion guidelines (Abortion Supervisory Committee, 2009) which included recommendations for staff training. Particular care was afforded to ensuring the package aligned with professional standards, codes of conduct, The Treaty of Waitangi and scopes of practice and competencies (Nursing Council New Zealand, 2007) which in turn demonstrates accountability in the professional context. Whilst
student nurses and midwives are not directly involved in the care of these women, the SLP was designed to be a resource for nursing and midwifery students during their clinical placements in gynaecology. Feedback about the package was sought from gynaecology nurses and midwifery colleagues including the Clinical Midwife Specialist from the Foetal Maternal Medicine (FMM) service and the Midwifery Educators. The circulation of the package throughout the service was coordinated by the gynaecology service quality facilitator and feedback was incorporated into subsequent editions until the final version was signed off by the Service Manager. The staff who provided feedback during the consultation phase felt it was important to include not only a written assessment to demonstrate competency but that nurses new to abortion care should be supported whilst they undertake at least three procedures and be credentialed by a senior nurse. They were also of the opinion that it would be inappropriate to expect nurses new to gynaecology to care for these women until they had worked in the speciality for a reasonable amount of time.

During the first procedure the nurse would be an observer only, assisting the primary nurse, double checking medication, assisting with the delivery and care of the foetus/baby. For the second they would be identified as the primary nurse alongside a senior nurse and the third they would care for the women independently but the senior nurse would be available as required. It was agreed by the senior nursing team that while the nurses were undergoing the initial three procedures it was important that their patient loads were significantly reduced or ideally they had no other patients. The expectation was that the three procedures would be completed within a month however it was acknowledged that this would not always be possible and that some individuals would require more support and experiences than others before they could provide care safely, confidently and independently. The first nurse to complete the SLP did so in June 2013 and was allocated eight hours professional development credit.

In April 2014 I constructed the first draft of a four-hour workshop programme dedicated to care of women undergoing STT in the gynaecology ward; Gynaecology PGTOP/IOL Workshop. My goal was to advance, complement and strengthen the learnings gained from the SLP, formally include STT into the nursing staff orientation process and better prepare staff for the clinical reality of the STT process which would ultimately benefit the women. This would merge with the SLP to become The
**PGTOP/IOL Learning Package.** The first draft of the programme included; The Law and Abortion, The Patient Journey from Pre-Admission to Post-Discharge, Pharmacology (Pharmacokinetics and Pharmacodynamics), Spiritual, Ethical and Personal Care and managing a Clinical Emergency. Clinical experts would contribute to the workshop and would include the Maori Health Worker and Chaplain, as their roles in supporting the cultural and spiritual needs of the women and their families as well as staff was recognised by the gynaecology service as essential. I was also keen to have representation from the regional Sands group, a voluntary, parent-run, non-profit organisation set up to support parents and families who have experienced the death of a baby or infant at any stage during pregnancy, and with whom I had developed a professional relationship. My initial conversation with a local Sands representative indicated that they would like to be involved as they felt this would contribute to the education of the gynaecology staff and add value to the experience of women and their families who utilised our services.

To begin with I felt that new staff would complete the theory element of the SLP and then attend the four-hour workshop and only after that would they undertake the practicum component. However, I also thought that some practical experience in patient care would give them something to contextualise their learning to, so acknowledged that the order of the learning package would need to be reconsidered as well as deciding how often the workshop would be run to coincide with the arrival of new nursing staff. Prerequisite skills before nurses could commence the package included; intravenous therapy competence, completion of the organisation’s Entonox SLP and attendance at a Gynaecology Core Competency study day within the last 12 months which includes a Cardio Pulmonary Resuscitation (CPR) competency assessment. Links were made to Ministry of Health and District Health Board initiatives as well as Nursing Council New Zealand domains of practice to show relationships between training and patient safety goals. I emailed a draft programme to the Charge Nurse Manager and senior nursing colleagues for comment and input and received feedback from one source.

The workshop has yet to occur.

As I undertake this study I am increasingly aware of additional aspects that could be included in the education component.
1.8 Professional responsibilities and nursing scope of practice

Abortion is one area in which many nurses struggle with the conflict between their personal convictions and their professional duty (Marek, 2004). Professional standards, codes of conducts, scopes and practice and competencies are all taken into account to determine the standard of care expected (New Zealand Nurses Organisation, 2010). In New Zealand an independent agency, the Health and Disability Commissioner was set up to promote and protect the rights of consumers who use a health a disability services (Health & Disability Commissioner, 2012). The Code of Health and Disability Services Consumers' Rights (The Code) applies to all health and disability services in New Zealand and covers a wide range of providers including hospitals, doctors, nurses and midwives (Health and Disability Commissioner, 2012) and clearly states the standard of care consumers should expect when accessing healthcare services. Abortion care is not exempt from these standards and neither are those who provide it. The gynaecology service participates in regular certification audits from Ministry of Health auditing agencies who ensure hospitals, rest homes, residential disability care facilities and fertility providers provide safe and reasonable levels of service for consumers, as required under the Health and Disability Service (Safety) Act 2001 (Ministry of Health, 2014).

The Health Practitioners Competence Assurance Act (HPCAA) 2003 (the Act) principle purpose is to protect the health and safety of members of the public by providing for mechanisms to ensure that health practitioners are competent and fit to practise their professions. Under the Act, the Nursing Council of New Zealand (the Council) governs the practice of nurses by setting and monitoring standards and competencies for registration, which ensures safe and competent care for the public of New Zealand. Nurses are obliged to show competency to maintain their annual practicing certificate by undertaking regular education and maintaining set hours of clinical practice. The gynaecology nurses who complete the PGTOP/IOL SLP are awarded eight hours professional development which contributes to their registration requirements of 60 hours every three years. However, competency is not only demonstrated by nursing tasks and procedures. Cultural safety, the Treaty of Waitangi and Maori health are aspects of nursing practice that are reflected in the Council’s standards and competencies and patient care should be carried out within the nurse’s scope of practice, being aware they operate under the Nursing Council of
NZ requirements, which states “They (R/N) provide comprehensive nursing assessments to develop, implement, and evaluate an integrated plan of health care, and provide nursing interventions that require substantial scientific and professional knowledge and skill” (Nursing Council of New Zealand, 2007 p. 3). The Nurses Code of Conduct (2012) is a set of standards defined by the Council describing the behaviour or conduct that nurses are expected to uphold and include a requirement to practice safely, act ethically and with respect, traits I believe are not unreasonable. All the advances in abortion care point towards greater nursing involvement (Lipp, 2011) and require a health practitioner to be responsible for their actions whilst always keeping the needs of the patient and their families central to care is key to the provision of care, wherever the healthcare setting and whatever the healthcare circumstances.

However, abortion is a complex issue, and the controversy lies not only in the public arena but also within the nursing profession. As nurses are taking a more central role with women undergoing abortion, Lipp (2008a) challenges research to focus on investigating effective attributes otherwise known as the emotional qualities required of nurses to anticipate problems and challenges for future abortion care.

1.9 Structure of the thesis
1.9.1 Research question

The question which underpins this research is “what are the issues faced by nurses caring for women undergoing STT of pregnancy in the gynaecology inpatient setting in a tertiary hospital?”

1.9.2 Aims of the study

This study aims to gain a detailed understanding of nurses’ perceptions of the impact of caring for women undergoing second trimester termination (STT) of pregnancy, and specifically for nurses working in the gynaecology, inpatient setting.

A comprehensive literature review identified an abundance of literature regarding women’s experiences of termination or abortion. However, there has been limited research addressing the impact on nurses who provide abortion services in the second-trimester, internationally or in the New Zealand setting. The focus of this study is on the experiences of nurses who care for women undergoing STT of pregnancy.
1.9.3 Objectives of the study

- To explore nurses’ experiences of caring for women having a STT;
- To examine the emotional impact on nurses who are supporting women having a STT;
- To assess the effectiveness of educational and other resource support for nurses when caring for women having a STT.

1.9.4 Overview of the thesis

This thesis comprises of five chapters that explore the issues faced by nurses caring for women undergoing STT of pregnancy in the gynaecology inpatient setting of a tertiary hospital. Chapter one has provided a background to the study, explains why I chose to pursue the subject and states what I aim to learn from the research. It includes information about the procedure in both the study setting and the New Zealand context and highlights the responsibilities of the nurse who provides care. In Chapter Two, I examine the literature about the topic of second trimester termination of pregnancy and the experiences of the nurse which include: staff experiences and attitudes, strategies and managing demands and challenges, and training and support. Gaps in the literature are identified and how I will address these are explored. Chapter three outlines the research design and why it is appropriate for this study as well as describing the methodology. The findings of the interviews with the nurses, document review and retrospective audit of 12 women’s clinical notes are presented in Chapter four. The fifth and final chapter consists of a discussion about the findings in relation to current literature available on the topic. It describes implications of the study and how it will potentially impact on practice. Opportunities for future research, strengths and limitations of the study and recommendations arising from the study are respectfully made.

1.10 Summary

I continued to reflect on the reasons why some staff were reluctant to provide care; was it indeed fear, (particularly if the foetus was perceived to be alive when delivered) moral opposition to termination of pregnancy or a knowledge deficit? With many experienced staff leaving and new staff arriving I was particularly mindful about our next generations of gynaecology nurses who would need to develop skills,
knowledge and training around care of women undergoing STT. Of concern too was ensuring they were provided with adequate emotional support or supervision to maintain a healthy work life balance so they would want to remain in the gynaecology setting. It would seem to be in the best interests of both the women and nurses to have staff who are not ambivalent about their own commitment to abortion provision. Nurses also need basic counselling skills, including an understanding of the need for clear boundaries and mechanisms for debriefing and reviewing practice (Abortion Supervisory Committee, 2009). I felt if I could better understand this, a supportive, patient-centric and learner focused framework could be put in place and following discussion with members of the nursing team I developed a strategy to create this.

This chapter has provided an introduction and background to the research setting and explained why I have chosen to pursue this topic. Information about the STT procedure and the role of the nurse relating to abortion in New Zealand has been included to provide context. The strategy I have developed to address the gaps I see in the current provision of skills, knowledge and training for nurses who provide patient care has been described. The chapter concludes by outlining the structure of the thesis. In the next chapter I will examine the existing literature relating to the issues facing nurses providing second trimester termination of pregnancy in the gynaecology inpatient setting.
Chapter Two: Literature Review

2.1 Introduction

The aim of this chapter is to present a literature review on issues nurses face when caring for women undergoing second trimester termination of pregnancy in the inpatient gynaecology setting. A literature review is a systematic, explicit, and reproducible method for identifying, evaluating, and synthesizing the existing body of completed and recorded work produced by researchers, scholars, and practitioners (Fink, 2005), from a range of different sources including academic and professional journal articles, books, and web-based resources. It may also identify questions a body of research does not answer and make a case for why further study of research questions is important to a field. As well, legislation relating to abortion services in New Zealand will be consulted to examine current law. Guidelines and research about the experiences of nurses who work in abortion care will be examined and discussed. What follows is a review of the most relevant literature on the subject of second trimester termination of pregnancy and the experiences of the nurse. The topics being covered in this section include staff experiences and attitudes, strategies and managing demands and challenges, and training and support.

2.2 Search strategy

A literature search was carried out using several health-related databases including Google Scholar, CINAHL Plus, PubMed, Ovid Medline and ProQuest. Literature was sourced via these databases using key words: nursing, gynaecology, attitudes, second trimester termination of pregnancy, mid-trimester termination of pregnancy, training, job satisfaction, support, supervision, debrief. An initial basic search of nurse’s attitude to pregnancy termination yielded 3162 results.

Initial exclusions were first trimester termination of pregnancy, terminations that occurred in the maternity setting and terminations where care was not provided by nurses but by midwives. However, I amended my original decision and included two articles where pregnancy termination occurred in the labour and delivery setting as I felt they contained pertinent information that would add value to my discussion. Another case that described midwives’ experiences was included because in the study
country (Sweden), midwives deal with all aspects of reproductive health including termination of pregnancy rather than nurses. Literature that described care provision by nurse/midwives was included but not when the focus of interest was doctors or medical students.

In addition, I hand-searched the reference lists of the current journals to ascertain whether they would provide additional information that may not have revealed itself in the initial search. This resulted in further sources of literature such as that relating to organisational culture and its impact on the working environment and how (perhaps also why?) staff working in abortion services who identify a conscientious objection continue to work in the area.

Websites were searched for national and international guidelines relating to second trimester termination of pregnancy, including staff educational resources and training packages (Abortion Supervisory Committee (2005; 2009), Abortion Law Reform Association of New Zealand (2014), Ministry of Health New Zealand (2013), Nursing Council of New Zealand (2012), and World Health Organisation (2012)).

Whilst I was not specifically searching for evidence about the potential influence of religion in my study I did anticipate that for some nurses’ their religious affiliation may have an impact on attitudes to provision of termination of pregnancy care. I found an article in the local newspaper about a popular religious group and its attitude to abortion and subsequently viewed the official website of His Holiness Pope Francis for additional information. This site proved useful in terms of confirming the Roman Catholic Church’s stance on abortion (it remains anti-abortion) and revealing a recent newsworthy announcement from The Vatican (The Press, 2015) which will be discussed in chapter five.

A number of nursing textbooks, both contemporary (Paul, Lichtenberg, Borgatta, Grimes, Stubblefield & Creinin, 2009) and aged (Cairney & Cairney, 1963) were sourced because I was interested in how the learning resources of the past about abortion compared with those currently available, principally how they dealt with the emotional impact on nursing staff. Databases for abortion statistics from New Zealand provided numbers of abortions undertaken in the last year, specifically those that had occurred in the second trimester (Statistics New Zealand, 2016). As my search progressed I sought to include articles about moral distress, conscientious
objection, professional responsibility and organisational culture. These concepts will be explored through the body of the work and the influence they have in the study setting considered.

Each paper was summarised in a table that comprised: author/s and year of publication, country where the research occurred, study design, setting and information about the participants (Table 1).
Table 1. Summary of studies used in the literature review

<table>
<thead>
<tr>
<th>Author &amp; Date</th>
<th>Title of article</th>
<th>Country</th>
<th>Study Design</th>
<th>Setting</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kane, R. (2009).</td>
<td>Conscientious objection to termination of pregnancy: the competing rights of patients and nurses</td>
<td>UK</td>
<td>Literature review</td>
<td>Review of the academic literature around implications for staff with a conscientious objection to abortion</td>
<td></td>
</tr>
<tr>
<td>McCreigh, B, S. (2005).</td>
<td>Perinatal grief and emotional labour; a study of nurses' experiences in gynae wards</td>
<td>UK</td>
<td>Qualitative design using semi-structured interviews</td>
<td>Gynaecology units in Northern Ireland</td>
<td>14 nurses</td>
</tr>
<tr>
<td>McQueen, A, C, H. (2004).</td>
<td>Emotional intelligence in nursing work</td>
<td>UK</td>
<td>Literature review</td>
<td>Analysis of the literature on emotional intelligence and emotional labour and consider the value of EI to nursing</td>
<td></td>
</tr>
<tr>
<td>Huntington, A, D. (2002).</td>
<td>Working with women experiencing mid-trimester termination of pregnancy; the integration of nursing and feminist knowledge in the gynaecological setting</td>
<td>NZ</td>
<td>Praxis from PhD thesis</td>
<td>Based on clinical experiences in the gynaecological ward and research working in the area</td>
<td>Gynaecology nurses</td>
</tr>
<tr>
<td>Gallagher, K., Porock, D., &amp; Edgley, A. (2010).</td>
<td>The concept of 'nursing' in the abortion services</td>
<td>UK</td>
<td>Exploratory qualitative design using semi-structured interviews</td>
<td>Three different abortion clinics where TOP up to 24 weeks gestation</td>
<td>9 nurses/midwives</td>
</tr>
<tr>
<td>Natan, M, B., &amp; Melitz, O. (2010).</td>
<td>Nurses' and nursing students' attitudes towards later abortion</td>
<td>Israel</td>
<td>Descriptive study questionnaire</td>
<td>Maternity ward of a large hospital including gyna, labour, delivery, NICU in northern Israel. Nursing school in central Israel</td>
<td>100 nurses 100 student nurses</td>
</tr>
<tr>
<td>Lipp, A, J. (2010).</td>
<td>Conceding and concealing judgment in termination of pregnancy; a grounded theory study</td>
<td>UK Wales</td>
<td>Grounded theory using individual interviews</td>
<td>9 healthcare Trusts in Wales where surgical and medical terminations occurred</td>
<td>12 nurses/midwives</td>
</tr>
<tr>
<td>Lipp, A, J. (2008).</td>
<td>Service provision for women undergoing termination of pregnancy: Progress in Wales, UK</td>
<td>UK Wales</td>
<td>Audit</td>
<td>A questionnaire survey was sent to all National Health Service (NHS) Trusts in Wales</td>
<td>10 out of 13 responded</td>
</tr>
<tr>
<td>Lipp, A, J. (2011).</td>
<td>Stigma in abortion care: Application to a grounded theory study</td>
<td>UK Wales</td>
<td>Grounded theory using individual interviews</td>
<td>Nurses and midwives working in abortion care in the national health service in South Wales, UK</td>
<td>12 nurses/midwives</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Title/Abstract</td>
<td>Country</td>
<td>Method</td>
<td>Description</td>
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<tr>
<td>Nicholson, J, Slade P., &amp; Fletcher, J. (2010).</td>
<td>Termination of pregnancy services; experiences of gynaecological nurses</td>
<td>UK</td>
<td>Interpretive phenomenological analysis (IPA) interviews and questionnaires</td>
<td>Nurses who work in public sector Ward-based TOP service. Ward also had Early Pregnancy unit.</td>
<td></td>
</tr>
<tr>
<td>Gmeiner, A. C., Van Wyk, S., Poppenpoel, M., &amp; Myburgh, C, P, H. (2000)</td>
<td>Support for nurses directly involved with women who chose to terminate a pregnancy</td>
<td>South Africa</td>
<td>Qualitative phenomenological interviews</td>
<td>Nurses who voluntarily directly involved with women who choose to terminate</td>
<td></td>
</tr>
<tr>
<td>Christensen A, V., Christiansen, A, H., &amp; Petersson, B. (2013).</td>
<td>Faced with a dilemma: Danish midwives experiences with and attitudes towards late termination of pregnancy</td>
<td>Denmark</td>
<td>Exploratory study using semi-structured individual interviews</td>
<td>Midwives who had taken part in late termination of pregnancy</td>
<td></td>
</tr>
<tr>
<td>Parker, A., Swanson, H., &amp; Frunchak, V. (2014).</td>
<td>Needs of labor and delivery nurses caring for women undergoing pregnancy termination</td>
<td>Canada</td>
<td>Interviews</td>
<td>Labor and delivery unit university affiliated hospital in Quebec</td>
<td></td>
</tr>
<tr>
<td>Marek, M. J. (2004).</td>
<td>Nurses attitudes toward pregnancy termination in the labor and delivery setting</td>
<td>USA</td>
<td>Survey</td>
<td>Six Californian hospitals</td>
<td></td>
</tr>
<tr>
<td>Wolkomir, M. &amp; Powers, J. (2007).</td>
<td>Helping women and protecting the self: The challenge of emotional labour in an abortion clinic</td>
<td>USA</td>
<td>In-depth loosely structured interviews and observation</td>
<td>Abortion Clinic</td>
<td></td>
</tr>
</tbody>
</table>

