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**Bringing Together the ‘Threads of Care’ in Possible
Miscarriage for Women, Their Partners and Nurses in Non-
Metropolitan Emergency Departments**

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Abstract

Pregnancy is usually a significant event in a woman's life: a time of great expectation and attachment to the possibilities and dreams placed on the new life growing inside her. Complications in early pregnancy can be physically and psychologically traumatic experiences that generate high levels of anxiety. For some women and their partners, the fear of possible miscarriage is so overwhelming and unexpected that the emergency department seems the most appropriate healthcare service to attend. Women who seek emergency care often consider or anticipate the possible loss of their pregnancy when presenting for urgent medical care. Vaginal bleeding occurs in about 25% of all pregnancies, and of these roughly one in six (15–20%) end in miscarriage. Symptomatic first-trimester pregnancies are a common presentation in an Australian emergency department, yet research has shown that women often feel dissatisfied with the care provided in this setting.

In Australia, emergency departments play an important role in the provision of healthcare, especially in regional, rural and remote areas. Unfortunately, access to and quality of healthcare has been strained in recent times because of the unique challenges associated with the delivery of health in these locations. The aim of this study is to examine and explain current approaches to care provided to women who present to non-metropolitan emergency departments with first-trimester bleeding and possible miscarriage. Using a grounded theory methodology, three participant groups were included in this study: women who presented to an emergency department, their partners, and the nursing staff who provided care in these settings. The multiple participant views informed the development of a grounded theory, titled 'threads of care'. This theory enhances the understanding of what constitutes optimal and effective care for women and their partners when presenting to regional, rural and remote emergency departments with possible miscarriage.

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List of Abbreviations

ARIA+	Accessibility/Remoteness Index for Australia
ATS	Australasian Triage Scale
ED	Emergency Department
GP	General Practitioner
NP	Nurse Practitioner
RN	Registered Nurse

Chapter 1: Background to the Study

There is no such thing as 'just a miscarriage'. I am reminded of that every time I answer that question, 'How many pregnancies?' This is when I remember I am a mother of eight.

Stacey, October 2013

1.1 Introduction

Pregnancy is a time of change and, for most women, a joyous occasion. Unfortunately, miscarriage is a loss experienced by many women in the first trimester of pregnancy, which ultimately ends in their attendance to their local emergency department (ED). This study investigates the experiences of these women and their partners in relation to the adequacy, quality and expectations of current ED approaches to care in regional, rural and remote areas of Australia. Understandings of staff experiences were also gained and compared with those of the women and their partners. This study highlights differences in the experiences and expectations of these cohorts, so as to provide a platform for the development of approaches to care that are current and that meet the wants and needs of patients, partners and staff alike.

Grounded theory methodology was employed to facilitate a systematic, inductive approach to understanding the area of study. Multiple participant views informed the development of the final theory and enhanced the understanding of what constitutes effective care in non-metropolitan EDs for women presenting with first-trimester bleeding. The theory produced is grounded in the data generated to ensure its relevance for everyday use in the care of these patients. This chapter provides an introduction to the study that resulted in this theory and serves as a precursor to the more detailed exploration in the chapters that follow.

1.2 Background

Approximately one in four pregnancies end in miscarriage, and around 25% of all pregnancies has vaginal bleeding at some stage in early pregnancy (Hure et al., 2012; Warner, Saxton, Fahy, Indig, & Hovart, 2012). There is no real agreement in the literature regarding the frequency of miscarriage, as statistics range from an 8% to 50% occurrence (Hure et al., 2012). Additionally, statistics show that 55,000 women experience a miscarriage in Australia each year, with 85% of all miscarriages occurring in the first 12 weeks of gestation and 80–90% of these patients attending the ED (Queensland Government, 2010). Women who present to the ED with first-

trimester bleeding find themselves in a situation that is sudden and unexpected (Aacharya, 2011). The immediate and attentive care that some women demand from the health professionals usually stems from their anxiety and the innate need to ensure the survival of their pregnancy (Thorstensen, 2000).

