

ADOLESCENT MOTHERS' SATISFACTION WITH POSTPARTUM NURSING
CARE: QUANTITATIVE AND QUALITATIVE APPROACHES

By

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A Thesis

Submitted to the School of Graduate Studies

In Partial Fulfilment of the Requirements

for the Degree

Doctor of Philosophy

Clinical Health Sciences (Nursing)

McMaster University

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**ADOLESCENT MOTHERS' SATISFACTION WITH POSTPARTUM
NURSING CARE**

DOCTOR OF PHILOSOPHY (2004)

McMaster University

(Clinical Health Sciences – Nursing)

Hamilton, Ontario

TITLE: Adolescent Mothers' Satisfaction with Postpartum Nursing Care:

Quantitative and Qualitative Approaches

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NUMBER OF PAGES: xiii, 179

Abstract

Adolescent Mothers' Satisfaction with Postpartum Nursing Care:

Quantitative and Qualitative Approaches

The objective of this research was to investigate adolescent mothers' perceptions of the quality of their postpartum nursing care. The first of two studies was a matched cohort survey designed to compare unmarried adolescent and married adult mothers' satisfaction with their postpartum nursing care. Eighty adolescent/adult postpartum mother pairs were matched according to parity, mode of delivery, infant health status, and infant feeding method. Although the two mother groups had similar health status, and received nursing care on the same postpartum unit during the same time period, adolescent mothers scored lower on the Newcastle Satisfaction with Nursing Scales (NSNS). Among the adolescents, post-cesarean section mothers were less satisfied than those who had delivered vaginally. Psychometric testing of the NSNS demonstrated its validity as a measure of postpartum patients' satisfaction with nursing care. The second study used a phenomenological approach to seek in-depth understanding of satisfactory and unsatisfactory nursing care from the perspective of adolescent mothers. Fourteen adolescent mothers recently discharged from one of four postpartum units were interviewed. Results indicate that adolescent mothers' satisfaction with nursing care is influenced by the interpersonal skills of nurses. Adolescent mothers' hesitancy to join in the interplay required to establish effective nurse-patient relationships places the initial responsibility of relationship development on the nurse. Adolescents expressed feeling 'at ease' with nurses and were encouraged to participate in relationship development when

they perceived nursing care to be provided in a manner that was friendly, patient, respectful and understanding of their individual needs. When some of these qualities were diminished or absent, or if nursing care was perceived to be judgmental, adolescents were discouraged from interacting with nurses. Therefore the ability of nurses to place adolescent mothers 'at ease' was found to be the essence of adolescent mothers' satisfactory postpartum nursing care experiences. The findings have direct implications for nursing practice in postpartum settings and for the design, implementation and evaluation of interventions to improve adolescent mothers' satisfaction with postpartum nursing care.

Acknowledgements

I have not accomplished this achievement alone. There are many people who have supported and encouraged me throughout my time as a graduate student.

First and foremost, thank you to Alba DiCenso. I am extremely fortunate to have had the opportunity to learn under Alba's mentorship. Her endless optimism and energy for learning is truly remarkable. Alba's support and encouragement for my endeavors has propelled me to achieve even more than I imagined when I first entered graduate school.

Thank you to my committee members, Wendy Sword and Cathy Charles, for consistently demonstrating how interdisciplinary teamwork can be so rewarding.

I thank you both for challenging me to learn, and for your thoughtful reflection and contributions to this research. I also thank Stuart MacLeod for his interest in my research and his confidence in my abilities as a researcher. Earning the respect of my mentors has been, and continues to be, one of the most rewarding aspects of this work.

A very heartfelt thank you to my husband, and best friend, Michael Rudnicki. Your unwavering faith in my ability to succeed has nurtured me throughout this journey. Thank you for fostering my determination and helping me to see the forest through the trees.

I am thankful to my parents Eleanor and Grant Peterson. To mom, from whom I believe I've inherited the gifts of empathy and optimism. And to dad, for your unending support for whatever I've set out to accomplish accompanied by the perseverance to do it. "If you're going to do something, do it right".

And finally, thank you to all my friends and colleagues who, through their continued presence in my life have demonstrated their understanding of the qualitative rather than the quantitative nature of friendship. Special thanks to Charlotte MacDonald, Nancy MacDonald, Carol Cheney, Susan Jack, Joanne Doucette, Sue Askin and Andrea Sweeney.

For Isaac, Jonathan and Erika

Take the opportunities that life offers you!

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Preface

This sandwich thesis includes one manuscript that has been published in a peer-reviewed journal (Chapter 2) and two manuscripts that have been prepared for submission to peer-reviewed journals (Chapters 3, 4). The multiple authorship on these manuscripts is intended to reflect the invaluable advice and feedback of my thesis supervisor, Alba DiCenso and my thesis committee members, Wendy Sword and Cathy Charles. Throughout the time period during which the two studies were conducted, these individuals were instrumental in providing me with feedback regarding the study design, implementation, data analysis, and the written manuscripts. The purpose of this preface is to clarify my role in this research by describing my contributions to the research reported in this thesis.

I developed an interest in the nursing care of adolescent mothers while employed as a nurse in a high-risk antenatal unit and subsequently, in a neonatal intensive care unit. The conception of the questions addressed by this thesis research emerged directly from my clinical encounters with adolescent mothers, nurse colleagues and my review of the literature. For both studies, I conducted the literature review and took the lead in designing the studies, preparing the research proposals, collecting and analyzing the data, and preparing the manuscripts.

Regarding the survey, Alba DiCenso accompanied me to the Research Ethics Board meeting, at which the proposed study was discussed. Data collection occurred between March 1999 and June 2001. I took responsibility for approximately 1/3 of the interviewer-administered questionnaires. I trained a research assistant to collect the

remainder of the data and supervised this process. With Alba DiCenso's guidance, I conducted the data analysis.

With regards to the phenomenological study, I obtained full approval from the University Research Ethics Board and permission to conduct the study from the project manager of the community program from which participants were recruited. Data collection occurred between January and November 2003. I recruited the participants, and conducted and transcribed all of the interviews. I conducted the data analysis under the guidance and expertise of Wendy Sword and Cathy Charles.

I wrote the manuscripts included in this thesis. My thesis committee members, Alba DiCenso, Wendy Sword, and Cathy Charles reviewed the manuscripts and provided comments on several drafts of each chapter.

CHAPTER 1

Introduction

This thesis includes three separate manuscripts that report the findings from two studies of adolescent mothers' satisfaction and experiences with inpatient postpartum nursing care. One of these manuscripts has been published in a peer-reviewed journal and the remaining two manuscripts have been prepared for submission to peer-reviewed journals. The purpose of this introductory chapter is to describe the problem that this body of research was designed to address, to explain how the problem was conceptualized for this research, to outline the objectives of the thesis, and to describe the content of the thesis.

Problem Statement

During the year 2001, over 16,500 infants were born to adolescent mothers 19 years of age or less in Canada (Statistics Canada, 2003). This statistic is concerning because when compared to adult mothers, adolescents are more likely to have poorer obstetrical, psycho-social, and economic outcomes. These factors have long-term implications for the health of adolescent mothers and their children. The reasons for the vulnerable state of adolescent mothers and their children are complex. There is some debate in the literature about the importance of socio-economic versus biological determinants, but it is generally agreed that both play a role (Fraser, Brockert, & Ward, 1995; Lesser & Escoto-Lloyd, 1999; Seidman & Stevenson, 1995; Stevens-Simon, 1995).

Implications of Adolescent Motherhood

Eighty percent of adolescent mothers are single at the time of their infants' birth (Statistics Canada, 2003). Although it remains unclear whether poverty is a determinant or an outcome of adolescent motherhood, their young age and single-parent status place these mothers in a demographic category that is highly associated with living in poverty (Reutter, 2000). The negative effect that adolescent motherhood has on educational attainment likely perpetuates their socio-economic disadvantage (Klepinger, Lundberg, & Plotnick, 1995).

Pregnant adolescents are at higher risk of anemia, preterm labour, and delivering low-birth weight infants than women who delay childbearing (Fraser et al., 1995; Jacono, Jacono, St. Onge, Van Oosten, & Meininger, 1992; Jolly, Sebire, Harris, Robinson, & Regan, 2000). Very young teens (≤ 15 years) and multiparous adolescents are at particularly high risk of delivering premature and stillborn infants (Akinbami, Schoendorf, & Kiely, 2000; Blankson et al., 1993; Smith & Pell, 2001).

Studies that have examined long-term outcomes have raised concern about the coping skills, parenting skills, and mental health of adolescent mothers. For example, although adolescents significantly reduce their regular use of tobacco, alcohol, marijuana, and crack/cocaine during pregnancy, their use increases steadily over the first six months postpartum (Gilchrist, Hussey, Gillmore, Lohr, & Morrison, 1996). When compared with adult mothers, adolescent mothers perceive care-giving practices to have less influence on infant development, and are less involved with and less responsive to their children

(Parks & Arndt, 1990). Finally, there has been an association observed between early motherhood and depression in later life (Mirowsky & Ross, 2002).

The children of adolescent mothers have also been identified as being at-risk. Young, single, low-income mothers are less likely to breastfeed or adequately immunize their children, practices that are well known as being advantageous to children's health (Luman, McCauley, Shefer, & Chu, 2003; Nolan & Goel, 1995; Wambach & Cole, 1999). Studies have found that the children of adolescent mothers are more likely to be hospitalized during their first year of life, and that there is a relationship between young maternal age and infant death prior to age one (Phipps, Blume, & DeMonner, 2002; Strobino, Ensminger, Nanda, & Kim, 1992). Longitudinal studies have concluded that by age five, the children of adolescent mothers have a higher rate of educational disabilities, and that as adults, they are less self sufficient than the children of mothers who delay childbearing (Gueorguieva et al., 2001; Hardy et al., 1997).

Pre- and Postnatal Health Care Services for Adolescents

Health care services believed to improve the outcomes associated with adolescent motherhood are available in Canada. Traditional prenatal care is universally available and involves monitoring throughout pregnancy and the postpartum period for the purpose of early detection and treatment of complications. Studies of low-income and adolescent mothers have concluded that adequate prenatal care has some beneficial effect on their obstetrical outcomes (e.g., maternal weight gain, preterm deliveries, birth weight) (Mustard & Roos, 1994; Scholl, Hediger, & Belsky, 1994; Scholl, Miller, Salmon, Cofsky, & Shearer, 1987).

Public health departments offer preventive services meant to supplement traditional care. For example, prenatal and early parenting classes are often available and are sometimes specifically designed for adolescents (Fedak, Peart, & Connolly, 1996). Classes such as these have been shown to improve adolescent mothers' knowledge related to pregnancy, childbirth, and infant care (Slager-Earnest, Hoffman, & Beckmann, 1987; Timberlake, Fox, Baisch, & Goldberg, 1987). In most provinces, public health nurses conduct home visits with new mothers. Home visiting that is started during pregnancy and continues long-term has beneficial effects on the health of socio-economically disadvantaged women and their children (Kitzman et al., 1997). There is evidence to suggest that this is also true for adolescent mothers and their children (Koniak-Griffin, Anderson, Verzemnieks, & Brecht, 2000; Koniak-Griffin et al., 2003).

In some Canadian cities, comprehensive pre/post natal programs that include educational and social services in addition to traditional prenatal care are available for pregnant adolescents. Similar programs are known to be effective in reducing some of the negative outcomes associated with adolescent pregnancy (NHS Centre for Reviews and Dissemination, 1997; Scholl et al., 1994).

Adolescent Mothers' Under-utilization of Services

The effectiveness of pre/postnatal services is, of course, dependent on the participation of the mothers. Studies of adolescent and low-income mothers in Canada and the United States have identified them as populations with: a) high rates of inadequate prenatal care (Blankson et al., 1993; Lena et al. 1993; Mustard & Roos, 1994; Phipps et al., 2002); b) low attendance rates at prenatal classes (Lena et al.); and c) high

drop-out rates from parenting programs, even when programs are specifically designed for them (O'Sullivan & Jacobsen, 1992); and d) high drop-out rates from public health nurse home visiting programs (Josten et al., 2002). When pregnant for the second time, adolescent mothers are even less likely to receive adequate prenatal care than they were during their first pregnancies (Blankson et al.).

There are many determinants of health service utilization. Utilization is more likely to occur when the delivery of services is congruent with personal and situational factors (Sword, 1999). Barriers that deter usage can exist at the public policy, community and individual levels (Sword). Very little research regarding barriers to care encountered by adolescent mothers has been conducted. The majority of existing studies have focused on barriers to accessing prenatal care. Frequently, the strength of study findings is limited due to small sample size, and the potential for recall bias. Nevertheless, there is some understanding of barriers to care as perceived by adolescent mothers.

Policy level barriers include pregnant adolescents' reports of having inadequate finances to pay for prenatal care (Cartwright et al., 1993; Lee & Grubbs, 1995; Teagle & Brindis, 1998). Several studies have identified characteristics of services that are perceived as barriers. For example, adolescents have reported feeling uncomfortable in prenatal classes that are primarily attended by married couples, and sharing waiting rooms or postpartum rooms with adult mothers (Lena et al., 1993). Long waiting times prior to appointments are another service-related barrier (Teagle & Brindis). However, most studies have identified individual level factors that create barriers to adolescent mothers' utilization of care.

Personal and situational reasons for not seeking care include unwanted pregnancy, lack of transportation to appointments, and a lack of knowledge regarding: the importance of first trimester care, where to go for care, and signs of pregnancy (Kinsman & Slap, 1992; Lee & Grubbs, 1995; Lena et al., 1993; Teagle & Brindis, 1998). Other barriers are related to fears of parents' response to pregnancy, physical exams, and attending clinics or seeing health care providers (Kinsman & Slap; Lee & Grubbs; Lena et al; Teagle & Brindis).

Other barriers focus on adolescents' interactions with service providers. Studies have suggested that poor past experiences with providers and negative attitudes towards providers are barriers to care (Kinsman & Slap, 1992; Teagle & Brindis, 1998). There are anecdotal reports of providers making insensitive comments and demonstrating negative attitudes towards adolescent mothers (Lena et al., 1993). Teagle and Brindis found that significant differences exist between providers' and pregnant adolescents' perceptions of motivators and barriers to prenatal care. They concluded that poor communication between providers and adolescents is a barrier to care that is frequently experienced by pregnant adolescents (Teagle & Brindis).

Conceptualization of the Problem

The research reported in this thesis was stimulated by research reports of pregnant and parenting adolescents' negative experiences with health care providers. The overall objective was to further investigate the extent and the meaning of adolescents' negative health care experiences. Are these experiences common among adolescents? Are they unique to adolescents? What are their perceptions of these experiences? For this research

‘poor experiences with health care providers’ was conceptualized as patient dissatisfaction and inpatient postpartum nursing care was selected as a specific example of a health care experience.

Patient Satisfaction

Pascoe (1983) defines patient satisfaction as “...a health care recipient’s reaction to salient aspects of the context, process, and result of their service experience” (p. 189). Patient satisfaction is a patient’s evaluation of the health care service received (Pascoe). This evaluation is based upon a comparison between the actual health care experience and a subjective standard. The subjective standard can be: a) an ideal; b) a sense of what one deserves; c) based upon past experiences; and/or d) a minimally acceptable level of care (Pascoe). Comparison of the health care experience and the subjective standard requires the patient to express both a cognitive judgment and an emotional reaction about the health care services received (Pascoe).

Patient satisfaction with care is important because: a) it allows for the incorporation of patients’ ideas when planning, implementing, and evaluating health care (Vuori, 1991); b) satisfied patients have been shown to be more compliant with medical regimens (Kyngas, Hentinen, & Barlow, 1998); c) satisfied patients are more likely to seek appropriate health care services in the future (Cleary & McNeil, 1988; Litt & Cuskey, 1984); and, d) satisfied patients are more likely to have better health outcomes (Cleary & McNeil).

Patient satisfaction can be conceptualized as an outcome or as a process variable. Most commonly, surveys are employed to quantify patient satisfaction as an end-point or

outcome variable. However, there has been criticism that this method ignores the context of patients' health care experiences (Williams, 1994). This observation has led to a recent appreciation for the use of qualitative methods to explore and to understand how patients arrive at their evaluation of health care experiences. Avis (1997) explains that:

people's contact with health services can be thought of as a story. It starts when the patient decides to seek help, and develops through the processes of investigation, diagnosis, treatment and evaluation. Along the way the patient learns more about his or her condition, forms judgments about the helpfulness and competence of staff, and considers the meaning and value of each health encounter...in this process patients experience moments of expectation, disappointment, frustration, hope, pessimism, and relief. Attempts to measure satisfaction are usually one off attempts to capture the patients' feelings at one moment in this narrative. Patients' views, therefore, can become divorced from the background narrative of their own health care story (p. 88).

There is value to both quantitative and qualitative investigation of patients' satisfaction with health care experiences. A strength of the research reported in this thesis is that both methodologies were used, in a complementary manner, to investigate adolescent mothers' satisfaction with inpatient postpartum nursing care.

The Inpatient Postpartum Nursing Care Experience

This research focused on adolescent mothers' satisfaction with inpatient postpartum nursing care. Postpartum nurses provide care to the majority of adolescent mothers. In many cases, it may represent the most intensive contact that young mothers have with health care providers. Therefore, it is an important opportunity to teach mothers about newborn care, preventive health behaviours, and available community resources. The provision of highly satisfactory postpartum nursing care may be an important strategy for optimizing adolescent mothers' compliance with health teaching

and their utilization of recommended services. Moreover, the provision of satisfactory nursing care is a potentially meaningful way to engage young mothers in the health care system so that they are more likely to turn to health care professionals/the health care system when specific health-related needs or concerns arise.

The inpatient postpartum experience provides an opportunity to determine if a difference in patient satisfaction exists between adolescent and adult mothers with similar nursing care needs. This comparison between mother groups is important because patient satisfaction is a relative measure and the adult mother group provides a standard for comparison.

Adolescent Mothers' Satisfaction with Inpatient Postpartum Nursing Care

There are a large number of published studies reporting various patient populations' satisfaction with inpatient nursing care. Reviews of this body of literature have consistently concluded that among the care-related variables, the interpersonal dimensions of nursing care have an important influence on patient satisfaction (Gunther & Alligood, 2002; Johansson, Oleni, & Fridlund, 2002; Larrabee & Bolden, 2001; Lin, 1996). For example, studies have identified the importance of the manner in which nurses provide care and the degree to which nurses are caring, empathetic, friendly, and responsive to patient needs (Gunther & Alligood; Johansson et al.; Larrabee & Bolden; Lin). Other dimensions of nursing care that influence patient satisfaction include nurses' communication skills, the provision of information and, to a lesser degree, their competence in terms of technical skills and knowledge (Gunther & Alligood; Johansson et al.; Lin) The relative unimportance of nurses' technical/knowledge competence is

attributed to patients' assumption that this dimension of care is a given (Gunther & Alligood).

This body of literature has also described two important limitations common to studies of patient satisfaction. First, the concept of patient satisfaction is not well understood (Mahon, 1996). As a result, many authors either fail to provide a definition or use sufficiently varied definitions that it is difficult to interpret findings across studies (Merkouris, Ifantopoulos, Lanara, & Lemonidou, 1999; Thomas & Bond, 1996). Secondly, very few of the instruments designed to measure patient satisfaction with nursing care have undergone adequate psychometric testing. Therefore findings are often limited due to concerns regarding the validity and reliability of the measures (Lin, 1996; Merkouris et al.; Thomas & Bond).

Some studies have specifically investigated patients' satisfaction with inpatient postpartum nursing care. Although most studies report a high level of satisfaction among postpartum patients, dimensions of care with which mothers are relatively dissatisfied include the lack of personalized care and the provision of inadequate information (Alexander, Sandridge, & Moore, 1993; Wilcock, Kobayashi, & Murray, 1997).

A search of the literature was conducted to identify studies of adolescent mothers' experiences and satisfaction with inpatient postpartum nursing care. The Cumulative Index of Nursing and Allied Health Literature (CINAHL), PubMed, and Medline databases were searched for research published in English using combinations of terms including: adolescence, patient satisfaction, postnatal care, nursing care, adolescent, pregnancy in adolescence, mothers, and obstetrics. The reference lists of relevant articles

were searched. There were no date limitations imposed on the search. Only two studies were identified that reported findings regarding adolescent mothers (Lena et al., 1993; Sullivan & Beeman, 1981).

Sullivan and Beeman (1981) mailed questionnaires to all women residents of Arizona who were issued a birth certificate during a one-month period. Questions focused on prenatal care, labour and delivery, and postpartum care. Specific to the postpartum period, women were asked about procedures and information they had desired and received. Limitations of the study included a moderately low response rate (52.4%) and failure to follow-up with non-respondents. These limitations are particularly problematic in studies of satisfaction with care because it may be that those who choose not to respond are those who are less, or possibly more, satisfied than those who do respond. Of the 1900 respondents, 9% were dissatisfied and 57% reported they were very satisfied with their postpartum care. A separate analysis was conducted of data from mothers who were underrepresented in this population study. These included mothers from low socioeconomic backgrounds, teenagers, and/or multiparas. Thirty-five percent (n = 219) of mothers aged 19 years or less responded to the survey. This underrepresented-mother group was less satisfied with postpartum care than other mothers (Sullivan & Beeman). The authors concluded that women's reports of less-than-optimal satisfaction with postpartum care were related to the lack of opportunity to hold or touch their newborn babies after delivery, to discuss their birth experiences, and to receive sufficient information regarding postpartum and infant care (Sullivan & Beeman).

Lena et al. (1993) surveyed 100 adolescent (< 20 years) and 100 adult (≥20 years) mothers who delivered at a hospital in Ottawa, Ontario. A self-report questionnaire that focused on prenatal care, labour and delivery, and postpartum care and experiences was used. Participants completed the questionnaire while they were inpatients on the postpartum unit and a 99% response rate was reported. The analysis of postpartum data was limited to descriptive statistics. Fifty-nine percent of adolescents reported feeling uncomfortable sharing a postpartum room with older women, and 33% reported not receiving information regarding contraception compared with 11% of adult mothers. Additionally, adolescents reported insensitive comments and attitudes of some staff involved in prenatal care (Lena et al.).

The findings from these studies suggest that adolescent mothers may be dissatisfied with some dimensions of inpatient postpartum nursing care. However, no studies were identified that had been specifically designed to measure adolescent mothers' satisfaction with postpartum nursing care. Moreover, no studies were found that utilized qualitative methodology to explore patient satisfaction of postpartum nursing care from the perspective of adolescent mothers.

Thesis Objectives

An important gap in our knowledge regarding the degree of adolescent mothers' satisfaction with inpatient postpartum nursing care exists. Before making recommendations to improve adolescent mother satisfaction, there is a need to determine if, in fact, adolescent mothers are dissatisfied with their care. Further exploration of

adolescent mothers' nursing care experiences and the meaning of those experiences could guide changes in nursing practice. The objectives of this thesis were:

1. To measure adolescent mothers' satisfaction with inpatient postpartum nursing care;
2. To test the validity of the Newcastle Satisfaction with Nursing Scales instrument (Thomas et al., 1996) in a Canadian postpartum patient population;
3. To describe adolescent mothers' experiences of inpatient postpartum nursing care and to interpret the meaning of the experiences using the concept of patient satisfaction.

Content of the Thesis

This thesis research consists of two separate studies. The first study was a matched cohort survey conducted in a city in southwestern Ontario. Data were collected from 80 matched, unmarried adolescent/married adult mother pairs during the years 1999-2001. The methods and findings from this survey are detailed in Chapter 2: A Comparison of Adolescent and Adult Mothers' Satisfaction with their Postpartum Nursing Care. This manuscript has been published in the Canadian Journal of Nursing Research (Peterson & DiCenso, 2002). Permission has been granted by the managing editor of the journal and Alba DiCenso, co-author, to reprint this manuscript as part of this thesis. The objectives of this study were:

1. To measure unmarried adolescent mothers' level of satisfaction with inpatient postpartum nursing care;
2. To measure married adult mothers' level of satisfaction with inpatient

postpartum nursing care; and

3. To determine if there is a difference between unmarried adolescent and married adult mothers' levels of satisfaction with inpatient postpartum nursing care.

The general research question that this study was designed to answer is: Is there a difference in the level of satisfaction with inpatient postpartum nursing care between unmarried adolescent and married adult mothers?

The Newcastle Satisfaction with Nursing Scales (NSNS) (Thomas et al., 1996) was selected as the most appropriate instrument to measure inpatient satisfaction with nursing care. Given that these scales were originally developed and tested with medical/surgical inpatients in the United Kingdom, strategies for testing their construct validity with postpartum mothers were incorporated into the study design. The results from this testing are reported in Chapter 3 of the thesis. The objective of the research was to determine if the NSNS are valid scales to measure inpatient satisfaction in a Canadian, obstetrical population.

Chapter 4 is a manuscript that describes findings from the second study, a phenomenological study of adolescent mothers' satisfaction with inpatient postpartum nursing care. The data for this study were collected between January and November 2003 in a city in eastern Ontario. Participants had recently been discharged from one of four inpatient postpartum units in three hospitals. The objective was to provide a more in-depth understanding of adolescent mothers' experiences on the postpartum unit. The research question was: How do adolescent mothers perceive and describe their experience of satisfactory/unsatisfactory postpartum nursing care?

The thesis concludes with Chapter 5, a discussion of the major findings reported in the previous three chapters. The contributions that this research has made to our understanding of adolescent mothers' satisfaction with nursing care, the value of using both quantitative and qualitative methods to address patient satisfaction, and the strengths and limitations of the two studies as a body of research are discussed. The implications for nursing practice, education, policy, and research are described.

References

- Akinbami, L.J., Schoendorf, K.C., & Kiely, J.L. (2000). Risk of preterm birth in multiparous teenagers. *Archives of Pediatric and Adolescent Medicine*, 154, 1101-1107.
- Alexander, L., Sandridge, J., & Moore, L. (1993). Patient satisfaction: An outcome measure for maternity services. *Journal of Perinatal & Neonatal Nursing*, 7(2), 28-39.
- Avis, M. (1997). Incorporating patients' voices in the audit process. *Quality in Health Care*, 6, 86-91.
- Blankson, M.L., Cliver, S.P., Goldenberg, R.L., Hickey, C.A., Jin, J., & Dubard, M.B. (1993). Health behavior and outcomes in sequential pregnancies of black and white adolescents. *Journal of the American Medical Association*, 269(11), 1401-1403.
- Cartwright, P.S., McLaughlin F.J., Martinez, A.M., Caul, D.E., Hogan, I.G., Reed, G.W., & Swafford, M.S. (1993). Teenagers' perceptions of barriers to prenatal care. *Southern Medical Journal*, 86(7), 737-41.
- Cleary, P.D. & McNeil, B. J. (1988). Patient satisfaction as an indicator of quality care. *Inquiry*, 25, 25-36.
- Fedak, J.M., Peart, D.E., & Connolly, L.M. (1996). A teen driven prenatal program. *Canadian Nurse*, 92(1), 51-2.
- Fraser, A.M., Brockert, J.E., & Ward, R.H. (1995). Association of young maternal age with adverse reproductive outcomes. *The New England Journal of Medicine*,

332(17), 1113-1117.