24
2.3 Overview of the literature

From the total articles initially located (504), 22 studies about registered nurses and or registered midwives and their respective experiences with women undergoing second trimester termination of pregnancy were chosen for closer scrutiny. All the authors held health qualifications and most were registered nurses. The literature was published between 2002 and 2014. Countries of origin included Sweden, South Africa, the United Kingdom, New Zealand, Israel, Sweden, Denmark, Canada and the United States of America. I sought to have a variety of nations and cultures represented as I felt this would add rigour, interest and a sense of cultural contrast to my study. New Zealand was represented through the work of Annette Huntington whose studies were set in the gynaecology clinical setting (Huntington, 2002). Three of the articles were literature reviews, three involved questionnaires only and the remaining 15 comprised of qualitative design using semi-structured interviews.

The settings for the studies were predominantly publically funded gynaecology clinics or wards and maternity units within a tertiary facility where termination of pregnancy occurred up to 24 weeks gestation. Sample sizes ranged from seven to 100 participants, the larger samples were those who took part in questionnaires or surveys. As most of the studies involved in-depth semi-structured interviews the small sample sizes were appropriate for case study research.

2.4 The themes in the literature

There were a number of themes that emerged from the literature and included; staff experiences and attitudes, strategies for managing demands and challenges, and training and support. Under each heading I will introduce the literature and compare and contrast between the findings. The findings will be critiqued and gaps in the literature identified.
2.4.1 Staff experiences and attitudes

Termination of pregnancy is unique as an area of practice in that healthcare professionals are unlikely to be able to separate their own attitudes from the care they provide and staff involved with second trimester termination of pregnancy have been found to experience both positive and negative views (Lipp, 2008a). A study by Nicholson, Slade and Fletcher (2010) demonstrated that for gynaecology nurses working in termination of pregnancy services there were challenges and benefits, and McCreight (2005) observed in her study of 14 gynaecology nurses in Northern Ireland, that despite the nurses finding the work emotionally demanding, they also reported that strong emotional involvement in patient care can be a positive and rewarding experience for nurses.

A longitudinal study by Bolton (2005) found that nurses referred to miscarriage and abortion care as the most demanding but rewarding aspect of their work in gynaecology. The termination procedure is described as a complex one and requires skilled nurses who maintain an emotional connection to the woman (Christensen, Christiansen, & Petersson, 2013). This confirms the findings of Lindstrom, Jacobsson, Wulff, and Lalos (2007) where Swedish midwives’ experiences of working with women seeking an abortion for a prolonged time evoked positive experiences. In addition, midwives who have had a termination themselves have fewer misgivings, thereby demonstrating empathy with the women, a very powerful emotion.

In Sweden, midwives can choose whether or not they wish to work in termination of pregnancy services (Lindstrom et al., 2007), however in other parts of the world such as South Africa, nurses feel coerced or fear retaliation if they refuse and would prefer to choose whether they work in termination of pregnancy services of free will (Mokgethi, Ehlers & van der Merwe, 2006). Integrated units, where women undergo abortion on all legal grounds at all gestations, staffed by nurses/midwives who are choosing to do this work are anecdotally reported to have clear advantages in the areas of job and client satisfaction (Abortion Supervisory Committee, 2005). Even within a dedicated abortion service, where staff have chosen to be employed, they need to have a choice about how they are involved in abortion of advanced pregnancies (Abortion Supervisory Committee, 2005). Gallagher, Porock and Edgley (2010) describe how developing one’s own philosophy of care, created by the nurses
themselves would foster a sense of purpose which recognised and acknowledged the important work they do, thereby theoretically enhancing the nurse’s experience. Several studies found that as gestation advances nurses are less likely to willingly take part (Christensen et al., 2013; Gallagher et al., 2010; Lipp, 2008; Natan & Melitz, 2010), particularly if the foetus could potentially show signs of life when it was born (Huntington, 2002). The Abortion Supervisory Committee (2005) acknowledges that the gestation of the woman might have an influence on which staff are suitable and willing to care for women undergoing second trimester abortions.

The attitude of the nurse was also found to be dependent on the reason for the termination in a number of studies. Nurses felt less inclined to be involved if the termination was for social reasons including abortion for contraception, repeat abortion and abortion for sex or gender selection (Lipp, 2008a; 2011; McLemore & Levi, 2011; Marek, 2004) as compared to procedures undertaken for foetal death or foetal abnormality (Lipp, 2008; Natan & Melitz, 2010). Religious affiliation was found to be influential in how nurses develop their attitudes toward abortion and abortion care in a number of studies (Lipp, 2008; McLemore & Levi, 2011; Marek, 2004; Natan, & Melitz 2010) but had no impact in others (Lindstrom, Jacobsson, Wulff, & Lalos, 2007).

Exploration of the health professional’s own value system and honesty about personal issues and beliefs that might influence client management is always advisable in abortion service provision (Abortion Supervisory Committee, 2005).

2.4.2 Strategies for managing demands and challenges

Second trimester termination of pregnancy is a social, emotional, and management challenge that most clinicians would be glad to avoid (Bryant, Grimes, Garret & Stuart, 2011). Many issues dealt with on a daily basis by gynaecology nurses are socially ‘difficult’: cancer, infertility, miscarriage and foetal abnormalities; or socially ‘distasteful’: termination of pregnancy, urinary incontinence, menstruation and sexually transmitted disease (Bolton, 2005) and nurses may find specific ways to deal with the challenges they meet when caring for women in the termination setting.
A 2007 study by Wolkomir and Powers of nine abortion clinical staff analysed how staff balanced the requirements of the job with their own emotional needs and found that nurses managed women on a continuum from investment to detachment depending on the circumstances of the individual woman. However, when Huntington (2002) explored the experiences of New Zealand nurses working in the gynaecology setting she counsels that if nurses distance themselves emotionally or physically from the women this would add to the trauma that the woman is already experiencing. One study identified that whilst nurses and midwives were generally supportive of a woman’s right to choose termination they recognised that women having abortions are stigmatised and “as the wise, nurses suffer from affiliate stigma” (Lipp, 2011, p. 8).

Andersson, Gemzell-Danielsson and Christensson (2014) described how the feeling of doing something good for women's right bridges the difficulties nurses face when caring for women undergoing second trimester medical termination of pregnancy. Other studies have identified some nurses are more supportive of a termination for foetal demise or foetal abnormality that one for social reasons (Lipp, 2008; 2011; Marek, 2004; McLemore & Levi, 2011). A Welsh study of 12 nurses and midwives who worked across nine healthcare Trusts where surgical and medical terminations occurred found that nurses made judgments but concealed them, enabling them to portray what might be described as an illusion of an acceptance and understanding of the women’s decision (Lipp, 2011). Several studies describe how nurses who work in termination care demonstrate unconditional acceptance and understanding for the women’s right to choose a termination (Christensen, Christiansen, & Petersson, 2013; Gallagher, Porock, & Edgley, 2010; Natan & Melitz, 2010) which could be interpreted as absolving them of responsibility for or separating them from any part of the decision making process but allowing them to concentrate on providing physical and emotional care.

Some nurses employed self-preservation in the form of ‘switching off’ from their situation or ‘getting on with it’ when they encountered the foetus or women who were ‘blasé’ (Lipp, 2011) and Wolkomir and Powers (2007) described staff creating emotional boundaries which allowed them to maintain their own integrity and avoid burnout. Other research found that support from nursing colleagues was an important aspect of how nurses coped with their role (Gallagher et al., 2010; Parker, Swanson, & Frunchak, 2014; Nicholson, Slade, & Fletcher, 2010) and nurses have
traditionally dealt with the stress that their feelings engender by talking to people they feel safe with (Huntington, 2002).

2.4.3 Training and support

The majority of literature established that the training of nurses who work in abortion care was inadequate (Andersson, Gemzell-Danielsson, & Christensson, 2014; Gmeiner, Van Wyk, Poppenpoel, & Myburgh, 2000; Huntington, 2002; Lipp, & Fothergill, 2009; McCreight, 2005; McQueen, 2004; Natan, & Melitz, 2010; Nicholson et al., 2010; Parker, Swanson & Frunchak, 2014) and identified the need for training, mentoring and support by experienced colleagues.

None of the studies described specifically what they meant by support however, the Cambridge online dictionary states that to support is to agree or give encouragement to someone or something because you want him, her, or it to succeed (Cambridge University Press, 2016) and the Oxford dictionary uses the definition approval, encouragement or comfort (Oxford University Press, 2016). My interpretation of what is meant by ‘support’ in these studies is that it embraces emotional, collegial, technical and professional help.

The emotionally demanding work affects individual nurses and the organisation as a whole through absences and nursing turnover (Huntington, 2002; Nicholson et al., 2010) amid concerns about the workload and patient–to-nurse ratios on patient care (Parker et al, 2014). However, the emotional aspect of how pregnancy loss may impact on staff is not included in education programmes for nurses who work in the speciality and nurses sought more training in the form of specific gynaecology courses (Lipp, 2011; McCreight, 2005).

This is similar to the needs of a group of Canadian labour and delivery nurses who sought knowledge and skill-building through access to evidence-based literature, continuing education sessions, and workshops (Parker et al., 2014). In addition to providing emotional support, experienced colleagues were identified as the source of most knowledge as nurses’ valued interpersonal support from nurse colleagues (Gmeiner et al., 2000) and the ward sister was seen as both a role model and source of training (McCreight, 2005). When a nurse first works with a woman having a mid-
trimester termination, Huntington (2002) recommends that she should work alongside an experienced nurse and Nicholson et al, (2010) advocates for training which facilitates understanding of the processes, ways of managing these and their implications in a supportive environment. McCreight’s 2005 study of nurses’ experiences in gynaecology wards suggests that study programmes that start from the experience of parents who have experienced a pregnancy loss have the potential to provide authentic learning experiences for nurses, and several nurses related that these study days were the most beneficial.

Acknowledging that second trimester termination care is a task that requires professional knowledge, empathy and the ability to reflect on ethical attitudes and considerations was considered by several studies as justifying incorporating reflective practice and self-evaluation into nursing education programmes (Andersson et al., 2014; Lipp & Fothergill, 2009; McQueen, 2004). This recommendation is supported by McCreight (2005) who states, “reflection on experience is, then, at the heart of learning for professionals, who have to cope with trauma and offer care on an individual basis” (p. 445). A number of authors stated that debriefing and/or regular clinical supervision should always be offered (Gallagher et al., 2010; Gmeiner et al., 2000; Huntington, 2002) and stressed the importance of not assuming that more experienced nurses will require less support, as becoming blasé about mid-trimester terminations can be as concerning to an experienced nurse as a new nurse’s anxiety about managing the process competently (Huntington, 2002). Time out for nursing staff involved in abortion care was seen as beneficial after dealing with a pregnancy loss (McCreight, 2005).

The Abortion Supervisory Committee (2005) recommends that managers and nurse/midwife leaders must ensure that adequate education and regular professional supervision to enable review of practice and debrief mechanisms are readily available to nurses who work in abortion care. Second trimester services in particular, put significant psychological stresses on staff and this must be acknowledged and provided for by incorporating physical, mental, emotional, cultural and spiritual aspects of abortion care in training.
2.4.4 Knowledge gaps or limitations

While all the studies described the experiences of nurses or midwives when caring for women seeking second trimester abortions, many of the studies occurred in clinical areas dedicated solely to the provision of abortion and not in a clinical setting where other gynaecology care occurs. Therefore, how nurses deal with caring for other patients, some of whom may be experiencing miscarriage, post-natal complications or end of life care in addition to providing termination care was not explored.

2.5 Summary

The literature supports the concept that taking care of women undergoing second trimester termination of pregnancy is a complex task that requires not only professional knowledge and empathy but also the ability to reflect on ethical attitudes, particularly as the gestation advances. It would appear that nurses can identify positive aspects when providing abortion care, specifically that they are supporting the women’s choice and doing something ‘good’. Even if they do not agree with the woman’s decision they have the ability to conceal their judgments from both the women and their colleagues. This strategy allows nurses to continue to provide care in this area but they also rely heavily on the emotional support they receive from nursing colleagues as formal processes for debriefing are not common practice. The findings of this literature review has identified that training for nurses is inadequate, and particularly education around the emotional aspect of abortion care, both for themselves and the women and confirm the need for training, mentoring and support by experienced colleagues. My research will explore whether the same issues exist for the gynaecology nurses in my area of study, a clinical setting where termination of pregnancy is not the primary focus but where nurses provide care for women with other gynaecological anomalies.
Chapter Three: Study Design and Methodology

3.1 Introduction

This chapter will describe the study design and the choice of case study methodology and explain how it was used to answer the research question. The research question that guided my study was: what are the issues faced by nurses caring for women undergoing STT of pregnancy in the gynaecology inpatient setting in a tertiary hospital? The overall aim of the study was to gain a detailed understanding of healthcare professional’s perceptions of the impact of caring for women undergoing second trimester termination (STT) of pregnancy, and specifically for nurses working in the gynaecology, inpatient setting. I will discuss the process of data collection and how I chose and recruited participants to the study and the means I used to analyse the data.

3.2 Methodology

The option of using either quantitative or qualitative methodology is guided by the research question (Polit & Beck, 2010) and in this instance qualitative case study methodology was deemed most appropriate given its focus on a contemporary phenomenon within a real-life context (Yin, 2009). Case study methodology provides researchers with an opportunity to gain a comprehensive knowledge of the phenomenon of interest in this case the issues affecting the nurses who provide care for women undergoing STT. When the approach is applied correctly, it becomes a valuable method for health science research to develop theory, evaluate programs, and develop interventions (Baxter & Jack, 2008). Therefore, in the context of the objectives I had identified for my research: explore nurses’ experiences of caring for women having a STT, examine the emotional impact on nurses who are supporting women having a STT and assess the effectiveness of educational and other resource support for nurses when caring for of caring for women having a STT, this methodology was ideal.
3.2.1 Why Case Study Design?

Case studies are in-depth investigations of a single entity (a thing with distinct and independent existence) or a small number of entities (Polit & Beck, 2010). Case study contributes uniquely to our knowledge of individual, organisation, social and political phenomena (Yin, 1994) and this approach was deemed most appropriate given its focus on the human experience of health, a central concern of nursing science (Beanland & Schneider, 1999). Case study methodology is described by Bromley (1990, as cited in Zucker, 2009) as a systematic inquiry into an event or a set of related events which aims to describe and explain the phenomenon of interest, in this case the issues affecting the nurses who care for women undergoing STT. This is comparable to the definition by Polit and Beck (2010), whereby case study research involves a thorough, in-depth analysis of an individual group, or other social group, who views the greatest strength of this method as the depth that is possible when a limited number of individuals, institutions or groups is being investigated. Typically, data are gathered from a variety of sources and by using several different methods (e.g. observations and interviews). However, this same strength is a potential weakness because familiarity with the person or group may make objectivity more difficult and the tendency to over generalise more likely to occur.