Studies have shown that a majority of women are often dissatisfied with the care provided, and although there are many influences that can affect these feelings, they most commonly relate to increased waiting times (Stratton & Lloyd, 2008; Department of Health and Ageing, 2010). Increased waiting times are often a result of the growing number of patients presenting to a local ED. The increasing number of patient presentations, the increasing complexity of these presentations and issues related to overcrowding and access block are ultimately responsible for increased patient wait times and dissatisfaction (Department of Health and Ageing, 2010; Ferero, McCarthy, & Hillman, 2011). Women experiencing vaginal bleeding (spotting) in early pregnancy (14 weeks and under) who present to the ED can often experience significant delays in being assessed and treated by staff. Unfortunately, vaginal bleeding, especially within the first trimester, does not have a high acuity level and is often triaged in the lower spectrum of care (that is, category four or five within the Australasian Triage Scale [ATS]; Queensland Government, 2011). Conversely, vaginal bleeding at any stage in the first trimester rates highly on an emotional scale for the patient, as it can be an indicator of spontaneous miscarriage.

While medical and nursing care does not change the likelihood of the outcome of miscarriage, it is a highly emotive and stressful event for women (Department of Health Victoria, 2011). There have been many highly publicised incidents in which women have had to wait extended periods of time in the ED with first-trimester bleeding, during which the woman ends up miscarrying in the waiting room toilets (Hughes & Walters, 2007; Jones & Sharpe, 2011; Levy, 2011; Warner et al., 2012). Such incidents have led to government inquiries that have produced negative findings highlighting a lack of care and compassion by ED staff. These events are discussed as part of the detailed background to this study in Chapter Two.

1.3 Aims

The aim of this research was to construct a grounded theory that explains the experiences of women and their partners who present to regional, rural and remote EDs with first-trimester bleeding, and that explains the experiences of the nursing staff who provide the care. This study was guided by the following questions:

1. How do women and their partners experience current approaches to care when presenting to non-metropolitan EDs with first-trimester bleeding?
2. How do staff experience caring for these women and their partners?
3. What factors influence expectations and experiences of the women, their partners and nursing staff in these circumstances?

1.4 Impetus for the Study

Presentations of vaginal bleeding and pain in the first trimester of pregnancy are common in any ED (Rawal, 2009). Concern by women regarding possible spontaneous miscarriage or loss of the pregnancy is the most common reason for presenting to their local ED (Hessert, 2011). For most women, experiencing first-trimester bleeding is an extremely difficult and stressful time because of the perceived threat to their pregnancy, and if loss does occur the grief and associated guilt can be profound (Adolfsson, 2006). Having worked in a regional ED for 15 years, I have seen the emotional impact and significance that first-trimester bleeding can have for a woman. Bacidore, Warren, Chaput and Keough (2009) have affirmed that the emotional impact of pregnancy loss or even the suggestion of loss can be crippling for the woman, and the subsequent effect can be long-lasting. This emotional strain and the added stress of having to wait for extended periods of in the ED often increase patient distress. The impact of this distress, especially if these women feel that they have not been seen in a timeframe deemed appropriate by themselves or their family, results in patient dissatisfaction and hospital-based complaints (Condous, 2008).

It is well known that current EDs are busy, and waiting times for patients have increased. Duffield, Conlon, Kelly, Catling-Paull and Stasa (2010) have explained that one of the most significant pressures facing Australian EDs is the increase in patient attendances. A recent ethical analysis of EDs suggested that long waits are not only an inconvenience for the patient, but also give rise to concerns regarding quality of care, endangerment of patients and impairment of staff morale (Aacharya, 2011). I have often completed my shift at triage in utter exhaustion, and concerned as to whether the decisions I made were correct for each individual person that presented to the ED. One area of alarm for me and for many of my colleagues has been the presentation of women to the ED with first-trimester bleeding. On many occasions, women have had to wait a very long time to be seen and often the waiting time has been greater than the recommended national waiting times for ED presentations (as per the ATS). These women wait with great concern and fear for the possible outcomes that accompany first-

trimester bleeding. I accept there are often good reasons for such long service delays, as I see both sides of the situation, but I feel that there must be a better way to provide care and services for these women.

1.5 Significance of the Study

Pregnancy is usually a significant event in a woman's life: a time of great expectation and attachment to the possibilities and dreams placed onto the new life growing inside her (Douglas & Fox, 2009). Complications in pregnancy are usually both physically and psychologically traumatic experiences that generate high levels of anxiety (Aacharya, 2011). The care that is provided to women presenting to the ED can have a significant impact on their mindset and on subsequent pregnancies (Thorstensen, 2000). The most common presenting symptoms are bleeding and concern for foetal viability (O'Rourke & Woods, 2009). A large majority of these patients are haemodynamically stable and are triaged accordingly. Despite the frequency of early pregnancy complications and the ultimate attendance of these women to their local ED, there tends to be a gap in the provision of care.