Gilchrist, L.D., Hussey, J.M., Gillmore, M.R., Lohr, M.J., & Morrison, D.M. (1996).

Drug use among adolescent mothers: Prepregnancy to 18 months postpartum. *Journal of Adolescent Health*, 19(5), 337-44.

Gueorguieva, R.V., Carter, R.L., Ariet, M., Roth, J., Mahan, C.S., & Resnick, M.B.

(2001). Effect of teenage pregnancy on educational disabilities in kindergarten. *American Journal of Epidemiology*, 154(3), 212-220.

Gunther, M. & Alligood, M.R. (2002). A discipline-specific determination of high quality nursing care. *Journal of Advanced Nursing*, 38(4), 353-359.

Hardy, J.B., Shapiro, S., Astone, N.M., Miller, T.L., Brooks-Gunn, J., & Hilton, S.C.

(1997). Adolescent childbearing revisited: The age of inner-city mothers at delivery is a determinant of their children's self-sufficiency at age 27 to 33. *Pediatrics*, 100(5), 802-9.

Jacono, J.J., Jacono, B.J., St. Onge, M., Van Oosten, S., & Meininger, E. (1992). Teenage pregnancy: A reconsideration. *Canadian Journal of Public Health*, 83(3), 196-199.

Johansson, P., Oleni, M., & Fridlund, B. (2002). Patient satisfaction with nursing care in the context of health care: A literature study. *Scandinavian Journal of Caring Sciences*, 16, 337-344.

Jolly, M.C., Sebire, N., Harris, J., Robinson, S., & Regan, L. (2000). Obstetric risks of pregnancy in women less than 18 years old. *Obstetrics and Gynecology*, 96(6), 962-966.

- Josten, L.E., Savik, K., Anderson, M.R., Benedetto, L.L., Chabot, C.R., Gifford, M.J., et al. (2002). Dropping out of maternal and child home visits. *Public Health Nursing, 19*(1), 3-10.
- Kinsman, S.B. & Slap, G.B. (1992). Barriers to adolescent prenatal care. *Journal of Adolescent Health, 13*, 146-154.
- Kitzman, H., Olds, D.L., Henderson, C.R. Jr., Hanks, C., Cole, R., Tatelbaum, R., et al. (1997). Effect of prenatal and infancy home visitation by nurses on pregnancy outcomes, childhood injuries, and repeated childbearing: A randomized controlled trial. *Journal of the American Medical Association, 278*(8), 644-52.
- Klepinger, D.H., Lundberg, S., & Plotnick, R.D. (1995). Adolescent fertility and the educational attainment of young women. *Family Planning Perspectives, 27*(1), 23-28.
- Koniak-Griffin, D., Anderson, N.L.R., Verzemnieks, I., & Brecht, M.L. (2000). A public health nursing early intervention program for adolescent mothers: Outcomes from pregnancy through 6 weeks postpartum. *Nursing Research, 49*(3), 130-138.
- Koniak-Griffin, D., Verzemnieks, I.L., Anderson, N.L.R., Brecht, M.L., Lesser, J., Kim, S., et al. (2003). Nurse visitation for adolescent mothers: Two-year infant health and maternal outcomes. *Nursing Research, 52*(2), 127-136.
- Kyngas, H., Hentinen, M., & Barlow, J.H. (1998). Adolescents' perceptions of physicians, nurses, parents and friends: Help or hindrance in compliance with diabetes self-care? *Journal of Advanced Nursing, 27*, 760-769.

- Larrabee, J.H. & Bolden, L.V. (2001). Defining patient-perceived quality of nursing care. *Journal of Nursing Care Quality, 16*(1), 34-60.
- Lee, S.H., & Grubbs, L.M. (1995). Pregnant teenagers' reasons for seeking or delaying prenatal care. *Clinical Nursing Research, 4*(1), 38-49.
- Lena, S.M., Marko, E., Nimrod, C., Merritt, L., Poirier, G., & Shein, E. (1993). Birthing experience of adolescents at the Ottawa General Hospital Perinatal Centre. *Canadian Medical Association Journal, 148*(12), 2149-2154.
- Lesser, J. & Escoto-Lloyd, S. (1999). Health-related problems in a vulnerable population: Pregnant teens and adolescent mothers. *Nursing Clinics of North America, 34*(2), 289-299.
- Lin, C.C. (1996). Patient satisfaction with nursing care as an outcome variable: Dilemmas for nursing evaluation researchers. *Journal of Professional Nursing, 12*(4), 207-216.
- Litt, I.F. & Cuskey, W.R. (1984). Satisfaction with health care: A predictor of adolescents' appointment keeping. *Journal of Adolescent Health Care, 5*, 196-200.
- Luman, E.T., McCauley, M.M., Shefer, A., & Chu, S.Y. (2003). Maternal characteristics associated with vaccination of young children. *Pediatrics, 111*(5), 1215-1218.
- Mahon, P.Y. (1996). An analysis of the concept 'patient satisfaction' as it relates to contemporary nursing care. *Journal of Advanced Nursing, 24*, 1241-1248.
- Merkouris, A., Ifantopoulos, J., Lanara, V., & Lemonidou, C. (1999). Patient satisfaction: A key concept for evaluating and improving nursing services. *Journal of Nursing*

Management, 7, 19-28.

Mirowsky, J. & Ross, C.E. (2002). Depression, parenthood, and age at first birth. *Social Science & Medicine*, 54(8), 1281-1298.

Mustard, C.A. & Roos, N.P. (1994). The relationship of prenatal care and pregnancy complications to birthweight in Winnipeg, Canada. *American Journal of Public Health*, 84(9), 1450-1457.

NHS Centre for Reviews and Dissemination (1997). Preventing and reducing the adverse effects of unintended teenage pregnancies. *Effective Health Care*, 3(1), 1-12.

Nolan, L., & Goel, V. (1995). Sociodemographic factors related to breastfeeding in Ontario: Results from the Ontario Health Study. *Canadian Journal of Public Health*, 86(5), 309-312.

O'Sullivan, A.L. & Jacobsen, B.S. (1992). A randomized trial of a health care program for first-time adolescent mothers and their infants. *Nursing Research*, 41(4), 210-215.

Parks, P.L., & Arndt, E.K. (1990). Differences between adolescent and adult mothers of infants. *Journal of Adolescent Health Care*, 11, 248-253.

Pascoe, G.C. (1983). Patient satisfaction in primary health care: A literature review and analysis. *Evaluation and Program Planning*, 6, 185-210.

Peterson, W.E. & DiCenso, A. (2002). A comparison of adolescent and adult mothers' satisfaction with their postpartum nursing care. *Canadian Journal of Nursing Research*, 34(4), 117-127.

Phipps, M.G., Blume, J.D., & DeMonner, S.M. (2002). Young maternal age associated

with increased risk of postneonatal death. *Obstetrics & Gynecology*, 100(3), 481-486.

Reutter, L.I. (2000). Socioeconomic determinants of health. In M.J. Stewart (Ed.), *Community Nursing: Promoting Canadians' Health* (174-193). Toronto, ON: W.B. Saunders Company.

Scholl, T.O., Hediger, M.L., & Belsky, D.H. (1994). Prenatal care and maternal health during adolescent pregnancy: A review and meta-analysis. *Journal of Adolescent Health*, 15, 444-456.

Scholl, T.O., Miller, L.K., Salmon, R.W., Cofsky, M.C., & Shearer, J. (1987). Prenatal care adequacy and the outcome of adolescent pregnancy: Effects on weight gain, preterm delivery, and birth weight. *Obstetrics & Gynecology*, 69(3), 312-316.

Seidman, D.S. & Stevenson, D.K. (1995). Adverse reproductive outcomes and young maternal age [Letter to the editor]. *The New England Journal of Medicine*, 333(12), 800.

Slager-Earnest, S.E., Hoffman, S.J., & Beckmann, C.J. (1987, November/December). Effects of a specialized prenatal adolescent program on maternal and infant outcomes. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 422-429.

Smith, G.C.S. & Pell, J.P. (2001). Teenage pregnancy and risk of adverse perinatal outcomes associated with first and second births: Population based retrospective cohort study. *British Medical Journal*, 323, 476-9.

Statistics Canada (2003). Births 2001 (Statistics Canada Catalogue No. 84F0210XPB).

- Stevens-Simon, C. (1995). Adverse reproductive outcomes and young maternal age[Letter to the editor]. *The New England Journal of Medicine*, 333(12), 801.
- Strobino, D., Ensminger, M., Nanda, J., & Kim, Y.J. (1992). Young motherhood and infant hospitalization during the first year of life. *Journal of Adolescent Health Care*, 13, 553-560.
- Sullivan, D.A., & Beeman, R. (1981). Satisfaction with postpartum care: Opportunities for bonding, reconstructing the birth and instruction. *Birth and the Family Journal*, 8(3), 153-159.
- Sword, W. (1999). A socio-ecological approach to understanding barriers to prenatal care for women of low income. *Journal of Advanced Nursing*, 29(5), 1170-1177.
- Teagle, S.E. & Brindis, C.D. (1998). Perceptions of motivators and barriers to public prenatal care among first-time and follow-up adolescent patients and their providers. *Maternal and Child Health Journal*, 2(1), 15-24.
- Thomas, L.H., & Bond, S. (1996). Measuring patients' satisfaction with nursing: 1990-1994. *Journal of Advanced Nursing*, 23, 747-756.
- Thomas, L.H., McColl, E., Priest, J., Bond, S., & Boys, R.J. (1996). Newcastle satisfaction with nursing scales: An instrument for quality assessments of nursing care. *Quality in Health Care*, 5(2), 67-72.
- Timberlake, B., Fox, R.A., Baisch, M.J., & Goldberg, B.D. (1987). Prenatal education for pregnant adolescents. *Journal of School Health*, 57(3), 105-108.
- Vuori, H. (1991). Patient satisfaction - does it matter? *Quality Assurance in Health Care*,

3(3), 183-189.

Wambach, K.A. & Cole, C. (1999). Breastfeeding and adolescents. *Journal of Obstetric, Gynecologic and Neonatal Nursing*, 29(3), 282-294.

Wilcock, A., Kobayashi, L., & Murray, I. (1997). Twenty-five years of obstetric patient satisfaction in North America: A review of the literature. *Journal of Perinatal & Neonatal Nursing*, 10(4), 36-47.

Williams, B. (1994). Patient satisfaction: A valid concept? *Social Science and Medicine*, 38(4), 509-516.

CHAPTER 2

A Comparison of Adolescent and Adult Mothers' Satisfaction with their Postpartum Nursing Care

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This chapter is a reformatted version of a published manuscript.

Peterson, W.E. & DiCenso, A. (2002). A comparison of adolescent and adult mothers' satisfaction with their postpartum nursing care. *Canadian Journal of Nursing Research*, 34(4), 117-127.

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Abstract

The purpose of this matched-cohort survey was to determine whether there is a difference between unmarried adolescent mothers and married adult mothers in terms of satisfaction with inpatient postpartum nursing care. Eighty adolescent/adult postpartum pairs from a mid-sized teaching hospital were matched according to parity, mode of delivery, infant health status, and infant feeding method. Adolescents scored lower than adults on both the Experiences of Nursing Care Scale and the Satisfaction with Nursing Care Scale of the Newcastle Satisfaction with Nursing Scales. Among the adolescents, post-caesarean mothers were less satisfied than mothers who had delivered vaginally. Adolescent mothers' dissatisfaction with nurse availability and nurse-client communication are possible explanatory factors. Future qualitative studies will inform the design of interventions to improve satisfaction among adolescent mothers.

Keywords: postnatal care, nursing care, adolescent mothers, patient satisfaction, pregnancy in adolescence.

Literature Review

Recent Canadian statistics indicate that over 17,000 infants are born to adolescent mothers annually (Statistics Canada, 2002). This is a concern because young mothers and their children are at high risk of poor physical, psychosocial, and economic outcomes. For example, when compared with older mothers, adolescent mothers are more likely to deliver low-birthweight infants and to be unmarried, and less likely to be educated and responsive parents (Fraser, Brockert, & Ward, 1995; Parks & Arndt, 1990; Wadhwa & Millar, 1997). Their children are more likely to be formula fed, to be hospitalized during the first year, and to have educational disabilities by age 5 (Gueorguieva et al., 2001; Nolan & Goel, 1995; Strobino, Ensminger, Nanda, & Kim, 1992).

Adequate pre- and postnatal care, prenatal classes, and other, more comprehensive, programs are effective in reducing many of the negative outcomes associated with adolescent motherhood (O'Sullivan & Jacobsen, 1992; Timberlake, Fox, Baisch, & Goldberg, 1987). However, adolescent mothers' under-use of these services is well documented (O'Sullivan & Jacobsen; Scholl, Hediger, & Belsky, 1994).

Studies with outpatient adolescents have shown that those who are satisfied with the care they receive are more likely to engage in better self-care and to return for follow-up (Kyngas, Hentinen, & Barlow, 1998; Litt & Cuskey, 1984). Evidence suggests that the health behaviour of obstetrical patients may also be influenced by their satisfaction with care. For example, mothers with inadequate prenatal care are more likely to report poor past health-care experiences and dissatisfaction with health-care providers (Lia-Hoagberg et al., 1990). Conversely, maternal satisfaction with inpatient breastfeeding experience is

an important factor in breastfeeding success (Kuan et al., 1999).

Given the relationship between satisfaction with care and health-care utilization among outpatient adolescents, and given the influence of satisfaction on the health behaviours of obstetrical patients, adolescent mothers' satisfaction with their care is important. This study was designed to measure adolescent mothers' degree of satisfaction, relative to that of adult mothers, with their inpatient postpartum nursing care.

We chose to measure maternal satisfaction with inpatient postpartum nursing care because the inpatient setting allowed us to compare satisfaction among adolescents to that among adults with similar nursing-care needs and resources. Furthermore, the postpartum hospital stay represents an opportunity for nurses to provide highly satisfactory care to virtually all adolescent mothers, including those who have not received adequate prenatal care. If adolescent mothers are found to be more dissatisfied than adult mothers, consideration can be given to the design and evaluation of interventions to improve satisfaction and, ultimately, health-care utilization and health outcomes.

Methods

Design

The nursing-care needs of postpartum mothers depend on many factors, including birth outcomes and infant feeding choices. Therefore, we used a matched-cohort survey to ensure that the adolescent and adult groups had similar nursing-care needs. Each adolescent was matched with an adult according to parity (primipara/multipara), mode of delivery (vaginal/caesarean), current infant health status (rooming-in/neonatal unit), and feeding method (breastmilk/formula). Mothers who supplemented breastmilk with

formula were considered breastfeeders because they were receiving nursing care related to breastfeeding.

Sample

The sample was recruited from a 34-bed postpartum unit in a 400-bed teaching hospital located in a mid-sized multi-ethnic city in Ontario, Canada. The hospital is a publicly funded Catholic institution in which approximately 4,000 babies are delivered annually. The postpartum unit is staffed with a mix of registered nurses and registered practical nurses.

To be included in the study, the adolescent mothers had to be (a) no more than 19 years old, and (b) unmarried, and the adult mothers had to be (a) at least 20 years old, and (b) married. The marital-status criterion was included to reflect the norm for each maternal age group. This distinction is important because nurses have been found to potentially treat mothers differently based on marital status (Ganong & Coleman, 1997). For this reason, we grouped together the less conventional marital situations (single and common-law). The common-law status was assigned if the mother described her marital status as common-law, as opposed to using the legal definition.

For both groups, mothers were excluded from the study if they (a) were not English-speaking, (b) had spent less than 24 hours in the postpartum unit, or (c) were in isolation, or if their infant was (d) stillborn, (e) born with anomalies, (f) being placed for adoption, or (g) being investigated by the Children's Aid Society prior to discharge.

The sample size was based on previous use of the patient satisfaction instrument. A difference of at least five points (on a scale of 0–100) between adolescent and adult

mothers in mean scores on the Experiences of Nursing Care Scale of the Newcastle Satisfaction with Nursing Scales (NSNS) would indicate a clinically important difference in perceptions of nursing care (Appendix A). The sample size necessary to detect this degree of difference with 80% power is 80 patients per group (Thomas, McColl, Priest, Bond, & Boys, 1996).

Measures

The NSNS is a questionnaire designed to measure patient satisfaction with nursing care during one hospital stay. It addresses nurses' attentiveness, availability, reassurance, openness, professionalism, and knowledge, as well as individual treatment received, information provided, and ward organization and environment. Psychometric testing indicates that the NSNS has good construct validity and test-retest reliability and is capable of detecting differences between groups of patients (Thomas et al., 1996).

The NSNS consists of two scales, a patient demographics section, and two open-ended questions. The Experiences of Nursing Care Scale consists of 26 items that describe aspects of nursing care. Respondents use a seven-point Likert scale to indicate the degree to which each item describes their experience. The Satisfaction with Nursing Care Scale consists of 19 items that describe aspects of nursing care. Respondents use a five-point Likert scale to indicate their degree of satisfaction with each identified aspect of nursing care. Item responses are re-coded and summed, resulting in an Experience Scale score and a Satisfaction Scale score. Scores of 100 indicate that the patient experienced the best possible care (Experience Scale) and is 100% satisfied with the care they received (Satisfaction Scale) (Thomas et al., 1996).

Data Collection

Ethical approval was obtained from the hospital's Research Ethics Board (Appendix B). Notices were posted in each postpartum room stating that mothers could be asked to participate in a survey of patient satisfaction (Appendix C). To maximize the response rate among adolescent mothers, the questionnaires were administered prior to hospital discharge.

Training of interviewers (two) included role-playing and rehearsal of a standard script to introduce the study, give instructions, and respond to requests for clarification. The instructions emphasized that we were interested in both negative and positive experiences and that patients' individual responses would not be shared with the nursing staff. Patients were not dependent on the interviewers in any way for their care. The NSNS was pilot tested with five adolescent and five adult mothers and minor changes to wording were made.

The interviewer introduced the mothers to the study and obtained their written consent (Appendix D). The interview, which took less than 20 minutes to complete, was conducted as close to the mother's day of discharge as possible. An effort was made to use a private room so that mothers would feel comfortable providing honest opinions about their nursing care. Nurses were not in the same room at any point during any of the interviews.

Once an adolescent mother had consented to participate, all married adult postpartum inpatients were identified from the patient census in an effort to find a match. If more than one adult mother was eligible, a mother was randomly selected. If there

were no eligible adult mothers, one was selected as soon as possible after the adolescent's interview. The same method of data collection was followed for adult mothers.

Data Analysis

Descriptive baseline data were compared using independent t-tests (two-tailed) for continuous data and chi-squared or Fisher's exact test (two-tailed) for nominal data. Independent *t* tests were used to determine whether the Experience and Satisfaction scores differed for the adolescent and adult groups. Although our score distributions for both scales were slightly negatively skewed, the sample size was sufficient ($n = 80/\text{group}$) to support the use of parametric tests (Norman & Streiner, 2000).

A linear regression model was used to determine whether baseline variables that differed between groups explained the difference in satisfaction scores. The variables entered into this model were: involvement of an obstetrician, attendance at pre-registration visit, attendance at hospital tour, and patient perception of maternal and infant health. Finally, based on the adolescent-mother data only and a cutoff score of 70 (< 70 indicating dissatisfaction and ≥ 70 indicating satisfaction), logistic regression was used to determine whether specific variables explained the difference in adolescents' satisfaction scores. The variables entered in this model were: mode of delivery, education, involvement of an obstetrician, attendance at the pre-registration visit, attendance at the hospital tour, parity, and method of infant feeding.

Results

Sample

Recruitment was ongoing until 80 matched pairs were identified. In total, 198 mothers were invited to participate. Four adolescent and five adult mothers declined because they had visitors or were feeling unwell or tired. A total of 189 mothers agreed to participate, resulting in a 95% response rate.

Of the 189 questionnaires, 29 were excluded from the final analysis because there was no match ($n = 17$), the matched adolescent and adult were interviewed more than 2 months apart ($n = 8$), or there had been an error in eligibility ($n = 4$).

The mean number of days between the adolescent and matched adult interviews was 13.4 days (range = 0–62 days). Fifty-one percent of the pairs were interviewed within 7 days of each other. In six cases, the adult mother was interviewed prior to the adolescent mother. The majority (88%) of mothers were interviewed in a private room.

Comparison of Baseline Data

Baseline data for the two groups of mothers are shown in Table 1. The majority of pairs were primiparas (90%) who had delivered vaginally (86%) and were breastfeeding (78%) their healthy newborn infant (95%). A minority of the breastfeeding mothers were supplementing their breastmilk with formula (11% of adolescents; 8% of adults). Fifteen adolescents (19%) described themselves as being in a common-law relationship.

Predictably, adolescent mothers had significantly less education than the adults ($p < 0.0001$). Adolescents were also less likely to have seen an obstetrician ($p = 0.01$) or to have attended the hospital pre-registration visit ($p < 0.0001$) or the tour ($p < 0.0001$).

Table 1

Baseline Characteristics of Adolescent and Adult Mothers

Variables	Adolescents <i>n</i> = 80	Adults <i>n</i> = 80	<i>p</i> value
Age (years) mean (<i>SD</i>)	17.4 (1.3)	29.0 (3.8)	
	range: 15–19	range: 22–39	
Education			
≤ High school	76 (95%)	17 (21%)	< 0.0001
> High school	4 (5%)	63 (79%)	
≥ 1 Prenatal care visit			
	78 (98%)	80 (100%)	= 0.25
Prenatal care provider*			
Obstetrician	60 (75%)	72 (90%)	= 0.01
Family physician	53 (66%)	54 (68%)	= 0.87
Midwife	3 (4%)	2 (3%)	= 0.32
Attendance at ≥ 1 prenatal class			
	41 (51%)	49 (61%)	= 0.20
Hospital pre-registration visit			
	55 (69%)	76 (95%)	< 0.0001
Hospital tour			
	42 (53%)	65 (81%)	< 0.0001

* Totals will be greater than 100% because some women saw two types of prenatal care provider.

At the time of the survey, the adolescent and adult groups had spent a similar number of hours on the unit (52.1 and 51.9, $p = 0.97$). However, the adolescents rated their own health ($p = 0.03$) and their infant's health ($p = 0.01$) higher than the adults.

Comparison of Scale Scores

Table 2 presents a comparison of scores for the two groups of mothers.

Adolescent mothers scored lower than adult mothers on both the Experience Scale and the Satisfaction Scale. The linear regression ($n = 160$) indicated that baseline differences between groups (involvement of an obstetrician, attendance at the pre-registration visit or the hospital tour, patient perception of maternal or infant health) did not explain the difference in satisfaction scores.

Table 2

Comparison of NSNS Scores

Scale	Adolescents	Adults	Difference and 95% CI around difference	p -value
	Mean (SD) ($n = 80$)	Mean (SD) ($n = 80$)		
Experience Scale*	73.4 (15.6)	79.2 (12.9)	- 5.8 (-10.3, -1.4)	0.01
Satisfaction Scale*	71.2 (20.6)	77.5 (18.0)	- 6.3 (-12.3, -0.2)	0.04

*Range = 0–100 (with 0 signifying a poor score and 100 an excellent score).

Predicting Dissatisfaction Among Adolescent Mothers

Mode of delivery was the one variable found to be significantly associated with dissatisfaction. Adolescent mothers who had delivered by caesarean were more likely

than those who had delivered vaginally to be dissatisfied with inpatient postpartum nursing care (Experience Scale: 59.9 vs. 75.5, $p = 0.03$; 95% CI around difference of -15.6: -29.0, -2.2; Satisfaction Scale: 56.6 vs. 73.5, $p = 0.05$; 95% CI around difference of -16.9: -33.5, -0.4).

Discussion

Our results provide evidence that unmarried adolescent mothers are less satisfied with their inpatient postpartum nursing care than married adult mothers. The matched design contributes to the strength of this finding, in that we can be reasonably assured that adolescent/adult mother pairs required similar nursing care. However, the matched design also caused some delays in the recruitment of mother pairs. Nevertheless, given that the mean time between paired interviews was less than 2 weeks, it is unlikely that differences in scores were due to changes in unit policy or practices.

Our use of the NSNS overcomes two common limitations of satisfaction surveys. First, items for the instrument were generated by asking patients, rather than health-care providers or researchers, to identify important aspects of care. Second, the psychometric properties of the instrument have been established (Thomas et al., 1996). A limitation of using the NSNS is that it was developed and originally tested with medical-surgical patients, who are likely to be older and less healthy than postpartum patients. However, recent psychometric testing indicates that the NSNS is a valid instrument for measuring satisfaction among postpartum inpatients (Peterson & DiCenso, 2001).

Our findings are consistent with evidence from two less conclusive studies. In a sub-analysis of their data, Sullivan and Beeman (1981) found that mothers from low

socio-economic backgrounds, teenagers, and multiparas were less satisfied with postpartum care than other mothers. More recently, Lena et al. (1993) found that 59% of adolescents felt uncomfortable sharing a postpartum room with older women, and 33% did not receive information regarding contraception, compared with 11% of adults.

Although we should be cautious about drawing conclusions from the analysis of individual item scores, the data allow us to hypothesize which aspects of postpartum nursing care are most unsatisfactory from the point of view of adolescent mothers. The scale items that were most often scored low by the adolescent mothers were those addressing the availability of nurses. Adolescent mothers' responses to an open-ended question supported this finding, with descriptions of waiting for long periods after calling for assistance and comments that nurses should check on mothers more frequently. Also, many of the instances of unsatisfactory care described by the adolescents can be attributed to poor communication between adolescent mothers and nurses (e.g., lack of understanding regarding the infant's health or the rationale for taking the infant to the nursery).

Among the adolescent mothers, those who had had a caesarean section were the most dissatisfied with their nursing care. Perhaps dissatisfaction with nurse availability and nurse-client communication is intensified when mothers are recovering from a surgical delivery. Post-operative pain and immobility are possible explanatory variables.

The purpose of this study was limited to determining whether adolescent and adult mothers differ in terms of their satisfaction with nursing care. Future research should address the underlying reasons for the disparity in satisfaction. Is the difference in

perception of care attributable to differences in patient characteristics (e.g., education, socio-economic status, social support, marital status, expectations), or is it attributable to differences in the manner in which nurses provide care, based on those characteristics?