Despite the many positive aspects of qualitative research, studies continue to be criticised for their lack of objectivity and generalisability (Myers, 2000). There has also been concern too over the lack of rigour of case study research, the complaint that they take too long, resulting in massive, unreadable documents (Yin, 1994). Conversely Zucker (2009) states that case studies in nursing have a practical function in that they can be immediately applicable to the participant’s diagnosis or treatment. Furthermore, Amerson (2011) proposed that for the nurse educator conducting evaluation research, case studies are probably the most useful, particularly when the researcher must take into account the contextual conditions of the phenomenon being studied. This methodology would appear to be appropriate for this research as in this instance data would come largely from documentation, archival records and interviews, as expressed by Yin (2004). Additional strategies commonly integrated into qualitative studies to establish credibility include the use of reflection or the maintenance of field notes (Baxter & Jack, 2008). Determining the type of case study also needs to be considered and I believe the needs of the research questions are
best met by instrumental or possibly intrinsic case studies. Stake (1995) uses the term instrumental, which is used when one is attempting to accomplish something other than understand a particular situation but gain insight into an issue or help to refine a theory whilst Yin (2003) recommends an intrinsic approach for researchers who have a genuine interest in the case when the intent is to better understand the case, such as in my particular study. Finally, the usefulness of a case study is that it encourages educators to consider additional steps in a caring educational curriculum that emphasizes communication and relationships between human beings (Scott, 2005), which was precisely my intention.

Other qualitative methodologies were also considered: Qualitative Descriptive methodology and narrative research. Qualitative descriptive study is the method of choice when straight descriptions of phenomena are desired (Sandelowski, 2000). Such study is especially useful for researchers wanting to know the who, what, and where of events and it would seem this approach would fit the aim of my research particularly as small sample sizes are a feature. However, as my intent was to gain a deep understanding of the issues facing the gynaecology nurses so as to provide a level of detail and understanding, this approach was rejected as potentially too superficial. The second methodology I contemplated was Narrative research, a qualitative strategy in which the researcher studies the lives of individuals and asks one or more individuals to provide stores about their lives (Creswell, 2014), thus, the study of narrative is the study of the ways humans experience the world (Connelly & Clandinin, 1990). A feature of this approach I found particularly appealing was not only the focus on the spoken word but the use of journal entries made by both participants, researcher and practitioner as a source of data, as described by Connelly and Clandinin (1990). But as a key component of my research was to hear what the nurses had to say but to also investigate the value of the learning package, this method was also discounted as not meeting the needs of the study.

3.2.2 Ethical considerations

Nursing was founded on the moral premise of caring and the belief that nurses have a commitment to care. Society’s expectation of nurses is that they are moral agents in their provision of care, and that they have a responsibility to conduct themselves ethically in what they do and how they interact with persons receiving care
Nurse researchers conducting qualitative studies need to be acutely aware of the unique way ethics, both nursing and research ethics, affects all phases of the qualitative research process and Creswell (2014) recommends consulting early in the development of your proposal the code of ethics for your professional association. In respect to my study I accessed the website of NZNO, a professional association and a registered union which provides professional support and leadership for nurses and midwives in Aotearoa New Zealand. In 2010 the NZNO revised the Code of Ethics to guide nurses’ practice, and communicate to society the nursing profession’s ethical values. The Code informed both the ethical and professional components of my study, specifically that; Nurses demonstrate ethical nursing practice when they advocate individually and collectively for the elimination of social inequities. Nurses address social inequities by: collaborating with other health care professionals and organisations for change in unethical health and social policies, legislation and regulations; advocating for accessible, appropriate and affordable health care services that are available to all; recognising the significance of the socio-economic determinants of health; and supporting environmental preservation and restoration.

3.2.3 Informed consent

Ethical standards prescribe that respondents should never be coerced to take part in a study; participation should be free, voluntary and fully informed. This means that respondents should not only know that they are taking part in a study, but also that they give their consent to it and, moreover, that this consent is based on correct facts (informed consent) (Sarantakos, 2013). Before I collected data it was necessary to have participants sign informed consent forms agreeing to the provisions of the study. The forms were created to include a standard set of elements as recommended by Sarantakos (2013), a template for Informed Consent Form developed by the World Health Organisation (2016) and one kindly donated by a fellow Masters colleague (Appendix 4).
3.2.4 Ethical approval

As I am collecting personal healthcare data and interviewing health professionals, formal application for ethical approval is required for my research and ethical approval for this study was granted by the Human Ethics Committee of Victoria University of Wellington in October 2014 (Ethics Approval: 21293, Appendix 1). In addition, I sought endorsement from my professional leader (Nursing Director) and the Clinical Director Obstetrics and Gynaecology, who supported the research and suggested alignment with the similar clinical work done by the midwives in the second and third trimesters. She felt midwives experienced similar issues as the nurses working in gynaecology. I wholeheartedly agreed but felt strongly about the experiences of nurses and suggested research could occur in the midwifery setting by a midwife researcher. This testimonial ensured access to clinical records. Encouragement was also received from the hospital Chaplain who is a wise and thoughtful woman. She recognised that the nature of the work for the nurses working in gynaecology was emotionally challenging and a large portion of her pastoral role was dedicated not only to patients, but to the support of staff.

3.2.5 Treaty of Waitangi considerations

Consultation with local iwi representatives applying Guidelines for Cultural Safety, the Treaty of Waitangi and Maori Health in Nursing Education and Practice (Nursing Council of New Zealand, 2005), Statement on Cultural Competence for Midwives (Midwifery Council of New Zealand, 2012) occurred with the support and guidance of the gynaecology Maori Health Worker (Kaiwhina Whaea me nga pepi). Participants in the study may include nurses who identify as Maori. The principles of partnership and sharing implicit in the Treaty should be respected by all researchers and, where applicable, should be incorporated into all health research proposals (Health Research Council of New Zealand, 2010). Our Kaiawhina Whaea me nga pepi (Maori Health Worker) offered cultural tautoko (support) for my study as she felt it would be of benefit to all our nurses and turoto (patients) on their journey through gynaecology. She offered to liaise and provide guidance from a cultural perspective or assist when required in interviewing turoto and whanau (patients and family).
3.2.6 Protecting participant identity and maintaining confidentiality

Participants are assured that every care would be taken to protect their identity as much as possible by using pseudonyms for the interviews, secure storage of data (including transcripts of recorded interviews), confidentiality forms for the transcribers and access to raw data restricted to myself and my supervisor. In addition, aspects of the interviews such as their or other participant’s comments were not discussed at work, during breaks or in social settings with anyone other than my supervisor.

3.2.7 The Participant/Researcher relationship

Interviews should begin from the premise that a power imbalance exists between the data collector and the participants (Creswell, 2014) and it could be perceived that my senior nurse role as an educator gave me power or influence over some or all of the participants. In addition, it is thought that selecting a site to study in which you have an interest in outcomes is not a good idea as it does not allow for the objectivity required for quantitative research or for the full expression of multiples perspectives that is needed by qualitative research (Creswell, 2014). The decision as to whether the study should occur in my current area of employment was thought through early in the planning stages and raised during the ethics application, however it was felt that the area of study was unique nationally, and so the decision was made to continue. To further minimise these potential risks and maintain an ethical stance, I was clear about the boundaries of the research, ensure informed consent is an ongoing process, was explicit about my professional background (i.e. a nurse conducting research as compared to a therapist), and made certain I received adequate training for the interviews and regular professional supervision. I was aware that the interview process may activate painful memories and experiences for the nurses and provision was be made for counselling support to be available through an Employee Assistance Programme. However, over familiarity may potentially pose other issues with the local nurse participants being reluctant to fully disclose their true attitudes and feelings, for fear of judgment by a colleague in addition to the potential for them providing answers to the questions, they think I want to hear. This phenomenon is known as social desirability (Matthews, Baker & Spillers, 2003) generally defined as providing responses that are perceived as more acceptable than
the response that the participant would have made under different or neutral conditions.

All care was taken to preserve confidentiality and the anonymity of the research site and participants due to the sensitive nature of the research subject. Throughout the course of my research journey I maintained a reflective journal and engaged in regular telephone and face to face discussions with my supervisor. This allowed me to freely, privately and honestly talk about any difficulties or successes I encountered and the journal was useful to record reflections that I could potentially use in my thesis. The ethical code for researchers is to protect the privacy of the participants and to convey this protection to all individuals involved in a study (Creswell, 2014). By adhering to these ethical and cultural principles I believe it is possible to conduct the research in my current area of employment and mitigate ethical risks.

The dynamics of the participant/researcher relationship changed in the early stages of the study as I was offered a 12 month secondment to another service within the organisation. How this affected the research will be described nearer the end of this chapter.

3.3 The Methods (The Design)

Case study research is not limited to a single source of data, and this ensures that the issue is not explored through one lens, but rather a variety of lenses which allows for multiple facets of the phenomenon to be revealed and understood (Baxter & Jack, 2008). Yin (1994) identified six primary sources of evidence for case study research: documentation (letters, memoranda, agendas, study reports, newspaper clippings and other internal documents), archival records (service records, maps, charts, lists of names, survey data, and even personal records such as diaries), interviews (open-ended, focused, or structured), direction observation (when the investigator makes a site visit to gather data), participant observation (a unique mode of observation in which the researcher may actually participate in the events being studied) and physical artefacts (physical evidence that might be gathered during a site visit such as tools, art works, notebooks, computer output, and other such physical evidence). Whilst all not sources are essential in every case study, the importance of multiple sources of data to the reliability of the study is well established (Yin, 1994).
The use of multiple sources extended to my use of several different versions of Yin’s work (1994; 2003; 2009). As his thinking changed and evolved so did my understanding of case study methodology. I would use this to my advantage when justifying the inclusion of my own journal excerpts in chapters three and five.

In this section I will introduce the types of data that were utilised in the study. They were: the interviews with the gynaecology nurses, clinical record review and assessment of the learning package, in terms of its usefulness to the gynaecology nurses. I will also describe the processes involved in choosing and collecting the data: sampling, eligibility, recruitment, audit and analysis of the data.

3.3.1 Sampling

Sampling refers to the process used to select a portion of the population for study (Burnard, 1991) and sampling decisions are made for the explicit purpose of obtaining the richest sources of information to answer the research question (Ploeg, 1999). A purposive sampling strategy was chosen for this study as with it, researchers deliberately choose the cases or types of cases that will best contribute to the information needs of the study (Polit & Beck, 2010). In this case nurses currently employed in the gynaecology inpatient setting where second trimester termination of pregnancy regularly occurs were approached to participate. This method of sampling offers researchers a degree of control rather than being at the mercy of any selection bias inherent in pre-existing groups, such as clinic populations (Barbour, 2001) as compared to earlier qualitative sampling methods such as convenience sampling, when the group of interest was difficult to access. Qualitative researchers recognise that some informants are ‘richer’ than others and that these people are more likely to provide insight and understanding for the researcher (Marshall, 1996), in addition to diversity of individual experiences. In the gynaecological setting, it could be assumed that nurses who had worked in the discipline for the longest period of time would be considered a ‘richer’ source of information given their prolonged exposure to termination, interaction with a greater variety of women and ‘having seen it all’, in terms of evolution of the service, however the study may identify that this is not necessarily so.
An appropriate sample size for a qualitative study is one that adequately answers the research question (Marshall, 1996) however sample sizes in qualitative research tend to be small because of the large volume of verbal data that must be analysed, in addition to the intensive and prolonged contact with subjects (Beanland & Schneider, 1999). Phenomenologists tend to rely on very small samples of participants – typically 10 or fewer (Polit & Beck, 2010), however all participants must have experienced the phenomenon and must be able to articulate what it is like to have lived that experience.

3.3.2 Recruitment

To recruit participants for this study a letter of introduction and invitation to participate (Participant Information form, Appendix 2) was distributed by a third party (Gynaecology Nurse Clinical Co-ordinator) to eligible nurses currently employed in the gynaecology inpatient setting (n=30).

3.3.3 Eligibility criteria

Inclusion criteria:

• Registered Nurse whose current role is to provide direct care for women undergoing second trimester termination of pregnancy in the gynaecology ward of a tertiary hospital in New Zealand.

Exclusion criteria:

• All other staff who are not Registered Nurses (i.e. Enrolled Nurses, Student Nurses, Administration staff, Healthcare assistants and other registered health professionals)
• Registered nurses not providing care to women undergoing STT in the gynaecology ward

At the commencement of the study I was employed as the Nurse Educator for the gynaecology service. To make sure that there was no awkwardness if nurses did not wish to take part or a feeling that they had no choice or perceived they were in any
way coerced to participate in the study, recruitment was delegated to a senior nursing colleague. The Gynaecology Nurse Clinical Co-ordinator acted in a third party capacity on behalf of the researcher to place the letters in each nurse’s pigeon hole. Nurses willing to be involved completed a Participant Expression of Interest (EOI) form (Appendix 3) and a Consent to Participate in Research form (Appendix 4) and returned the forms to the Gynaecology Nurse Clinical Coordinator. The forms were forwarded to me and I contacted each nurse to confirm their understanding of the process and arranged days and times to meet with them. A total of six nurses indicated a willingness to participate in the study however six is appropriate for case study methodology. One of the six nurses had recently resigned but as she remained on the casual roster, she remained eligible for participation in the study according to the pre-determined criteria.

3.3.4 The participants

The six participants were all registered nurses aged between 23 and 63 years at the time of the interviews. Their experience in gynaecology ranged between three and 30 years and one nurse held additional qualifications in midwifery.

3.3.5 Interviews

Interviews are guided conversations that are usually one of the most important sources of case study evidence (Yin, 2009). Face-to-face interviews were conducted with each participant, nurses who were working in the gynaecology inpatient setting where second trimester termination of pregnancy occurred, using a semi-structured interview question schedule (Study Interview Questions, Appendix 5). The advantages of this type of data collection is that it allows the researcher control over the line of questioning, is useful when participants cannot be directly observed and participants can provide historical information (Creswell, 2014). In semi-structured interviews, a researcher is able to refocus the questions, or prompt for more information, if something interesting or novel emerges (Baskarada, 2014). However, this method has limitations as the presence of the researcher may affect participant’s responses, a behaviour known as social desirability bias, in which people respond to questioning in
ways that make them seem more accepting or appealing to others rather than choosing responses that are reflective of their true thoughts or feelings and not all people are equally articulate and perceptive. In addition, the information is filtered through the views of the interviewees in what may be considered an unnatural setting (Creswell, 2014). Owing to the sensitivity of the matter, my relationships with some of the participants and respect for privacy, individual interviews were deemed the most appropriate method for data collection rather than group interviews. Participants were given the choice of where the interviews occurred and four interviews took place in the participant’s home, one at my home and one in an office in their work environment outside of working hours.

3.3.5.1 Data collection: Interviews

The interviews with the nurses were audio-recorded (Panasonic model RR-US300 IC Recorder) and the length ranged from one to two hours. The interviews were transcribed verbatim by me and took an average of eight hours for each transcript. I then returned the transcripts by mail to each participant to their home address, including a stamped self-addressed envelope, asking them to confirm the accuracy of the content prior to analysis. One participant requested that her transcript be emailed to her. Giving the transcribed interview (or the completed analysis) back to the participant is known as member checking (Morse, 2015), and this was considered a necessary step in case study by Stake (1995). None of the participants requested any changes to the transcripts. My initial intent was to have the interviews transcribed by someone skilled in the art but I made the decision to transcribe all the interviews myself as I felt listening to the recordings over and over again would give me a greater understanding of their meanings as compared to just reading a document transcribed by someone else. This experience of reading and rereading as data is received as an important set of activities in case study research (Zucker, 2009). I also took notes during the interviews with the permission of the participants which proved useful as even when the interview was formally concluded and the tape turned off, most continued to share their stories. Of interest is that a limitation of interviews as a qualitative data collection type is not all people are equally articulate and perceptive (Creswell, 2014). After the transcripts were returned to each participant and
authenticity was confirmed the audio-recordings were electronically wiped. Individual letters of acknowledgment were sent to each nurse, thanking them for their time and willingness to participate in the study.

3.4 Document review

This section describes the retrospective document review and examination of the training package and legislation related to STT. The purpose of the clinical record review was to confirm that organisational policy in terms of following a clinical pathway for care has been adhered to as well as reading additional entries made by nurses during episodes of care (or something to that effect). Both the documentation audit and the examination of the training package were scrutinised to ensure that legislation relating to abortion services in New Zealand revealed no breach of compliance with current guidelines and law.

3.4.1 Documentation audit

A retrospective review of 12 clinical records from women who had undergone STT in the gynaecology ward in the past 12 months was undertaken to measure compliance with documentation relating to patient consent, administration of medications and delivery records as well as completion of organisational patient care pathways that guide practice (Appendix 6 Retrospective Clinical Record Review Audit Tool). Twelve clinical records were selected at random from procedures that had occurred between July and November 2014 but purposely included a mix of records where the procedure occurred following referral from the Foetal Maternal Medicine (FMM) service for foetal abnormality or foetal demise (Induction of Labour under 20 weeks) and the records of women who had a Prostaglandin Termination of Pregnancy (PGTOP 14 – 20 weeks). Each clinical record was stored in a locked filing cabinet in a locked office until it had been analysed and was then returned to the clinical record department in a sealed envelope. The Patient NHI has been removed to maintain anonymity of the women.
3.4.2 The training package

The Self Learning Package (PGTOP/IOL SLP) has previously been described in detail on page 13 in section 1.7 Skills, Knowledge and Training. During the interviews the gynaecology nurses were asked if the content of the package that is currently available was useful or added value to their ability to provide care. I.e. did it provide them with adequate information to confidently and competently provide STT care?

3.4.3 Guidelines and legislation

Guidelines and legislation relating to abortion services in New Zealand were consulted to examine current recommendations relating to training for nurses who work in the provision of abortion care (Abortion Supervisory Committee, 2005). The purpose was to check that the training that was provided to the nurses in the area of study was in line with national standards. The organisation has a commitment to adhere to best practice guidelines and in the absence of actual nursing ones, these are the best we have got. It will contribute to the overall case study as it identifies gap in resources for nurse training.