The ED provides an important component in the Australian healthcare system. It is a place where patients receive emergency care, but also a place where primary healthcare is provided when general practitioner (GP) services are closed (Wellstood, 2005). The ED is also a place where first point of contact is made for those individuals who do not have GPs (Wellstood, 2005). Waiting times in EDs have increased along with the stress and pressure on staff to provide safe and adequate care within appropriate time frames. Aacharya (2011) explains that emergency care is one of the most sensitive areas in healthcare and dissatisfaction is usually based on a combination of factors, such as perceived urgency and overcrowding. In Australia, there has been increasing concern regarding the mounting pressures on all EDs. International and Australian studies have identified that increased demand in ED care has led to longer waiting times and overcrowded waiting rooms in which patients are having to wait extended periods of time (Affleck et al., 2013; Bernstein et al., 2009; Crawford et al., 2014; Di Somma et al., 2015; Ferero, McCarthy, & Hillman, 2011; Lee et al., 2015; Van Vonderen, 2008). Boyle, Beniuk, Higginson and Atkinson (2012) and Di Somma et al. (2015) have explained that ED overcrowding represents an international crisis and has become an increasingly significant public health issue that can lower the provision of quality care and decrease healthcare access.

Frequent media reports document the consequence of increased waiting times, overcrowding and compromised quality of care (Wellstood, 2005). In September 2007, a highly publicised incident was reported when a woman miscarried in the toilet of the Royal North Shore ED (Warner et al., 2012). Another incident occurred at the Logan Hospital in 2010, when a woman spent nine hours in the ED waiting room without treatment (Bayfield, 2010). These and similar stories suggest, that the current system of care for women who present to the ED with first-trimester bleeding is inadequate. While there has been a great deal of research undertaken into women's experiences of first-trimester bleeding and miscarriage, there has been limited research examining patient perspectives of care received in the EDs of tertiary hospitals, and even less in the context of regional, rural and remote Australian EDs. Thus, this study explores the patient's perception of the care provided in non-metropolitan EDs, the factors that shape the experience, and the partners' and the nursing staff's experiences.

In Australia, around 80% of the population live in major cities, approximately 15% live in regional cities and towns, and the remainder live in rural and remote towns (Department of Infrastructure and Regional Development, 2015). There is no single, universally accepted, definition of regional or rural Australia (McCracken, 1988). In the broadest sense, it can simply mean non-metropolitan. The term non-metropolitan is used to refer to all parts of the country outside centres with populations of more than 100,000 (Australian Bureau of Statistics, 2004). A key issue of differentiation within regional Australia is also that of remoteness, or distance from metropolitan areas and services.

For the purpose of this study, the Accessibility/Remoteness Index for Australia (ARIA+) classification system as endorsed by the Australian Bureau of Statistics was used (see Appendix A). The ARIA+ classification system is a geographical measure of remoteness derived from measurements of road distance between populated areas (Hutchinson, 1986). The reality of living in regional, rural and especially remote areas of Australia is that there is a decreased level of access to healthcare (McCracken, 1988). This decreased access is primarily a result of geographical remoteness, but also due to problems with the provision of and access to healthcare services, especially access to and shortage of health personnel (Jeon, 2004). Dixon and Welch (2000) have explained that the implications for healthcare provision require approaches to care that are different to metropolitan models. Further, these authors suggested that models of care developed for regional, rural and remote areas may need to be different from one location to another to ensure healthcare for all.