Conclusions and Nursing Implications

We found that unmarried adolescent mothers are less satisfied with inpatient postpartum nursing care than married adult mothers. Furthermore, we found that post-caesarean adolescent mothers are a sub-group at particularly high risk of being dissatisfied. Further research is required in order to explore the sources of dissatisfaction among adolescent mothers. However, we hypothesize that the low availability of nurses and inadequate communication between nurses and adolescent mothers are important factors.

Implications for postpartum nursing practice include the need for increased sensitivity to the special needs of newly delivered adolescent mothers. Improvements could be made in the frequency of rounds to check on young mothers, in the quality of communications skills among nurses, and in the consistency of nursing assignments. Nurse managers should be alerted to the potential need for increased staffing when adolescent mothers are admitted, to allow nurses time to provide satisfactory care.

We are currently conducting a phenomenological study to further explore the quality of postpartum nursing care from the perspective of adolescent mothers. Future qualitative inquiry into adolescent mothers' satisfaction with care by other health-care providers, and how their satisfaction changes over time, will also inform the design of interventions to improve health-care satisfaction among adolescent mothers.

References

- Fraser, A. M., Brockert, J. E., & Ward, R. H. (1995). Association of young maternal age with adverse reproductive outcomes. *New England Journal of Medicine*, 332(17), 1113–1117.
- Ganong, L. H., & Coleman, M. (1997). Effects of family structure information on nurses' impression formation and verbal responses. *Research in Nursing and Health*, 20, 139–151.
- Gueorguieva, R. V., Carter, R. L., Ariet, M., Roth, J., Mahan, C. S., & Resnick, M. B. (2001). Effect of teenage pregnancy on educational disabilities in kindergarten. *American Journal of Epidemiology*, 154(3), 212–220.
- Kuan, L. W., Britto, M., Decolongon, J., Schoettker, P. J., Atherton, H. D., & Kotagal, U. R. (1999). Health system factors contributing to breastfeeding success. *Pediatrics*, 104(3), 1–7. Retrieved November 13, 2002, from <http://www.pediatrics.org/cgi/content/full/104/3/e28>
- Kyngas, H., Hentinen, M., & Barlow, J. H. (1998). Adolescents' perceptions of physicians, nurses, parents and friends: Help or hindrance in compliance with diabetes self-care? *Journal of Advanced Nursing*, 27, 760–769.
- Lena, S. M., Marko, E., Nimrod, C., Merritt, L., Poirier, G., & Shein, E. (1993). Birthing experience of adolescents at the Ottawa General Hospital Perinatal Centre. *Canadian Medical Association Journal*, 148(12), 2149–2154.
- Lia-Hoagberg, B., Rode, P., Skovholt, C. J., Oberg, C. N., Berg, C., Mulltett, S., et al. (1990). Barriers and motivators to prenatal care among low-income women.

Social Science and Medicine, 30(4), 487–495.

- Litt, I. F., & Cuskey, W. R. (1984). Satisfaction with health care: A predictor of adolescents' appointment keeping. *Journal of Adolescent Health Care*, 5, 196–200.
- Nolan, L., & Goel, V. (1995). Sociodemographic factors related to breastfeeding in Ontario: Results from the Ontario Health Study. *Canadian Journal of Public Health* 86(5), 309–312.
- Norman, G. R., & Streiner, D. L. (2000). *Biostatistics: The bare essentials* (2nd Ed.). Hamilton, ON: B. C. Decker.
- O'Sullivan, A. L., & Jacobsen, B. S. (1992). A randomized trial of a health care program for first-time adolescent mothers and their infants. *Nursing Research*, 41(4), 210–215.
- Parks, P. L., & Arndt, E. K. (1990). Differences between adolescent and adult mothers of infants. *Journal of Adolescent Health Care*, 11, 248–253.
- Peterson, W. E., & DiCenso, A. (2001). [Validity of the NSNS in a postpartum population.] Unpublished raw data.
- Scholl, T. O., Hediger, M. L., & Belsky, D. H. (1994). Prenatal care and maternal health during adolescent pregnancy: A review and meta-analysis. *Journal of Adolescent Health*, 15, 444–456.
- Statistics Canada. (2002). Births 2000 [electronic version]. *The Daily*, September 26, 5–6 (Statistics Canada Catalogue #11-001-XIE).
- Strobino, D., Ensminger, M., Nanda, J., & Kim, Y. J. (1992). Young motherhood and

infant hospitalization during the first year of life. *Journal of Adolescent Health Care, 13*, 553–560.

Sullivan, D. A., & Beeman, R. (1981). Satisfaction with postpartum care: Opportunities for bonding, reconstructing the birth and instruction. *Birth and the Family Journal, 8*(3), 153–159.

Thomas, L. H., McColl, E., Priest, J., Bond, S., & Boys, R. J. (1996). Newcastle Satisfaction With Nursing Scales: An instrument for quality assessments of nursing care. *Quality in Health Care, 5*(2), 67–72.

Timberlake, B., Fox, R. A., Baisch, M. J., & Goldberg, B. D. (1987). Prenatal education for pregnant adolescents. *Journal of School Health, 57*(3), 105–108.

Wadhera, S., & Millar, W. J. (1997). Teenage pregnancies 1974 to 1994. *Health Reports 9*(3), 9–17 (Statistics Canada Catalogue #82-003-XPB).

Authors' Note

Wendy Peterson received support for this study from the Father Sean O'Sullivan Research Centre.

The authors would like to thank Drs. Wendy Sword and Cathy Charles for their helpful feedback, Ruthanne Cameron, BA, for assistance with data collection, and Lauren Griffith, MSc, and Dr. George Wells for assisting with statistical analyses.

CHAPTER 3

**Establishing the Validity of a Measure of Patient Satisfaction with Postpartum
Nursing Care**

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Abstract

Background: The purpose of this paper is to report the results of validity testing of the Newcastle Satisfaction with Nursing Scales Instrument (NSNS) as a measure of satisfaction with nursing care in a postpartum population. These results are based on data collected as part of a study designed to determine if a difference existed between unmarried adolescent and married adult mothers' satisfaction with postpartum nursing care. Given that the NSNS was originally designed and tested for use among medical-surgical patients in the U.K., we conducted further testing to determine the validity of the instrument with postpartum patients. **Methods:** We tested the construct validity of the NSNS by making five 'a priori' predictions: mothers who were more satisfied would be more likely to first, have one nurse caring for them and second, recommend the unit to a friend. We also predicted that the two NSNS scales would be positively correlated first, with each other, second, with a global question about satisfaction with nursing care, and third, with a global question about satisfaction with the overall postpartum stay. **Results:** Four of the five 'a priori' predictions regarding construct validity of the NSNS were supported by the data. The mean NSNS scale scores of mothers who would recommend the unit to a friend were higher than those who would not ($p = 0.00$). The two NSNS scales were positively and significantly correlated with each other ($r = 0.9$). There was a positive and significant correlation between both NSNS scales and global ratings of nursing care (Experience Scale $r = 0.79$, Satisfaction Scale $r = 0.82$) and overall hospital stay (Experience Scale $r = 0.64$, Satisfaction Scale $r = 0.68$). **Conclusion:** The NSNS is a

valid instrument for the measurement of maternal satisfaction with inpatient postpartum nursing care.

Key Words: Patient satisfaction, Nursing care, Postpartum, Measurement.

Introduction

The provision of high quality health care is a major responsibility for health care organizations. Attainment of this goal is dependent on an understanding of the concept, quality of care, so that comprehensive evaluations of quality can be undertaken. To this end, various frameworks of quality of care have been proposed and used to identify appropriate indicators of quality (Attree, 1996; Campbell, Roland & Buetow, 2000; Donabedian, 1966; Larrabee, 1996). While there are variations among the frameworks, there is consensus that quality of care is a multidimensional concept that can be viewed from multiple perspectives (Attree).

The importance of the patients' perspectives of quality of care has been emphasized (Attree, 1996; Larabee, 1996). Reasons for attention to patient perspectives are varied and include: increased accountability of governments and health care institutions to the public, the shift to consumerism in health care, the recognition of the importance of involving patients in their own care, and evidence that satisfied patients are more likely to comply, return for care and have better outcomes (Federman et al., 2001; Johansson, Oleni & Fridlund, 2002; Kyngas, Hentinen & Barlow, 1998; Perla, 2002). One way that assessment of quality of care from the patients' perspective has been operationalized is through the development and application of patient satisfaction measures.

Pascoe (1983) defined patient satisfaction as "...a health care recipient's reaction to salient aspects of the context, process, and result of their service experience" (p. 189).

He explained that satisfaction is a patient's evaluation of the health care service received. This evaluation is based on a comparison between the patient's cognitive judgment of a health care experience and his/her emotional reaction to the experience (Pascoe). Pascoe refers to the patient's emotional reaction as a subjective standard which can be (a) an ideal, (b) a sense of what one deserves, (c) based upon past experiences, and/or (d) a minimally acceptable level of care (p. 189).

Patient satisfaction is a multidimensional construct that is influenced by patient variables and health care variables (Sitzia & Wood, 1997). For example, patient sociodemographic characteristics (e.g., gender, age, marital status), physical and psychological health, and expectations of care may be reflected in satisfaction survey results (Cleary & McNeil, 1988; Foss, 2002; Thi, Briancon, Empereur, & Guillemin, 2002). Health care variables that have been found to influence patient satisfaction across broad settings include the interpersonal manner of health professionals, technical quality of care, accessibility/convenience, efficacy/outcomes, continuity of care, physical environment, and availability of resources (Sitzia & Wood, 1997; Ware, Davies-Avery, & Stewart, 1978).

Studies have found that, in the hospital setting, overall patient satisfaction is influenced by several components: nursing care, medical care, health professional/patient communication, ward management, and ward environment (Abramowitz, Cote, & Berry, 1987; Rubin, 1990). A ranking of the relative importance of these individual dimensions in several studies has revealed that, in hospital settings, the nursing care dimension was most strongly related to overall patient satisfaction (Abramowitz et al.; Rubin). This

strong positive relationship between patients' satisfaction with nursing care and their satisfaction with overall hospital stay has also been reported in more recent literature (Jacox, Bausell, & Mahrenholz, 1997).

Recent reviews of inpatient satisfaction with nursing care have identified patient and care variables that are related to satisfaction with nursing care as well as important limitations in this body of research (Johansson et al., 2002; Merkouris, Ifantopoulos, Lanara & Lemonidou, 1999b). Dimensions of nursing care that influence inpatient satisfaction include the provision of clear information, the patients' opportunity to participate in their own plan of care, nurse availability, and care that is competent with regards to interpersonal relations, nursing knowledge, and technical skills (Gunther & Alligood, 2002; Johansson et al.; Thomas et al., 1995). Patient characteristics that have been noted to influence satisfaction with nursing care are age, gender, level of education, and expectations (Jacox et al., 1997; Johansson et al.).

One major limitation in this body of research relates to widespread variation in how patient satisfaction has been conceptualized and/or the lack of attention to defining patient satisfaction (Merkouris et al., 1999b). These issues have created difficulty in the interpretation of study findings. In addition, many measures of patient satisfaction have been developed from providers' or researchers' perspectives; that is, questionnaire items are derived from providers' opinion or from reviewing the academic literature rather than from patients who are the recipients of care. Several reviewers have suggested a need for more patient-oriented measures that validly reflect the perspectives of patients and have recommended that in-depth qualitative interviews with patients be undertaken to inform

the development of new patient satisfaction measures (Johansson et al., 2002; Thomas & Bond, 1996).

Another limitation in this body of research is that while several instruments have been developed to measure patient satisfaction with inpatient nursing care, less attention has been paid to testing the psychometric properties of such instruments. A review of the literature that was published between the years 1970 and 1989, and that described instruments designed to measure patient satisfaction with nursing care, identified only four instruments that were designed to measure satisfaction with nursing care in a hospital setting (McDaniel & Nash, 1990). Of these instruments, only two had undergone testing of reliability and validity (Hinshaw & Atwood, 1982; La Monica, Oberst, Madea & Wolf, 1986). Even by 1996, most studies that used existing or new instruments failed to test their psychometric properties (Bond & Thomas, 1992; Thomas & Bond, 1996). It is now more common to find reports of reliability and validity testing of new and existing instruments designed to measure inpatient satisfaction with nursing care (Jacox et al., 1997; Merkouris, Ifantopoulos, Lanara & Lemonidou, 1999a). The LaMonica-Oberst Patient Satisfaction Scale (LOPSS) and the Patient Satisfaction Instrument (PSI) have demonstrated relative superiority in terms of psychometric properties over other instruments (Mahon, 1997; Merkouris et al., 1999b).

These advances in psychometric testing have led to concerns regarding the validity and discriminatory power of many instruments. Common problems include inconsistency in the dimensions of nursing care that influence patient satisfaction as determined by factor analyses and positively skewed scores of patient satisfaction (Lin,

1996; Mahon, 1997). These challenges are not unique to the measurement of patient satisfaction with nursing care and have also been noted in the broader patient satisfaction literature (Williams, Coyle & Healy, 1998). Researchers advocate the use of qualitative methods to generate questionnaire items as one method of improving the validity of patient satisfaction instruments (Larrabee & Bolden, 2001).

Background

We designed a matched cohort survey to measure inpatients' satisfaction with postpartum nursing care. The patient satisfaction results are published elsewhere (Peterson & DiCenso, 2002). The purpose of this paper is to report our findings regarding the construct validity of the Newcastle Satisfaction with Nursing Scales (NSNS) when used with a Canadian, postpartum population (Appendix A) (Thomas, McColl, Priest, Bond, & Boys, 1996).

We selected the NSNS for several reasons. First, it is an instrument that is designed specifically for measuring patient satisfaction with one inpatient episode of care. Secondly, it addresses only nursing care and not other dimensions of the hospital experience. Importantly, the items for this scale were derived from qualitative analysis of data collected from interviews and focus groups with 150 medical/surgical patients. This represents a strength over many other patient satisfaction instruments because the items reflect aspects of nursing care that are important to patients rather than to professionals or researchers (Thomas et al., 1995). Furthermore, in previous psychometric testing of the NSNS it demonstrated good construct validity, test-retest reliability, and an ability to detect differences in satisfaction between patients on different medical-surgical units of

the same hospital and different hospitals (Thomas et al., 1996). And finally, the NSNS represents a good conceptual fit with Pascoe's (1983) definition of patient satisfaction; that is, patients' evaluations of health care services are based on both a cognitive judgment of the experience (Experiences of Nursing Care Scale) and an emotional reaction to that experience (Satisfaction with Nursing Care Scale). The main objective of the research reported in this paper was to determine if the NSNS performs well, from a psychometric perspective, with inpatient postpartum patients.

The Newcastle Satisfaction with Nursing Scales Instrument

The NSNS consists of two scales, a patient demographics section, and two open-ended questions. Each of the two scales consists of statements (items) that describe patients' perceptions of important aspects of nursing care (Thomas et al., 1995; Thomas et al., 1996). The themes or dimensions of nursing care that are addressed include nurses' attentiveness, availability, reassurance, openness, professionalism, and knowledge, as well as individual treatment received, information provided, and ward organization and environment. The Experiences of Nursing Care Scale (Experience Scale) consists of 26 items. Respondents use a seven-point Likert scale to indicate the degree to which each item accurately describes their nursing care experience (cognitive evaluation). The Satisfaction with Nursing Care Scale (Satisfaction Scale) consists of 19 items. Respondents use a five-point Likert scale to indicate their degree of satisfaction with each identified aspect of nursing care (emotional evaluation). In order to reduce response-set bias, some statements in both scales are worded negatively and others positively, and some of the Likert descriptors are reversed in the Experience Scale. For each scale,

individual item responses are re-coded to reflect consistent valences prior to summation. The result is an Experience Scale score and a Satisfaction Scale score that both range from 0 to 100. A score of 100 signifies that the patient perceived that she experienced the best possible care (Experience Scale) and is 100% satisfied with that care (Satisfaction Scale) (Thomas et al., 1996).

Previously Established Validity of the NSNS

Validity refers to the level of confidence that we have in the ability of an instrument or test to measure what it is intended to measure (Streiner & Norman, 1995). There are different methods of establishing the validity of a measure that are commonly referred to as content validity, criterion validity and construct validity (Streiner & Norman).

Content validity refers to the comprehensiveness of the measure, that is, does the instrument address all dimensions of the variable being measured? This type of validity is often determined by asking for the opinions of experts. Thomas et al. (1995) established the content validity of the NSNS through qualitative analysis of interviews and focus groups with 150 medical/surgical patients. The purpose of this strategy for item selection was to ensure that the key dimensions of satisfaction, from the patients' perspectives, were included in the content of the measure. In this case, the patients were the expert advisors.

Criterion validity refers to the correlation between a new measure and a well-established 'gold standard' measure of the same variable. While this represents the strongest form of validity testing, there is no 'gold standard' for the measurement of

patient satisfaction. Lack of a gold standard is a common problem when the variable of interest is an abstract concept rather than a quantifiable biological attribute (e.g., blood pressure).

Validity can also be established by comparing the measure with a measure of another variable that is theoretically associated with the variable of interest. This method of assessment is referred to as construct validity. Various methods of assessing construct validity include: (a) comparing the results of the measure between groups who are expected to exhibit the trait and those who are not (extreme group comparison), and (b) correlating the measure with a measure of another variable that is expected to be related to it (convergent validity) or (c) with one that is not expected to be related (divergent validity) (Streiner & Norman, 1995; Streiner, Norman & Monroe Blum, 1989).

Thomas et al. (1996) assessed the construct validity of the NSNS by using the extreme group comparison method. Based on evidence from the literature that older and less educated patients are more likely to be satisfied, they predicted that these sub-groups from their sample would have higher Experience and Satisfaction Scale scores. Secondly, based on pre-existing evidence, they predicted that patients who could identify a nurse responsible for their care would also have higher scale scores (Thomas et al., 1996). As predicted, the Experience and Satisfaction Scale scores were significantly associated with these patient characteristics ($p < 0.01$) with only one exception. No association was found between patient age and the Satisfaction Scale score ($p = 0.22$). As Thomas et al. (1996) suggested, these results indicate good construct validity.

Problem Statement

Validity is not a static property. Rather, it is necessary to re-establish validity whenever there are variations in the characteristics of the population or in their circumstances (Streiner & Norman, 1995). There are several important differences between postpartum patients and the medical-surgical patients for which this instrument was designed. The women admitted to postpartum units after childbirth are generally healthier and younger than the medical/surgical inpatient population. Furthermore, we were unaware of other studies that had used the NSNS to measure satisfaction among hospital inpatients in a Canadian setting. Therefore, further validity testing of the NSNS in the context in which we were using it was required.

Methods

Design

Validity testing of the NSNS was conducted as part of a study designed to determine if a difference existed between unmarried adolescent (≤ 19 years of age) and married adult (≥ 20 years of age) mothers' satisfaction with inpatient postpartum nursing care (Peterson & DiCenso, 2002). Based on evidence of adolescents' poor experiences with health care professionals from prior studies, we hypothesized that the adolescent group would be less satisfied with nursing care. To ensure that adolescent and adult mothers had similar nursing care needs, a matched cohort survey design was utilized. Each unmarried adolescent mother was matched with a married adult mother according to parity (primipara/multipara), mode of delivery (vaginal/cesarean), current infant health

status (rooming-in/neonatal unit), and feeding method (breastmilk/formula) (Peterson & DiCenso).

Sample

The sample was recruited from an urban, 400-bed teaching hospital in southwestern Ontario, Canada. The hospital is a publicly funded institution at which approximately 4,000 babies are delivered annually. All mothers were patients on a 34-bed postpartum unit that was staffed with a mix of registered nurses and registered practical nurses.

To be included in the study, the adolescent mothers had to be (a) no more than 19 years of age, and (b) unmarried, and the adult mothers had to be (a) at least 20 years of age, and married. The marital status criterion was included to reflect the norm for each maternal age group. Mothers were excluded from the study if they were not English-speaking, had spent less than 24 hours in the postpartum unit, were in isolation, were being investigated by the Children's Aid Society prior to discharge, or if their infant was stillborn, born with anomalies or being placed for adoption.

The sample size was based on Thomas et al.'s (1996) previous use of the NSNS and a predetermined clinically important difference (5 points on a scale of 0-100) in adolescent and adult mothers' perceptions of nursing care. The sample size necessary to detect this degree of difference with 80% power was 80 patients per group (Thomas et al., 1996).

Measures

Construct validity of the NSNS was tested by making ‘a priori’ predictions about the correlation between the Experience and Satisfaction Scale scores of the NSNS and other variables related to patient satisfaction. Our predictions were as follows:

1. Based on construct validity testing conducted as part of the original testing of the NSNS, we predicted that mothers who responded yes to the question, “Is there one particular nurse caring for you on this unit?” would report more positive experiences of and greater satisfaction with postpartum nursing care;
2. It is believed that satisfied patients will recommend a particular hospital to friends and family members (Greeneich, 1993). Therefore, we predicted that mothers who responded yes to the question, “Would you recommend this postpartum unit to a friend?” would report more positive experiences of and greater satisfaction with postpartum nursing care than those who responded negatively;
3. Assuming that patients who reported having a positive nursing care experience would express satisfaction with that experience, we predicted that there would be a positive correlation between the Experience Scale and the Satisfaction Scale scores of the NSNS;
4. Given that the NSNS was designed to specifically measure satisfaction with nursing care, and that nursing care has been found in a number of studies to be the most important influencing factor regarding inpatient satisfaction with overall hospital stay, we predicted that the Experience and Satisfaction Scale scores would be positively correlated with the single global questions regarding satisfaction with nursing care and with overall postpartum stay (Table 1), but

5. the Experience and Satisfaction Scale scores would have a higher correlation with the score on the single global question regarding satisfaction with nursing care, than with the single global score regarding satisfaction with overall postpartum stay.

Table 1

Global Questions

<p>For the next two questions please tell me the number of the answer on this gold card that matches your opinion of the nursing care you have received on this unit.</p>						
<p>1. How would you rate the nursing care you received on this unit? Think about only the nursing care, not the atmosphere, food, cleanliness, noise etc.</p>						
<p>2. Overall how would you rate your stay on this unit? Think about everything about this unit – nursing care, atmosphere, food, cleanliness, noise etc.</p>						
Dreadful	Very poor	Poor	Fair	Good	Very good	Excellent
1	2	3	4	5	6	7

Data Collection

Permission was granted from the joint hospital/university Research Ethics Board to conduct the study (Appendix B). Nurses were notified that a study investigating patient satisfaction with nursing care was ongoing. Notices were posted in each postpartum room stating that a study of patient satisfaction was taking place and that mothers might be invited to participate (Appendix C).

Although the NSNS was originally designed for self-completion, in this study an interviewer administered the questionnaires prior to discharge in order to maximize the response rate of adolescent mothers. Eligibility was determined by the interviewers using patient census data from hospital records. The interviewers approached eligible mothers and asked if they would be interested in participating in a study of patient satisfaction. The interviewers explained the study, verbally reviewed the consent form with interested mothers, and obtained their written consent (Appendix D). The interview, which took less than 20 minutes to complete, was conducted in the postpartum unit of the hospital and as close to the mother's day of discharge as possible. An effort was made to interview patients in a private room so that mothers would feel comfortable providing honest opinions about their nursing care. At the request of some participants, family members or visitors sometimes were present during the interviews. Nurses were not present during any of the interviews.

Fourteen additional questions were added to the NSNS questionnaire for this study (Appendix A, section 2 question #4, section 3 question #2-5, 7, 8, 10-16). The purpose of these additional questions was to confirm information related to the matching criteria, and to collect data about mothers' prenatal experiences and perceptions of their health that may influence inpatient satisfaction. We pilot tested the NSNS with five adolescent and five adult mothers. As a result of this pilot testing, minor changes were made to the wording of two items on the Experience Scale (Table 2). Additionally, we predicted that patients may request clarification regarding four of the Experience Scale

items and three of the Satisfaction Scale items. Therefore, we devised standard responses for the interviewers to use when such clarification was requested.

Table 2

Changes to Wording of Two Experience Scale Items Based on Pilot Test:

Item #	Original wording of Experience Scale	Item #	Wording changed to:
6.	Nurses give me information just when I need it.	6.	Nurses give me information when I need it.
16.	Nurses explained what I should expect.	16.	Nurses explained what I should expect during this postpartum period.

Structured interviews were conducted by the principal investigator (W.E.P.) and a research assistant. Training of both interviewers included role-playing and rehearsal of a standard script to introduce the study, standard instructions for completion of the questionnaire, and standard responses to requests for item clarification. The standard instructions emphasized that we were interested in the patients' satisfaction with the nursing care on the postpartum unit and not the labour and delivery unit. The instructions also emphasized our interest in hearing about both negative and positive experiences with nurses, and that patients' individual responses would not be shared with the nursing staff. Patients were not dependent on either interviewer in any way for their care.

Data Analysis

Given that matching was not necessary for construct validity testing, the analysis was conducted on the sample of adolescent and adult mothers as one group. Therefore, questionnaires that were excluded from the patient satisfaction analysis because there was no match ($n = 17$), the matched adolescent and adult were interviewed more than two months apart ($n = 8$), or there had been an error in eligibility ($n = 4$) were included in this analysis (Peterson & DiCenso, 2002).

Although our score distributions for both scales were slightly negatively skewed, the sample size was sufficient ($N = 189$) to support the use of parametric tests (Norman & Streiner, 2000). The students t-test was used to test the first two a priori hypotheses. The students t-test is a statistical test of whether two means differ significantly (Last, 2001). Pearsons correlation coefficient was used to test the hypothesis that the two scale scores would be positively correlated with each other, and with mothers' global ratings of nursing care and overall hospital stay. The Pearsons correlation coefficient is "a measure of association that indicates the degree to which two variables have a linear relationship" (Last, 2001, p. 41). To reflect the significance of these tests, p-values were calculated. The p-value refers to "the probability that the test statistic would be as extreme as or more extreme than observed if the null hypothesis were true" (Last, 2001, p. 146).

Results

Sample

Data collection occurred between March 1999 and June 2001. In total, 198 mothers were invited to participate. Four adolescent and five adult mothers declined to

participate because they had visitors or were feeling unwell or tired. One hundred and eighty-nine mothers agreed to participate, resulting in a 95% response rate.

The majority of mothers (90%) were interviewed privately. All interviews were conducted either in a patient room or a private conference room in the postpartum unit. The mean number of hours that mothers had spent on the postpartum unit at the time of their interviews was 52 hours or approximately two days.

Characteristics of the sample are described in Table 3. The matched design of this study resulted in an over-representation of unmarried, adolescent mothers (n = 90 adolescents, n = 99 adults). The mean maternal age was 23.5 years. Fifty percent of the mothers were married and 11% described themselves as living common-law. Forty-two percent of the mothers had more than a high school education. The mean scores for perceived health indicated that mothers viewed themselves and their infants to be healthy. Most mothers were primiparas (88%), had delivered vaginally (82%), were breastfeeding at least some of the time (72%), and had infants that were healthy enough to room-in or be cared for in the newborn nursery (93%).