3.5 Data Analysis

3.5.1 Introduction

In the context of case studies data analysis consists of examining, categorising, tabulating, testing, or otherwise recombining evidence to address the initial propositions of the study (Yin, 1994), although the analysis of case study is one of the least developed aspects of the case study methodology. Yin advised that every investigation should have a general analytic strategy, so as to guide the decision regarding what will be analysed and for what reason. He presented some possible analytic techniques: pattern-matching (compares a pattern which has been established by experience with a predicted pattern. The goal is to see if the two patterns match. If matching occurs, the internal validity of the case study is stronger), explanation-building (a special type of pattern matching which involves analysing case
study data by building an explanation about the case), and time-series analysis (the researcher matches the observed trend using either a theoretically significant trend or a rival trend. The more intricate and precise the pattern, the more the time-study analysis will support the conclusions of the study. Logic models, an additional form of analysis, establishes events over an extended time period, and sets up a cause and effect relationship pattern, whereby an event at an earlier time causes another event to occur (Yin, 2009). In general, the analysis will rely on the theoretical propositions that led to the case study. The initial proposition in this research is that the gynaecology nurses are affected by circumstances that impact on their ability to provide care for women undergoing STT. Incorporating aspects of Yin’s analysis strategy allowed the various data sources to contribute to the overall findings of the study. Other methods will be utilised to compliment scrutiny of the data.

At the heart of qualitative data analysis is the task of discovering themes, depicted by Ryan and Bernard (2003) as ‘abstract, often fuzzy, constructs which investigators identify before, during, and after data collection’ (p. 87). In qualitative study the data collection and analysis may occur concurrently (Sandelowski, 2000; Baxter & Jack, 2008; Zucker, 2009) and as I was conducting one interview I was already analysing the transcript from the previous one. According to Ryan and Bernard (2003) looking for themes in written material can occur in a number of ways and typically involves ‘pawing through texts and marking them up with different coloured pens’ (p. 88). They recommend repetition as one of the easiest ways to identify themes as well as looking for local terms that may sound unfamiliar or are used in unfamiliar ways. An alternative scrutiny-based approach works in reverse from typical theme identification techniques so instead of asking, what is here, we can ask, what is missing? Researchers have long recognised that much can be learned from qualitative data by what is not mentioned (Ryan & Bernard, 2003). The themes are then further coded by an inductive approach, working from the specific to the general. Coding is the process of organising the material into chunks or segments of text and assigning a word or phrase to the segment in order to develop a general sense of it and a strategy for data analysis was described by Creswell (2014). This approach recommends using a linear, hierarchical approach building from the bottom to the top in seven steps; organising and preparing data for analysis, reading through all data, coding the data (by hand or computer), generating themes, interrelating themes and
interpreting the meaning of themes. Validating the accuracy of the information occurs at every step and is considered the seventh step which provided further clarity to the process and helped keep me on track when I was tempted to stray. I particularly valued how the focus was on the researcher as an active participant in the research process and this was particularly so during the interviews. Transcribing the interviews took time and required me to listen closely to what was said, often playing the recording back several times to ensure accuracy. Moving between the data sources gave me a sense of being truly immersed in the data and encouraged me to write in my reflexive journal. In between analysing the interview transcripts, I undertook the documentation review.

3.5.2 Triangulation

A hallmark of case study research is the use of multiple data sources, a strategy which also enhances data credibility (Yin, 2003). The most important advantage of using multiple sources of evidence is the development of converging lines of inquiry – a process of triangulation (Yin, 2009). Triangulation involves using multiple data sources in an investigation to produce understanding (Cohen & Crabtree, 2006). Triangulation is the combination of at least two or more theoretical perspectives, methodological approaches, data sources, investigators or data analysis methods with the intent to decrease, negate, or counterbalance the deficiency of a single strategy, thereby increasing the ability to interpret the findings (Thurmond, 2001). Although some see triangulation as a method for corroborating findings and as a test for validity as this assumes that a weakness in one method will be compensated for by another method. This, however, is controversial according to Cohen and Crabtree (2006). A single method can never adequately shed light on a phenomenon and using multiple methods can help facilitate deeper understanding. Yet Baxter and Jack (2008) warn of the dangers of collecting overwhelming amounts of data that require management and analysis. Triangulation was employed in this study to increase confidence in the data by the use of a variety of data sources; semi-structured interviews, retrospective clinical notes review and evaluation of a teaching resource. For example, the interviews with the nurses may reveal that they had issues with completing documentation associated with the STT procedure and audit of the clinical records
might confirm compliance with the multidisciplinary care pathways was poor. During the interviews the nurses might divulge dissatisfaction with how the patients are allocated and the clinical record audit may confirm that the same nurses are undertaking the procedure. Review of national guidelines around training for nurses engaged in second of trimester termination of pregnancy care may recommend specific expectations however what is provided may not be adequate.

3.5.3 Rigour/Reflexivity

Rigour is the integrity in which a study is conducted and evaluating the quality of research is essential if findings are to be utilised in practice and incorporated into care delivery (Noble & Smith, 2015). Several strategies were used to enhance the credibility of my research, including the aforementioned triangulation, inviting participants to comment on the accuracy of the interview transcripts (member checking), use of extracts from the interviews to illustrate the experience of the participants, the researcher keeping a reflective journal and reflexivity on the researcher’s own perspectives. Reflexivity means that researchers reflect about how their biases, values, and personal background, such as gender, history, culture, and socioeconomic status, shape their interpretations formed during a study (Creswell, 2014). This validity procedure uses the lens of the researcher but is clearly positioned within the critical paradigm where individuals reflect on the social, cultural, and historical forces that shape their interpretation (Creswell & Miller, 2010). Validity also relates to the honesty and genuineness of the research data (Anderson, 2010). Becoming a skilled researcher and understanding the link between position and derived insights is only accomplished through action and reflection (experience) and Gallais (2008) describes the concept of insider/outsider research whereby her objectivity shifts when she goes from a familiar research setting (insider) to an unfamiliar setting. We have insider status when we share some group identity with our participants – for example, a male researcher researching men would be an insider; we have outsider status when we do not share some group identity with our participants – for example, a Caucasian man researching Asian men would be an outsider). For any research, we are likely to have multiple insider and outsider positions (Clarke & Braun, 2013). This particularly resonated with me as I too had
moved outside the familiar study (and employment) setting part way through my study to undertake a 12-month seconded position to another service. During the study I kept a research or reflective journal to record my thoughts, feelings and experiences and how this affected my stance will be discussed more in future chapters.

3.5.4 Personal Reflection

Although sharing excerpts from a reflexive journal is not traditionally a component of case study methodology I felt that I could justify the inclusion as adding further rigour and interest to the study as well as being an additional source of data (archival records) under the category of triangulation. I acknowledge that researcher bias and lack of objectivity (Myers, 2000) is considered a weakness of this methodology however I felt that if keeping a reflective journal or diary was acceptable then using the contents was permissible to facilitate deeper understanding from another perspective, albeit my own. Yin (1994) held the belief that the researcher needs to rely on experience and the literature to present the evidence in various ways, using various interpretations. Therefore, the use of personal reflection is my interpretation of presenting my experiences as evidence using a unique approach.

Prior to the interviews being conducted I was offered and accepted a secondment to the corporate quality and patient safety service for 12 months to facilitate amalgamation of nursing services in preparation for migration into a newly constructed healthcare facility. Whilst I questioned the timing in terms of my study, I felt this was an opportunity too good to be missed as it would allow me to utilise my clinical, teaching and interpersonal skills as well as challenging me both personally and professionally. However, the challenges revealed themselves in different ways as I discovered. Initially I was concerned what effect that working away from the gynaecology area may have on my study, but on the other hand I experienced an increasing sense of clarity when being physically disconnected from the gynaecology setting and in fact when I returned to the area I felt more like a visitor than a member of the team. What follows is an extract from my journal.

“I’ve moved outside [study area] to a 12 month secondment in [another service] which if I’m honest, has come at a perfect time. But oddly, I now feel like a visitor to an area where I was previously a friend, colleague, team member and worker
for more than five years and this both saddens and intrigues me. Of interest is how this has changed the way I view the research. I feel more like a consumer of a service and less of a participant in the study. This has changed my objectivity. The greatest epiphany was that I felt I was now looking at the SST process more from a consumer’s point of view than I had previously and whilst we as healthcare providers believe that we keep the patient at the centre of care I felt I was really now seeing it through the patient’s eyes. This glimmer of reality confirmed my initial theory: if we could make it better for the nurses then the patients should reap the benefits. Ironic that I had to walk away to see that” (2015).

3.6 Summary

This chapter described the study design and the choice of case study methodology and explained how it will be used to answer the research question: what are the issues faced by nurses caring for women undergoing STT of pregnancy in the gynaecology inpatient setting in a tertiary hospital? Case study methodology is a systematic inquiry into an event or a set of related events which aims to describe and explain the phenomenon of interest, in this case the issues affecting nurses care of women undergoing STT. The reason for the study is because it is hard to care for women undergoing STT in the gynaecology ward when you have a mix of patient acuity. Because it is ethically challenging, emotionally draining, bureaucratically demanding (in terms of paperwork) and there is little or no training or ongoing education, no formal support in terms of debrief and wellbeing support and more often than not the same nurses are providing the care. Therefore, we need to know what issues arise for nurses so that we can develop structures, processes and training to support them in their practice with a view to maintaining high quality care.

I also explained how I collected data using retrospective review of 12 randomly selected clinical records and semi-structured face-to-face interviews with six gynaecology nursing staff who were selected because they had experienced the phenomenon of interest. The potential for power imbalance in the researcher-participant relationship was identified and how this risk was addressed and mitigated and finally, how I would analyse the data whilst maintaining an ethical, transparent and
honest stance was stated. For case study the most important use of documents is to corroborate and augment evidence from other sources such as the interviews which is termed triangulation. Therefore, the retrospective medical record review examined compliance with the guidelines which are based on best practice from legislation and research. The following chapter presents the findings of the study using excerpts of narratives from the participant's interviews and the researchers' reflective journal to provide context.
Chapter Four: Findings

4.1 Introduction

This chapter will describe what has emerged from the interviews with the gynaecology nurses. I will also describe the characteristics of the nurses I interviewed. The findings of the retrospective clinical record review of 12 women who had undergone STT in the gynaecology ward in the preceding 12 months of the study period and scrutiny of the usefulness of the Prostaglandin Termination of Pregnancy/Induction of Labour in the second trimester (14-20/40 weeks) self-learning package (PGTOP/IOL SLP) for the nurses will also occur. Caring became the overwhelming principal category and brought me back to my starting point of “What are the issues for nurses caring for women undergoing second trimester termination of pregnancy in the gynaecology setting?” Caring about the Women and Caring about the Nurses became the sub-categories. Several themes supported the main categories and as I read the interview transcripts and thought about the motifs I was identifying, several themes unfolded and in some cases were common to both main categories. The themes were: skills, knowledge and training, time, patient allocation and the environment. The findings are presented in one chapter because the interviews with the nurses provided the richest data. The chapter was divided into two sections: the interviews and documentation review and the audit, followed by a summary.

4.2 Section A: Interviews

The interviews began by my asking each nurse to tell me about her experience of caring for women undergoing second trimester termination of pregnancy. The next section contains their responses which have been written exactly as they spoke them.

4.2.1 Caring about the women

My original thinking was that care of the women was distinct from caring about the women and comprises the physical components or provision of patient care; safe,
professional and competent practice (Nursing Council of New Zealand, 2007), because I believed that a nurse can give care to a patient while not actually caring about them, their feelings or their emotional needs. This I found to be unsubstantiated as evidenced in the testimonials from the nurses I interviewed. The nurses in the study both cared for and about the women by showing sympathy, respect for their feelings and their experience, as well as aiming to give excellent physical care under sometimes challenging circumstances which are described in the quotes from the nurses. To provide care it would seem appropriate that a nurse receives training about the tasks she is expected to undertake and one of the interview questions specifically asked participants what kind of training they received.

This section will examine the themes that underpinned the sub-categories; skills, knowledge and training, the learning package, time, patient allocation and the environment. Within the themes there were sub-themes; secrecy vs privacy, professionalism, professional responsibility vs conscientious objection, fixtures, fitting and furniture, language and documentation. I will use direct quotes from the nurses I interviewed, using a pseudonym to protect their identities.

4.2.2 Skills, knowledge and training

A number of guidelines and text books were read for recommendations around training of nursing staff who worked in abortion care, and specifically second trimester termination of pregnancy facilities (Abortion Supervisory Committee, 2009; Abortion Law Reform Association of New Zealand, 2014; Ministry of Health New Zealand, 2013; Nursing Council of New Zealand, 2007, 2012; World Health Organisation, 2012). None of the literature provided much detail in terms of standard operating procedures for second trimester termination of pregnancy (STT) care, however some did acknowledge that nurses working in abortion care required training that incorporated specifically physical, mental, emotional, cultural and spiritual aspects of abortion care (Abortion Supervisory Committee, 2009). Basic counselling skills, including an understanding of the need for clear boundaries and mechanisms for debriefing and reviewing practice were also considered important.

Every nurse I interviewed for my study stated that without exception they had received no formal training specific to abortion but had learnt how to look after women
having STT by working alongside more experienced nurses until they were ready to work independently, as these excerpts describe.

*I learnt on the job* (Nurse C). *I learnt by working in a buddy system with experienced nurses* (Nurse A). *See one do one. There wasn’t anything. I was shown by a senior member of staff. The procedure was explained probably about three times and after than we had to just do it ourselves.* (Nurse D).

Others described fear when first doing terminations.

Whilst initially I was probably a wee bit scared of it, there was no formal training so you had a mentor, you found a staff member probably that you liked or you liked her way of working or admired the way the patients were well looked after… or was just caring and nurturing. [She too identified a mentor but chose carefully.]
*I never followed the ones that weren’t going to do a good job for me to learn from.* (Nurse B)

One of the nurses was fortunate as she had several experienced nurses to learn from.

*I did have lots of support doing it, I had [nurse name] there and I had [nurse name] there and [nurse name] was there so they are three very experienced people that had done terminations for much longer than I had and I think that I had never done them before, I had done surgical terminations previously but not as an induction of labour up to 20 weeks. No, I hadn’t done that.* (Nurse D)

Several of the nurses who trained by this method, now mentor others. Nurse B said, ‘I was trained by a mentor and word of mouth and I now know it off pat’, whilst Nurse C stated: ‘See one do one… Learnt on the job. No training and I now mentor’. One nurse described how she felt unprepared for how emotionally draining it would be particularly caring for these women. ‘You get no training and the IOLs (induction of labour) are intense emotionally’ (Nurse C).

These nurses did not have access to guidelines to inform best practice. ‘When we started we didn’t have the package like we’ve got now. There were protocols but they weren’t as informative’ (Nurse E), and subsequently there was no standardised way of working. ‘I did a couple with one of the senior nurses but there was inconsistency
with practice’ (Nurse F), who described these inconsistencies with practice as ‘challenging’.

4.2.3 The learning package

The Self Learning Package (PGTOP/IOL SLP) was created in 2013 because no training strategy existed to make sure that gynaecology nursing staff were both confident and competent in provision of second trimester termination of pregnancy care (STT). The package was structured according to the organisation’s self-learning package education framework and included learning aims and objectives linked to written and practical assessment and evaluation components. The primary aim was to provide contemporary information for nurses who work in gynaecology services, on accepted practice, professional responsibilities and legislation specific to the provision of care for women presenting for PGTOP/IOL in the second trimester.

Many of the nurses felt it would be inappropriate to expect nurses new to gynaecology to care for these women so they would not be doing the package immediately.

No, I don’t think it would be fair. I would say you should be in gynaecology working and dealing with all the other sorts of conditions that women get, seeing their pain and controlling them, I would say for a year. (Nurse B)

One nurse referred specifically to new graduate nurses in their first year of practice,

As they are not directly involved in any TOP’s [termination of pregnancy] for the first year, but they will have had the opportunity to observe and listen to conversations between the team and the nurses. At the very least it will have given them time to process the information and to explore their own feelings around the procedure so that they are at peace with the decision themselves. (Nurse D)

In addition, while the nurses were undertaking training it was important that their patient loads were significantly reduced or ideally they had no other patients, particularly if you were trying to teach someone,

For the person that is inexperienced to have other patients as well, it’s setting you up to fail really. Well it’s kind of a practical skill, like you wouldn’t go to a
hairdresser that had just learnt how to cut hair from a book you know, and I think it's the same thing with this labour business. (Nurse B)

The Self Learning Package (SLP) provided guidance and was described as helpful by one participant; ‘The SLP gives you an overview of what you are doing because you want the information before you get there so you feel more comfortable and confident’ (Nurse F). However, whilst the SLP was useful, it did not provide the clinical reality staff felt was very important.