Generally, patient experience in the ED is an under-researched area, with a large majority of the existing research focused on assessing patient satisfaction using qualitative methods (Harrison, Walton, & Manias, 2015; Hsieh, 2010; Wellstood, 2005). A great deal of research also explores the management of spontaneous abortion or early pregnancy loss (Bacidore et al., 2009; Cahill, 2001; McLean & Flynn, 2012; Thorstensen, 2000). Over the last 20 to 30 years there has been considerable research conducted on the consequences of early miscarriage, grief, anxiety, depression, guilt and relationship problems that can have lasting effects, for up to two years post the event (Bacidore et al., 2009; Brier, 2008; Petrou & McIntosh, 2009; Smith, Frost, Levitas, Bradley, & Garcia, 2006). The body of research is quantitative in nature and involves a range of standardised anxiety scales to illuminate the experience of miscarriage and its effects on the woman (Petrou & McIntosh, 2009; Smith et al., 2006). A number of research studies set in Australia and England have explored healthcare provided to women following a miscarriage (Nikcevic, 2007; Séjourné et al., 2010a; Stratton & Lloyd, 2008). These studies have mainly focused on assessing the care provided; most studies found that women did not find the behaviour and the attitudes of the health professionals helpful (Stratton & Lloyd, 2008). Many authors point to the need for more qualitative research to explore women's experiences of miscarriage, so as to understand the social and personal impacts, and also to understand and improve the care that is provided (Brier, 2008; Smith et al., 2006).

1.6 Research Design

The design or method for any research study provides structure and direction, with qualitative research being the most flexible (O'Connor, 2012). Qualitative research encompasses a variety of approaches that ensure that useful data are always gained and are more able to fully describe a phenomenon (Salinger, Plonka, & Prechelt, 2008). Qualitative research, as defined by Strauss and Corbin (1990), is 'any kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification' (p. 17). Qualitative research provides typically rich data that are detailed with insights gained from the participants' experiences (Strauss & Corbin, 2008). As discussed in Chapter Three, a number of methodological frameworks can be used in the qualitative paradigm. This study employed grounded theory methodology.

1.7 Why Grounded Theory?

Grounded theory is a qualitative research design that explores and develops theory that is grounded in data that have been systematically gathered and analysed (Urquhart, 2010; Walker & Myrick, 2006). Walker and Myrick (2006) have explained that Glaser and Strauss crafted a methodology that enabled researchers to develop a “theory that had grab”, was grounded in data and would work in the real world (p.548). The researcher generates a general explanation (a theory) of a process, action or interaction that is shaped by the views of the participants (Creswell, 2007). Grounded theory has proven useful in developing context-based, process-orientated descriptions and explanations of phenomena (Urquhart, 2010). Bowen (2008) has clarified that grounded theory research can provide a better understanding of a phenomenon about which little is known, and that investigations into uncharted areas or experiences can gain a fresh perspective on a familiar situation. Grounded theory was chosen as the most appropriate methodology for this research as it provided creative insight into the phenomenon being studied through the generation of a theory that has explanatory power (Birks & Mills, 2015).

In this study, data were generated through the collection of narratives from the participants who I invited to tell stories of their experiences in non-metropolitan EDs. These stories were told by both the women and their partners who presented for care with first-trimester bleeding (under 12 weeks’ gestation), and by the nursing staff who provided care in these situations. I recorded the narratives, which were then transcribed verbatim. Initially, the research was guided by purposeful sampling methods, and was then directed by theoretical sampling. Theoretical sampling uniquely dictates the direction of the study and is used by the researcher to make strategic decisions that are needed to guide the generation of information-rich data (Birks & Mills, 2015; Glaser & Strauss, 1967). The collection of data was not time discrete, but interwoven with data analysis, which allowed for a more cyclical process (see Figure 1.1). Concurrent data collection and analysis is considered one of the essential grounded theory methods, along with initial coding and categorising of data, the writing of memos, theoretical sampling, constant comparative analysis, theoretical sensitivity, intermediate coding, identification of a core category, advanced coding and theoretical integration (Birks & Mills, 2015).