Table 3
Characteristics of Mothers

Variables	N = 189
Age in years mean (SD)	23.46 (6.43) range: 15-39
<u>Marital Status</u>	
Married	95 (50%)
Single	74 (39%)
Common-law	20 (11%)
<u>Education</u>	
≤ High school	109 (58%)
> High school	80 (42%)
<u>Prenatal Care</u>	
At least one appointment	187 (99%)
No prenatal care	2 (1%)
<u>Prenatal Care Provider*</u>	
Obstetrician	159 (84%)
Family Physician	128 (68%)
Midwife	5 (3%)
<u>Prenatal Classes</u>	
Attended ≥ 1 class	101 (53%)
None	88 (47%)
Attended Hospital Pre-Registration Visit	155 (82%)
Attended Hospital Tour	125 (66%)
Mean Hours on Postpartum Unit at Time of Interview (SD)	51.66 (28.44)
Perceived Maternal Health** mean (SD)	5.74(1.07) range: 1-7
Perceived Infant Health** mean (SD)	6.22 (0.88) range: 4-7
Parity: Primiparas	167 (88%)
Multiparas	22 (12%)*
Mode of delivery: Vaginal	155 (82%)
Cesarean	34 (18%)
Infant feeding: Breastmilk only	118 (62%)
Formula only	53 (28%)
Breastmilk and formula	18 (10%)
Nursery: Rooming-in or normal newborn	176 (93%)
Level II nursery	11 (6%)
Level III nursery	2 (1%)

*totals greater than 100% because some women saw two types of prenatal care providers.

**range for perceived health: 1-7 (not healthy to very healthy)

***number of children ranged from 2-5.

Construct Validity Testing

Table 4 presents the results from the construct validity testing. The first a priori prediction was not supported by the data. Sixty-eight percent of mothers stated that they had one particular nurse providing their care. However, their Experience and Satisfaction Scale scores were not significantly higher than the mothers who did not have one nurse responsible for their care ($p > .05$).

The remaining a priori predictions were supported. As predicted, the mean NSNS scale scores of mothers who responded that they would recommend the unit to a friend were significantly higher than those who would not recommend the unit to a friend ($p=0.00$). The Experience and Satisfaction Scale scores were positively and significantly correlated with each other ($r = 0.9, p < 0.001$). There was a positive and significant correlation between both the Experience and Satisfaction Scale scores and the global rating of nursing care ($r = 0.79$ and 0.82 respectively; $p < 0.001$), and between the Experience and Satisfaction Scale scores and the global rating of overall hospital stay ($r = 0.64$ and 0.68 ; $p < 0.001$). Finally, the correlations between the scale scores and the global rating of nursing care were higher than the correlations between the scale scores and the global ratings of overall care.

Table 4
Construct Validity Results:

Construct	Experience of Nursing Care Scale Score (N=189)	Satisfaction with Nursing Care Scale Score (N=189)
One nurse responsible for care yes (n =128) mean (SD) no/not sure (n =61) mean (SD) p value	77.4 (14.1) 74.2 (16.9) 0.21	75.9 (18.7) 72.1 (21.9) 0.23
Recommend to a friend yes (n =168) mean (SD) no/not sure (n =21) mean (SD) p value	79.3 (12.1) 53.0 (16.4) 0.00	78.3 (16.6) 45.8 (19.4) 0.00
Correlation between Experience and Satisfaction scales	$r = 0.90, p < 0.001$	
Global rating of nursing care	$r = 0.79 (p < 0.001)$	$r = 0.82 (p < 0.001)$
Global rating of overall stay	$r = 0.64 (p < 0.001)$	$r = 0.68 (p < 0.001)$

Discussion

Four of the five predictions that we made to test the construct validity of the NSNS in a Canadian, postpartum population were supported. We conclude that although the NSNS was originally designed to measure satisfaction among medical/surgical patients in the U.K., it is also a valid measure of patient satisfaction with postpartum nursing care in settings similar to our study setting.

Generally, studies report very high scores for patient satisfaction. For example, Thomas et al. (1996) used the NSNS to measure satisfaction with nursing care in a

sample of 1559 male and female medical/surgical inpatients in the United Kingdom. They reported a mean Experience score of 84.6 and a mean Satisfaction score of 84.1. Another study using the NSNS reported high levels of satisfaction with nursing care among a primarily male inpatient surgical population (47% scored $\geq 90/100$ on Experience Scale; 59% scored $\geq 90/100$ on Satisfaction Scale) (Walsh & Walsh, 1999). In contrast, our mean Experience Scale and Satisfaction Scale scores were relatively low (76.4 and 74.7 respectively).

There are several possible interpretations for these lower scale scores. First, we can infer that this sample of postpartum mothers were satisfied but not highly satisfied with their nursing care. The study characteristics designed to ensure that mothers felt comfortable reporting dissatisfaction (e.g., privacy, interviewers who were not involved in patient care) contribute to our confidence that these lower scale scores reflect patient perceptions of the care they received. However, we must also consider that our lower scores may be explained by the fact that our sample was entirely younger females. Both female patients and those who are younger than 40 years have been shown to be less satisfied than older or male patients (Foss, 2002; Johansson et al., 2002). Therefore our results may be, in part, a reflection of patient characteristics. Regardless of the explanation, the lower mean scores and the range of Experience and Satisfaction Scale scores that we obtained (range: 23 -100 and 13 -100 respectively) suggest that the NSNS can discriminate between degrees of patient satisfaction.

The difference in scale scores between mothers who identified one particular nurse as responsible for their care and mothers who did not was not statistically

significant. There are several possible interpretations for this finding. Recent evidence suggests that patients' trust in their health care provider may be more important than continuity of provider (Green, Renfrew & Curtis, 2000). Another explanation may be that consistency of postpartum nurses is not important to adolescent mothers. It is noteworthy that despite a lack of statistical significance, the scores did differ from each other in the expected direction.

Mothers who stated that they would recommend the postpartum unit to a friend scored higher than those who would not. In fact, the mean Experience Scale score for mothers who would not recommend the unit to a friend was dramatically low (53.0) and may represent an appropriate upper cut-off point for defining highly dissatisfied postpartum patients. This construct is particularly relevant in obstetrical patients because they exert some control in choosing hospitals (Alexander, Sandridge, & Moore, 1993).

The Experience and Satisfaction Scale scores were positively correlated as predicted. However, this high correlation should be interpreted with caution as it indicates that both scales are measuring very similar constructs. The question of whether both scales are necessary arises. Given that for this study patient satisfaction was defined as an evaluation of care that is based on a cognitive judgment and an emotional reaction, it is important to include both scales for conceptual clarity (Pascoe, 1983).

The positive correlation between the scale scores and the global rating of nursing care supports the validity of the NSNS. Furthermore, the moderately strong correlation indicates that although the two scores are correlated they are sufficiently different to warrant use of the NSNS. The advantage of the NSNS is that examination of patients'

responses to individual items can be used for hypothesis generation regarding areas of nursing care that require improvement. This detail is lacking in a global measure.

Finally, the positive correlation between scale scores and the global rating of overall postpartum stay was predicted based on evidence of the important influence that patient satisfaction with nursing care has on patient satisfaction with overall hospital stay (Abramowitz et al., 1987; Rubin, 1990). However, as we also predicted, this correlation is lower than that of the scale scores and the single global rating of nursing care. This indicates that the NSNS scales were successful in separating out patients' satisfaction with nursing care from their satisfaction with their overall hospital stay.

Conclusions and Nursing Implications

We conclude that the NSNS is a valid measure of inpatient satisfaction with postpartum nursing care. This is an important finding with implications for nursing practice, management, and research.

The NSNS can be used by nurses and managers to quantify patient satisfaction among postpartum patients. One potential use of the NSNS is to acquire a baseline measurement of patient satisfaction in order to set goals for quality improvement. Examination of individual item scores can be used to suggest aspects of nursing care that require change. The NSNS can also contribute to the evaluation of changes in nursing service characteristics (e.g., primary nursing, staff qualifications) or interventions (e.g., staff training) as a before and after measurement of patient satisfaction (Thomas et al., 1996). As our earlier study demonstrated, the NSNS can also be used to identify groups

of patients that are more likely to be dissatisfied with nursing care (Peterson & DiCenso, 2002).

The NSNS has been shown to be valid among medical/surgical and postpartum inpatient populations. While further psychometric testing with other inpatient groups is recommended, we are optimistic that this instrument has a strong potential to be a valid measure of inpatients' perceptions of nursing care across types of hospital units. The use of a consistent measure among various inpatient populations will be helpful for administrators by simplifying the collection and interpretation of patient satisfaction data. Use of the same measure may also encourage collaboration among the staff of different units regarding the development of strategies to improve patient satisfaction. For example, staff from units that have documented high patient satisfaction results can act as consultants to other units regarding their successful strategies in attaining and maintaining excellent patient satisfaction.

The establishment of the validity of this measure of patient satisfaction among different inpatient populations is valuable to the research community. Future research should continue to test the psychometric properties of the NSNS and contribute towards the development of conceptual clarity and methodological rigor regarding the measurement of patient satisfaction with nursing care.

References

- Abramowitz, S., Cote, A.A., & Berry, E., (1987). Analyzing patient satisfaction: a multianalytic approach. *Quality Review Bulletin*, 13 (4), 122-130.
- Alexander, L., Sandridge, J., & Moore, L. (1993). Patient satisfaction: An outcome measure for maternity services. *Journal of Perinatal & Neonatal Nursing*, 7(2), 28-39.
- Attree, M. (1996). Towards a conceptual model of 'Quality Care'. *International Journal of Nursing Studies*, 33(1):13-28.
- Bond, S., & Thomas, L.H. (1992). Measuring patients' satisfaction with nursing care. *Journal of Advanced Nursing*, 17, 52-63.
- Campbell, S.M., Roland, M.O. & Buetow, S.A. (2000). Defining quality of care. *Social Science & Medicine*, 51,1611-25.
- Cleary, P.D. & McNeil, B. J. (1988). Patient satisfaction as an indicator of quality care. *Inquiry*, 25, 25-36.
- Donabedian, A. (1966). Evaluating the quality of medical care. *Milbank Memorial Fund Quarterly Bulletin*, 44, 166-203.
- Federman, A.D., Cook, E.F., Phillips, R.S., Puopolo, A.L., Haas, J.S., Brennan, T.A., & Burstin, H.R. (2001). Intention to discontinue care among primary care patients: Influence of physician behavior and process of care. *Journal of General Internal Medicine*, 16(10), 668-674.
- Foss, C. (2002). Gender bias in nursing care? Gender-related differences in patient satisfaction with the quality of nursing care. *Scandinavian Journal of Caring*

Sciences, 16, 19-26.

- Green, J.M., Renfrew, M.J., & Curtis, P.A. (2000). Continuity of carer: What matters to women? A review of the evidence. *Midwifery, 16*(3), 186-196.
- Greeneich, D. (1993). The link between new and return business and quality of care: Patient satisfaction. *Advances in Nursing Science, 16*(1), 62-72.
- Gunther, M. & Alligood, M.R. (2002). A discipline specific determination of high quality nursing care. *Journal of Advanced Nursing, 38*(4), 353-359.
- Hinshaw, A.S. & Atwood, J.R. (1982). A patient satisfaction instrument: Precision by replication. *Nursing Research, 31*(3), 170-175.
- Jacox, A.K., Bausell, B.R., & Mahrenholz, D.M. (1997). Patient satisfaction with nursing care in hospitals. *Outcomes Management for Nursing Practice, 1*(1), 20-28.
- Johansson, P., Oleni, M., & Fridlund, B. (2002). Patient satisfaction with nursing care in the context of health care: A literature study. *Scandinavian Journal of Caring Sciences, 16*, 337-344.
- Kyngas, H., Hentinen, M., & Barlow, J. H. (1998). Adolescents' perceptions of physicians, nurses, parents and friends: Help or hindrance in compliance with diabetes self-care? *Journal of Advanced Nursing, 27*, 760-769.
- La Monica, E.L., Oberst, M.T., Madea, A.R., & Wolf, R.M. (1986). Development of a patient satisfaction scale. *Research in Nursing & Health, 9*, 43-50.
- Larrabee, J.H. (1996). Emerging model of quality. *Image: Journal of Nursing Scholarship, 28*(4), 353-358.
- Larrabee, J.H. & Bolden, L.V. (2001). Defining patient-perceived quality of nursing care.

Journal of Nursing Care Quality, 16(1), 34-60.

Last, J.M. (2001). *A Dictionary of Epidemiology* (4th Ed.). Oxford: Oxford University Press.

Lin, C.C. (1996). Patient satisfaction with nursing care as an outcome variable: Dilemmas for nursing evaluation researchers. *Journal of Professional Nursing*, 12(4), 207-216.

Mahon, P.Y. (1997). Review of measures of patient satisfaction with nursing care. *Image: Journal of Nursing Scholarship*, 29(2), 196.

McDaniel, C. & Nash, J.G. (1990). Compendium of instruments measuring patient satisfaction with nursing care. *Quality Review Bulletin*, (May), 182-188.

Merkouris, A., Infantopoulos, J., Lanara, V., & Lemonidou, C. (1999a). Developing an instrument to measure patient satisfaction with nursing care in Greece. *Journal of Nursing Management*, 7, 91-100.

Merkouris, A., Infantopoulos, J., Lanara, V., & Lemonidou, C. (1999b). Patient satisfaction: A key concept for evaluating and improving nursing services. *Journal of Nursing Management*, 7, 19-28.

Norman, G. R. & Streiner, D. L. (2000). *Biostatistics: The bare essentials* (2nd Ed.). Hamilton, ON: B. C. Decker.

Pascoe, G.C. (1983). Patient satisfaction in primary health care: A literature review and analysis. *Evaluation and Program Planning*, 6, 185-210.

Perla, L. (2002). Patient compliance and satisfaction with nursing care during delivery and recovery. *Journal of Nursing Care Quality*, 16(2), 60-6.

- Peterson, W.E. & DiCenso, A. (2002). A comparison of adolescent and adult mothers' satisfaction with their postpartum nursing care. *Canadian Journal of Nursing Research, 34*(4), 117-127.
- Rubin, H.R. (1990). Can patients evaluate the quality of hospital care? *Medical Care Review, 47*, 267-326.
- Sitzia, J. & Wood, N. (1997). Patient satisfaction: A review of issues and concepts. *Social Science and Medicine, 45*(12), 1829-1843.
- Streiner, D.L. & Norman, G.R. (1995). *Health Measurement Scales: A practical guide to their development and use* (2nd Ed.). Oxford: Oxford University Press.
- Streiner, D.L., Norman, G.R. & Munroe Blum, H. (1989). *PDQ Epidemiology*. Toronto: B.C.Decker Inc.
- Thi, P.L.N., Briancon, S., Empereur, F., & Guillemin, F. (2002). Factors determining inpatient satisfaction with care. *Social Science & Medicine, 54*, 493-504.
- Thomas, L.H. & Bond, S. (1996). Measuring patients' satisfaction with nursing: 1990-1994. *Journal of Advanced Nursing, 23*, 747-56.
- Thomas, L.H., MacMillan, J., McColl, E., Priest, J., Hale, C., & Bond, S. (1995). Obtaining patients' views of nursing care to inform the development of a patient satisfaction scale. *International Journal for Quality in Health Care, 7*(2), 153-163.
- Thomas, L.H., McColl, E., Priest, J., Bond, S., & Boys, R.J. (1996). Newcastle satisfaction with nursing scales: An instrument for quality assessments of nursing care. *Quality in Health Care, 5*(2), 67-72.

- Walsh, M. & Walsh, A. (1999). Measuring patient satisfaction with nursing care: Experience of using the Newcastle Satisfaction with Nursing Scale. *Journal of Advanced Nursing*, 29(2), 307-15.
- Ware, J., Davies-Avery, A., & Stewart, A. (1978). The measurement and meaning of patient satisfaction. *Health and Medical Care Services*, 1, 1-15.
- Williams, B., Coyle, J., & Healy, D. (1998). The meaning of patient satisfaction: An explanation of high reported levels. *Social Science & Medicine*, 47(9), 1351-1359.

Author's Note

Wendy Peterson received funding for this research from the Father Sean O'Sullivan Research Centre.

The authors would like to acknowledge the assistance and advice of Janet Rush, RN, PhD, Stuart MacLeod, MD, PhD, Ruthanne Cameron, B.A., Eileen Bain, BScN, MHSc, George Wells, PhD, and Lauren Griffith, MSc.

CHAPTER 4

Adolescents' Experiences and Perceptions of Inpatient Postpartum Nursing Care:

A Phenomenological Study of Patient Satisfaction

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Abstract

A transcendental phenomenological approach was used to describe the experience of postpartum nursing care from the perspective of adolescent mothers. The data from fourteen in-depth interviews were analyzed using a method described by Moustakas (1994). We found that adolescent mothers' satisfaction with nursing care is dependent on the nurse's ability to put adolescent mothers 'at ease'. This is accomplished when nurses are perceived as friendly, patient, respectful and understanding of individual needs. When some of these qualities are diminished or absent, care is perceived as less satisfactory. In extreme cases, unsatisfactory experiences stifle the potential for an effective nurse-adolescent mother relationship. Findings can be used for self-reflection and evaluation of one's own nursing practice, and have implications for basic nursing education and continuing education programs. Our results illustrate the value of qualitative inquiry for understanding patients' satisfaction with care.

Keywords: adolescent mother, patient satisfaction, postnatal care, nursing care, phenomenology.

Introduction

Over 16,500 infants were born to adolescent mothers aged 19 years or less in Canada during the year 2001 (Statistics Canada, 2003). This statistic is concerning because of the poor health, social and economic outcomes associated with adolescent motherhood. For example, when compared with adult mothers, adolescent mothers are more likely to deliver low birthweight infants (Fraser, Brockert, & Ward, 1995). In particular, multiparous adolescents are at a significantly higher risk of delivering premature and stillborn infants (Smith & Pell, 2001). Like other mothers with low levels of education and income, adolescents are less likely to breastfeed or ensure their infants receive recommended vaccinations (Luman, McCauley, Shefer & Chu, 2003; Nolan & Goel, 1995; Wambach & Cole, 1999). Furthermore, there is some evidence that adolescent mothers are less involved with, and less responsive to, their infants than adult mothers (Parks & Arndt, 1990).

Comprehensive programs for pregnant and parenting adolescents are those that, in addition to usual medical care, include counseling, social services, nutritional assessment, prenatal and parenting education, linkage to other needed services, and facilitation of high school completion (Scholl, Hediger & Belsky, 1994). Such programs are effective in reducing some of the negative outcomes associated with adolescent pregnancy (NHS Centre for Reviews and Dissemination, 1997; O'Sullivan & Jacobsen, 1992; Scholl et al., 1994). Some communities that do not offer comprehensive programs are able to provide individual program components. Prenatal and parenting classes and home visits by public health nurses are some examples of individual services that have been shown to improve

outcomes for disadvantaged mothers (Koniak-Griffin, Anderson, Verzemnieks, & Brecht, 2000; Koniak-Griffin et al., 2003; Scholl et al., 1994; Scholl, Miller, Salmon, Cofsky, & Shearer, 1987; Slager-Earnest, Hoffman, & Beckmann, 1987; Timberlake, Fox, Baisch, & Goldberg, 1987). Unfortunately, the effectiveness of these programs is compromised by pregnant and parenting adolescents' under-use of available services (O'Sullivan & Jacobsen; Scholl et al., 1994).

Many factors have been identified as barriers to adolescent mothers' utilization of health care services. For example, system-related factors such as lack of finances or transportation have been cited as reasons for not seeking prenatal care (Kinsman & Slap, 1992; Lee & Grubbs, 1995). Specific socio-demographic factors (multiparity, lack of father involvement, unemployment) have also been associated with adolescent mothers' under-utilization of services (Wiemann, Berenson, Garcia-del Pino, & McCombs, 1997).

Another factor that may contribute to pregnant and parenting adolescents' under-use of services is dissatisfaction with care. Studies have suggested that adolescent mothers' poor past experiences with providers, negative attitudes towards providers and dissatisfaction with provider interactions are barriers to health care utilization (Kinsman & Slap, 1992; Teagle & Brindis, 1998). Therefore, improving adolescent mothers' satisfaction with their health care may be an important strategy for encouraging their use of health care services.

While it is important that adolescent mothers are satisfied with all of their health care encounters, our research focused on their experience with inpatient postpartum nursing care. Postpartum nurses have an important opportunity to assess adolescent

mothers' knowledge, address their learning needs, and inform them of available community resources. A highly satisfactory experience will likely optimize adolescent mothers' compliance with health teaching and utilization of recommended resources (Kyngas, Hentinen, & Barlow, 1998; Litt & Cuskey, 1984).

Studies of satisfaction with inpatient postpartum care have shown that adolescent mothers are less satisfied than adult mothers. In an early population-based survey in Arizona, adolescent mothers were identified as a sub-group that may be less satisfied than older mothers (Sullivan & Beeman, 1981). Adolescent mothers surveyed by Lena et al. (1993) described aspects of postpartum care that suggested dissatisfaction (e.g., sharing a room with older mothers, inadequate information).

In a recent study, we concluded that unmarried adolescent mothers were less satisfied than married adult mothers with their postpartum nursing care experience. Our explanation for adolescent mothers' relative dissatisfaction was limited to an analysis of individual scale items and content analysis of responses to an open-ended question. From this analysis, we hypothesized that adolescent mothers were dissatisfied with the unavailability of nurses on the postpartum unit and with situations resulting from poor nurse-adolescent mother communication (Peterson & DiCenso, 2002).

These quantitative studies of patient satisfaction have been useful in identifying adolescents as a population of mothers at risk of dissatisfaction with postpartum nursing care. However, prior to making recommendations intended to improve adolescent mothers' satisfaction, there is a need to develop our understanding of satisfactory and unsatisfactory care from their perspective. Herein lies the value of qualitative studies of

patient satisfaction. Qualitative studies provide patients with the opportunity to describe their health care experiences in their own words rather than attempting to fit their responses into predetermined categories (Avis,1997). This approach assists our understanding of “...why they (patients) believe what they do and how they arrived at that view” (p. 509) and is an important step towards making relevant changes to services (Williams, 1994). This paper reports our findings from a qualitative study of adolescent mothers’ experiences with inpatient postpartum nursing care.

Objectives

The purpose of this study was to describe satisfactory and unsatisfactory experiences of postpartum nursing care from the perspective of adolescent mothers. Furthermore, the study sought to understand the meaning of these experiences to adolescent mothers. The study addressed the following research question: How do adolescent mothers perceive and describe their experiences of satisfactory and unsatisfactory inpatient postpartum nursing care? The findings contribute to the interpretation of the results from our earlier study that concluded that adolescent mothers are less satisfied than adult mothers with inpatient postpartum nursing care, and provide specific direction for improving adolescent mothers’ satisfaction with postpartum nursing care (Peterson & DiCenso, 2002).

Method

Study Design

Phenomenology was selected as the method best suited to address the research objective. Phenomenology is a holistic method of inquiry that was advanced in response

to the notion that the complexity of human experiences cannot be fully understood through reductionist methods. According to Descartes, whose philosophy underlies positivistic inquiry, there is a separation between the thinking substance and the material substance (LeVasseur, 2003). In contrast, the father of phenomenology, Edmund Husserl, advanced the philosophy that material objects do not exist without consciousness of the object (LeVasseur; Moustakas, 1994). One's consciousness is intentional, that is, it is directed at objects; reality of an object is related to one's consciousness of it and therefore reality is both objective and subjective (Creswell, 1998; Jasper, 1994; Moustakas).

The goal of phenomenology as a method of inquiry is the description, rather than the explanation, of phenomena (Moustakas, 1994). This description emerges from careful reflection upon multiple accounts and expressions of individuals who have had direct experience with the phenomenon. The intended result is a description of the experience that is common to those who have had exposure to the phenomenon rather than a description of individual experiences (Cohen & Omery, 1994).

The phenomenological approach used for this study, transcendental (or eidetic/descriptive) phenomenology, as described by Moustakas (1994), is based primarily on the philosophy of Edmund Husserl. There are two major features of the transcendental approach that distinguish it from other phenomenological approaches (Moustakas).

First, the researcher brackets or "sets aside" any preconceived theories or ideas about the phenomenon under study (Moustakas, 1994). The purpose of bracketing is to

assist the researcher in becoming aware of her own experiences and attitudes that may potentially influence data collection, analysis or interpretation. Although the strategy of bracketing may be used in other qualitative approaches, Moustakas explains that transcendental phenomenology is distinguished by the disciplined and systematic efforts (the Epoche process) used by the researcher to set aside knowledge about the phenomenon (p. 22). Second, there is an emphasis on intuition, imagination, and universal structures in developing an understanding of how the individuals' perceived their experiences to be what they were (Moustakas).

Sampling

Purposeful sampling was used to select a small number of adolescent mothers who could provide rich accounts of a recent experience with postpartum nursing care (Baker, Wuest, & Stern 1992; Patton, 1990). The mothers who were invited to participate in the study were drawn from attendees of a community drop-in program for young mothers in a city in Ontario, Canada. This program is held weekly at two sites in the city and is open to young women aged 25 years or less who are pregnant or have an infant under six months of age. The program begins with an unstructured discussion of issues that are relevant to the group. Two facilitators use the discussion as an opportunity to provide education regarding healthy eating, food preparation, healthy pregnancies and infant care, and to provide breastfeeding and social support. Participants then have the opportunity to prepare and eat a meal together. Milk coupons and bus tickets are provided. Individual mothers' attendance at the group is generally irregular, with some mothers participating more consistently than others.

Patton (1990) described sixteen types of purposeful sampling strategies. The primary sampling strategy employed for this study was criterion sampling, in that participants were selected based upon specific eligibility criteria. Eligible mothers were those who (a) were expected to deliver during the data collection time period, or had given birth and been discharged from an inpatient postpartum unit within the last two months, (b) were between 15 and 19 years of age, and (c) spoke English.

Two secondary sampling strategies were proposed to select a sample with some variation in patient satisfaction. The first was a theory-based strategy that recognized the potential influence of patients' health status and marital status on patient satisfaction (Thi, Briancon, Empereur, & Guillemin, 2002). We proposed to select mothers, from those who were eligible, who varied in terms of their parity, mode of delivery, marital status and the health of their newborn. However, due to the small number of mothers attending the program who met the eligibility requirements, most mothers who agreed to participate in the study were interviewed. When data analysis indicated that we had reached saturation on themes reflecting satisfactory care, intensity sampling was utilized to select eligible mothers who expressed some dissatisfaction with their experience. This strategy was operationalized by selecting mothers based on their response to a global question asking how they would rate their postpartum nursing care ranging from dreadful (1) to excellent (7).