That learning package was great for those that had no idea but the actual physical looking after someone you needed to do it and you need to do it with someone beside you because it's quite frightening watching someone, you know?… and even seeing the foetuses, it's kind of a bit… uurrggh. (Nurse B)

4.2.4 Time

The concept of time came up repeatedly during the interviews including the boundaries that surrounded gestation timeframes which dictated the location where the women received care. Originally when I thought about ‘what a difference a day makes’ I considered it in terms of where the women went for the procedure, whether to the gynaecology ward or birthing unit, who cared for them and the language the healthcare professionals used. At the study site the gynaecology ward nurses routinely provide care for women having PGTOP/IOL STT procedures up to 20 completed week’s gestation. Women who were over 20 weeks, even by one day, were admitted to the birthing suite for an Induction of Labour (for foetal death or foetal abnormality) where they were cared for by a midwife and the words baby and mother were used. STT for unwanted pregnancy did not occur over 20 week’s gestation in the study setting. The difference of a day also came to mean that one day you’re pregnant and then you’re not. One of the nurses talked about how when the women walked out of the ward they walk out a different person, ‘they’ve got no tee-shirt’ (Nurse D) with nothing to show for the pregnancy. Yesterday they were pregnant but today they’re not.
Meanwhile, back in gynaecology, time was marching on for Nurse B and her colleagues. ‘There weren’t enough hours to do everything that had to be done and too many people needing too many things at once’. All the nurses felt frustrated at being unable to give enough time to the women having an STT procedure as well as to the other patients they had been allocated for that shift. It was particularly difficult during the first hour after the women were admitted (usually at 0700) on the second day of the two-day procedure. After welcoming the woman to the ward and orientating her to her room the nurse took a set of recordings, checked consents were completed and medication charted. Before she could start administering medication the nurse had to find a doctor to insert an intravenous line as only a few nurses in the ward could cannulate. Any inaccuracies in the documentation or difficulty locating a doctor could delay the start of the procedure and this would have a flow on effect to giving care to other patients, including medication administration, and the day in general. There were times when nurses missed meal breaks or stayed after their shift had ended to complete paperwork and sometimes nurses stayed after their shift was over to continue to provide care to women. Nurses C and B told me about an induction of labour for a foetal abnormality they had worked on together, the first for both of them that occurred 13 years ago which they both referred to during their interviews. ‘I think we were on a seven to three thirty and we didn’t get away til four thirty in the afternoon because we didn’t want to leave her you know?’ (Nurse C).

4.2.5 Patient allocation

In the study setting, nurses cared for other patients as well as women having STT during their eight-hour shift. Most found it challenging.

*The most frustrating thing was not being able to be allocated a proper workload so while you were dealing with these people and trying to give them everything, you were given other patients to look after though you were reassured as years went on that wouldn’t happen but it did and so because of the nature of the ward if you were the senior one you may have had the red dot (a red dot is placed next to the name of a nurse on the roster which signifies they are the nurse in charge of the shift) and you may have been in charge staffing wise, and allocation for the other nurses, you know mentoring them, you may have had the sickest
oncology patient and then you had the lady delivering as well and needing you, you just couldn’t possibly cover acute admissions, sick patients and give a proper service to that woman. (Nurse A)

The result was the knowledge that the patients missed out. ‘Oh they definitely did. Absolutely, how could they not? You couldn’t do all of that, you can’t be everything to everyone can you?’ (Nurse A).

One nurse described a situation where trying to meet the needs of multiple patients became difficult for a colleague.

[Nurse name] who was relieving one day had a terrible situation where she had quite a big caseload, and the lady kept calling her and she was there on her own … and she just wanted constant reassurance, someone to be there and she got pain more or less straight away, because she had a partner and then it broke up and I think there was a lot of emotional pain there. (Nurse B)

This experience was shared by other nurses and most referred to the promise of a reduced workload to allow them to provide one-to-one care to the STT women.

It’s not always easy because obviously if you do have a delivery right in the middle of when you are looking after people requiring post-op surgical cares it is really difficult. I mean, we were sort of told, maybe one-on-one you know, but that’s never really happened… I think maybe once you know in the time I’ve been here so you just have to get on with it. (Nurse C)

Two nurses said they would make sure they took a lesser patient load or not over burden themselves with high acuity patients because they felt not to would compromise patient safety. In this situation they were confident their colleagues would ‘pick up the slack’ however that depended on who they were working with, their experience and how busy the ward was. ‘Colleagues can help but if they’re busy it is hard’ (Nurse F).
4.2.6 Environment

The impact of the environment on the work of the nurses and the care of the women was not only dependent on the physical layout of the ward but was also influenced by the culture of the ward, ‘the beliefs and practices common to any particular group of people’ (Nursing Council of New Zealand, 2012). Within this section I will include findings about how the cultural environment of the ward influences language, how patients are allocated and to whom, and where they are positioned. What some nurses said about the physical ward space, equipment or furnishings will also be disclosed.

4.2.6.1 Secrecy vs privacy

The gynaecology ward comprises of 27 patient beds, consisting of single, double and triple bed rooms, all with ensuite toilet and shower. Patients undergoing STT are allocated single rooms, located as near as possible to the ward entrance and ward office and whenever feasible as far away as practicable from inpatient mothers and babies. This segregation was intended to spare the feelings of the STT patients so they did not have to walk the length of the ward to get to their room, potentially past rooms where babies could be heard or meeting someone they may know. Placing the women in a room near the ward office also meant that staff could respond quickly when the woman rang or if staff needed assistance. Every woman admitted to the gynaecology ward is given the option of whether they have their name displayed outside their room or not and sometimes the STT women request anonymity.

All the nurses were committed to making the women’s experience as least traumatic for them as possible and several mentioned that to do this they would try to keep the number of personnel involved in their care to a minimum to maintain privacy.

*I make sure I bring the same person in with me, so I say when I go into the room, “Oh look this is [Nurses name], she’s working with me today, and if I’m not here [Nurses name] will be”, so that the patient is aware I’ve flagged someone else to come in.* (Nurse D)

By doing this they were reducing the opportunities for the woman to meet someone new and having to explain their story over again. However, for others the option of not putting their name on the door in case someone found out the woman
was in the ward, was also about keeping the women’s secret and described as ‘secret squirrel’ by Nurse B. For some women time inside their room is their time, where they are still pregnant and outside the room is reality and once they move outside they face the reality of where they are and what is happening.

Nurse A talked about STT being a very lonely and isolating experience for both the nurse and the patient because potentially for a large part of the shift there was only you and the patient in a small space behind a closed door and it was only when “it all goes wrong” that you end up with someone else in the room. Medical staff may see the woman at admission to put an intravenous line in but would not see them again unless there was a problem so they may never have any interaction with the woman at all unless they are called in an emergency.

4.2.6.2 Professionalism

Caring for patients requires nurses to be professional and abide by the policies set down by their governing professional body. In New Zealand this is the Nursing Council of New Zealand whose primary function is to protect the health and safety of members of the public by ensuring that nurses are registered, competent and fit to practise (Nursing Council of New Zealand, 2012). During the interviews the nurses talked about ‘the job’ of caring for women having STT whilst maintaining a professional stance. ‘That’s just part of the job, you’re there doing a job and you just have to remember it’s a job you just have to do what you need to and then go home’ (Nurse F). Others saw professionalism as providing a good service, being professional by providing safe care such as identifying drug allergies and responding appropriately to changes in the woman’s condition. ‘It’s a nursing responsibility to make sure that the woman is looked after professionally and not jimmed into a corner then told to get on with it’ (Nurse D). Being professional was also considered to be about not letting your personal beliefs of judgments affect the care that was provided and definitely not letting the patient know. ‘Whether I agree personally I don’t show that to them…I treat them all the same’ (Nurse E). The notion of treating the patients all the same was shared by many of the nurses or expressed in a slightly different way as, ‘I suppose you would want for the patient what you would want for yourself and treating them as
you would want to be treated and it doesn’t get any more basic than that really’ (Nurse D).

All the nurses talked about respecting the choice the women made in deciding to terminate their pregnancy. Several talked about being pro-choice but not necessarily pro-abortion. Whilst they had their own opinions and beliefs they would never share these with the women and preferred to maintain a professional persona of neutrality.

*Probably the thing that gets me the most is the fact that it’s a life that could be given to couples that desperately want children and here we are terminating perfectly healthy children. Yet we’ve got women that come through and it’s their choice and you know you have to respect that but you still have your opinions on it but you would never reflect those opinions on to the patient.* (Nurse D)

This view was shared by Nurse E who said, ‘*Keep it to yourself whether I agree personally I don’t show that to them. They wouldn’t know, I treat them all the same*.’

Three participants voiced empathy for the women and Nurse E talked about not passing judgment about what the women are doing because ‘*I think myself fortunate that I have never had to be put in that situation and had to make that decision so I respect them. I don’t envy them having to make these decisions because it wouldn’t be easy*.’ This included hoping that if it was their daughters or son’s partners in this situation that they would receive kind, safe and professional care. Nurse B aimed to be welcoming, warm and nurturing and ‘*if they were younger I would treat them like my daughters if they were in pain, you rubbed their backs, and you had physical contact*.’

Many nurses shared their experiences of building up a relationship with the woman over the duration of the procedure and wanting to make their experience as least traumatic as possible, describing the event as ‘*the worst day of their life probably just about*.’ They respected the woman’s privacy by limiting the number of staff the woman came into contact with because some didn’t want other people in the room although at times this was problematic. For example, Nurse D said how hard it was when you have someone who needs emotional support but other patients need you too.
You’ve already made an attachment or that person has made an attachment to you and they might ring a bell and someone else goes in and they say “Oh no, can I see the other nurse”, because you’ve sort of been through the worst of it. (Nurse D)

Handing over care was challenging depending on which stage the women were in the procedure. Nurse D described ‘the pleading look in their eyes but you just have to hand over because you can’t stay there forever and people can’t be dependent on you’.

4.2.6.3 Professional Responsibility vs Conscientious Objection

Those with opposing ethical positions on the status of the foetus and the legitimacy of abortion have to appreciate the force of the ethical argument put forth by the other side and this is particularly important for health workers who have to deal professionally with people upholding differing value systems (Campbell, Gillett & Jones, 2001).

All the nurses spoke about staff who declined to participate in the STT procedure and while they unanimously respected their colleague’s rights to their own beliefs, they also felt frustrated when the responsibility for care of these women regularly went to the same nurses.

It was frustrating because especially we were having weeks where we were having one every second day and so for three out of five days if you were the only senior on you were getting nominated to do that a lot. I know a lot of the more senior girls get really frustrated with that because I know that it is a big part of the job… I understand and respect individual’s decisions but at the same time coming into this job it is an aspect that is a big part of the job and people need to be aware that well actually, you know it’s not fair on just certain people having to do all of them. (Nurse F)

I asked whether caring for STT women day after day happened very often.

Oh no, it did, it did. Because if you were working with others that didn’t want to do it..., so if you didn’t mind then you were always going to get it. Because when
the allocation came at the end of handover at the beginning of the shift people just put their head down and not say anything and you’d just kind of shrug and say, “Aargh I’ll do it” and so you would end up doing it day after day. (Nurse B)

One nurse described how it felt when staff are employed and they agree to care for women having STT but then change their minds.

That’s quite a tough one too you know, you think that they are employed and your understanding is that when they get employed that they have agreed they are going to care for these women yet once they are here and working you find out later that that’s not correct. (Nurse E)

Many questioned whether those who refused to provide care were working in the right speciality. ‘Are you in the right area then?’ (Nurse F). ‘I just don’t understand it if you are working in that area you have to be able to look after everybody. I am supportive but I guess it is difficult or if you’re the only one’ (Nurse C). Two nurses stated they would rather volunteer for an induction than let someone who is not ready or not willing take it because they were not confident of the standard of care the woman would receive. One nurse thought that unwillingness to participate in termination might in part be due to lack of education.

There was avoidance by some staff because they didn’t agree with the process themselves but didn’t openly front up and say it. They just avoided it if they could and so they neglected to educate themselves as well and wouldn’t seek out opportunities to get educated. (Nurse B)

In some cases, it was the medical staff who objected to provide care and this put the nurses in a difficult position.

There was a lot of resistance from medical doctors as well. They were actually employed to work on the ward and refused to even chart a Panadol for these women. Only for these women. You are supposed to be caring for the women and there you are doing political catch-up between the doctors you know that should never have been something that we had to do. Maybe you might have
been able to coerce them by selling them a sob story but generally they heard termination or induction of labour and they just said no, no I just can’t. No, I won’t take off bloods, no I won’t put in leurs. So much for the ethical oath of keeping people safe. (Nurse B)

This posed a significant problem if there was a clinical emergency in terms of accessing medical support.

A number of the nurses had a preference between caring for women having an elective termination procedure (PGTOP) and induction of labour (IOL) for foetal abnormality or foetal death. Many preferred the elective procedure because they felt there was less emotion involved and because the inductions were subsequently harder to deal with emotionally. One nurse described inductions as ‘morally it’s better if you know what I mean?’ but would still prefer to care for a PGTOP because of the perceived lack of emotion expressed by the woman, whilst another said

Well, in my mind there is a difference but I don’t treat the patient any different…you know, it’s still a loss for them just because they have decided to terminate the pregnancy doesn’t mean they are not sad about it. (Nurse E)

It was accepted amongst the study participants that the PGTOP and IOL processes were the same however conversely they all said that no two patient experiences were the same. ‘I don’t think you can say what will happen with this one will happen with the next one, will happen with the next one’ (Nurse B). IOLs were also considered more resource intensive because these women were given the opportunity to have footprints, handprints and photos taken of their babies. Women having PGTOPs were not routinely offered these services although all women were provided with the option of seeing the chaplain, social worker or Maori Health Worker.
4.2.6.4 Fixtures, fittings and furniture

Whilst the single patient rooms provided privacy, several of the nurses felt that a dedicated, purpose built room would improve the experience of the women undergoing STT in the gynaecology ward. They all made reference to wanting something like the room located in the hospital’s birthing suite that was specially commissioned when the hospital was built in 2005, where women undergoing IOL from 20 weeks gestation were cared for.

*I think it would be nice and I think the idea was mooted a while back is to have like a garden room that is already set up specifically for them…I think it needs to be brought up again. It’s got more room for the support person and their bits and pieces.* (Nurse E)

The special room in birthing suite was large, with a double bed, ensuite toilet and shower, comfortable seating, tea and coffee making facilities, designed as a place where families could stay together in a less clinical environment. Although the room was within the birthing suite it was located at the very end of the ward to reduce the sounds from labouring women who were birthing live children. It had one of only two opening windows in the entire hospital, intended to allow the spirit of the recently departed to be released to wherever it needed to be. The other window is in the Whanau (family) room of the Neonatal Unit. A baby preparation room was situated within the room where footprints or laboratory tests could be performed without the babies having to be separated from their families for any length of time and nurses didn’t have to walk through the ward with the baby.

The small size of the single rooms in the gynaecology ward did not encourage the women to move around, which was a strategy used by many of the nurses; using gravity to progress labour by optimising descent of the foetus. However, Nurse D felt there were other reasons why the women did not want to mobilise. ‘*A lot of them don’t want to [move around] because they know its progressing labour and they are still pregnant…they don’t want to be not pregnant…they still hope*.’ Other nurses encouraged women to sit on a chair with a toilet seat and bedpan below, commonly called a commode or a toilet chair.
Yes, but we’ve changed it to a ‘birthing chair’ [laughs], but it’s not, it’s a commode. It’s just a little bit barbaric really, you think we could pull something out of the hat and make things just a bit easier. (Nurse D)

Nurse B said ‘They don’t like the thought of sitting in the chair because they think it’s a toilet…especially the inductions’.

4.2.6.5 Language

Many nurses followed the lead of the mother when referring to the baby or foetus, although Nurse D said

I always flatly tend to call it a baby. Basically I think that the women that are terminating their pregnancies need to know that it’s actually a baby they are terminating, I don’t think that we should pussy foot around that idea at all because I don’t want them coming back and have another one.

Whilst this may sound harsh I believe the nurse was demonstrating a consistent approach to the language she uses and bringing a sense of reality in the situation, rather than sounding punitive. Most commonly, the nurses used the terms baby for an induction of labour and foetus for termination of pregnancy, although they were also guided by whatever language the mother used. For one nurse the choice of language extended to what she called the procedure itself, preferring to use the term miscarriage rather than termination when in the public domain. She explained the reason for this was because of privacy as well as a desire to show consideration for the feelings of the women.

I thought it was a better privacy cover, you know you might have someone come in acutely that is miscarrying and they wouldn’t want to know that there was someone having a termination in the room next door so you would call everyone a miscarriage out in the corridor or public places or in the shared office. So when I say miscarriage I mean termination. (Nurse B)
The selection of language extended to the documentation used in the STT procedure. Which documentation pathway was used was dependent on the reason for the STT, either the Induction of Labour pathway or the Prostaglandin Termination of Pregnancy pathway.

The different pathways were intended to spare the feelings of the IOL patients because there had been complaints from patients about staff language. They felt the doctors were using terminology that was offensive so there was a change of wording in the forms. (Nurse B)

The terminology referred to was staff calling the women’s baby a foetus or referring to products of conception rather than a baby.

4.2.6.6 Documentation

The nurses had mixed feelings about the documentation required for STT. Some nurses found the pathways easy to use. ‘The documentation is a lot easier than what it used to be because we’ve got pathways and packages that direct nurses on the correct documents that they need to use for each induction’ (Nurse E). Only having only to tick a box and sign to confirm you had completed a task was considered useful as it saved time.

The pathways were certainly easier when you were writing up at the end of the day. Writing in the clinical notes was difficult if everything was happening all at once and you had other things going on with your patients … trying to remember and sometimes you just had to take yourself away and think “ok, what happened there”. (Nurse C)

However, the pathways had limitations such as not allowing the women’s story to be told because there was not much room to write. One nurse talked about ‘those silly pathways’ [which] ‘didn’t leave room when things weren’t straight forward’ (Nurse F). It would seem that the pathways were also intended to guide practice if there was a knowledge deficit.
Because we were all trained by word of mouth there was nothing on paper either so you just do what you do because you know it works so that’s why we were setting about to do the pathways so that the next girls would have prompts and the less educated or less experienced would have prompts so at least they were covering the basic things to provide a good service.  (Nurse B)

However, whilst most of the nurses stated that no two patient experiences were ever the same the use of a generic pathway would indicate that the outcome is predictable in the majority of cases.  ‘I don’t think you can say what will happen with this one will happen with the next one, will happen with the next one’ (Nurse B).

4.2.7 Summary of this section

Time was something that all the nurses wanted more of.  They felt unable to deliver the standard of care they believed the women in the gynaecology ward deserved because there were so many challenges on their time and the nature of the work meant that they were interrupted often. Allocation of patients was an issue because they were having to juggle the needs of both the women having STT with the other ward patients and felt all the patients were missing out on quality care. Although the SLP provided some information about care of women having a second trimester termination of pregnancy, they believed the clinical reality was best learnt by working alongside an experienced nurse but staffing issues meant that this did not always occur. Whilst they respected the beliefs of those nurses and doctors who did not want to participate in abortion care they were nevertheless frustrated that responsibility for the care of the women fell to the same nurses, yet would rather volunteer for a PGTOP/IOL than let a nurse who wasn’t confident or willing provide care. Some nurses would prefer to care for a women having an elective PGTOP rather than an IOL as they felt it was emotionally less difficult but others felt quite the opposite and stated a preference for IOL from a moral standpoint. Opinion about the usefulness of the MCPs was varied but all agreed the amount of documentation they were required to undertake was significant. Despite these obstacles, the nurses were committed to providing the women with the best experience she could hope for in the circumstances and respected that the decision made by the women did not come easily.
4.3 Section B: Documentation review and audit

4.3.1 Document Review

A component of the research was a retrospective review/audit of the clinical records of women who had undergone second trimester termination of pregnancy in the gynaecology inpatient setting. The aim of the audit was to confirm that documentation had occurred according to service and organisational policy and clinical notes were reviewed for completion by the researcher using an audit tool to record data (Appendix 6 Retrospective Clinical Record Review Audit Tool). To determine whether the nursing staff involved in the provision of care had undertaken the PGTOP/IOL Self Learning Package (SLP) the staff training database was searched for evidence of completion of the SLP.

Twelve clinical records were selected at random from procedures that had occurred between July and November 2014 and purposely included records where the procedure occurred following referral from the Foetal Maternal Medicine (FMM) service for foetal abnormality or foetal demise (Induction of Labour under 20 weeks) and the records of women who had a Prostaglandin Termination of Pregnancy (PGTOP 14 – 20 weeks).

4.3.2 Audit

Of the 12 cases reviewed four were induction of labours and eight were PGTOP ranging in gestation from 12 weeks to 19 weeks and 6 days gestation. Eight (66%) of the nurses caring for these women had undergone the training package at the time of providing this care, however only four (33%) of the clinical notes provided complete documentation (Table 2).
The gynaecology service uses a combination of free text and multidisciplinary care pathways (MCP) to document the patient’s clinical journey, in addition to generic medication charts and consent for treatment forms. For a STT procedure a MCP PGTOP (Prostaglandin Termination of Pregnancy) pathway is used and for a STT for foetal abnormality or foetal demise a MCP Second Trimester Induction of Labour (IOL) < 20/40 pathway is used. Documentation in the clinical records was not complete in eight out of 12 records. Omissions included: non-completion of the medical or initial nursing assessment, medical consent for misoprostol not signed, medication chart signatures missing and in one case the second signature for identification of a patient prior to administration of a blood product was absent. One woman underwent an Evacuation of Retained Products of Conception (ERPOC) and experienced an estimated blood loss of 1500mls, however the postoperative handover from the perioperative nurse to the ward nurse was not documented. On one occasion the MCP Second Trimester Induction of Labour (IOL) < 20/40 pathway was used for a patient who underwent a PGTOP, which was potentially confusing for staff and the patient as the language differs between the two documents. For example, this pathway refers to the baby throughout, whereby the MCP PGTOP uses the term foetus and given the circumstances for the termination could be upsetting for both the woman and nurse. On the adult observation chart the Early Warning Score (EWS), an assessment tool used to assist with the recognition and appropriate management of clinically deteriorating patients, was not consistently undertaken, specifically the pain score, sedation score and phlebitis score. Entonox (inhaled mixture of 50% Nitrous oxide

<table>
<thead>
<tr>
<th>Number</th>
<th>Date of Procedure</th>
<th>Gestation (40 weeks)</th>
<th>PGTOP</th>
<th>IOL</th>
<th>SLP Completed</th>
<th>Documentation complete</th>
<th>Comments</th>
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<tr>
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<td>Jul-14</td>
<td>15</td>
<td>x</td>
<td></td>
<td>Yes</td>
<td>No</td>
<td>twin pregnancy</td>
</tr>
<tr>
<td>2</td>
<td>Sep-14</td>
<td>14</td>
<td>x</td>
<td></td>
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<td>No</td>
<td>one day procedure as lived more than one hour away</td>
</tr>
<tr>
<td>3</td>
<td>Aug-14</td>
<td>12</td>
<td></td>
<td>x</td>
<td>No</td>
<td>Yes</td>
<td>uneventful procedure</td>
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<tr>
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<td>Oct-14</td>
<td>17</td>
<td></td>
<td>x</td>
<td>Yes</td>
<td>No</td>
<td>Minor</td>
</tr>
<tr>
<td>5</td>
<td>Aug-14</td>
<td>15</td>
<td></td>
<td></td>
<td>No</td>
<td>No</td>
<td>retained placenta → Theatre for removal under general anaesthetic</td>
</tr>
<tr>
<td>6</td>
<td>Oct-14</td>
<td>16</td>
<td></td>
<td>x</td>
<td>Yes</td>
<td>Yes</td>
<td>retained placenta → Theatre for removal under general anaesthetic</td>
</tr>
<tr>
<td>7</td>
<td>Sep-14</td>
<td>16</td>
<td></td>
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<td>No</td>
<td>uneventful procedure</td>
</tr>
<tr>
<td>8</td>
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<td>19+6/40</td>
<td>x</td>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Baby showed signs of life for 60/60. Post Partum Haemorrhage transfer theatre</td>
</tr>
<tr>
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<td>Nov-14</td>
<td>18</td>
<td></td>
<td></td>
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</tr>
<tr>
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<td>17/40</td>
<td>x</td>
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<td>No</td>
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</tr>
<tr>
<td>11</td>
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<td>16/40</td>
<td></td>
<td></td>
<td>No</td>
<td>No</td>
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</tr>
<tr>
<td>12</td>
<td>Nov-14</td>
<td>15</td>
<td></td>
<td>x</td>
<td>Yes</td>
<td>Yes</td>
<td>manual removal of placenta</td>
</tr>
</tbody>
</table>
with 50% oxygen indicated in adults and children for analgesia) was prescribed by a doctor and administered to one patient but was not signed for by the nurse on the medication chart.

4.3.3 Summary of this section

The findings of the audits would indicate that care is not always accurately recorded and in some instances those omissions had the potential for harm, both physical, such as when the consent for misoprostol was not signed by the doctor but the medication was still administered to the patient, and psychological, as in the instance where the PGTOP MCP was used instead of the IOL pathway. The absence of the second signature prior to the blood transfusion contravenes organisational policy around medication safety and second checking of blood products. This would suggest that despite the creation of a MCP specifically designed to avoid duplication and error, errors were occurring, primarily in the form of omissions.

4.4 Caring about the Nurses

In much the same way that I originally thought caring for and about the women were two distinct subjects, I also assumed the same would be true for the nurses. Namely that they would be catered for in terms of training to undertake the physical or task orientated component of their role but that scant attention would be paid to how they were supported psychologically. The first part of the findings chapter revealed issues that the nurses identified around skills, knowledge and training deficits, patient allocation disparity and documentation. This section of the chapter will report on what the nurses said about the support they received and how they were cared for and about and by whom; themselves, each other and the service.
4.4.1 Skills, knowledge and training

All the nurses in the study had learnt on the job and were committed to sharing their knowledge with the less experienced staff particularly as owing to resignations and retirement some of the nurses who had been doing STT for a long time were leaving the service.

*That’s the shame of it, I know that a lot of that knowledge has left the ward but in the ward today you needed someone that was doing a good job mentoring these people. We don’t get buddied up like that very much, there was just too much going on and not enough staff to do it.* (Nurse B)

4.4.2 Caring for the carers

When asked about what would support nurses undertaking STT, the opinions were varied. ‘I always used to think we badly needed debriefing after difficult, traumatic or upsetting experiences in the ward whether they were the death of a young person or these challenging kinds of termination patients’ (Nurse B). She recalled one occasion when debriefing had been offered but ‘ironically when something quite dramatic did happen in the ward the debriefing was offered on the day when three of us that were involved in the situation couldn’t get there!’ Two of the nurses talked about how in years gone by they would have gone out for a drink after work and that’s where you would debrief. ‘It always happened in the old days’, but because of family responsibilities and busy lives this no longer happened. However, others felt that there were enough options for nurses to talk about their experiences with the senior nurses, hospital chaplain, social workers and the Maori health worker and that offering a more formal process like clinical supervision was not necessary.

*I think it is because we haven’t had any feedback to suggest otherwise. There’s been no complaints or no senior nurses have said the “process is not right” and “things aren’t going well” and we always get good feedback from patients generally.* (Nurse E)

One nurse described an episode following a clinical situation when a representative from the Employee Assistance Programme (EAP) came to speak to the staff involved.
They did get someone in to talk but I didn’t find it that helpful. She was lovely but I find it easier to talk to your colleagues who know the whole story whereas talking to a random it was like “yeah, what do I say now? Ok it was frustrating but I’m not traumatised, I just need to vent about it for a bit”. (Nurse F)

Another felt there is always a place for clinical supervision, ‘making sure that you nurse the patients the correct way and your needs as well as the patients’ needs are met’ (Nurse D). She like many of the nurses voiced concern for the young nurses who may not have much support outside of nursing.

I mean, they can talk to the nurses that are on the ward but sometimes you need to talk to other people and I don’t know where they would go, I don’t know where I would advise them to go. (Nurse D)

She talked about the concept of a support system whereby a junior nurse liaises with a senior nurse regularly when they start doing terminations to make sure they have ‘dealt with it psychologically’ which would lead to ‘protecting our brains so we have healthy minds’. Few of the nurses talked about their work at home and specifically did not talk about the terminations.

4.4.3 Strategies for self help

Several of the nurses described particular elements of the STT role they found challenging and all had developed strategies to make dealing with these situations less difficult for themselves. Nurse D recalled caring for a woman who had given birth eight months prior to a live baby and was now having a termination at 19 weeks gestation, and feeling really upset about it. After talking with one of the other nurses she developed a strategy.

When the baby is born make sure you have somebody else in the room with you particularly with a 15, 16 to 19, 20 week because effectively they are real babies and all they need to do now is grow, it’s just that they can’t survive out of the womb.
She encourages other nurses to do this including when handling the baby.

*I do make sure if there is a later one that someone else comes into the products room with me, does the photos and the handprints, footprints with me, that I don’t do it by myself. I’m sure I’d be fine now but I don’t really want to go back to feeling that way again.*

Handling the foetus was difficult for most of the nurses and Nurse C said that she sometimes thought ‘*it would be nicer to just leave them alone*’ as undertaking footprints and handprints on small and fragile babies was hard. To help her deal with this she would ‘*say a little something over them like “you’re at rest now”…*’ Another nurse said that she reconciled the difficultly [of handling the foetus] by telling herself that ‘*no one wants an unwanted child in the world to be abused or neglected so those things overrode that for me*’ (Nurse A) but another said she because she had been doing it for some time now she manages to cope.

4.4.4 Summary of this section

The nurses I interviewed demonstrated how they cared about their nursing colleagues, particularly those new to gynaecology and second trimester termination of pregnancy, and this included those who would not participate in termination care. Support was mostly obtained from other nurses, usually gynaecology colleagues as they felt only they would understand the uniqueness of what they encountered in their work. There was trepidation by some of the nurses about the usefulness of employee assistance programmes provided by the organisation as their experiences had not been positive. They felt unsupported by management so they developed their own strategies for self-care which were largely reliant on their gynaecology nursing colleagues.
4.5 Summary

The findings presented were the result of gathering and examining a variety of data sources: the transcripts of the interviews with the gynaecology nurses, audit of the clinical notes of women who had undergone second trimester termination of pregnancy, evaluation of the value of the PGTOP/IOL self-learning package and a review of guidelines, policy and legislation relating to second trimester termination of pregnancy. This is known as triangulation, a strategy used in case study methodology which involves using multiple data sources to increase the credibility of the data.

All the nurses acknowledged there were challenges associated with their line of work. For some it was about lack of training, not only for them but for nurses new to gynaecology whilst for others it was difficult dealing with the foetus. Most were frustrated that some staff who were employed to work in gynaecology did not participate in STT which put pressure on them and their colleagues who would. Despite this they all found satisfaction with the service they provided even when they felt constantly time pressured. Most of them could think of things that would enhance their roles, or strategies they employed so they could continue to feel positive about going through the process with the women. For most of the women a STT is something they will experience only once in their lifetime but for these gynaecology nurses, it is an experience they many repeat alongside the women, many times in their careers.
Chapter Five: Discussion and Conclusion

5.1 Introduction

The proceeding chapters have identified the issues that exist for nurses who provide care for women undergoing second trimester termination of pregnancy, through literature review, audit of clinical notes, review of guidelines, policy and legislation relating to second trimester termination of pregnancy and the findings of the interviews from the six gynaecology nurses.

This final chapter will discuss two main themes (caring about the women and caring about the nurses) and four subthemes (skills, knowledge and training, time, patient allocation and the environment) of the study that were identified from the interviews with the nurses and review of documents. This will be supported by excerpts from my reflective journal. A number of assumptions emerged from the interviews that will be presented as a way of further illuminating the key findings, one of which was the notion of a journey shared by the women and the nurses. The implications these findings have for nursing practice will be determined using the Nursing Council of New Zealand Code of Conduct (2012) and Nursing Council of New Zealand Competencies for Registered Nurses (2007), two sets of standards authored by the Council describing the behaviour, skills and conduct that nurses are expected to uphold, as a comparative framework. The strengths and limitations of the study will be considered as well as making recommendations for solutions and further research.

5.2 Key findings of the study

5.2.1 A journey shared

As I read and reread the interview transcripts I felt I needed a way to explain what I had termed the journey which both the women and the nurses were on during a STT procedure. I recognised there were commonalities or shared experiences between the women and the nurses, which is described by Huntington (2002) as, ‘although only one woman will physically experience the termination, psychological and emotional responses can be seen as experienced by both, albeit in very different ways’ (p. 277). I likened this to getting on a dual carriageway or two lane highway, to get to somewhere. The trajectory was forward, one way only and no U turns were
permitted, although to be fair I had never heard of anyone deciding to cancel their trip. Once you got on the road there was no turning back or stopping and the ETA (estimated time of arrival) was unknown. The trip required the travellers to navigate some tricky obstacles, emotions and challenges such as: fear, pain, loneliness, guilt, assumptions, judgement, culture and society. Although the nurse and the woman were headed the same way, they didn’t necessarily come up against the aforementioned emotions, obstacles and challenges at the same time which occasionally made conversation difficult, but they sometimes found they had shared interests to pass the time. When they finally get to their destination they say good-bye and they part company, the woman’s exit leading her one way and the nurse’s another. However, the nurse’s exit takes her to the on-ramp at the beginning of the highway and she finds herself back on the same road but this time with a different travelling companion. And so on it goes.

Figure 1 shows the journey shared by the women and the nurses. The journey is a metaphor for second trimester termination of pregnancy. It depicts how for most women this is a journey they will make only once in their lifetimes but the gynaecology nurses may repeat the experience (or journey) with other women many times in their careers, described previously by Huntington (2002). As the Irish say “It is a long road that has no turning”. Just as a long road eventually has a turning, problems also eventually have a solution, even though one might have to wait. This is about offering encouragement when things are not going well. In the bigger scheme of things this is also about my two-year thesis journey which has taken me on a road trip to find a solution to the issues faced by the gynaecology nurses.
Figure 1. The journey shared by the women and the nurses

Assumptions Expectations Professionalism Learnings Time Choice Baby Fear Guilt Pain Policy Loneliness Conflict Environment Language Culture Foetus Friends Protection Society Care Family Patient Worst day Colleagues Documentation Privacy vs Secrecy Experience Judgement Mother Partnership Trust Respect

Entries:
- Women on ramp

Exits:
- Nurse's on ramp
- Exit for Women
- Exit for Nurse

Restrictions:
- No stopping
- One way only
- No u turn

Entry Y points to a circle containing Assumptions, Expectations, Professionalism, Learnings, Time, Choice, Baby, Fear, Guilt, Pain, Policy, Loneliness, Conflict, Environment, Language, Culture, Foetus, Friends, Protection, Society, Care, Family, Patient, Worst day, Colleagues, Documentation, Privacy vs Secrecy, Experience, Judgement, Mother, Partnership, Trust, Respect.
5.2.2 Assumptions and attitudes

Several assumptions were revealed throughout the study, one being that inductions of labour (IOL) for foetal demise or foetal abnormality are usually a much wanted pregnancy and conversely that women undergoing prostaglandin termination of pregnancy (PGTOP) always do so for an unwanted pregnancy. Many of the nurses stated that whatever the reason for the procedure, none of the women wanted to be placed in the position of having to terminate their pregnancy, but that several of the women having a PGTOP did so because they felt they had no other choice and had found themselves, according to the nurses I interviewed, in this terrible place, having to make a really difficult decision. The same may be said for the women whose baby had a foetal abnormality that was not compatible with life. Another assumption is that the women are happy or relieved when the procedure is over but I doubt that is always the case. Without exception the nurses said they would withhold judgment from the women as they all identified as pro-choice and supported the women’s right to choose however in some instances their words appeared to reflect judgment.