Given that the purpose of sampling was to obtain rich accounts of individual experiences, the sample size was small (Baker et al., 1992). Fourteen adolescent mothers were interviewed before saturation of both satisfactory and unsatisfactory care themes

was achieved. It was evident that we had reached saturation when the data collected were no longer contributing new meaning units of satisfactory and unsatisfactory experiences to existing themes or to the creation of new themes (Morse, 1995).

Data Collection

Ethical approval for the study was obtained from the university's Research Ethics Board and the director of the community program (Appendix E). Data collection occurred between January and November 2003.

Prior to data collection, the primary investigator (W.E.P.), who was responsible for all data collection, completed a written summary of her own beliefs about the phenomenon under study and relevant personal experiences. This bracketing document included a description of her experiences as a nurse, a mother, and a researcher, and a discussion of how these various roles influenced the assumptions and beliefs she initially brought to this topic. In addition, during data collection, she continued to write about her thoughts and reactions to the data. These insights were stimulated by noting what it was that surprised her about the adolescent mothers' stories. This strategy assisted her to remain aware of her potential biases.

A poster that briefly described the study purpose and invited participation was displayed at each of the two sites (Appendix F). In addition, W.E.P. attended the weekly drop-in programs to briefly describe the study purpose, eligibility criteria, and the method of data collection to the group. Initially, interested mothers were asked to write their name and telephone number on a form that was circulated. However, it became evident that mothers were more receptive to speaking to W.E.P. directly rather than completing

the form or leaving a phone message. Therefore, W.E.P. began to remain at the program after providing a brief description of the study. During this time she assisted with holding infants and other tasks. This involvement allowed adolescents to get to know her and to verbally indicate an interest in the study.

Participants were interviewed between one week and two months after the birth of their infants. The rationale for this time frame was that it allowed mothers time to recover from the delivery and yet not so much time that their ability to accurately recall postpartum events was remarkably diminished. Interviews conducted at the program site were scheduled either just prior to or during the unstructured portion of the program, in consultation with the program facilitator. When mothers did not attend the program after their expected due date, they were interviewed at another location and time of their choice.

Participants were fully informed of the nature and purpose of the study. All of the information included in the consent form was verbally reviewed and written consent was obtained prior to the interviews (Appendix G). Consent to audio-tape the interview was re-affirmed verbally at the beginning of the recordings.

The interview consisted of two parts: (a) sixteen closed-ended questions designed to collect data regarding maternal demographics, characteristics of their postpartum stay and the global satisfaction with nursing care question; and (b) broad, open-ended questions designed to elicit detailed descriptions of mothers' experiences with inpatient postpartum nursing care (Appendix H). Written notes were kept of the participants' responses to the closed-ended questions. The open-ended portion of the interviews was

audio-taped. The initial interviews began with the closed-ended questions however this deterred the narrative style of interview that was intended. Therefore, in a successful effort to nurture the provision of rich data, the order of these two parts was reversed after three interviews.

During the open-ended portion of the interview, probes were used to encourage the provision of rich information. Some of the probes were based on the results of the earlier survey (Peterson & DiCenso, 2002). Other probes were detail-oriented questions (who, where, what, when, how), and elaboration, clarification, and contrast probes (Patton, 1990). The interview guide was used as a template to focus conversation rather than as a rigid format to be followed. Based on the ongoing analysis, the interview guide was modified several times by adding probes as an informal strategy of member checking, and deleting probes that were not producing relevant data. The modifications to the guide as the study progressed and individual participants' varying ease with conversation meant that each interview followed a slightly different course.

Fieldnotes were written after each interview and later organized as a document called a contact summary. These summaries included a description of the participant, the main issues that were discussed, W.E.P.'s thoughts and feelings about the interview, potential themes, contributions of the interview to the overall study, and ideas for follow-up in future interviews. Participants were given a \$20.00 grocery store coupon in appreciation for their time.

Data Analysis

The audio-taped interviews were transcribed verbatim. NVivo 2.0 software was used throughout data analysis to facilitate management of data and the emergent analysis.

Data analysis was conducted concurrently with data collection and followed the modification of the Stevick-Colaizzi-Keen method of analysis of phenomenological data described by Moustakas (1994) (Appendix I). For each transcript, the statements that described the participant's main ideas about what happened, why it happened, and how she felt were coded as meaning units of the experience. Meaning units were clustered into themes that described related experiences. Some themes were directly related to the participants' postpartum experiences and others captured contextual data. These themes and the original transcripts were reviewed to reduce the data to that which was relevant to the research question and to create a description of each individual's experience using verbatim examples (textural description). The exercise of imaginative variation was used to reflect and consider the structures of the experience, that is, the ideas about "how did the experience of the phenomenon come to be what it is?" (Moustakas, 1994, p.98). From this reflection, a second, more interpretive description of the experience was written (structural description). Finally, a third description of the experience that described the essence of that individual's experience (textural-structural description) was written (Moustakas, 1994). Throughout this process, the meaning units, themes and descriptions were regularly reviewed with the three co-investigators (W.S., C.C. and A.D.).

Moustakas (1994) explains that the next analytical step is to create “...a composite textural-structural description of the meanings and essences of the experience, integrating all individual textural-structural descriptions into a universal description of the experience representing the group as a whole” (Moustakas, 1994, p. 122). In order to facilitate this integrative description, two lists were created from the fourteen textural-structural descriptions. The first list consisted of positive nursing care experiences and their associated meanings, and the second list captured negative experiences and meaning statements. The meaning statements were clustered into themes. At this point, an additional confirmatory analytic strategy was undertaken.

The last step of creating two lists was repeated, however, this time the lists were derived directly from a review of the original transcripts instead of from the textural-structural descriptions. In essence, the analysis was repeated without writing the textural, structural, and textural-structural descriptions explained above. The resulting themes clarified and confirmed the initial analysis.

Through careful reflection of these themes, the essence of the participants’ experiences emerged. The essence was confirmed through re-consideration of the fit between the essence with each of the fourteen textural-structural descriptions. The co-investigators were in agreement with these findings.

Member checking refers to reviewing emerging concepts with participants in order to elicit their reaction and receive feedback (Krefting, 1991). Moustakas (1994) describes member checking as an appropriate strategy for ensuring the credibility of phenomenological data and their analysis. Several strategies were used. First, a method of

'interweaving' was carried out by checking information from a previous interview with the next participant (Krefting). Secondly, when two mothers were interviewed on two occasions, the opportunity was taken to verify our interpretation of their initial description of the experience. Finally, formal member checking was conducted. The themes of satisfactory and unsatisfactory nursing care experiences were reviewed verbally with three participants. Despite attempts to include more participants, many could not be reached for member checking because they were no longer attending the program and had changed their phone numbers by this point in the study. Nevertheless, the member checking that was conducted was confirmatory. Mothers indicated agreement and contributed confirmatory anecdotes while listening to W.E.P. verbally describe the themes.

Findings

All seventeen of the eligible mothers invited to participate expressed an interest in contributing to the study. However, one mother decided not to participate after three failed attempts to meet for an interview because she was too busy with her baby. Because data saturation with respect to positive experience themes was reached before negative themes, two mothers who rated their nursing care experience as excellent (7) on the global satisfaction question were not interviewed. Therefore, the final sample consisted of fourteen adolescent mothers between 16 and 19 years of age.

Table 1 summarizes maternal characteristics of the sample. The majority of mothers were 18 or 19 years old, primarily English speaking, born in Canada, and had not yet completed high school. Two were from visible minorities. All of the participants were

unmarried; however eleven mothers had some degree of involvement with the father of the baby. Thirteen of the participants were first time mothers. There were an equal number of male and female infants.

Table 1: Maternal Characteristics

Maternal Characteristic		n =14
Maternal age (years)	16	1
	17	3
	18	5
	19	5
Primary language	English	9
	French	3
	English and French	2
Country of birth*	Canada	10
	United States	1
	Other	2
Maternal education	Less than high school	9
	High school graduate	5
Partner status	No boyfriend	4
	Boyfriend	10
Mother & infant co-reside in/with	Group home	4
	Boyfriend and others	4
	Boyfriend	3
	Parents	2
	Self	1

(*data unavailable for 1 mother)

Table 2 summarizes characteristics of the mothers' postpartum stay. All mothers had been inpatients on one of four postpartum units, in three hospitals, in the same city. Thirteen participants had delivered vaginally and one mother had an emergency cesarean delivery.

Maternal responses to the global question ‘How would you rate the nursing care that you received on the postpartum unit?’ (1=dreadful, 7=excellent) ranged from 4 (fair) to 7 (excellent) (Table 2). Five mothers found it difficult to provide a global rating due to the variation in care between individual nurses. In fact, two mothers would not give a global rating of nursing care. Instead, they rated the nursing care provided by individual nurses and these scores ranged from dreadful (1) to excellent (7).

Table 2: Characteristics of Mothers’ Postpartum Stay

Characteristics of Postpartum Stay		n = 14
Postpartum unit	A	5
	B	4
	C	4
	D	1
Length of stay	1 night	5
	2 nights	6
	3 nights	3
Roomed-in		12
Roomed-in and newborn nursery		2
Infant feeding	Breastmilk	10
	Formula	1
	Both	3
Global score of nursing care*	4 (fair)**	2
	5 (good)	5
	6 (very good)	2
	7 (excellent)	3

*2 mothers refused to provide a global rating.

**Range of scores 1-7. (1 = dreadful, 2 = very poor, 3 = poor, 4 = fair, 5 = good, 6 = very good, 7 = excellent).

Half of the mothers were interviewed within one month of delivering their infant and half within two months of delivery (range 7-58 days). Seven participants were interviewed at one community program site and four at the second site. At their request,

two participants were interviewed in their apartments and one at the group home where she was living. The length of the interviews ranged from 27 minutes to 1.5 hours. In two cases, participants did not complete the verbal accounts of their experiences during the initial interview and we continued during a second interview the following week. All interviews were conducted privately.

In the interviews, adolescent mothers described experiencing many emotions during their postpartum stay. Participants recalled feeling the ‘high’ of having given birth, the amazement of becoming a mother, and the excitement of meeting the infant that they had long awaited. Some described bonding with the infant immediately whereas for others, it had taken time.

These adolescent mothers also felt considerable anxiety while they were in the hospital. Mothers described having felt nervous, scared, and shy for various reasons. Specific examples included worry about the infant’s health or safety, nervousness with infant care, dislike of hospitals, and fear of the infant being apprehended by the Children’s Aid Society. This brief description of the emotions that the participants experienced provides important contextual knowledge that is useful for understanding their experiences.

Satisfactory Nursing Care Experiences

Four themes common to satisfactory nursing care experiences emerged from the interviews. Experiences were positive when nursing care was provided in a manner that was perceived as friendly, patient, respectful, and understanding of mothers’ individual needs. Two of these themes had subthemes. Adolescent mothers described nursing care

that was perceived as friendly in terms of nurses ‘enjoying their work’ and engaging mothers in conversation that went ‘beyond small talk’. Care was perceived as respectful when mothers felt nurses were ‘showing confidence’ in them, and when they were ‘treated like a new mother, rather than like a teenager with a baby’.

Friendliness

When adolescent mothers described nursing care with which they were satisfied, they spoke about friendly nurses. Nurses demonstrated friendliness by the manner in which they carried out their work and by engaging adolescents in meaningful conversation.

Enjoying the work. Nurses who were perceived to be friendly carried out their work in a happy manner; they smiled, laughed and even joked with the mothers. They were perceived as being enthusiastic about working with new mothers and babies. Participants often interpreted the nurses’ enthusiasm and happiness as meaning that the nurses loved their work. Describing what it was that she liked about her favourite nurse, one mother explained:

I just found her really friendly and like she just seemed just very uh...like I think she was really happy with her job you know, she just seemed really excited by [baby’s name] and I could hear her in the room next to me being all excited about the baby over there. She just seemed like she really enjoyed working with babies and new moms and stuff.

Another mother recalled how she knew that the nurses “...were there because they loved their job, they’re not there for the pay or anything...[because]...They were always happy, they were always smiling and laughing, they’re not ever sad or anything or like mad...”. It was important to the participants that nurses enjoyed their work because it meant that

they had a genuine interest in, and concern for, mothers and infants. As one mother explained, a friendly nurse is: "...Somebody that shows an interest in, you know, my baby and... me and seems, you know, excited about the...like somebody who seems to like their job really more than anything else I think is what's important." Mothers expected nurses who had chosen to work on a postpartum unit to enjoy their work. The birth of their infants was a happy time for these young mothers and they expected the nurses to be happy for them. When nurses were happy and enjoyed their work, it reduced the mothers' anxiety about being in the hospital: "... cause it makes you feel comfortable when you're in there because you don't got anybody that's like mad around you or anything. They're in a happy mood as well as you are..."

Beyond small talk. Friendly nurses stayed after the initial 'small talk' and continued to engage mothers in conversations of more depth. There was an element of time to these interactions that contributed to mothers' perceptions of nurse friendliness as this mother explained: "She would talk with me and we'd have discussions and that...Some of the other nurses would have just like small talk and just leave, kind of thing. And she would stay for a bit and she'd talk."

In addition to time, there was a quality about these friendly conversations that can be described as evolving from small talk to a more personal discussion. This quality is illustrated in the following quote from a mother's description of a nurse who she felt was "heaven sent" at a time when she needed her:

She made me feel comfortable she didn't make me feel like I was just another patient like, "OK we gotta do this, this, and this" and then start reading my chart again. No, she... "how's life?" and all this stuffShe made me feel like a friend,

instead of just another person that was gonna pass through with a couple of hours...

During these interactions there was a mutual sharing of information. Sometimes there was an unstated characteristic of the nurse (e.g., being pregnant) that the mother perceived as something that she shared in common with the nurse. In some cases this commonality increased the nurse's credibility as the following quote illustrates:

She..I'd ask her that day like about pacifiers and stuff like that and she had had two sons before and she was like "I don't recommend using them unless your baby has a strong sucking reflex. So don't worry about it." It was also nice, also getting like, a mom's kind of experience of the whole thing. Cause I didn't know about the other nurses, if they were moms, I'm guessing they were but I had already known cause she was pregnant and this was her third child. So it was nice.

Other "friendly" nurses volunteered personal information about themselves as is evident from this adolescent's description of her favourite nurse: "She was my favourite because she was really nice to me. She had kids of her own and she had one when she was really young too, her oldest she had when she was younger." Nurses who went 'beyond small talk' by making time for conversation and sharing about themselves contributed to a rapport between the nurse and mother that was perceived as friendliness.

Friendly nursing interactions meant that adolescent mothers felt comfortable with the nurses. As one mother summarized, "...she helps me relax and feel comfortable asking questions. She is more like a friend, than a nurse."

Patience

Descriptions of satisfactory experiences included having the sense that the nurse would give mothers as much time as needed. Nurses demonstrated this characteristic by going about their work in an unhurried manner. The ideal nurse does "...not make you

feel like they only have two minutes to spend with you. [They] give [you their] full attention”. The following quote illustrates another mother’s appreciation of the time that one nurse gave her:

Like one thing she did too was um...I was just uh...I couldn’t believe how tired I was the first time she woke me up in the night or whatever and she sort of, she stayed there with me the whole time I tried to feed him just to make sure that I didn’t fall back to sleep. Make sure that I was doing OK....sort of energy wise and stuff.

In addition to the giving of time, the nurse’s demeanor was important. One mother described how her infant would cry when awakened by the nurses for feedings. The infant’s crying upset the mother and she expressed appreciation for the nurses who not only stayed with her throughout a feeding, but who also were calm in their approach.

Yeah, yeah it’s really hard to describe because she was...She didn’t...like um she came in and checked up on me like all the time but um, she sat there through the entire feeding and helped out. And uh, and she didn’t get all worked up when [baby] threw a fit you know, being woken up for a feeding. It was really helpful, she was really helpful. Yeah. I asked her everything. I asked her about pacifiers and I asked her about [unclear] It was really nice, I could ask her about anything.

Nurses who gave time and interacted with mothers in a calm manner were perceived as patient. The presence of one of these qualities, without the other, was perceived as less satisfactory care. The value of both qualities is illustrated by the following quote from the above participant as she described the care of another nurse who gave good, but not excellent care: “She was really, she was nice. She was calm. But she wasn’t really there too much, I guess because she was trying to stay off her feet as much as possible. But, um yeah she was nice.”

When nursing care was perceived as being provided in a patient manner, adolescent mothers were encouraged to interact with nurses. This meant that adolescent mothers would participate more actively in their own care by identifying their needs. One mother described this effect well when she explained why she was more comfortable asking questions of some nurses:

Yeah some nurses were more, I guess, calm. So it was easier to talk to them than the nurses that were sort of rushing through every now and then ...I mean when they rush through then its uh...you sort of forget the questions that you were gonna ask, in a way. I mean you just have so much on your mind because you just had a baby. So you don't remember all the questions that...It's easier when they sit and they ask you, you know, they're calm with you so that you're relaxed.

Respect

Adolescent mothers' descriptions of satisfactory experiences reflected a perception that nurses regarded them as responsible, capable individuals.

Showing confidence in me. Nursing behaviours that were perceived as demonstrating confidence in the adolescents' capabilities included complimenting them as parents. As one participant said,

It was great because we were getting compliments on how good of parents we are and like that just, you know, made me tickled pink you know like "oh that's good - it's my first baby" you know, I never had brothers and sisters...

Sometimes nurses complimented mothers indirectly by indicating approval. Another young mother commented, "I was doing very, very, very well like every nurse was very impressed with the way that I was handling myself and the way that I was moving around and trying to go for walks all the time." Reassuring comments and knowing when to "back off" were other strategies that nurses used to communicate confidence in the mother's abilities.

Treating me like a new mother instead of a teenager with a baby. Participants described themselves as new mothers rather than young or adolescent mothers. They did not consider their needs to differ from those of other new mothers. Therefore they expected their nursing care to be similar to that received by others.

Mothers expressed being treated like a new mother rather than a teenager with a baby when they perceived that nurses considered them to be intelligent. One mother suggested that the perfect nurse would:

...explain[s] things calmly but not like stupid because I'm not stupid, I might be young but you don't have to say like [unclear] and then this is like... you know like, I'm not stupid. You don't have to sugarcoat things for me just tell me straight up.

Adolescent mothers also expressed satisfaction with their care when they perceived it to be equal to that of other new but older mothers. The following quote illustrates how they observed other nurse-mother interactions to evaluate the degree to which their care was similar:

The nurse didn't treat me differently. She treated both of us. Cause I think our room was the only room that she had to worry about. Maybe she had another room but...um yeah she was helping the both of us and um she didn't treat me any differently. She talked the same to the other mom as she did to me. The other mom was a middle age kind of woman maybe not middle age, but, like around 30, 35. And she had just had a baby girl. And she didn't treat us any differently. She was nice, I liked her.

Respectful care was perceived as that which demonstrated confidence in the adolescents' capabilities and did not differ from the care provided to older mothers. One participant summarized her positive experience as one in which "I felt like I was a 35 year old woman, I was married and you know ..."

Understanding individual needs

The adolescent mothers who participated in the study were a heterogeneous group. They had varied levels of social support, different levels of experience with childcare, and unique prenatal and labour and delivery experiences. Their diverse circumstances resulted in varied physical, emotional, and informational needs that required individualized nursing care.

Nursing care that was responsive to individual needs contributed to satisfactory experiences. Examples included basic pain relief:

It was a really good experience cause um, the nurses helped out a lot actually. Like, if you had a problem, they were there. They came in and gave me my medicine on time (laughs) and so I was a happy camper.

A multiparous adolescent described how the nurses met her information needs:

It was really really good. Like the nurse I had, like I only had one nurse at that point. And she was really nice she told me everything she was doing before she did it, and like she gave me like any advice that I needed even though I have a child already she still went through everything just to be sure.

For various reasons, the adolescent mothers in this study did not necessarily express their needs to nurses. Some mothers described a fear of having their infant apprehended by the Children's Aid Society. This fear resulted in a need to impress nurses with their parenting abilities, and therefore they were not always comfortable identifying their learning and emotional needs to the nurses. Other reasons for not sharing their learning needs with nurses included fear of being negatively judged by the nurses and a sense of powerlessness. For example, in explaining why she did not ask about the tests being

carried out on her infant, one mother stated, “Well you’re in a hospital they’re going to do what they need to do anyways.”

Satisfactory experiences were often characterized by the nurse’s ability to anticipate the young mothers’ unique needs. The following quote describes how important it was to one mother that the nurses recognized her frustration with breastfeeding and normalized it by offering to help:

...on the second day my colostrum wasn’t filling him up so he cluster fed for four hours and... I got, uh... kind of upset... and uh, I needed a break so the nurses took him while I went for a walk around the hospital, just...it was very frustrating but...they were ...extremely helpful.

Another mother, who expressed feeling extremely confused by all the advice she had been given, described a satisfactory experience with a nurse that recognized her need for direction. She explained that this nurse was helpful because:

She was stern. She said “...you take the baby like this, you hold the head, you open, make sure the mouth is really [open], you just stick them on and hold her little neck, like make a second neck with your hand and you just stay there. You have to feed, like 10-15 on each side at least don’t like ‘OK 10 minutes’ and take her off, do it until she has at least that much. Make sure to burp her and switch sides.” I’m like “OK”.

Nursing care that was perceived as satisfactory was responsive to mothers’ stated and unstated needs. These experiences contributed to mothers’ feelings of being understood by the nurses.

Unsatisfactory Nursing Care Experiences

Four themes common to unsatisfactory nursing care experiences emerged from the data. Experiences were negative when nursing care was perceived to be too serious, rushed, judgmental, or reflected a misunderstanding of individual needs. In many cases,

these themes of unsatisfactory care can be supported by the absence of satisfactory nursing care experience themes. The data on unsatisfactory care are presented below and organized by themes that reflect as closely as possible the language used by study participants.

Too Serious

Adolescent mothers expressed dissatisfaction with nursing care when they perceived that the care had been provided in a serious manner. One mother's description of a nurse that she remembered fondly because she was not so serious illustrated this well:

Participant: Like she wasn't always depressed or like look depressed or just super serious cause she was at work or something. She would like laugh...

W.E.P.: Were some of the others the other way?

Participant: Yeah, they were all like you know 'ok I'm at work so I have to be professional.'

The mother quoted above continued with a comparison of care that was friendly with that which was too serious. According to her, the friendly nurse was able to determine: "Like, you know, deep down how are [mothers] doing instead of just like [asking] "OK are you OK?" Mothers say "fine" instead of [the nurse] asking like you know, "are you sure you're fine, how was your day?" This participant suggested that the serious manner of the nurses hindered her from sharing all of the information she would have otherwise been willing to provide. Another mother, who was asked what she would like to tell nurses about how to best help young mothers, expressed dissatisfaction with care that was perceived as too serious. She suggested that nurses should:

Participant: Lose the serious attitude. They take their job too seriously. They need

to lighten up and get more into an easier mood.

W.E.P.: So how do they show that... taking their job too seriously?

Participant: I don't know they just never smile, or never laugh, or never crack a joke once in a while. They're like "well do you need help?" "no" "OK well, bye then". "OK, well you're plain and simple", like geez.

Clearly, mothers expressed wanting further interaction with the nurses, but the degree of interaction was limited by the nurses' manner that was interpreted as too serious.

Rushed

Adolescent mothers realized how busy nursing work can be. In fact, one mother's statement reflected this understanding by illustrating how the busy conditions of the unit increased her appreciation of the nursing care: "Yeah. It was busy. And they were still good to me so I was impressed." In light of this and other comments, rushed nursing care was defined in terms of the manner in which nurses provided care independent of the conditions of the postpartum unit. Rushed nursing care refers to adolescent mothers' perceptions of care that is limited to the job that had to be done:

She'd still come in and check us but she didn't stay and help with breastfeeding or uh that kind of stuff... she was just, you know quick with what she did. Did what she had to do and that was it.

Later in the interview this mother provided another example of rushed care, describing how the nurse "...checked the car seat...quickly. You know, tug tug, it's OK, it's tight alright bye. That kind of thing so yeah, it was quick."

Nurses who were rushed didn't stay in the room long enough to help with problems that arose. One participant remarked:

I had a really bad nurse. It was really a nurse who...who, um it seemed like she never really came in the room. And she wasn't really there to help me out or anything. Like after getting [the baby] to be latched on she'd get up and leave.

And that was a problem because she [the baby] liked to push me away. And she had really gotten into a habit of that. So um that was a big problem.

Rushed nursing care was often perceived as inadequate care. After experiencing a particularly bad night with one nurse, a mother described how she "...couldn't stay another night and have that same woman take care of me." Explaining further why she left the hospital 24 hours early, she stated:

That was it, you know I could go home and get my mom to take care of him for free and she'd have more time and then I'd have more time to heal. And I healed probably a lot faster than I would have in there.

Judgmental

Adolescent mothers expressed dissatisfaction with nursing care that made them feel negatively judged based on their age. Nurses were perceived as judgmental when they behaved differently around adolescent mothers than they did around older married mothers. One participant described overhearing nurses speak to her older roommate. This young mother perceived a difference in the nurses' tone of voice and the content of their conversations, depending on to whom they were speaking. She interpreted this difference as meaning that the nurses were negatively judging her:

Some of the nurses were kind of bitchy though. Cause beside me I had a woman who was older, she was like in her mid...late twenties. And I swear they're so much like "oh that's nice, is this your first?" and everything. And then they're like "oh your baby's cute" you know, and then they're like "oh what's her name?" and like they're all "do you have any other children?", "how's your husband taking it?" They didn't care about that for me. They just said "this is what you're gonna do". [When they were talking to the older mother]... they're being all nice and friendly and "Ahhhh". To me it's just like "heh, we're going to teach you how to do stuff cause you probably don't know how to do anything". Yeah that's how it felt. And they're so really like uninvolved...

Experiences of being negatively judged were not limited to verbal comments. Judgment also took the form of a general attitude towards the mother. These experiences were most often limited to an individual nurse; however, some mothers spoke about how the nurses at certain hospitals were viewed as being more judgmental than those at other hospitals.

The following quote describes how a nurse's behaviour made one mother feel:

I was warned though, at the [hospital name], if you're a young mom you might get looked down on a little bit and I think that's what she was doing cause she knew I was young and... she thought I was stupid and...she wasn't that bad it's just...I don't know. I'd just had a baby I wasn't in the best of moods. And she just...I guess didn't understand. I didn't give her a hard time or anything but it seemed to me like she was giving me one.