Several studies revealed that the attitude of the nurse was found to be dependent on the reason for the termination; nurses feeling less inclined to be involved if the termination was for social reasons including abortion for contraception, repeat abortion and abortion for sex or gender selection (Lipp, 2008a: 2011; McLemore & Levi, 2011; Marek, 2004) as compared to procedures undertaken for foetal death or foetal abnormality (Lipp, 2008; Natan & Melit, 2010). In contrast, some of the nurses in my study showed a preference for providing care to women having PGTOP as they felt it was more straight forward because they assumed there was less emotion attached with the decision to terminate the pregnancy and conversely that the induction of labours (IOLs) were too emotionally challenging. Of interest though is that several of the nurses described how they would treat the women as they would want to be treated or would treat them all the same, that is, whether they were having a PGTOP or an IOL. This is admirable and I understand this to mean that they were not concerned why the women are here, whether for a PGTOP or IOL, and that they would treat them all with compassion, skill and kindness.

However, this could be interpreted as being culturally unsafe as assuming that not only do you know what is best for the woman but that you would care for them all
homogeneously, not acknowledging their unique circumstances and needs. The Code of Conduct (Nursing Council of New Zealand, 2012) Principle 2, **Standard 2.4 requires nurses to reflect on and address your own practice and values that impact on nursing care in relation to the health consumer’s age, ethnicity, culture, beliefs, gender, sexual orientation and/or disability.**

5.2.3 Skills, knowledge and training

All the nurses I interviewed stated that they had received no formal training but had learnt how to look after women having STT by working alongside more experienced nurses until they were ready to work independently. This was likely a sign of the times as prior to 1980 a nurse in New Zealand trained in the hospital system and as a product of this system I can bear testimony to the fact that this is how it was. You worked alongside nurses of varying experience and that was how you learnt the art of nursing. Quite often they all did variations on the task but in the hierarchy that was hospital-based training, one did not question a more senior nurse. Occasionally you were fortunate enough to have received education about a body system’s pathophysiology before you did your rotation to the related clinical area but that was likely due more to good luck than strategic planning. I distinctly recall working in the eye ward with complex surgical patients and having not yet attended the ophthalmology study block. Ironically this was very much a case of the blind leading the blind. The same could probably be said for the experiences of many of my contemporaries and I like to think of it as an exercise in character building. However, despite these challenges, my time management skills were excellent and I could mobilise, shower and return to a freshly made bed, six medical patients before morning tea, whether they wanted to or not.

The literature established that the training of nurses who work in abortion care was inadequate (Andersson, Gemzell-Danielsson, & Christensson, 2014; Gmeiner, Van Wyk, Poppenpoel, & Myburgh, 2000; Huntington, 2002; Lipp, & Fothergill, 2009; McCreight, 2005; McQueen, 2004; Natan, & Melitz, 2010; Nicholson, Slade & Fletcher, 2010; Parker, Swanson & Frunchak, 2014) and this was expressed by each nurse I interviewed for my study. Although I would propose that to an extent this is still the case for both nursing students and newly registered nurses in today’s healthcare
arena, or even for an experienced nurse working in an unfamiliar practice environment. Whilst they all have an understanding of the theoretical and fundamental components of patient care they really learn how to nurse by working alongside other nurses. As one of the gynaecology nurses stated so clearly, ‘Well it’s kind of a practical skill, like you wouldn’t go to a hairdresser that had just learnt how to cut hair from a book you know, and I think it’s the same thing with this labour business’ (Nurse B). Whilst she was referring specifically to STT nursing care, I would say this sentiment could be applied to many nursing situations.

According to the Nursing Council of New Zealand Competencies for Registered Nurses (2007) registered nurses may practice in a variety of clinical contexts depending on their educational preparation and practice experience, therefore provision of training for nurses specific to abortion would seem to be fundamental in the gynaecology setting. To meet the requirements of Domain two: Management of nursing care a registered nurse needs to demonstrate the ability to provide care which is responsive to the consumers’ needs, and which is supported by nursing knowledge and evidence based research. If the nurse is unable to access or is not offered opportunities for education and because of time constraints she feels she is not providing the kind of care she feels the patient deserves, the service has a responsibility to address these needs. Although the nurse must be proactive in seeking opportunities as well. The Code of Conduct (Nursing Council of New Zealand, 2012) Principle 4: Maintain health consumer trust by providing safe and competent care, places responsibility with the individual nurse to keep their professional knowledge and skills up to date.

Reflection

‘I was not surprised that the nurse felt they received no training. This was why I had created the SLP in the first place and why I was keen to progress the training to include a workshop for new staff. I had the benefit of coming in from the outside and my newness allowed me to be curious and play the part of the naive inquirer. I recognised that many of our experienced gynaecology nurses were in the autumn/twilight of their careers and was committed to capturing their expertise before they left’.
There is also contractual agreements to support nursing staff accessing professional development opportunities namely the District Health Boards/NZNO Nursing and Midwifery Multi-Employer Collective Agreement 2015 - 2017 (MECA). This contract between DHBs nationally and the New Zealand Nurses Organisation (NZNO), a professional body that represents over 46,000 nurses and health workers includes the provision that “The employer acknowledges a commitment to supporting the continued safe practice of its workforce and to supporting opportunities for the development of knowledge and skills which will benefit the patient, organisational effectiveness and workforce” (MECA, 2015 - 2017, p. 50). Under the terms of the MECA its members are entitled to protected time for professional development. This leave is to enable employees to complete qualifications, to attend courses and to undertake research or projects that are relevant to the employer and which facilitate the employee's growth and development. However, the gynaecology nurses reported they were sometimes not granted leave to attend study days and workshops or leave was cancelled at short notice because of staff shortages, which added to their frustration.

More than one study found that the emotional aspect of how pregnancy loss may impact on staff is not included in education programmes for nurses who work in the specialty and nurses sought more training in the form of specific gynaecology courses (Lipp, 2011; McCreight, 2005). The nurses in my study felt that they were not prepared for how emotionally challenging caring for women having STT was going to be. Whilst the Abortion Supervisory Committee (2005) recommends that managers and nurse/midwife leaders must ensure that adequate education and regular professional supervision occurs, this did not happen in the study area. In addition, to enable the nurses to review their practice, debrief mechanisms should be readily available to nurses who work in abortion care. Second trimester services, in particular, put significant psychological stresses on staff and this must be acknowledged and provided for by incorporating physical, mental, emotional, cultural and spiritual aspects of abortion care into training and staff support. These components were not present in the study setting and the literature would support the view of debriefs and/or regular psychological support for nurses to meet their needs.

A number of authors stated that debriefing and/or regular clinical supervision should always be offered (Gallagher et al., 2010; Gmeiner et al., 2000; Huntington,
and stressed the importance of not assuming that more experienced nurses will require less support. My study revealed that nurses who had been working in gynaecology for some time had just learnt to cope because a suitable alternative wasn’t there. By suitable I mean a system or option that met their individual needs in terms of wellbeing support. However, some of the nurses felt that additional resources for clinical supervision or formal debrief were not necessary and that they would prefer to talk to gynaecology colleagues or the hospital chaplain who had a real understanding of the clinical reality of their work. On the other hand, the nurses were concerned about the ongoing mental wellbeing of the newly registered nurses, who had not yet built up a robust social or support structure amongst their nursing colleagues. But we are running out of experienced gynaecology nurses.

In the study setting nurses new to STT but who have been working in gynaecology for about a year complete the SLP and then ‘do’ three procedures under the direct and indirect supervision of a senior nurse, after which time they are considered competent. This was potentially problematic as while the three procedures could all be straightforward multiparous - PGTOPs, what happens when the next one (and first independent one) is a tricky primiparous - IOL and the woman becomes physiologically or psychologically compromised? The expectation is that three STT procedures would be completed within a month but it was also recognised that it may take longer due to patient availability and suitability, in addition to the individual nurse’s ability to become competent, confidence and comfortable. The rationale stands currently that if one knows the normal then deviations can be easily recognised and dealt with but in reality when thing go wrong it’s a very scary and lonely place. Also, the nurses identified that no two procedures are the same so what is normal? What’s more, although all agree that no procedure is the same we have a pathway that says it has a predicted outcome.

Reflection

‘I feel like I’ve let the nurses down by not being more proactive and insisting they got proper debriefs and really pushing to make the PGTOP/IOL study days happen. And why didn’t I make a fuss when the new ones were doing their first procedures but still got other patients? And as for patient allocation… The
deb briefs that did happen were a joke, like organising them for when three of the keys players couldn’t come and making them feel bad for not making an effort to attend. Whose needs were being met? Not theirs. Lots of promises but never followed through. It always seemed to be too busy and not enough staff and it was so hard to get the message across. People got sick of asking and just sucked it up but they lost faith and stopped asking.’

The emotionally demanding work affects individual nurses and the organisation as a whole through absences and nursing turnover (Nicholson et al., 2010; Huntington, 2002) amid concerns about the workload and patient-to-nurse ratios on patient care (Parker et al., 2014). In recent months several experienced gynaecology nurses had reduced their hours of work or left the service completely, in fact before the end of this study three of the study nurses had resigned. There were concerns that a significant body of knowledge has left the ward with those nurses and who is left to care for the women yet alone mentor the next generations of gynaecology nurses.

McCreight’s 2005 study of nurses’ experiences in gynaecology wards recommends that study programmes that start from the experience of parents who have gone through a pregnancy loss (and I would include PGTOP as well as IOL in this category) have the potential to provide authentic learning experiences for nurses. This is why I was keen to involve Sands in the PGTOP/IOL workshops. During my current period of secondment, I have been privileged to work with a colleague who interviews and captures on film the stories of patients and families about their journeys (both positive and suboptimal) navigating the archipelagos of our health service. This footage is shown to healthcare workers at study days to illustrate what the reality is for the patient, and the patients report feeling positive about sharing their experiences if it will help others. There is nothing like listening to the patient’s story to make you alternate between feeling extremely uncomfortable or proud of the care you provide. This is a medium for learning that is honest and powerful and I was keen to embrace it in gynaecology.
5.2.4 Never enough time

My original assumption was that there was a disparity in the time nurses spent in the room with the women undergoing STT, depending on their reason for the STT; with elective STT women generally receiving less time than those referred from FMM who were usually well supported with the presence of family or friends. I equated more time with better care which is strange because I usually wouldn’t have thought about quantity over quality. This generalisation I now know to be incorrect because the majority of nurses I interviewed were frustrated at not being able to spend what they felt was enough time with the women. They wanted more time. What I had likely observed was nurses who were not willingly providing care, perhaps due to training deficits or their beliefs associated with abortion and who didn’t want to spend any more time than necessary with the women. Furthermore, because the nurses had other patients, or patients with high acuity or needs, they may not have had the luxury of spare time to just sit and be with the women.

The concept of care rationing, ‘the withholding or failure to carry out necessary nursing tasks due to inadequate time, staffing level, and/or skill mix’ could be applied in this situation (Kalisch, Landstrom & Williams, 2009). Tasks omitted could include discharge planning and patient education, hygiene and mouth care, documentation of fluid intake and output and emotional support (Carryer, 2014), so relevant in my area of interest. In the study by Kalisch et al., (2009) the choice to complete, delay or omit items of patient care was influenced by four factors internal to a nurse, namely team norms; decision-making processes; internal values and beliefs and habits. I found the factor about internal values and beliefs to be of most interest, because it can be assumed that each nurse has their own value system that underpins their nursing philosophy and influences their behaviours, which in turn leads to them making decisions about which aspects of care they will provide or omit. When behaviour is at odds with values, whether it is because nurses cannot or choose not to complete nursing care at the standard level, this often leads to feelings of regret and guilt (Kalisch et al, 2009). These feelings were expressed by the gynaecology nurses in the study and possibly also experienced by their colleagues.

The notion of moral distress could also be interpreted as being relevant to this setting. Moral distress is, put simply, when a nurse during his/her day-to-day practice
feels unable to do what they believe to be “the right thing to do”, resulting in feelings of frustration, guilt and anger which becomes so overwhelming that some nurses leave their jobs (Johnstone, 2013). A study by Woods, Rodgers, Towers and LaGrow (2015) found that of the 400 New Zealand hospital-based nurses who took part in a moral distress survey, 48 per cent of respondents had considered leaving their job and 16 per cent were considering leaving their current position immediately over moral issues beyond their control. The research findings showed that the major issue was ‘moral concerns over the delivery of less than optimal care due to pressures from management to reduce costs’ (p. 126). This mirrors the frustration felt by the gynaecology nurses; they didn’t have enough time to spend with their patients because of staffing numbers and felt all the patients suffered because of this. They wanted to do the right thing but felt that institutional obstacles such as a patient-nurse ratio based on numbers rather than acuity or need prevented this from happening. Nursing staff are concerned about staffing levels; they are stressed, distressed and anxious about their ability to deliver safe and effective care in an environment that is not appropriately resourced (New Zealand Nurses Organisation (NZNO), 2014). Three of the gynaecology nurses had left their jobs before the study was published.

5.2.5 Conscientious objection

The respect that the nurses felt for the women having STT extended to their colleagues who chose not to participate in STT procedures. However, they were also frustrated that other nurses could choose not to be involved. Conscientious objection in healthcare details the situation where nurses, midwives and assistants in nursing (however titled) have a right to refuse to participate in procedures which they judge, on strongly held religious, moral and ethical beliefs, to be unacceptable. Fear, personal convenience or preference, are not sufficient basis for conscientious objection (Australian Nursing and Midwifery Federation, 2015).

None of the nurses liked being part of the termination of pregnancy process however they felt it was their professional and ethical responsibility as a gynaecology nurse. The Abortion Supervisory Committee (2009) reported that ‘integrated units, where women undergo abortion on all legal grounds at all gestations, staffed by nurses/midwives who are choosing to do this work, are anecdotally reported to have
clear advantages in the areas of job and client satisfaction’. The committee also said that ‘even within a dedicated abortion service, where staff have chosen to be employed, they need to have a choice about how they are involved in abortion of advanced pregnancies’ (ASC 2005). However, Arthur (2014) says that conscientious objection in reproductive health care is actually a reflection of stigma against abortion and women’s autonomy, not conscientious objection in the true sense of that term and should be retitled ‘dishonorable disobedience’. Respecting the rights and practice of colleagues is an integral part of nursing practice according to the NZNO Code of Ethics (2010), and it is inevitable the nurse will encounter conflicting professional opinions that will require resolution by discussion. Good collegial relationships are free of discrimination or harassment (NZNO, 2012) but it could be portrayed that the exercise of conscientious objection is a violation of medical ethics because it allows health-care professionals to abuse their position of trust and authority by imposing their personal beliefs on patients (Fiala & Arthur, 2014). The Code of Conduct (2012) Principle 6: Work respectfully with colleagues to best meet health consumers’ needs, expects nurses to treat colleagues with respect, working with them in a professional, collaborative and co-operative manner whilst recognising that others have a right to hold different opinions. Opinions are one thing but what about fairness in allocation of workload? Playing the conscientious objection card could be considered one way of avoiding caring for these women, as second trimester termination of pregnancy is a social, emotional, and management challenge that most clinicians would be glad to avoid (Bryant, Grimes, Garret & Stuart, 2011).

Perhaps it is certain aspects of the STT that the nurses do not want to be involved in such as handling the foetus? In 2009 Abortion Law Reform Association President Margaret Sparrow said staffing abortion services in New Zealand generally did not pose problems, although those for the second trimester were more difficult. Sparrow reportedly said 'a lot of those nurses are quite happy to be involved in early abortions but with the increasing gestation they do find it difficult' (Johnston, 2009). Dr Sparrow said this was because of the greater development of the foetus, 'rather than having a complete moral objection to abortion'. But logistically and logically it would be difficult to allocate staff to certain stages of the procedure because this would result in the patient receiving fragmented care and increase risk of harm.
The Code of Conduct (2012) Principle One, states, *Respect the dignity and individuality of health consumers and principle 1.9. You have a right not to be involved in care (reproductive health services) to which you object on the grounds of conscience under section 174 of the Act*, is particularly pertinent to nurses who work in gynaecology. The Act referred to is the Health Practitioners Competence Assurance Act 2003, legislation whose principal purpose is to protect the health and safety of members of the public by providing for mechanisms to ensure that health practitioners are competent and fit to practice their professions (Ministry of Health, 2013). According to the Act,

Section 174 Duty of health practitioners in respect of reproductive health services

(1) This section applies whenever—

(a) a person requests a health practitioner to provide a service (including, without limitation, advice) with respect to contraception, sterilisation, or other reproductive health services; and

(b) the health practitioner objects on the ground of conscience to providing the service.

(2) When this section applies, the health practitioner must inform the person who requests the service that he or she can obtain the service from another health practitioner or from a family planning clinic.

The Royal College of Obstetricians and Gynaecologists’ (RCOG) Evidence-based Clinical Guidelines Number 7 (2011) states that in accordance with the Abortion Act 1967, nurses have similar rights to conscientious objections as doctors which permits nurses to refuse to participate in any treatment authorised by the Act if it conflicts with their religious or moral beliefs. The Code of Ethics of International Federation of Gynecology and Obstetrics (FIGO) states that conscientious objection to procedures does not absolve physicians from taking immediate steps in an emergency to ensure that the necessary treatment is given without delay (FIGO, 2014) and conscientious objections should not be based on self-interest, discrimination, or prejudice (Lachman, 2014).

The Catholic Church, represented by His Holiness Pope Francis announced that 2015 will be a Holy Year of Mercy (The Press, 2015). During this year both women
who have had abortions and the doctors and nurses who perform them will be pardoned – normally a sin punishable by excommunication from the church. While the pardon extends to those who in the past have either had an abortion or performed them the literature was not clear about procedures that will occur in the future. I was curious as to how this may impact on the experience of the Catholic nurse who works in abortion care however this will not be a focus of this work.

My interpretation of the legislation is that nurses who work in gynaecology services do have the right to refuse to participate in the provision of abortion care. The person requesting the service in my study setting would be the employer, and the health practitioner would be the nurse. However, nurses are also regulated by the Nursing Council New Zealand Competencies for Registered Nurses which dictate that nurses are accountable for ensuring all health services they provide are consistent with their education and assessed competence, meet legislative requirements and are supported by appropriate standards (Nursing Council New Zealand, 2007). I suggest that whilst the Act supports the work of Nursing Council and therefore the individual nurse, this legislation supersedes the competencies and nurses who work in gynaecology services do have the right to refuse to participate in the provision of abortion care. But what does this mean for their colleagues, the service and the women and how is it applied in nursing practice?

Which should prevail: the needs of women seeking safe legal, sexual and reproductive health care, or the right to freedom of those providing the services? asks Stewart (2013). The nurses in my study would say it’s not about us, it’s about the women so the question I come back to is “if you don’t want to do this then why are you working here?”
5.3 Conclusion

5.3.1 Introduction

Gynaecology is a challenging and unique nursing speciality which provides care for women at either ends of their healthcare continuum. The findings in this thesis have built on previous research which aims to explore how it is for gynaecology nurses who provide care for women undergoing termination of pregnancy in the second trimester in a tertiary hospital in New Zealand. The study has revealed that the issues faced by the gynaecology ward nurses are similar to those experienced by other nurses who work in abortion care, such as: gaps surrounding training, wellbeing support and the attitudes of colleagues, with additional issues around time and patient allocation. Increased attention to the needs of the nurses who provide care to women undergoing second trimester termination of pregnancy will enhance the quality and safety of care for this unique population of patients and this is particularly important in a setting with a variety of patient diagnosis, such as the study setting. This concurs with the work of Huntington (2002) who said that valuing nurses, recognising the difficult aspects of their work and the possible trauma that may be caused, and actively managing such situations in all clinical settings, could alleviate a considerable amount of stress for nurses and enhance the care the woman receives. Of concern is that not a lot has changed since Huntington raised these issues in her Doctoral thesis 16 years ago. Why is that?

Whilst the nurses identified the ward environment as sometimes not ideal in terms of space, and voiced a desire for a dedicated room similar to the special room in the birthing suite, none of them said that the gynaecology ward was not the right place for the women to receive STT care. I anticipated they would suggest the women should be cared for in the maternity setting, particularly those pregnancies over 16 weeks, however this was never mentioned which confirms my impression that they are committed to providing STT care whatever the reason the woman presents. The nurses say they don’t have time to deliver the care required to achieve a satisfactory outcome for patients because good systems are not in place, so the effect of nurse to patient ratio on patient care should not be underestimated.

It would seem reasonable then that nurses should give serious thought to avoiding pursuing a career in clinical areas where they can foresee that a situation of
conscientious objection may arise, such as in the gynaecology setting. As previously mentioned, time was an issue and specifically a lack of it. Time for training, time for caring, time for conversations with nursing colleagues and time spent with the patients was all in short supply.

5.3.2 Implications of the study

The study findings have implications for recognising the concept that caring about the nurses in terms of training, wellbeing support and allocation of patients is important to support them to care for the women having termination of pregnancy in the second trimester. In addition, the findings have revealed deficits in the training, allocation of patients, and the wellbeing support that gynaecology nurses receive to prepare them to care competently and confidently for these women. Whilst the nurses acknowledge the beliefs of their colleagues who will not care for women having STT, this disparity in work load puts pressure on these nurses who will look after the women most of the time.

The study has revealed that there are elements of practice and process that do not consistently meet the competencies for registered nurses as required by Nursing Council of New Zealand, particularly around documentation. This knowledge will shape the model of care in the gynaecology ward that is received by the women and their families.

5.3.3 Strengths and limitations of the study

A strength of the study was that it was undertaken by a researcher who was familiar with the area of focus and had an interest in the outcome. On the other hand, this prior knowledge may have influenced the direction of my enquiry and my relationship with the participants may have affected the recruitment process.
Limitations that were identified during the course of the study were:

- Transferability of the research results is limited because the study was conducted only in one tertiary hospital in New Zealand.
- The sample size may be considered small however six applicants is appropriate for case study methodology.
- The questions focused on the nurses who do provide STT services and did not explore the issues for nurse who did not.
- The study was limited to nurses working in the gynaecology area caring for women up to 20 weeks gestation. Inductions of labour occur in the maternity setting, with midwives, for foetal demise or foetal abnormality after 20 weeks.

5.3.4 Recommendations

The service makes a decision about whether nurses who do not want to participate in any aspect of termination of pregnancy, citing a conscientious objection to abortion, are employed in gynaecology. At initial interview for a nursing position it is made explicit that the role includes provision of termination of pregnancy care, for both PGTOP and IOL up to 20 weeks gestation and that staff will participate in all aspects of care, with training and support. If staff with a stated conscientious objection to abortion are employed in gynaecology, the service will need to give thought as to how this will be applied in practice to ensure neither the nurse nor the patients are disadvantaged.

A recommendation to service managers is they need to clarify the expectations of staff who work in gynaecology about their participation in first and second trimester termination of pregnancy.

A structured, individual orientation programme is put in place for nurses new to the service that includes timeframes about when they will undertake training specific to STT. An opportunity to discuss and plan this will occur at the start of employment and at annual performance appraisal with the Charge Nurse Manager. For those nurses who currently work in gynaecology but do not participate in STT, a needs based analysis is undertaken and a plan is put in place to provide them with the skills,
knowledge and training they require to undertake STT care, within a stated timeframe. A recommendation to service managers is that preparedness for nurses undertaking PGTOP is recognised as a key nursing competency of the gynaecology service.

A further recommendation is that the SLP and workshop proposal are revisited by the senior nursing team with input from the hospital chaplain, Maori health worker, Sands, professional development unit representative and medical representative with a view to implementing the proposal. As a framework is already in place, i.e. the existing self-learning package and the concept for the workshop, a foundation exists on which to develop the training package.

The service makes a decision about patient allocation when a nurse is caring for a women undergoing STT. The study has revealed that nurses providing STT care as well as caring for other patients feel unable to give the optimum level of safe care all the patients deserve. This study recommends consideration be given to nurses providing STT having a lesser patient load based on acuity and patient needs and not the number of patients. When nurses are first undertaking STT care they have a lesser patient load and are directly supported by a senior nurse.

The service adopts a team nursing model of care when a nurse has a STT patient. For example, two nurses work together to provide continuity of care, both are introduced to the woman, go on alternative breaks and support each other for the duration of the shift.

The practice of wellbeing support is incorporated into the culture of the gynaecology service. Whilst there is an existing Employee Assistance Programme (EAP) in place and access to the hospital chaplain it would seem that it does not always meet the needs of the nursing staff. The option of peer support or clinical supervision could be explored. If there is a distressing or significant event on the ward, a facilitated debrief occurs as soon as possible after the event that includes all those involved.

Education for nurses will include information about minimum requirements for documentation in the clinical records and audit of clinical records will measure compliance against existing organisation, legal and professional standards.
5.3.5 Recommendations for further research

I would recommend additional research is undertaken to explore the issues for nurses who work in gynaecology but do not want to take part in second trimester termination of pregnancy procedures, who despite their reluctance to participate in some aspects of care still want to work in this area.

It would also be worthwhile reproducing this study in the maternity setting because it is likely comparable issues may exist for the midwives providing care for inductions of labour for foetal abnormalities over 20 weeks gestation. In fact, this was proposed by the Clinical Director, Obstetrics and Gynaecology, in the planning stages of the study, so sponsorship has already been offered. This research is best undertaken by a midwife and I suggest the notion of moral distress be incorporated into the study.

5.3.6 Summary

The opportunity now exists for the issues that the gynaecology nurses have identified to be addressed. These issues are not new and are not unique to the New Zealand setting however despite this, long term and sustainable solutions have not previously been attempted. This will require commitment from both the nurses, doctors and the leadership teams to develop and maintain structures and processes to support nurses in their practice. Guidelines exist to inform these structures and key stakeholders such as Sands and Maternity have indicated a willingness to participate in the rebuild. Like Hemingway (2013) I urge nurses to re-examine their philosophy of care and move beyond the notion of patient-centred care to develop a compassionate, humanising approach. Nurses need to care by “head, hands and heart, integrating technical and practical knowledge with understanding” This is surely worth doing because if we can get it right for the nurses we will get it right for the women.
References


Beanland, C., & Schneider, Z. (1999). Nursing research: Methods, critical appraisal and utilisation. Mosby, Australia


Appendices

Appendix 1 Ethics Approval

MEMORANDUM

TO
Margaret Burns

COPY TO
Robyn Maude

FROM
Dr Allison Kirkman, Convener, Human Ethics Committee

DATE
8 October 2014

PAGES
1

SUBJECT
Ethics Approval: 21293
Second trimester termination of pregnancy in the gynaecology ward: a case study

Thank you for your application for ethical approval, which has now been considered by the Standing Committee of the Human Ethics Committee.

Your application has been approved from the above date and this approval continues until 30 April 2016. If your data collection is not completed by this date you should apply to the Human Ethics Committee for an extension to this approval.

Best wishes with the research.

Allison Kirkman
Human Ethics Committee
Appendix 2 Participant Information form

11 August 2014

Dear Colleague

You have been invited to participate in a study being conducted by Margaret Burns RN, as part of her Masters of Health Research thesis at Victoria University of Wellington.

This study aims to explore the issues facing nurses caring for women undergoing second trimester termination of pregnancy in the gynaecology inpatient setting.

We are interested in receiving responses from nurses employed in gynaecology services and would value your contribution. Your participation should take approximately two hours.

Included with this letter you will find:

- A participant information sheet
- Expression of interest form
- Consent to participate in research

If you are interested in participating in this study please complete the expression of interest form and return it to Susan Taylor, Clinical Coordinator, Gynaecology Ward, Level 2, Christchurch Women’s Hospital, who will forward this on to Margaret Burns, who will make contact with you shortly afterwards.

Thank you in advance for your participation in this study.

Kind regards

Susan Taylor
Clinical Coordinator
Gynaecology Services
Project Title: What are the issues facing nurses caring for women undergoing second-trimester termination of pregnancy in the gynaecology inpatient setting?

Research Team: Margaret Burns (Masters Student) and Dr Robyn Maude Senior Lecturer, Director Student Research, Graduate School of Nursing, Midwifery and Health - Te Kura Tapuhi Hauora, Victoria University of Wellington. New Zealand

An invitation to participate in a study from the University of Victoria
You are invited to take part in a study exploring issues facing nurses who provide termination of pregnancy services to women in the second trimester of pregnancy. We are asking nurses who work in gynaecology to share their thoughts and perceptions to understand current workforce issues in this area. The study is conducted by a researcher from the Graduate School of Nursing, Midwifery and Health, Victoria University of Wellington for a Masters of Health Research degree.

Your participation is entirely voluntary (your choice). You do not have to take part in this study. If you choose not to take part, your employment status will not be affected. You may take as much time as you like to consider whether or not to take part. You may discuss this with a friend, family or Whanau support to help you understand the risks and/or benefits of this study and any other explanation you may require.

What are the aims of the study?
The main aim of the study is to examine current issues facing nurses who care for women undergoing termination of pregnancy in the second trimester (i.e. between 14 and 20 weeks gestation). Specifically we aim to investigate how nurses who provide this service can be best supported, thereby improving outcomes for the women they care for.

Who can be involved in this part of the study?
Nurse currently involved in clinical practice in the inpatient gynaecology setting in a tertiary hospital in Christchurch, New Zealand.

How many people will be involved in this part of the study?
The aim is for at least 12 nurses to participate in this study.

What is the time span for the study?
Data collection for this study will be conducted between March and June 2015.

What will happen during the study?
If you decide you would like to take part, your participation would take approximately two hours. You will be interviewed one to one, face to face by me once for 60 – 90 minutes. The interview will be audio taped and the tapes transcribed. The transcripts will be sent to you to check you are happy it is a correct record of what you have chosen to share.
What are the risks and benefits of the study?
Taking part in this study will take some of your time and will require you to describe your experiences providing care for women undergoing termination of pregnancy in the second trimester. There is a possibility that you may feel distressed or emotional during the interview because of the sensitive nature of the topic. If this does occur I will stop the interview and give you the option of continuing or rescheduling the interview for another time.

The results obtained from your participation may help create awareness about the issues associated with willingness to engage with second trimester termination of pregnancy services. In addition, it is likely that this research will influence future training programmes for nurses and physicians.

Protecting your identity
Pseudonyms will be used in reports on this study so that no material could personally identify you. Records will be stored securely in accordance with the Victoria University Ethics guidelines to ensure information is kept confidential during this study. The researcher and study supervisor will be the only people who have access to the data during the study. After the study is completed the information goes into the thesis which is lodged in the University library and available publically. In addition the research findings will be published in academic or professional journals and disseminated at academic or professional conferences.
All computer records will be password protected. All future use of information collected will be strictly controlled in accordance with the Privacy Act.

If you have any questions or concerns about your rights as a participant in this research study you can contact an independent health and disability advocate. This is a free service provided under the Health and Disability Commissioner Act.
   Telephone: (NZ wide) 0800 555 050  
   Free Fax: (NZ wide) 0800 2787 7678 (0800 2 SUPPORT)  
   Email: (NZ wide) advocacy@hdc.org.nz

This study has received ethical approval from the Victoria University Ethics Committee.

If you would like more information on the study please feel free to contact the study supervisor;
Robyn Maude PhD, MA (Applied) Midwifery, BN, RM, RN
Senior Lecturer, Director Student Research
Graduate School of Nursing, Midwifery and Health - Te Kura Tapuhi Hauora
Victoria University of Wellington. New Zealand
Office: +6444636137; Mobile: +64274793826; Skype: robyn.maude6
http://www.victoria.ac.nz/nmh/about/staff/robyn-maude

The principal investigator for this study is:

Margaret BURNS
Appendix 3 Participant Expression of Interest form

Expression of interest form

What are the issues facing nurses caring for women undergoing second trimester termination of pregnancy in the gynaecology inpatient setting?

☐ I am interested in participating in this study

Thank you

☐ I am happy for the researcher to contact me

Name: .........................................................

Contact details;

Home telephone number:........................................

Cell phone number:..............................................

Email: .................................................................

Preferred method of contact:..............................
Appendix 4 Consent to participate in research form

Victoria University of Wellington
Graduate School of Nursing, Midwifery and Health

Consent to participate in research

What are the issues facing nurses caring for women undergoing second trimester termination of pregnancy in the gynaecology inpatient setting?

I have read the research information sheet explaining this research and I have understood the contents.

I have had an opportunity to ask questions and have had them answered to my satisfaction. I understand that I may ask further questions at any time.

I understand that I may withdraw myself (or any information I have provided) from this study before 1 June 2015 without having to give a reason, and if so, the data I have provided will be destroyed.

I understand that any information I provide will be kept confidential to the researcher and the supervisor. I understand the published results will not use my name and that no opinions will be attributed to me in any way that will identify me. I understand that the audio recording of the interview will be wiped at the end of the project.

I understand that I will have an opportunity to check the transcripts of the interview before publication. After the study is completed the information goes into the thesis which is lodged in the University library and available publically. In addition the research findings will be published in academic or professional journals and disseminated at academic or professional conferences.

I would like to receive a summary of the results of the research when it is completed. Yes/No (circle one)

I agree to take part in this research.

NAME OF PARTICIPANT; ___________________________________________

SIGNATURE; ___________________________________________

DATE; ___________________________________________

Signature of Researcher; ___________________________________________
Appendix 5 Study Interview questions

Victoria University of Wellington
Graduate School of Nursing, Midwifery and Health

Project Title: What are the issues facing nurses caring for women undergoing second trimester termination of pregnancy in the gynaecology inpatient setting?

Sample Interview Questions

Demographic Information:

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<th>Years working in the gynaecology specialty:</th>
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**Study Interview Questions:**

*“Can you tell me about your experience of caring for women undergoing second trimester termination of pregnancy?”*

- Can you give me an example of the training you receive for your role caring for women undergoing STT?
- Are there any aspects of your role that you find particularly challenging?
  - What would help?
- Are there any aspects of your role that are particularly satisfying?
- Can you tell me about your experiences working with the documentation associated with STT?
- Can you tell me about any strategies you use when caring for women undergoing STT?
- What other mechanisms are there for you to feel supported?
- How do you feel about clinical supervision/formal support?
- Can you think of anything that could improve the care received by women undergoing STT?

Thank you for your participation in this interview.
## Appendix 6 Retrospective Clinical Record Review Audit Tool

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**Date**

**Auditor**

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