When nurses were perceived as judgmental, adolescent mothers were inhibited from asking them for assistance. Several of the mothers described how they would rather have no nursing care than the judgmental care that they received. In response to a question about paging the nurse for assistance, one mother replied:

No. I didn't want to ask her anything. I...I honestly, whenever I saw her entering my room I'd rather her leave the room. Like cause I was so upset by the fact that...I...like...I can't even explain to you like her whole vibe of what she gave off it was like she didn't want to deal with me or something ... and she felt superior to me or something. And I felt like I was a bad person for having a baby so young like honestly that's the way she made me feel. It was awful ...it was the worst...(pause) It was really bad.

Not understanding individual needs

Nursing care that was perceived as failing to recognize or demonstrate knowledge of individual mothers' needs was perceived as unsatisfactory. One mother described how her need to feel supported after making a difficult decision went unrecognized by a nurse:

Participant: Yeah, one really pissed me off because she was so... cause obviously

I'm not breastfeeding right. She was so kind of gung-ho on getting me to breastfeed. And I did not, like I tried and tried and I started balling my eyes out because I couldn't. And uh...after trying so many positions I just said "listen, I'm going to formula feed". Cause every time I breastfeed I have to fill him up with formula anyways you know, and I'm going through this emotional roller coaster over it, its hurting, so... and he wasn't latching on properly and so it was causing a lot of pain for my poor nipples. [laughs]

W.E.P.: And she was trying to...

Participant: ...persuade me to keep trying...she was just kind of very pushy. She's like "oh breastfeeding-this, it's so good because you know", blah blah blah...

Later in the interview, this mother explained that the nurse "...kind of made me feel guilty about not wanting to breastfeed. You know, it's hard enough."

Another adolescent spoke about how her experience with one nurse made her feel that the nurse did not know what she had been through in labour, and therefore did not appreciate the pain that she was experiencing postpartally. As a result, when this mother dropped her pain medication and could not reach it because of her limited mobility, she did not ask the nurse for another dose.

I lost my medication - I didn't take it 'til the next morning. I didn't bother with her. I was in so much pain...I couldn't like - I wasn't functioning at all. I didn't even want to get up to the bathroom that's how bad [the pain] got.

When asked if she called the nurse for help, this mother explained:

I asked her to help me put some freezing gel that my doctor had specially ordered...And she just was like "Oh" and she grabbed a glove, which I'm allergic to latex. And they did a test on me and found out that I'm one step down from being deathly allergic. And she puts this latex glove on and then goes and rubs it like really hard with her fingers. Well that's gonna hurt me even more, you know. She just wasn't a very good nurse. I couldn't stand her, so.

When their needs were not recognized, adolescent mothers expressed feeling that their individual circumstances were misunderstood by nurses. This lack of understanding resulted in dissatisfaction with nursing care.

The Essence of Satisfactory Nursing Care Experiences

The essence of an experience is the common or universal quality without which it would not be what it is (Moustakas, 1994). Integration of the mothers' individual textural-structural descriptions of satisfactory and unsatisfactory experiences resulted in the following description of the essence of their satisfaction with postpartum nursing care.

Adolescent mothers are satisfied with postpartum nursing care when they actively participate in their own care. This participation is dependent on the establishment of a nurse-adolescent mother relationship in which the adolescent mother feels sufficiently 'at ease' with the nurse to identify her needs and concerns. The initial development of this relationship is dependent on the nurse's ability to put adolescent mothers at ease and to encourage open communication.

Qualities of nursing care that foster adolescent mothers' comfort level with nurses include care that is provided in a manner that is friendly, patient, respectful, and understanding of mothers' individual needs. Friendly, patient care encourages adolescents to be at ease with nurses and to feel comfortable identifying their needs. Care that is respectful and understanding also facilitates their participation by normalizing their needs.

When some or all of these qualities are diminished or absent, care is perceived as less satisfactory. Unsatisfactory nursing care experiences are those that are provided in a manner that is too serious, rushed, or judgmental, or that reflects misunderstanding of mothers' individual circumstances. Such care deters adolescent mothers from asking questions of nurses. In extreme cases, unsatisfactory nursing care experiences can stifle the potential for an effective relationship because the adolescent mothers push nurses away. They close the door on communication by not asking for assistance and even refusing care.

Discussion

The findings from this phenomenological study contribute to our understanding of adolescent mothers' satisfactory and unsatisfactory postpartum nursing care experiences in two important ways. First, the meaning of specific nursing actions that influence adolescent mothers' evaluation of nursing care have been described. Secondly, we have explained the way in which these actions encourage adolescent mothers to participate in the development of an effective nurse-patient relationship which, in turn, enhances patient satisfaction.

Satisfactory nursing care experiences were characterized by care that was perceived as friendly, patient, respectful and/or understanding of mothers' individual needs. Specific nursing behaviours that were perceived as friendly included spending time with adolescents, engaging in conversations that had a personal quality, and demonstrating enjoyment of nursing work by smiling, laughing, and joking with mothers. It was important to the adolescents that nurses enjoyed their work because it implied that

they were genuinely interested in, and happy for, the mothers. Descriptions of patient nursing care also characterized mothers' expressions of satisfaction. Nurses were perceived as patient when they gave time and interacted with mothers in a calm manner. Respectful care was described as care that did not differ from that provided to older mothers and which demonstrated confidence in adolescents' abilities to parent. Specific nursing actions included providing compliments and reassurance, and knowing when to let mothers care for their infants independently. And finally, care that reflected nurses' understanding of mothers' individual needs was described as satisfactory. Given that adolescents did not always verbalize their needs, it was particularly satisfactory when nurses anticipated their needs.

These findings suggest that, like other inpatient populations, adolescent mothers' satisfaction is primarily influenced by the interpersonal dimensions of nursing care (Johansson, Oleni, & Fridlund, 2002; Lin, 1996; Wilde, Starrin, Larsson, & Larsson, 1993). Moreover, studies of other inpatient populations' perceptions of high quality nursing care have identified specific aspects of the interpersonal dimension of care that reflect those described in this study (e.g., mutual understanding, respect, trust, honesty, humour, kindness, empathy, and patience) (Bond & Thomas, 1992; Johansson et al.; Wilde et al.). Although fewer studies have focused specifically on patients' experiences with postpartum nursing care, there is evidence that providing nursing care to adult mothers in a friendly manner is important to them (Bondas-Salonen, 1998; Tarkka & Paunonen, 1996). The congruence between this existing literature and the themes that we found to be common to adolescent mothers' satisfactory experiences suggests that the

meaning attributed to satisfactory nursing care experiences is similar between adolescent and adult mothers.

Coyle (1999) explains the importance of exploring patients' dissatisfaction with health care experiences as an important approach to identify specific problems. The adolescent mother participants in this study described dissatisfaction with their experiences when nursing care was perceived as being provided in a manner that was too serious, rushed, judgmental and/or reflected a misunderstanding of individual needs. Care perceived as being too serious in nature was described as professional or as being provided by nurses who took their jobs too seriously. Rushed care was limited to the job that had to be done and was often perceived as inadequate care. Care was perceived as judgmental when it differed from the care provided to older mothers. Specific behaviours that contributed to this perception included a change in the nurses' friendly tone of voice or conversation with adult mothers to one that was more business-like when speaking with adolescent mothers. When nurses did not recognize mothers' individual needs, mothers expressed feeling misunderstood by the nurses.

While less attention has been given to the study of patients' dissatisfaction, several studies have reported similar findings. For example, studies have reported dissatisfaction among postpartum mothers who perceived nursing care to be provided in a hurried manner and that did not meet mothers' individual needs (Hunter & Larrabee, 1998; Tarkka & Paunonen, 1996). Studies of other patient populations have reported perceptions of unequal care and provider stereotyping as sources of dissatisfaction among

female patients and those who belong to ethnic minorities (Browne, Johnson, Bottorff, Grewal, & Hilton, 2002; Coyle, 1999).

Williams and Irurita (1998) concluded that nurses' and patients' perceptions of quality care were dependent on the development of a therapeutically conducive relationship in which patient needs were identified. Studies have shown that both nurses and patients contribute to the establishment of effective therapeutic relationships (Morse, 1991; Williams & Irurita, 1998). However, our findings suggest that adolescent mothers are often hesitant to join in the interplay required to establish mutual relationships, and the responsibility of the initial relationship development rests with the nurse. Nursing care that was perceived as friendly, patient, respectful and/or understanding promoted adolescents' comfort level with nurses and reduced their feelings of anxiety. Consequently, adolescents expressed feeling that they could talk with the nurses, they could "ask them anything," and they could learn. We propose that this feeling of being sufficiently 'at ease' with nurses and thereby able to identify and communicate their needs to nurses is the essence of adolescent mothers' satisfaction with nursing care experiences.

In contrast, nursing care that was provided in a manner perceived to be too serious and/or rushed inhibited adolescents' interaction with nurses. When care was perceived to be judgmental, or when adolescent mothers' perceived that nurses misunderstood their needs, they intentionally avoided interaction with nurses and in one circumstance, refused further nursing care.

Findings from our earlier study identified adolescent mothers as being at-risk for dissatisfaction with postpartum nursing care. Based on the analysis of individual item scores and responses to an open-ended question in that study, we hypothesized that the specific dimensions of nursing care with which adolescents were dissatisfied were nurse availability and events related to nurse-mother miscommunication (Peterson & DiCenso, 2002). The findings from this phenomenological study provide insight into how adolescent mother satisfaction with these two dimensions of nursing care may be improved. Skilled interpersonal nursing care encourages adolescent mothers to feel ‘at ease’ with nurses and consequently facilitates nurse-adolescent mother communication. This link between provider-patient communication and patient satisfaction has been observed with other patient populations (Jacobson, Richardson, Parry-Langdon, & Donovan, 2001; Shaw, Williams, Assassa, & Jackson, 2000). In the case of adolescent mothers, improved communication likely contributes to the nurses’ ability to accurately assess individual adolescent’s needs and intervene appropriately. Individualized care may result in an improvement in adolescents’ perceptions of nurse availability. Therefore, interventions designed to improve nurses’ interpersonal relations with adolescent mothers will likely foster adolescent mothers’ satisfaction with multiple dimensions of nursing care.

Several study strengths contribute to the trustworthiness of the findings. Credibility refers to the degree to which the study findings represent “the truth” according to the participants and the context of the study (Krefting, 1991; Lincoln & Guba, 1985). Three study characteristics have contributed to the credibility of these

findings. First, the primary investigator's immersion in the data (W.E.P. conducted, transcribed, read and re-read the interviews, and analyzed the data) has assured a closeness of our interpretation to the data. Secondly, investigator triangulation in the form of regular discussion and confirmation of the ongoing analysis between W.E.P. and three experienced faculty members ensured that the interpretation was not underpinned by only one theoretical or disciplinary perspective. Finally, several member-checking strategies were employed. Foremost was the formal member checking with participants that confirmed our analysis. However, the fact that we were able to contact only three mothers to participate in this process is a limitation of the study.

An auditable study is one in which sufficient description about the decisions made by the investigators throughout data analysis is provided. Enough detail is required so that another researcher, conducting the same study in the same context, would understand the decisions that were made. Our use of the specific method of data analysis described by Moustakas (1994) facilitates this understanding. Audit records that have been kept include the audiotapes of the interviews, transcripts, fieldnotes, contact summaries, journaling, a bracketing document, coding of invariant meaning units and themes, memos (Appendix J), data analysis (data reduction and interpretation documents), and notes from meetings.

Transferability refers to the degree to which study findings are applicable to similar individuals under similar circumstances. Based on our detailed description of the study participants, researchers can determine the transferability of these results (Lincoln and Guba, 1985).

The trustworthiness of qualitative research is also dependent on whether the data are confirmable (Lincoln & Guba, 1985). The maintenance of an audit trail and the reflexive journal as records regarding the reasons for making specific methodological decisions contribute to the confirmability of this study.

Implications

We have described how specific nurse behaviours are perceived by adolescent mothers to contribute to satisfactory or unsatisfactory experiences of postpartum nursing care. Nurses can use these findings to practice self-reflection and evaluate their own practice. It was certainly evident from the interviews that one nurse can have an important positive (or negative) impact on an adolescent mother's experience. Our data include descriptions of participants' decisions to remain in hospital an extra day and to leave the hospital early based on their experiences with individual postpartum nurses.

Our findings contribute to existing evidence that nurses who are happy with their jobs enhance the quality of the patients' experiences. For example, an association between nurse burnout and patient dissatisfaction has been reported (Leiter, Harvie, & Frizzell, 1998). Therefore the provision of highly satisfactory nursing care is partially dependent on nurses' job satisfaction which, in turn, is dependent on the supportive nature of the health care organization (Kangas, Kee, & McKee-Waddle, 1999). Supportive organizational cultures are those in which peers are encouraged to work collaboratively in an equitable and sociable environment (Kangas et al.). Kangas et al. suggest that these organizational characteristics contribute to nurses' job satisfaction through the development of professional self-esteem.

Our findings support the importance of teaching the art and skill of initiating and maintaining therapeutic nurse-patient relationships to nursing students. Leenerts (2003) suggests that the students entering schools of nursing today are from technology-rich educational environments and may require even more interpersonal skill development than previous student cohorts. However, teaching how to establish and maintain therapeutic relationships is challenging. Effective teaching strategies include encouraging the development of personal knowledge through exercises of self-reflection and formal educational sessions followed-up with goal-setting and peer reinforcement (Leenerts; Yeakel, Maljanian, Bohannon, & Coulombe, 2003).

The design, implementation, and evaluation of interventions to improve adolescent mother satisfaction with postpartum nursing care are logical next steps in this area of research. Subsequently, prospective studies can be designed to determine if there is a relationship between satisfaction and health service utilization and, ultimately, improved service use and health outcomes for this high-risk population.

References

- Avis, M. (1997). Incorporating patients' voices in the audit process. *Quality in Health Care, 6*, 86-91.
- Baker, C., Wuest, J., & Stern, P. N. (1992). Method slurring: the grounded theory/phenomenology example. *Journal of Advanced Nursing, 17*, 1355-1360.
- Bond, S. & Thomas, L.H. (1992). Measuring patients' satisfaction with nursing care. *Journal of Advanced Nursing, 17*, 52-63.
- Bondas-Salonen, T. (1998). New mothers' experiences of postpartum care-A phenomenological follow-up study. *Journal of Clinical Nursing, 7*, 165-174.
- Browne, A.J., Johnson, J.L., Bottorff, J.L., Grewal, S., & Hilton, B.A. (2002). Recognizing discrimination in nursing practice. *Canadian Nurse, 98*(5), 24-27.
- Cohen, M.Z., & Omery A. (1994). Schools of phenomenology: Implications for research. In J.M. Morse (Ed.), *Critical Issues in Qualitative Research Methods* (pp. 136-156). Thousand Oaks, CA: Sage Publications.
- Coyle, J. (1999). Understanding dissatisfied users: Developing a framework for comprehending criticisms of health care work. *Journal of Advanced Nursing, 30*(3), 723-731.
- Creswell, J.W. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks, CA: Sage.
- Fraser, A.M., Brockert, J.E., & Ward, R. H. (1995). Association of young maternal age with adverse reproductive outcomes. *The New England Journal of Medicine, 332*(17), 1113-1117.

- Hunter, M.A., & Larrabee, J.H. (1998). Women's perceptions of quality and benefits of postpartum care. *Journal of Nursing Care Quality, 13*(2), 21-30.
- Jacobson, L., Richardson, G., Parry-Langdon, N., & Donovan, C. (2001). How do teenagers and primary healthcare providers view each other? An overview of key themes. *The British Journal of General Practice, 51*(471), 811-816.
- Jasper, M. A. (1994). Issues in phenomenology for researchers of nursing. *Journal of Advanced Nursing, 19*, 309-314.
- Johansson, P., Oleni, M., & Fridlund, B. (2002). Patient satisfaction with nursing care in the context of health care: a literature study. *Scandinavian Journal of Caring Sciences, 16*, 337-344.
- Kangas, S., Kee, C.C., & McKee-Waddle, R. (1999). Organizational factors, nurses' job satisfaction, and patient satisfaction with nursing care. *Journal of Nursing Administration, 29*(1), 32-42.
- Kinsman, S.B. & Slap, G.B. (1992). Barriers to adolescent prenatal care. *Journal of Adolescent Health, 13*, 146-154.
- Koniak-Griffin, D., Anderson, N.L.R., Verzemnieks, I., & Brecht, M.L. (2000). A public health nursing early intervention program for adolescent mothers: Outcomes from pregnancy through 6 weeks postpartum. *Nursing Research, 49*(3), 130-138.
- Koniak-Griffin, D., Verzemnieks, I.L., Anderson, N.L.R., Brecht, M.L., Lesser, J., Kim, S., et al. (2003). Nurse visitation for adolescent mothers: Two-year infant health and maternal outcomes. *Nursing Research, 52*(2), 127-136.
- Krefting, L. (1991). Rigor in qualitative research: The assessment of trustworthiness. *The*

American Journal of Occupational Therapy, 45(3), 214-222.

- Kyngas, H., Hentinen, M., & Barlow, J. H. (1998). Adolescents' perceptions of physicians, nurses, parents and friends: Help or hindrance in compliance with diabetes self-care? *Journal of Advanced Nursing*, 27, 760-769.
- Lee, S.H. & Grubbs, L.M. (1995). Pregnant teenagers' reasons for seeking or delaying prenatal care. *Clinical Nursing Research*, 4(1), 38-49.
- Leenerts, M.H. (2003). Teaching personal knowledge as a way of knowing self in therapeutic relationship. *Nursing Outlook*, 51(4), 158-164.
- Leiter, M.P., Harvie, P., & Frizzell, C. (1998). The correspondence of patient satisfaction and nurse burnout. *Social Science and Medicine*, 47(10), 1611-1617.
- Lena, S.M., Marko, E., Nimrod, C., Merritt, L., Poirier, G., & Shein, E. (1993). Birthing experience of adolescents at the Ottawa General Hospital Perinatal Centre. *Canadian Medical Association Journal*, 148(12), 2149-2154.
- LeVasseur, J.J. (2003). The problem of bracketing in phenomenology. *Qualitative Health Research*, 13(3), 408-420.
- Lin, C.C. (1996). Patient satisfaction with nursing care as an outcome variable: Dilemmas for nursing evaluation researchers. *Journal of Professional Nursing*, 12(4), 207-216.
- Lincoln, Y., & Guba, E. G. (1985). Establishing Trustworthiness. In *Naturalistic Inquiry* (pp. 289-331). Newbury Park, CA: Sage.
- Litt, I. F., & Cuskey, W. R. (1984). Satisfaction with health care: A predictor of adolescents' appointment keeping. *Journal of Adolescent Health Care*, 5, 196-

200.

Luman, E.T., McCauley, M.M., Shefer, A., & Chu, S.Y. (2003). Maternal characteristics associated with vaccination of young children. *Pediatrics, 111*(5), 1215-1218.

Morse, J. (1991). Negotiating commitment and involvement in the nurse-patient relationship. *Journal of Advanced Nursing, 16*, 455-468.

Morse, J. (1995). The significance of saturation. *Qualitative Health Research, 5*(2), 147-149.

Moustakas, C. (1994). *Phenomenological Research Methods*. Thousand Oaks, CA: Sage Publications.

NHS Centre for Reviews and Dissemination (1997). Preventing and reducing the adverse effects of unintended teenage pregnancies. *Effective Health Care, 3*(1), 1-12.

Nolan, L., & Goel, V. (1995). Sociodemographic factors related to breastfeeding in Ontario: Results from the Ontario Health Study. *Canadian Journal of Public Health, 86*(5), 309-312.

O'Sullivan, A.L. & Jacobsen, B.S. (1992). A randomized trial of a health care program for first-time adolescent mothers and their infants. *Nursing Research, 41*(4), 210-215.

Parks, P.L. & Arndt, E.K. (1990). Differences between adolescent and adult mothers of infants. *Journal of Adolescent Health Care, 11*, 248-253.

Patton, M. (1990). Qualitative Interviewing. In *Qualitative Evaluation and Research Methods* (pp. 277-359). London: Sage.

Peterson, W.E., & DiCenso, A. (2002). A comparison of adolescent and adult mothers'

- satisfaction with their postpartum nursing care. *Canadian Journal of Nursing Research*, 34(4), 117-127.
- Scholl, T.O., Hediger, M.L., & Belsky, D.H. (1994). Prenatal care and maternal health during adolescent pregnancy: A review and meta-analysis. *Journal of Adolescent Health*, 15, 444-456.
- Scholl, T.O., Miller, L.K., Salmon, R.W., Cofsky, M.C., & Shearer, J. (1987). Prenatal care adequacy and the outcome of adolescent pregnancy: Effects on weight gain, preterm delivery, and birth weight. *Obstetrics & Gynecology*, 69(3), 312-316.
- Shaw, C., Williams, K., Assassa, P.R., & Jackson, C. (2000). Patient satisfaction with urodynamics: A qualitative study. *Journal of Advanced Nursing*, 32(6), 1356-1363.
- Slager-Earnest, S.E., Hoffman, S.J., & Beckmann, C.J. (1987, November/December). Effects of a specialized prenatal adolescent program on maternal and infant outcomes. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 422-429.
- Smith, G.C.S. & Pell, J.P. (2001). Teenage pregnancy and risk of adverse perinatal outcomes associated with first and second births: Population based retrospective cohort study. *British Medical Journal*, 323, 476-9.
- Statistics Canada (2003). *Births 2001*. (Statistics Canada Catalogue No.84F0210XPB).
- Sullivan, D.A., & Beeman, R. (1981). Satisfaction with postpartum care: Opportunities for bonding, reconstructing the birth and instruction. *Birth and the Family Journal*, 8(3), 153-159.

- Tarkka, M.T., & Paunonen, M. (1996). Social support provided by nurses to recent mothers on a maternity ward. *Journal of Advanced Nursing*, 23, 1202-1206.
- Teagle, S.E. & Brindis, C.D. (1998). Perceptions of motivators and barriers to public prenatal care among first-time and follow-up adolescent patients and their providers. *Maternal and Child Health Journal*, 2(1), 15-24.
- Thi, P.L.N., Briancon, S., Empereur, F., & Guillemin, F. (2002). Factors determining inpatient satisfaction with care. *Social Science & Medicine*, 54, 493-504.
- Timberlake, B., Fox, R.A., Baisch, M.J., & Goldberg, B.D. (1987). Prenatal education for pregnant adolescents. *Journal of School Health*, 57(3), 105-108.
- Wambach, K.A. & Cole, C. (1999). Breastfeeding and adolescents. *Journal of Obstetric, Gynecologic and Neonatal Nursing*, 29(3), 282-294.
- Wiemann, C.M., Berenson, A.B., Garcia-del Pino, L., & McCombs, S.L. (1997). Factors associated with adolescents' risk for late entry into prenatal care. *Family Planning Perspectives*, 29(6), 273-276.
- Wilde, B., Starrin, B. Larsson, G., & Larsson M. (1993). Quality of care from a patient perspective: A grounded theory study. *Scandinavian Journal of Caring Sciences*, 7, 113-120.
- Williams, B. (1994). Patient satisfaction: A valid concept? *Social Science and Medicine*, 38(4), 509-516.
- Williams, A.M. & Irurita, V.F. (1998). Therapeutically conducive relationships between nurses and patients: An important component of quality nursing care. *Australian Journal of Advanced Nursing*, 16(2), 36-44.

Yeakel, S., Maljanian, R., Bohannon, R.W., & Coulombe, K.H. (2003). Nurse caring behaviors and patient satisfaction: Improvement after a multifaceted staff intervention. *Journal of Nursing Administration*, 33(9), 434-436.

Author's Note

The authors would like to acknowledge the support and assistance of Barbara Davies, RN, PhD, Faye Brooks, RN, MScN, Nancy McNider, Cathryn Fortier, RN, BScN, Nicola Day, RD, and Margaret Nicholls. We would also like to thank all of the mothers who participated in this study.

CHAPTER 5

Thesis Conclusion

Nurses who provide postpartum care in hospital have an opportunity to assess the individual needs of adolescent mothers, to provide appropriate teaching regarding infant and self-care, and to recommend health-promoting practices and community resources. Given that satisfied patients are more likely to practice better self-care, use health services appropriately, and follow the recommendations of health care professionals, it is important that adolescent mothers are satisfied with their inpatient postpartum nursing care (Kuan et al., 1999; Kyngas, Hentinen, & Barlow, 1998; Lia-Hoagberg et al., 1990).

Earlier research suggested that adolescent mothers might be less satisfied with inpatient postpartum nursing care than older mothers; however, no studies were found that specifically tested this hypothesis (Lena et al., 1993; Sullivan & Beeman, 1981). It is important to determine if adolescent mothers are a population at risk of dissatisfaction, as well as which aspects of their care are satisfactory/unsatisfactory to them, because improving their satisfaction with nursing care may be an important strategy for encouraging their compliance with recommended health practices and their utilization of available health services following discharge.

This thesis consists of three manuscripts that report the findings from two studies of adolescent mothers' satisfaction with inpatient postpartum nursing care. The first study was a matched cohort survey designed to determine if a difference existed between adolescent and adult mothers' satisfaction with inpatient postpartum nursing care (Peterson & DiCenso, 2002). The Newcastle Satisfaction with Nursing Scales (NSNS)

instrument was selected to measure mothers' satisfaction with their inpatient postpartum nursing care (Thomas, McColl, Priest, Bond, & Boys, 1996). Although both mother groups had similar nursing care requirements, and received care on the same postpartum unit during the same time period, the adolescent mothers perceived their nursing care experiences to be less satisfactory than did the adult mothers. Validity testing of the NSNS showed that it is a valid measure of inpatient satisfaction with postpartum nursing care.

The second study used a phenomenological approach to explore the meaning of satisfactory and unsatisfactory experiences with postpartum nursing care from the perspective of adolescent mothers. The results from this second study illustrate the importance of the nurse's role in establishing effective nurse-adolescent mother relationships. Descriptions of specific nursing actions and the meaning attributed to them by adolescent mothers inform the identification of strategies to improve adolescent mothers' satisfaction.

The purpose of this final chapter is to present a short summary of the findings from both studies in the context of the existing patient satisfaction literature, to discuss the value of using both quantitative and qualitative methods to address patient satisfaction, and to summarize the strengths and limitations of these two studies as a body of research. Finally, the implications for nursing practice, education, policy, and research will be described.

Contextualization of Study Findings: Factors that Influence Patient Satisfaction

Reviews of patient satisfaction studies have identified multiple factors that influence patients' evaluations of the care they receive. The following discussion of the major study findings will be framed by two main categories of factors that are commonly believed to influence patient satisfaction: (a) characteristics of the patients and (b) characteristics of the care received (Cleary & McNeil, 1988; Pascoe, 1983; Sitzia & Wood, 1997).

Characteristics of Patients

Certain patient groups have been identified as being more likely to be satisfied with health care. For example, specific patient sociodemographic characteristics and better self-perceived health status have been associated with higher patient satisfaction (Cleary & McNeil, 1988; Lin, 1996, Sitzia & Wood, 1997; Thi, Briancon, Empereur, & Guillemin, 2002).

Sociodemographic characteristics. The consideration of sociodemographic factors that influence patient satisfaction is important for interpretation of study results and identifying patients at risk of dissatisfaction (Thi et al., 2002). We compared patient satisfaction between two groups of mothers who differed in age and marital status. By virtue of their young age, adolescent mothers also differed from the adult mothers in that they had significantly lower levels of education. Although each of these demographic characteristics (i.e., age, marital status, education) have been associated with differences

in patient satisfaction, age is the variable for which there is the most consistent evidence (Thi et al.).

Patients older than 40 years are more likely to be satisfied with their health care than younger patients (Thi et al., 2002). While our study differed from many other surveys of inpatient satisfaction in that the entire sample was under the age of forty, it is interesting to note that the trend remained: the younger group of mothers were less satisfied with care than the older mothers.

By virtue of their age, adolescent mothers are less likely to have completed their education and are less likely to be married, both of which negatively influence socioeconomic status. A number of studies have shown that less affluent patients are less satisfied with care than more affluent patients (Campbell, Ramsay, & Green, 2001; Newacheck, Hung, Park, Brindis, & Irwin, 2003), and one of these studies focused specifically on adolescents (Newacheck et al.). Our finding that unmarried, less educated mothers were less satisfied with nursing care than married mothers with higher levels of education is consistent with the findings of these studies.

Physical and psychological status. Patients' self-perceptions of health status have been positively correlated with patient satisfaction (Thi et al., 2002). Two of the variables on which adolescent and adult mothers were matched include maternal and infant health status. Our findings indicate that adolescent mothers' health status did not explain their relative dissatisfaction because (a) they perceived themselves and their infants to be healthier than the adult mothers did and (b) linear regression analysis determined that

patient perception of maternal and infant health status did not contribute to the difference between adolescent and adult scores.

Among the adolescent group, mothers who had undergone a cesarean delivery were more dissatisfied with the nursing care than those who had delivered vaginally. This finding was not apparent in the adult mother group. Therefore, while we can be certain that health status does not explain our finding that adolescent mothers are relatively less satisfied than adult mothers, satisfaction among adolescent mothers is negatively influenced by cesarean delivery. It may be that there is a difference in perception of nurse culpability between adolescents recovering from cesarean and vaginal deliveries that explains this finding (Williams, Coyle, & Healy, 1998). For example, consider an adolescent who perceives that the nurse has a duty to assist with infant care and that the nurse has failed to perform this duty. The additional pain and immobility associated with a cesarean delivery may result in the mother assigning blame (culpability) to the nurse that would not be the case if she had delivered vaginally. This perception of nurse culpability is believed to be linked to expressions of dissatisfaction (Williams et al.). Although the same phenomenon would exist with adult mothers, there may be other factors that dissuade adults' perception of nurse culpability (Williams et al.).

The psychological status of adolescent mothers may contribute to their relative dissatisfaction with nursing care. During the qualitative interviews adolescents described feeling both contented and anxious during their postpartum stay. Like other mothers, the reasons for the adolescents' anxiety varied; however, they often centered around the safety and health of the infant. Another source of anxiety expressed by several of the

adolescents was the fear of having their infant apprehended by Children's Aid Services. Several mothers described being hesitant to ask questions due to fear that this would lead the nurses to consider them to be unfit parents and therefore to initiate a referral to Children's Aid. Our finding that satisfactory nursing care was that which made adolescents feel comfortable asking the nurses questions suggests that there is a relationship between adolescents' psychological state and their satisfaction with nursing care. Future research is required to test the hypothesis that when compared to adult mothers, adolescent mothers experience increased anxiety, which negatively influences their satisfaction with nursing care.

Characteristics of the Care Received

Interpersonal Care. Adolescent mothers' satisfactory experiences of nursing care were characterized by care that was perceived as friendly, patient, respectful, and understanding of mothers' individual needs. When some or all of these qualities were compromised or absent, nursing care was perceived as less satisfactory. These findings are consistent with those reported in studies of other patient populations, including adult postpartum patients, which conclude that the interpersonal dimension of nursing care has an important influence on patient satisfaction (Gunther & Alligood, 2002; Johansson, Oleni, & Fridlund, 2002; Larrabee & Bolden, 2001). Moreover, the specific aspects of the interpersonal dimension of nursing care that were identified by adolescent mothers as qualities of satisfactory care are similar to those identified by a variety of other patient populations. For example, other studies have reported that patient satisfaction is positively influenced when nursing care is perceived to be pleasant, friendly, attentive,

respectful, empathetic and patient regarding the individual needs of patients (Larrabee & Bolden; Morales-Mann, 1989; Price, 1993; Thomas et al., 1995; Wilcock, Kobayashi, & Murray, 1997; Williams, 1998).

Adolescent mothers' descriptions of unsatisfactory nursing care experiences contribute further evidence to the important influence of nurses' interpersonal skills on patient satisfaction. Unsatisfactory experiences were described as those in which the nursing care was too serious, rushed or judgmental, or that led to mothers' perceptions that nurses misunderstood their individual needs. Studies of other inpatient populations have reported similar interpersonal factors of nursing care that contribute to patient dissatisfaction, including abruptness, inattentiveness, a hurried manner, and a lack of personalized care (Alexander, Sandridge, & Moore, 1993; Hunter & Larrabee, 1998; Tarkka & Paunonen, 1996; Thomas et al., 1995). In the past, patient perceptions of judgmental care have not been commonly reported. However, two recent studies have concluded that dissatisfied female patients or those belonging to an ethnic minority often express having received care that was unequal to that of other patients, or that reflected negative stereotyping by health providers (Browne, Johnson, Bottorff, Grewal, & Hilton, 2002; Coyle 1999).

Effective Nurse-Patient Relationships. Another important finding from the phenomenological study was the meaning attributed by adolescent mothers to satisfactory nursing care experiences. Adolescents described feeling comfortable with nurses when care was provided in a manner that was friendly, patient, respectful, and understanding. Once adolescents felt 'at ease' in the presence of a nurse, they would participate more

actively in their own care by identifying their individual learning or physical needs to the nurse. These findings highlight the importance of the nurse's role in establishing effective nurse-adolescent mother relationships. Conversely, unsatisfactory nursing care experiences discouraged adolescents from interacting with the nurses and hence, participating in the identification of their own needs. In extreme cases, unsatisfactory nursing care experiences extinguished the potential for an effective relationship because the adolescent mothers would not ask for assistance, and sometimes refused care.

These results contribute to evidence from other qualitative studies that have found that an effective nurse patient relationship in which patients' needs are identified is essential to patients' satisfaction with nursing care (Bondas-Salonen, 1998; Price, 1993; Williams & Irurita, 1998). In the case of adolescent mothers, the patient is sometimes hesitant to establish a relationship with the nurse. Therefore nurses should take responsibility for the initiation of a relationship through the provision of care that is friendly, patient, respectful, and understanding. Once the relationship is established, adolescents expressed satisfaction with other dimensions of nursing care that other studies have identified, including the amount and type of information provided by nurses and the availability of the nurses (Alexander et al., 1993; Sullivan & Beeman, 1981; Thomas et al., 1995).

Combining Quantitative and Qualitative Methods

There are various ways in which both quantitative and qualitative methodology can be used to address a research topic. One approach is to conduct a single, multi-method study in which data collection occurs simultaneously. The approach taken in this

study was to conduct independent, consecutive studies that used different methodologies to address related but different research questions regarding adolescent mothers' satisfaction with inpatient postpartum nursing care.

The quantitative survey was designed to determine if a specific population (adolescent mothers) is at risk of a negative outcome (patient dissatisfaction). This approach is appropriate for determining whether adolescents are dissatisfied with postpartum nursing care, to compare their level of satisfaction with a reference group such as adult mothers, to compare satisfaction scores with findings from other studies, and to identify whether within the adolescent sample certain characteristics differentiate those most likely to be dissatisfied from those who are not. However, with regards to determining how to improve adolescent mothers' satisfaction, the results from this study were limited.

The qualitative study was designed to explore the meaning of satisfactory and unsatisfactory nursing care experiences from the perspective of adolescent mothers. Through improved understanding of the meaning of adolescents' experiences, the qualitative findings provide direction regarding how nursing care might be improved to increase the satisfaction of adolescent mothers. For example, based on the results of the quantitative study it was hypothesized that adolescent mothers' dissatisfaction likely resulted from difficulties in nurse-mother communication and nurse unavailability. The phenomenological study results suggest that in order to improve these aspects of care, from the perspective of adolescent mothers, nurses should take responsibility for

establishing relationships with adolescent mothers through the provision of care that is friendly, patient, respectful, and understanding.

An advantage of conducting these two studies consecutively rather than as a single, multi-method study was that examination of the adolescents' responses to the individual item scores of the NSNS informed the development of some of the probes used in the initial interview guide. On the other hand, "bracketing" of the quantitative results was required prior to data collection for the phenomenological study. In particular, it was necessary to bracket the knowledge that adolescents are more likely to be dissatisfied with their nursing care in order to be receptive to the adolescents' descriptions of both satisfactory and unsatisfactory experiences.

There were other challenges faced in conducting two studies using methods with differing philosophical roots. For example, a research team (thesis committee) that consisted of individuals with expertise in both approaches to inquiry was required. Furthermore, members with expertise in either qualitative or quantitative approaches had to have at least an appreciation for the value of the alternate approach. The multidisciplinary nature of this particular team was an additional strength.

There were challenges experienced by the primary investigator that can be described as those associated with "changing hats" after the quantitative study and as the phenomenological study began. This change from the objective stance of the quantitative researcher to a researcher role, in which subjectivity is recognized as part of reality, demanded changes in approach that included how the primary investigator interacted

with participants during the interviews and how she presented data and analyses to committee members.

Strengths and Limitations

Each of these two studies has its strengths and limitations that have been discussed in the respective chapters of this thesis. The following discussion addresses the strengths and limitations of the two studies as a body of research.

Together, the two studies have addressed limitations that are common to other studies of patient satisfaction. First, this research clearly defined patient satisfaction according to Pascoe (1983) and an instrument (NSNS) was selected to operationalize patient satisfaction that demonstrated congruence with this definition. Secondly, given that the NSNS was designed to be used with a medical/surgical inpatient population, validity testing was conducted with the postpartum population. These results provide confidence in the validity of the survey results, an essential study characteristic that is often overlooked. Third, among patient satisfaction researchers, there is recognition of the need for more qualitative exploration of patient satisfaction. This research has incorporated both the use of an instrument that was developed from the patients' perspective and qualitative inquiry to complement quantitative results.

Unlike many studies that assess patients' overall satisfaction with a health care experience or health care in general, these two studies focused on the nursing component of a defined inpatient experience. Vuori (1991) explained that the value of limiting the assessment of patient satisfaction to a defined component of care (e.g., nursing) is that it facilitates making specific recommendations for change.

The main limitation of this research is that the adolescents who participated in the phenomenological study were not drawn from the sample of surveyed mothers. In fact, the two study samples were recruited from two different geographical locations within Ontario. The primary reason for this decision was a change in the primary investigator's city of residence during the time that the survey was being conducted. It would have been advantageous to have recruited the qualitative sample from the quantitative sample. In that case, qualitative data analysis could have been used to interpret adolescents' satisfaction scores at the individual level. Furthermore, the observation that patient reports of dissatisfaction are more commonly found in studies using qualitative methodology than those using quantitative methods could have been examined (Avis, 1997; Williams et al., 1998).

Implications

Implications for nursing practice

The study findings have direct implications for nurses caring for adolescent mothers. Primarily, it is important to increase awareness among clinical nurses that adolescent mothers may be less satisfied with their care than adult mothers and to inform nurses of the specific nursing behaviours that were perceived by adolescents to promote their satisfaction with nursing care. Ensuring that these findings are used by nurses to improve adolescent mothers' satisfaction is dependent on effective dissemination of the findings. Academic detailing is an effective method of translating new knowledge into practice (Thomson O'Brien et al., 2003). For example, a small number of nurses from a unit who are interested and skilled in working with adolescent mothers could be invited

to serve as opinion leaders and mentors to other staff by modeling expertise in the interpersonal care of adolescent mothers.

Given adolescents' descriptions of feeling judged by nurses and the negative influence that such a perception can have on their experience and satisfaction, it is important that clinical nurses reflect on their own values. Clinical educators can encourage nurses' self-reflection by using an interactive approach that provides nurses with the opportunity to come together and reflect on their practice. Discussion among nurses of actual experiences with adolescent mothers may contribute to the development of personal knowledge necessary for the development of skills in building therapeutic relationships (Leenerts, 2003; Teekman, 2000).

Implications for nursing education

These findings contribute further evidence that nurses' interpersonal skills have an important influence on patients' perceptions of the quality of nursing care. It is essential that nursing students comprehend the important role of nurse-patient relations on patient satisfaction with nursing care and the implications of patient dis/satisfaction.

There are many challenges to teaching communication skills to nursing students, including the need for knowledge regarding effective communication strategies that are specific to certain patient groups and clinical settings (Chant, Jenkinson, Randle, & Russell, 2002). This thesis research contributes evidence regarding specific strategies that improve nurses' communication with adolescent mothers that can be incorporated into educational programs. In particular, the finding that there is a need for nurse-initiated interpersonal care that promotes adolescent mothers' comfort level and open

communication is important for nurse educators to emphasize to students. Specific teaching strategies that are believed to be effective include assignments designed to develop personal knowledge (Leenerts, 2003), the provision of opportunities to interact with certain patient groups (i.e., adolescent mothers), emphasis on relationship development rather than skills training, and consideration of the varied learning styles of individual students (Chant et al.).

Implications for policy

The responsibility for providing highly satisfactory nursing care does not stop at the level of the individual nurse. Adolescents' satisfaction with nursing care was positively influenced when they perceived that the nurses enjoyed their work. A positive relationship between nurses' job satisfaction and patient satisfaction with care has been reported in the past (Kangas, Kee, & McKee-Waddle, 1999). Given that nurses are more likely to be satisfied with their jobs when they feel that their work is highly valued, hospital administrators can advocate for policy that promotes a supportive culture within their organization (Kangas et al.). For example, a collaborative, encouraging culture may be fostered by the establishment of multidisciplinary (i.e., nurse, physician, social work, public health, administration) goal-setting, workshops, and peer review process (Kangas et al.; Yeakel, Maljanian, Bohannon, & Coulombe, 2003).

Unit managers can use the NSNS to measure patient satisfaction among postpartum patients for the purpose of quality assurance, for the development of unit policies that contribute to the provision of highly satisfactory nursing care, and to include patients in quality improvement initiatives. Examples of how the NSNS can be used at

the unit level include: (a) as a baseline measure of patient satisfaction, (b) to identify dimensions to nursing care requiring improvement, and (c) to monitor changes in patient satisfaction after the implementation of policy or practice changes (Thomas et al., 1996; Vuori, 1991).

Implications for research

The NSNS was shown to be a valid instrument for the measurement of postpartum inpatients' satisfaction with nursing care. Taking into consideration previous psychometric testing of the same instrument with medical/surgical patients, the NSNS shows promise as a valid measure of patient satisfaction among other inpatient populations. Therefore continued testing of the psychometric properties of the NSNS with other inpatient populations is recommended. Further psychometric testing will contribute to the confidence with which researchers can accurately and validly quantify inpatient satisfaction with nursing care.

The phenomenological investigation of adolescent mothers' satisfactory and unsatisfactory nursing care experiences has led to several possible explanations for adolescents' relative dissatisfaction with postpartum nursing care. Future study of these potential explanations for adolescent mother dissatisfaction will benefit from the use of both quantitative and qualitative methodologies. For example, it is recommended that future studies test the existence of a relationship between patients' anxiety levels and their satisfaction with nursing care; explore adolescent mothers' experiences of feeling judged or stereotyped by nurses and other health care providers; and, explore the process of the development of effective adolescent mother-nurse relationships. These suggested

areas for study may also be conducted with other patient groups that have been identified at risk of dissatisfaction with nursing care.

The design, implementation, and evaluation of interventions to improve adolescent mother satisfaction is a logical next step in this area of research. Examples of potential interventions for postpartum nurses include interactive workshops or an ‘academic detailing’ strategy. A randomized controlled trial or before-and-after measures of patient satisfaction could be used to evaluate the effectiveness of the intervention. In addition, studies could follow mothers prospectively after hospital discharge to test the relationship between patient satisfaction and use of recommended services, health practices, and health outcomes. In the case of adolescent mothers, suggested outcomes include attendance at follow-up appointments; utilization of public health nurse visits, parenting programs and other recommended community resources; duration of breastfeeding; completion of infant vaccinations; use of infant car seats; postpartum depression; and infant/maternal re-hospitalization.

Conclusion

This thesis reports the findings from two studies of adolescent mothers’ satisfaction with inpatient postpartum nursing care. The matched cohort survey found that unmarried adolescent mothers’ satisfaction with postpartum nursing care was lower than that of married adult mothers. This finding is important given that the study design was such that the two groups of mothers had similar health status, and received nursing care on the same postpartum unit during the same time period. Taking into consideration the existing literature on patient satisfaction, the question arises as to whether this difference

in patient satisfaction is attributable to characteristics of the patients themselves or to characteristics of the care that they received.

Findings from the phenomenological study lead us to conclude that both patient and care characteristics play a role in adolescents' relative dissatisfaction with care compared with adult mothers. The establishment of effective therapeutic relationships with adolescent mothers requires excellent interpersonal skills and is likely more difficult than it is with adult mothers. Given the importance of such a relationship to patient satisfaction, this may explain adolescent mothers' relative dissatisfaction with nursing care. In addition, adolescents' reports of feeling judged by some nurses on the basis of their young age and unmarried status may also contribute to their relative dissatisfaction with nursing care.

These findings have direct implications for nurses providing postpartum care to adolescent mothers. Future research has been recommended that will contribute to our further understanding of adolescent mothers' relative dissatisfaction with postpartum nursing care, and the design and evaluation of effective interventions to improve adolescent mothers' satisfaction with nursing care.

References

- Alexander, L., Sandridge, J., & Moore, L. (1993). Patient satisfaction: An outcome measure for maternity services. *Journal of Perinatal & Neonatal Nursing*, 7(2), 28-39.
- Avis, M. (1997). Incorporating patients' voices in the audit process. *Quality in Health Care*, 6, 86-91.
- Bondas-Salonen, T. (1998). New mothers' experiences of postpartum care – a phenomenological follow-up study. *Journal of Clinical Nursing*, 7, 165-174.
- Browne, A. J., Johnson, J. L., Bottorff, J. L., Grewal, S., & Hilton, B. A. (2002). Recognizing discrimination in nursing practice. *Canadian Nurse*, 98(5), 24-27.
- Campbell, J.L., Ramsay, J., & Green, J. (2001). Age, gender, socioeconomic, and ethnic differences in patient's assessments of primary health care. *Quality in Health Care*, 10(2), 90-95.
- Chant, S., Jenkinson, T., Randle, J., & Russell, G. (2002). Communication skills: Some problems in nursing education and practice. *Journal of Clinical Nursing*, 11(1), 12-21.
- Cleary, P.D. & McNeil, B. J. (1988). Patient satisfaction as an indicator of quality care. *Inquiry*, 25, 25-36.
- Coyle, J. (1999). Understanding dissatisfied users: Developing a framework for comprehending criticisms of health care work. *Journal of Advanced Nursing*, 30(3), 723-731.
- Gunther, M. & Alligood, M.R. (2002). A discipline-specific determination of high quality

- nursing care. *Journal of Advanced Nursing*, 38(4), 353-359.
- Hunter, M. A. & Larrabee, J. H. (1998). Women's perceptions of quality and benefits of postpartum care. *Journal of Nursing Care Quality*, 13(2), 21-30.
- Johansson, P., Oleni, M., & Fridlund, B. (2002). Patient satisfaction with nursing care in the context of health care: A literature study. *Scandinavian Journal of Caring Sciences*, 16, 337-344.
- Kangas, S., Kee, C.C., & McKee-Waddle, R. (1999). Organizational factors, nurses' job satisfaction, and patient satisfaction with nursing care. *Journal of Nursing Administration*, 29(1), 32-42.
- Kuan, L. W., Britto, M., Decolongon, J., Schoettker, P. J., Atherton, H. D., & Kotagal, U. R. (1999). Health system factors contributing to breastfeeding success. *Pediatrics*, 104(3), 1-7. Retrieved November 13, 2002, from <http://www.pediatrics.org/cgi/content/full/104/3/e28>
- Kyngas, H., Hentinen, M., & Barlow, J. H. (1998). Adolescents' perceptions of physicians, nurses, parents and friends: Help or hindrance in compliance with diabetes self-care? *Journal of Advanced Nursing*, 27, 760-769.
- Larrabee, J.H. & Bolden, L.V. (2001). Defining patient-perceived quality of nursing care. *Journal of Nursing Care Quality*, 16(1), 34-60.
- Leenerts, M.H. (2003). Teaching personal knowledge as a way of knowing self in therapeutic relationship. *Nursing Outlook*, 51(4), 158-164.
- Lena, S. M., Marko, E., Nimrod, C., Merritt, L., Poirier, G., & Shein, E. (1993). Birthing experience of adolescents at the Ottawa General Hospital Perinatal Centre.

Canadian Medical Association Journal, 148(12), 2149–2154.

Lia-Hoagberg, B., Rode, P., Skovholt, C. J., Oberg, C. N., Berg, C., Mulltett, S., et al.

(1990). Barriers and motivators to prenatal care among low-income women.

Social Science and Medicine, 30(4), 487–495.

Lin, C.C. (1996). Patient satisfaction with nursing care as an outcome variable: Dilemmas

for nursing evaluation researchers. *Journal of Professional Nursing*, 12(4), 207-

216.

Morales-Mann, E. T. (1989). Comparative analysis of the perceptions of patients and

nurses about the importance of nursing activities in a postpartum unit. *Journal of*

Advanced Nursing, 14, 478-484.

Newacheck, P.W., Hung, Y.Y., Park, M.J., Brindis, C.D., & Irwin, C.E. Jr. (2003).

Disparities in adolescent health and health care: Does socioeconomic status

matter? *Health Services Research*, 38(5), 1235-1252.

Pascoe, G.C. (1983). Patient satisfaction in primary health care: A literature review and

analysis. *Evaluation and Program Planning*, 6, 185-210.

Peterson, W.E. & DiCenso, A. (2002). A comparison of adolescent and adult mothers'

satisfaction with their postpartum nursing care. *Canadian Journal of Nursing*

Research, 34(4), 117-127.

Price, P. J. (1993). Parents' perceptions of the meaning of quality nursing care. *Advances*

in Nursing Science, 16(1), 33-41.

Sitzia, J. & Wood, N. (1997). Patient satisfaction: A review of issues and concepts. *Social*

Science and Medicine, 45(12), 1829-1843.

- Sullivan, D.A. & Beeman, R. (1981). Satisfaction with postpartum care: Opportunities for bonding, reconstructing the birth and instruction. *Birth and the Family Journal*, 8(3),153-159.
- Tarkka, M.T., & Paunonen, M. (1996). Social support provided by nurses to recent mothers on a maternity ward. *Journal of Advanced Nursing*, 23, 1202-1206.
- Teekman, B. (2000). Exploring reflective thinking in nursing practice. *Journal of Advanced Nursing*, 31(5), 1125-1135.
- Thi, P.L.N., Briancon, S., Empereur, F. & Guillemin, F. (2002). Factors determining inpatient satisfaction with care. *Social Science & Medicine*, 54, 493-504.
- Thomas, L.H., MacMillan, J., McColl, E., Priest, J., Hale, C., & Bond, S. (1995). Obtaining patients' views of nursing care to inform the development of a patient satisfaction scale. *International Journal for Quality in Health Care*, 7(2), 153-163.
- Thomas, L.H., McColl, E., Priest, J., Bond, S., & Boys, R.J. (1996). Newcastle satisfaction with nursing scales: An instrument for quality assessments of nursing care. *Quality in Health Care*, 5(2), 67-72.
- Thomson O'Brien MA, Oxman AD, Davis DA, Haynes RB, Freemantle N, Harvey EL. Educational outreach visits: effects on professional practice and health care outcomes. In *The Cochrane Library*, Issue 4, 2003. Chichester, UK: John Wiley & Sons, Ltd))
- Vuori, H. (1991). Patient satisfaction - does it matter?. *Quality Assurance in Health Care*, 3(3), 183-189.

- Wilcock, A., Kobayashi, L., & Murray, I. (1997). Twenty-five years of obstetric patient satisfaction in North America: A review of the literature. *Journal of Perinatal & Neonatal Nursing, 10*(4), 36-47.
- Williams, S. (1998). Quality and care: Patients' perceptions. *Journal of Nursing Care Quality, 12*(6), 18-25.
- Williams, B., Coyle, J., & Healy, D. (1998). The meaning of patient satisfaction: An explanation of high reported levels. *Social Science and Medicine, 47*(9), 1351-1359.
- Williams, A.M. & Irurita, V.F. (1998). Therapeutically conducive relationships between nurses and patients: An important component of quality nursing care. *Australian Journal of Advanced Nursing, 16*(2), 36-44.
- Yeakel, S., Maljanian, R., Bohannon, R.W., & Coulombe, K.H. (2003). Nurse caring behaviors and patient satisfaction: Improvement after a multifaceted staff intervention. *Journal of Nursing Administration, 33*(9), 434-436.

Appendix A

***The Newcastle Satisfaction with Nursing Scales (NSNS)
and Additional Questions for Survey***

INSTRUCTIONS AND EXAMPLE

The first set of questions ask about your experiences of nursing based on your stay on this unit.

The questions consist of a statement followed by seven possible answers.

I will read each statement and show you a card with the seven possible answers that you may choose from.

To answer the question, tell me the number of the answer on the card which best describes your experience.

This first question is an example:

Nurses were very quiet during the night.

Disagree completely	Disagree a lot	Disagree a little	Neither agree nor disagree	Agree a little	Agree a lot	Agree completely
1	2	3	4	5	6	7

If the nurses were always very quiet during the night, you would answer the question by saying ‘seven’ - that means ‘agree completely’.

I will use different coloured cards when the answers that you can choose from are different.

**If you are unsure about how to answer any question, please tell me.
(also use prompts if mother seems unsure)**

SECTION 1: YOUR EXPERIENCES OF NURSING CARE

1. It is easy to have a laugh with the nurses.

Disagree completely	Disagree a lot	Disagree a little	Neither agree nor disagree	Agree a little	Agree a lot	Agree completely
1	2	3	4	5	6	7

2. Nurses favour some patients over others.

Disagree completely	Disagree a lot	Disagree a little	Neither agree nor disagree	Agree a little	Agree a lot	Agree completely
1	2	3	4	5	6	7

3. Nurses did not tell me enough about my care.

Disagree completely	Disagree a lot	Disagree a little	Neither agree nor disagree	Agree a little	Agree a lot	Agree completely
1	2	3	4	5	6	7

4. Nurses are too easy going and laid back.

(to clarify: not professional; too casual)

Disagree completely	Disagree a lot	Disagree a little	Neither agree nor disagree	Agree a little	Agree a lot	Agree completely
1	2	3	4	5	6	7

5. Nurses take a long time to come when they are called.

Agree completely	Agree a lot	Agree a little	Neither agree nor disagree	Disagree a little	Disagree a lot	Disagree completely
1	2	3	4	5	6	7

6. Nurses give me information when I need it.

Disagree completely	Disagree a lot	Disagree a little	Neither agree nor disagree	Agree a little	Agree a lot	Agree completely
1	2	3	4	5	6	7

7. Nurses do not seem to know what I am going through.

Disagree completely	Disagree a lot	Disagree a little	Neither agree nor disagree	Agree a little	Agree a lot	Agree completely
1	2	3	4	5	6	7

8. Nurses turned the lights off too late at night.

Disagree completely	Disagree a lot	Disagree a little	Neither agree nor disagree	Agree a little	Agree a lot	Agree completely
1	2	3	4	5	6	7

9. Nurses make me do things before I am ready.

Agree completely	Agree a lot	Agree a little	Neither agree nor disagree	Disagree a little	Disagree a lot	Disagree completely
1	2	3	4	5	6	7

10. No matter how busy nurses are, they make time for me.

Disagree completely	Disagree a lot	Disagree a little	Neither agree nor disagree	Agree a little	Agree a lot	Agree completely
1	2	3	4	5	6	7

11. I see the nurses as friends.

Disagree completely	Disagree a lot	Disagree a little	Neither agree nor disagree	Agree a little	Agree a lot	Agree completely
1	2	3	4	5	6	7

12. Nurses spend time comforting patients who are upset.

Disagree completely	Disagree a lot	Disagree a little	Neither agree nor disagree	Agree a little	Agree a lot	Agree completely
1	2	3	4	5	6	7

13. Nurses check regularly to make sure that I am okay.

Agree completely	Agree a lot	Agree a little	Neither agree nor disagree	Disagree a little	Disagree a lot	Disagree completely
1	2	3	4	5	6	7

14. Nurses let things get to them.

(to clarify: Do the nurses seem to be frustrated when they are busy?)

Disagree completely	Disagree a lot	Disagree a little	Neither agree nor disagree	Agree a little	Agree a lot	Agree completely
1	2	3	4	5	6	7

15. Nurses take no interest in me as a person.

Disagree completely	Disagree a lot	Disagree a little	Neither agree nor disagree	Agree a little	Agree a lot	Agree completely
1	2	3	4	5	6	7

16. Nurses explained what I should expect (during this postpartum period).

(example to clarify: Did the nurses explain colour and amount of bleeding to expect?)

Disagree completely	Disagree a lot	Disagree a little	Neither agree nor disagree	Agree a little	Agree a lot	Agree completely
1	2	3	4	5	6	7

17. Nurses explain what they are going to do to me before they do it.

Disagree completely	Disagree a lot	Disagree a little	Neither agree nor disagree	Agree a little	Agree a lot	Agree completely
1	2	3	4	5	6	7

18. Nurses tell the next shift what is happening with my care.

(to clarify: the nurses that look after you seem to pass on information about you to each other)

Disagree completely	Disagree a lot	Disagree a little	Neither agree nor disagree	Agree a little	Agree a lot	Agree completely
1	2	3	4	5	6	7

19. Nurses know what to do without relying on doctors.

Agree completely	Agree a lot	Agree a little	Neither agree nor disagree	Disagree a little	Disagree a lot	Disagree completely
1	2	3	4	5	6	7

20. Nurses forget what patients ask for.

Disagree completely	Disagree a lot	Disagree a little	Neither agree nor disagree	Agree a little	Agree a lot	Agree completely
1	2	3	4	5	6	7

21. Nurses make sure that patients have privacy when they need it.

Disagree completely	Disagree a lot	Disagree a little	Neither agree nor disagree	Agree a little	Agree a lot	Agree completely
1	2	3	4	5	6	7

22. Nurses have time to sit and talk to me.

Agree completely	Agree a lot	Agree a little	Neither agree nor disagree	Disagree a little	Disagree a lot	Disagree completely
1	2	3	4	5	6	7

23. Doctors and nurses work well together as a team.

Disagree completely	Disagree a lot	Disagree a little	Neither agree nor disagree	Agree a little	Agree a lot	Agree completely
1	2	3	4	5	6	7

24. Nurses do not seem to know what each other is doing.

Disagree completely	Disagree a lot	Disagree a little	Neither agree nor disagree	Agree a little	Agree a lot	Agree completely
1	2	3	4	5	6	7

25. Nurses know the best thing to do.

Disagree completely	Disagree a lot	Disagree a little	Neither agree nor disagree	Agree a little	Agree a lot	Agree completely
1	2	3	4	5	6	7

26. There is a happy atmosphere in the unit, thanks to the nurses.

Disagree completely	Disagree a lot	Disagree a little	Neither agree nor disagree	Agree a little	Agree a lot	Agree completely
1	2	3	4	5	6	7

SECTION 2: YOUR OPINIONS OF NURSING CARE

Now I will ask your opinions of the nursing care you received during your stay on this unit. For each question, please tell me the number from this green card which best describes your opinion.

Thinking about your stay on the unit, how do you feel about:

		Not at all satisfied	Barely satisfied	Quite satisfied	Very satisfied	Completely satisfied
1	The amount of time nurses spent with you	1	2	3	4	5
2	How good nurses are at their job	1	2	3	4	5
3	There always being a nurse around if you need one	1	2	3	4	5
4	The amount nurses know about your care	1	2	3	4	5
5	How quickly nurses come when you call for them	1	2	3	4	5
6	The way the nurses make you feel at home (to clarify: make you feel welcome)	1	2	3	4	5
7	The amount of information nurses give to you (about your postpartum experience and care)	1	2	3	4	5
8	How often nurses check to see if you are okay	1	2	3	4	5
9	Nurses' helpfulness	1	2	3	4	5
10	The way nurses explain things to you	1	2	3	4	5
11	How comfortable nurses make your relatives or friends feel	1	2	3	4	5
12	The way nurses go about doing their work	1	2	3	4	5

		Not at all satisfied	Barely satisfied	Quite satisfied	Very satisfied	Completely satisfied
13	The type of information nurses give you (about your postpartum experience & care)	1	2	3	4	5
14	Nurses treatment of you as an individual	1	2	3	4	5
15	How nurses listen to your worries and concerns	1	2	3	4	5
16	The amount of freedom you are given on the unit	1	2	3	4	5
17	How willing nurses are to respond to your requests	1	2	3	4	5
18	The amount of privacy nurses give you	1	2	3	4	5
19	Nurses' awareness of your needs	1	2	3	4	5

For the next two questions please tell me the number of the answer on this gold card that matches your opinion of the nursing care you have received on this unit.

1. How would you rate the nursing care you received on this unit?
(to clarify: think about only the nursing care, not the atmosphere, food, cleanliness, noise etc.)

Dreadful	Very poor	Poor	Fair	Good	Very good	Excellent
1	2	3	4	5	6	7

2. Overall how would you rate your stay on this unit?
(to clarify: think about everything about this unit - nursing care, atmosphere, food, cleanliness, noise etc)

Dreadful	Very poor	Poor	Fair	Good	Very good	Excellent
1	2	3	4	5	6	7

For the next two questions, you may answer 'yes', 'no' or 'not sure'.

3. Is there one particular nurse caring for you on this unit?
(to clarify: is there one particular nurse in charge of your care?
Have you had this nurse for more than one day?)

Yes	1
No	2
Not sure	3

4. Would you recommend this postpartum unit to a friend?

Yes	1
No	2
Not sure	3

SECTION 3: QUESTIONS ABOUT YOU

These questions are about you. To help us understand your answers to the other sets of questions, we need some information about the kind of person you are. If you are unsure about how to answer a question, please let me know.

1. How long have you been on this unit?

Day of week admitted to unit _____ time _____AM PM

Day of week today _____ time _____AM PM

2. Counting this baby, how many children have you given birth to? _____

3. Did you have a cesarean section or a vaginal delivery?

Cesarean section 1

Vaginal 2

4. Which nursery is your baby being cared for in now?

Normal newborn (including rooming in) 1

Level II 2

Level III 3

5. Are you feeding your baby:

Breastmilk 1

Formula 2

Both 3

6. How old are you?

Age in years at last birthday _____

7. What is your marital status?

Single 1

Married 2

Other 3 describe: _____

8. What level of education have you finished?

No high school _____

Some high school (state last grade completed) _____

High school completed _____

Some college or university _____

College or university completed _____

9. Are you still in school?

No _____

How old were you when you stopped going to school full-time?

Age in years _____

Yes full time _____

part time _____

10. Did you go to prenatal classes?

Yes	1
No	2
Some	3

11. Did you go to a registration clinic visit ?

Yes	1
No	2

12. Did you go on a hospital tour before you delivered?

Yes	1
No	2

13. Did you see a doctor or midwife during your pregnancy for prenatal care ?

Yes	1
No	2

14. Was the person you saw for prenatal care a (circle as many as applicable):

Obstetrician	1
Family Doctor	2
Midwife	3

Please answer the next two questions with a number from this orange card. This is a scale from 1 to 7 where 1 means not healthy, 4 means healthy and 7 means very healthy. For example, 2 means somewhere between not healthy and healthy but closer to not healthy. 5 means somewhere between healthy and very healthy but closer to healthy.

15. In your opinion, how healthy are you?

1	2	3	4	5	6	7
not healthy			somewhat healthy			very healthy

16. In your opinion, how healthy is your baby?

1	2	3	4	5	6	7
not healthy			somewhat healthy			very healthy

17. Are there any ways in which the nursing care could have been improved during your current stay in the hospital?

18. Are there any other comments you would like to make?

THANK YOU FOR HELPING US WITH THIS SURVEY

Appendix B

***Ethical Approval for
A Comparison of Adolescent and Adult Mothers' Satisfaction with their Postpartum
Nursing Care***



ST. JOSEPH'S HOSPITAL

McMASTER UNIVERSITY

50 CHARLTON AVENUE EAST, HAMILTON, ONTARIO, CANADA L8N 4A6 PHONE (905) 522-1155



March 19, 1999

Ms. Wendy Peterson-Rudnicki
14 Sherwood Rise
Dundas, Ontario
L9H 4E8

**RE: R.P. #99-1695: MOTHERS' EXPERIENCES AND SATISFACTION WITH
INPATIENT POSTPARTUM NURSING CARE**

Dear Ms. Peterson-Rudnicki:

We are pleased to advise you that the Research Committee approved R.P.#99-1695 according to the submitted protocol.

We wish you well in completing your study.

Sincerely,

Marie Lynch

Marie Lynch
Acting Chair, Research Committee

MML/sj

cc: Dr. M. Coughlin

cc: Janet Rush
Director of Nursing Research
St. Joseph's Hospital
Martha Wing, Room 318

Appendix C

Notice to Mothers Regarding Patient Satisfaction Survey



Mothers,

We are interested in your thoughts and opinions about the nursing care you have received since your baby was delivered.

There is a patient satisfaction survey taking place on this unit from March until September 1999.

During your postpartum stay, you may be approached by an interviewer and invited to participate in this study.

Your decision to participate or not is completely voluntary and will not affect your care in any way.

Thank you

Appendix D

*Consent form for
A Comparison of Adolescent and Adult Mothers' Satisfaction
with their Postpartum Nursing Care*



ST. JOSEPH'S
HOSPITAL



Consent Form

Title of the Research Project: Mothers' Experiences and Satisfaction with
Inpatient Postpartum Nursing Care

Investigators: Wendy Peterson-Rudnicki, graduate student
Alba DiCenso, PhD., Cathy Charles, PhD., Wendy Sword, PhD.

By signing below, I understand the following:

- 1) I am being invited to take part in this study because I am a patient on the postpartum unit.
- 2) The purpose of this study is to learn about mothers' thoughts and opinions about nursing care on the postpartum unit.
- 3) I will be asked a series of questions by a researcher before I am discharged from the hospital. The questions will be about my experiences and my satisfaction with the postpartum nursing care. I will also be asked some questions about myself. This will take about 20 minutes of my time.
- 4) I can decide to stop the interview once it has begun. I can also ask that my answers be taken out of the study.
- 5) The researcher may look at my medical record to get information that is necessary for this study.
- 6) All of the information that I give will be kept confidential. My name, my family's names, or nurses' names will not be used. My answers will not be given to the nurses.
- 7) There are no direct benefits or risks to myself or my infant by participating in this study.

(please turn over)

8) Whether I decide to take part in this study or not, my care and my infants care will not be affected in any way.

9) I understand that I will not receive anything for being in this study. Taking part in this study will not cost me any money.

10) If I have any questions about this study I can phone the principal investigator or the hospital staff at the phone numbers listed below.

I agree to participate in this study.

name	signature	date
------	-----------	------

witness	signature	date
---------	-----------	------

If you have any questions about this study, please contact either the principal investigator:

Wendy Peterson-Rudnicki

Phone: (XXX) XXX-XXXX extension XXXXX

OR

Janet Rush
Director of Nursing Research
St. Joseph's Hospital
Phone: (XXX) XXX-XXXX
extension XXXX

Appendix E

***Ethical Approval for
Adolescents' Experiences and Perceptions of Inpatient Postpartum Nursing Care: A
Phenomenological Study of Patient Satisfaction***



RESEARCH ETHICS BOARD

December 13, 2002

PROJECT NUMBER: 02-307
PROJECT TITLE: "Adolescents' Experiences and Perceptions of Inpatient Postpartum Nursing Care: A Phenomenological Study of Patient Satisfaction"
PRINCIPAL INVESTIGATOR: Wendy Peterson

This will acknowledge receipt of your e-mail dated December 11, 2002 which enclosed a copy of your revised consent form and study notice/advertisement for the above-named study. These revisions were requested by the Research Ethics Board at their meeting held on November 19, 2002. Based on this additional information, we wish to advise your study has been given *final* approval by the full Research Ethics Board. The submission, including the revised consent form and study notice was found to be acceptable on both ethical and scientific grounds.

We are pleased to issue final approval for the above-named study for a period of 12 months from the date of this letter. Continuation beyond that date will require further review and renewal of REB approval. Any changes or amendments to the protocol or consent form must be approved by the Research Ethics Board.

We wish to advise the Research Ethics Board operates in compliance with ICH Good Clinical Practice Guidelines and the Tri-Council Policy Statement.

Investigators in the Project should be aware that they are responsible for ensuring that a complete consent form is inserted in the patient's health record. In the case of invasive or otherwise risky research, the investigator might consider the advisability of keeping personal copies.

A condition of approval is that the physician most responsible for the care of the patient is informed that the patient has agreed to enter the study. Any failure to meet this condition means that Research Ethics Board approval for the project has been withdrawn.

PLEASE QUOTE THE ABOVE-REFERENCED PROJECT NUMBER ON ALL FUTURE CORRESPONDENCE.

Sincerely,

Peter B. McCulloch, M.D., FRCP(C)
Chair, Research Ethics Board

/dm All correspondence should be addressed to the REB Chair and forwarded to:
REB Secretary, Henderson Campus, 90 Wing, Room #1 :
711 Concession Street, Hamilton ON L8V 1C3
Telephone: 905-527-4322, ext. 42013
Fax: 905-574-5645



Brighter Futures for Children of Young Single Parents
Grandir ensemble pour enfants de jeunes parents célibataires
Prenatal Nutrition Ottawa – Nutrition prénatale d'Ottawa
Buns in the Oven – Ça mijote
Success by 6 – 6 ans et gagnant



780, rue de L'Église, Ottawa ON K1K 3K7
Tel./Tél. : (613) 749-4584 Fax/Téléc. : (613) 749-7018 info@ottawayoungparents.com

October 23, 2002

Research Ethics Board
McMaster University,
Faculty of Health Sciences

Dear Committee Members:

I have reviewed the attached proposal and confirm that the Buns in the Oven Prenatal Nutrition Program has the resources (space, patient population) necessary to support this research. I have taken into consideration any research which is planned or already in progress in the program in making this assessment. Therefore, Wendy Peterson has my permission to recruit and interview mothers as described in the proposal.

Given that our program does not have a formal research ethics review process, final permission to carry out this research is dependent on approval of the McMaster University Research Ethics Board.

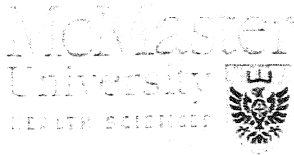
Sincerely,

Cathryn Fortier,
CPNP Project Manager
Prenatal Nutrition Ottawa & Buns in the Oven
780, rue de L'Église
Ottawa, Ontario K1K 3K7
Tel: 613-749-4584 ext. 736
Email: cfortier@ottawayoungparents.com

Projects of the Young/Single Parent Support Network - Projets du Réseau de soutien pour jeunes parents célibataires
Centre d'espoir Bethany Hope Centre. Centre Youville Centre. Logement Emily Murphy Non-profit Housing. St. Mary's Home/Maison Sainte-Marie

Appendix F

Notice to Adolescent Mothers Regarding Phenomenological Study



Are you between
15 and 19 years old?

Are you due before
October 2003, or have you just
had your baby?

If yes, you may be interested in
helping with a study...

I am a nurse researcher looking for
young moms to interview about their
experience in the hospital.

If you would like more information
or want to volunteer,

Please leave a message for:

Wendy Peterson R.N.
at XXX-XXXX
and I will call you back.

Appendix G

*Consent for
Adolescents' Experiences and Perceptions of Inpatient Postpartum Nursing Care: A
Phenomenological Study of Patient Satisfaction*



Title of research study: Adolescents' Experiences and Perceptions of Inpatient Postpartum Nursing Care

Principal Investigator: Wendy Peterson R.N., BSc.N.
Graduate student in Nursing at McMaster University
(XXX) XXX-XXXX

Student Supervisor: Alba DiCenso, R.N., Ph.D.
Professor, Nursing and Clinical Epidemiology & Biostatistics
McMaster University
(XXX) XXX-XXXX, ext. XXXXX

I understand that:

1. I am being invited to participate in this study because I am a new mother and I am between the ages of 15 and 19 years old.
2. The purpose of this study is to understand teenagers' thoughts, feelings and experiences of the nursing care they received after having a baby.
3. If I participate:
I will be interviewed by Wendy Peterson, a nursing research student.
I will be interviewed one or two times during the next 2 months.
Each interview will last for a maximum of one hour.
The interview will be done at [Name of Community Centre].
The interview(s) will be tape recorded.
During the interviews I will be asked to talk about my thoughts, feelings and my experiences with nurses while I was a patient on a postpartum unit.
4. After the interview, I will be given a \$20.00 Loeb coupon as thanks for my participation. There are no direct risks to me by participating. The results of this study may help nurses to understand the needs of other teenage mothers.
5. My participation in this study is completely voluntary. Even if I agree to participate I can decide not to answer any question or decide not to participate in any more interviews. My decision to participate or not will not affect the services that I receive from [Name of Community Program].

6. Reports of this study may include quotes of what I have said. However, my name will not be used in any reports. I will not be identifiable from the information in any report(s).

7. The tape cassettes used to record the interviews will be destroyed five years after the study is over.

8. If I have any questions about this study, or if I want to listen to the tape recording of my own interview, I should phone Wendy Peterson at XXX-XXXX.

9. I will receive a signed copy of this form.

I agree to participate in this study.

Name (printed)

Signature

Date

Name of witness (printed)

Signature of witness

Date

Appendix H

Interview Guide for Phenomenological Study

1. How old were you when you had your baby?
2. How many children do you have?
3. Would you describe yourself as:
 - single
 - have a boyfriend
 - living with my boyfriend
 - married
 - separated
4. What country were you born in?
5. When you were growing up, what language did you speak at home?
6. Who do you live with now?
7. What grade of high school have you finished?
 - If high school graduate – any college or university?
8. What is your baby's birthdate?
9. Is the father of your baby involved?
10. Which hospital did you have your baby at?
11. How many days were you in the hospital?
12. How many days were you on the postpartum unit?
13. Did you have a vaginal or cesarean delivery? If cesarean, emergency or planned?
14. Did your baby:
 - room-in with you the whole time
 - room-in some of the time and in the nursery some of the time?
 - stay in the nursery or neonatal unit?
15. How were you feeding your baby when you were in the hospital?
 - Breastfeeding, formula feeding or both
16. Thinking about your postpartum stay- How would you rate the nursing care that you received on the postpartum unit? (think only about the nursing care, not the atmosphere, food, cleanliness, noise, roommate, etc.)

1	2	3	4	5	6	7
dreadful	very poor	poor	fair	good	very good	excellent

Interview Guide

I am specifically interested in learning about the experiences of teenage mothers during their stay on the postpartum unit. During this interview, I would like you to talk about your thoughts, feelings and experiences of the nursing care that you received on the postpartum unit after having your baby. I am interested in hearing about both good and bad experiences that you may have had. Your participation in this study will help us to understand how to improve the care of teenage mothers.

Postpartum nursing care is the care that you receive from any and all of the nurses on the unit that you were admitted to after you had your baby. It is important to understand that I am not talking about the nursing care that you received on the labour and delivery unit.

I would like to begin by asking you some questions about what you thought it would be like in the hospital.

1. Tell me what you expected your postpartum stay to be like.
Probe for prenatal classes, prenatal provider, experiences of family/friends, past experiences, media.
2. Tell me how your postpartum experience was like or not like you expected it to be.
Probe for details: How? Why?

I would like to hear about your experience on the postpartum unit.

3. Tell me what happened during your first few hours on the postpartum unit.
Probe for presence of support person, time spent with nurse, understanding of nursing actions, information received, understanding of information, baby, any requests made.
4. How did the nurse(s) make you feel during that time?
Probe for sensitivity, responsiveness to needs, accommodation of requests, comfort of significant others.
5. Tell me about the nursing care during the rest of your stay on the postpartum unit.
Probe for sleep, availability of nurses, called nurses?, day/night shifts, interactions with nurses, communication among nurses/MDs, information about baby's tests.
6. How did the nurses help you learn to feed and care for your baby?
Probe for breastfeeding vs formula feeding, type & amount of information, conflicting advice.

Interview Guide (continued)

I'm interested in your description of the actions of any nurse or nurses that may stand out in your memory as being either excellent or very poor. These nurses may stand out because of something they did or did not do, or by how they made you feel.

7. (If there was a nurse(s) that was particularly helpful) Describe how s/he was helpful.
Probe for qualities that define 'helpful'; caring, empathy.
8. (If there was a nurse(s) that was particularly unhelpful) Describe how s/he was not helpful.
Probe for unhelpful qualities; attitude, stigma, lack of time, manner.
9. Can you describe how the nursing care could have been better?
Probe for details: why? when?
10. Is there anything else that you can tell me that would help me to understand your experience with the nurses on the postpartum unit?
11. How would you describe an ideal postpartum nurse?
Probe for characteristics of helpfulness, amount of time, response to requests, information, manner, communication, emotional support.

Appendix I

***Summary of Moustakas' Modification of the Stevick-Colaizzi-Keen Method of Analysis
of Phenomenological Data***

Summary of Moustakas' Modification of the Stevick-Colaizzi-Keen Method of Analysis of Phenomenological Data

(From: Moustakas, C. (1994). Phenomenological Research Methods. p. 122)

1. Using a phenomenological approach, obtain a full description of your own experience of the phenomenon.
2. From the verbatim transcript of your experience complete the following steps:
 - a) Consider each statement with respect to significance for description of the experience.
 - b) Record all relevant statements
 - c) List each non-repetitive statement. These are the invariant horizons or meaning units of the experience.
 - d) Relate and cluster the invariant meaning units into themes. Synthesize the invariant meaning units and themes into a description of the textures of the experience. Include verbatim examples.
 - e) Reflect on your own textural description. Through imaginative variation construct a description of the structures of your experience.
 - f) Construct a textural-structural description of the meanings and essences of your experience.
3. From the verbatim transcript of the experience of each of the other co-researchers, complete steps 2a) to 2g).
4. From the individual textural-structural descriptions of all co-researchers' experiences, construct a composite textural-structural description of the meanings and essences of the experience, integrating all individual textural-structural descriptions into a universal description of the experience representing the group as a whole.

Integration of Moustakas (1994) Method of Data Analysis and Input from Thesis Committee

Moustakas (1994)	Supervisory Committee
<p>Meaning units = free nodes Themes = tree nodes</p> <p>Textural Description Structural Description Textural-Structural Description for each interview</p> <p>Universal Description of the experience representing the group as a whole.</p>	<p>Level 1: Statement of experience in context (summary of +/- experiences for each interview)</p> <p>Level 2: Cross-Case Comparison of +/- experiences (list as a group from all interviews)</p> <p>Level 3: Interpretive (abstract) The essence of the experience</p>

Appendix J

Example of a Memo from Phenomenological Data Analysis

**Excerpts from memo illustrating the emergence of the sub-theme
“Treating me like a new mother, not a teenager with a baby”**

Interview 4 speaks about how she considers herself to be a new mother and how being young should not be a factor. She expresses feeling that there is no difference between being young and being new. When she speaks of the nurse that she didn't like she says that this nurse acted the way she did because X was a young mother. When she speaks of ideal nurse, she refers to that nurse being patient and understanding with new mothers.

Maybe a subtle but important difference between how nurses act and the feeling of being treated as a new mother versus a young mother.

Don't view themselves as anything different than other new mothers.

XX spoke of 2 hospitals - at one they treat you like a teenager having a baby and at the other they treat you like a new mother.

What is assumed about / how do people act differently towards:

New mothers - exciting, happy for mom and dad, happy for family, planned and prepared, partners, employed, ready for infant, new phase in life that is exciting and good, progression.

Young mothers - too young, a mistake, a secret, not ready, no job, unmarried, careless, unplanned pregnancy, how will they do it, relying on others, poor baby, poor mother, needs help, new phase in life but not finished youth, stuck.

Interview 6 talks about the nurses coming in and calling her 'hey mom...' confirming her new role. Treating her like a new mom. She speaks about feeling like a 35 year old married mother.

Interview 7 talks about how hard it is being young, single mother.

Interview 11 speaks about how age doesn't matter, it's whether you are ready or not.

To be treated like a mother -
joke, happy, enjoyed baby, enjoyed job
responsible
'hey mom'

Compare with - to be treated like a teen with a baby -
here are the facts
not chummy
different treatment than other mothers.