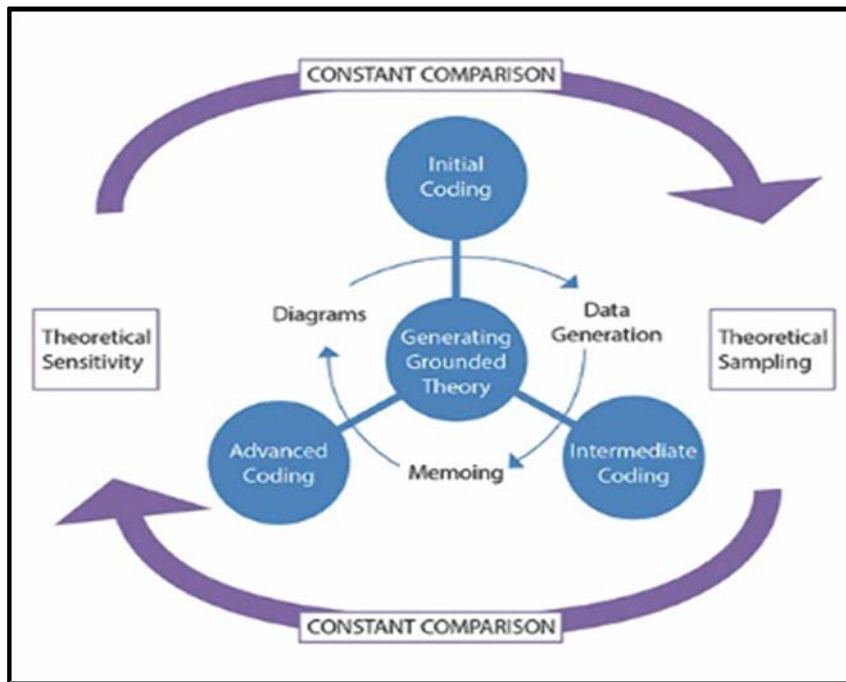


Figure 1.1: Grounded Theory Cycle.

As is discussed in Chapter Four, I commenced data analysis with initial coding where the data were coded by identifying the important words or groups of words and labelling them. Where possible, I used in-vivo codes in the labelling process. According to Birks and Mills (2015), in-vivo codes are the labels identified from the participants' own words that are applied in the coding process. Using constant comparison, I was able to identify new or dissimilar concepts, and through this process of inductive analysis the themes, patterns and categories emerged (Srivastava & Hopwood, 2009). The writing of memos was a key process from the outset of this research, as it recorded my thoughts, feelings and ideas in relation to the development of the grounded theory while ensuring theoretical sensitivity. Theoretical sensitivity reflects the researcher's level of insight into both themselves and the area they are researching, and is reflected in the research process as it progresses from the initial stage (Birks & Mills, 2015). Intermediate coding was a natural progression and required further comparison of the initial codes to identify relationships that indicated a higher or more specific overriding category (Bryant & Charmaz, 2007). Through the process of intermediate coding the linking together of the developed categories and sub-categories ultimately led to the identification of the core category (Birks & Mills, 2015). The core category unifies all the sub-categories and categories through selective coding and theoretical saturation, while encapsulating the central phenomenon of the study (Birks & Mills, 2015; Strauss & Corbin, 1990).

In identifying the core category, the process moved to the advanced level of coding and theoretical integration. Storyline was used as a mechanism for integrating and presenting the grounded theory, which is summarised in Chapter Five and discussed in greater detail in Chapters Six, Seven and Eight. Theoretical codes were drawn from existing theories to add to the explanatory power of the final theory (Birks & Mills, 2015) and the outcome of this process is explored in Chapter Nine.

1.8 Thesis Structure

This thesis consists of ten chapters, some of which contain work that is already published or has been submitted for publication. Chapter One provides an introduction to this thesis. This chapter presents an overview of the background and discusses the impetus for and significance of the study, along with the research aims and chosen methodology. Chapter Two specifies the context for this thesis by exploring the challenges faced by emergency nursing staff working in regional, rural and remote EDs. The second half of this chapter includes a published article that draws on contemporary literature to highlight the specific challenges relating to the provision of healthcare services for women who present to regional, rural and remote EDs with possible miscarriage.

Chapter Three presents a detailed discussion of grounded theory as the methodology used in this study. The application of grounded theory in this research is outlined in the study design that is described in Chapter Four. Chapter Five is the first of the findings chapters. It presents the developed grounded theory as a storyline, including a diagrammatic presentation of the theory. The findings in Chapter Five are elaborated in Chapters Six, Seven and Eight, where a deeper understanding of the results can be gleaned. Chapter Nine discusses the finding of the theory and describes how its explanatory power is enhanced through the application of Swanson's middle range theory of care as a theoretical coding framework. Lastly, Chapter Ten brings this thesis to a conclusion by discussing the contribution of this work to existing knowledge, the implications of the findings, limitations of the research and recommendations for further study.

1.9 Summary

This chapter has provided an introduction to this research by explaining the purpose and aims of the study. It also establishes the context of the study by describing the impetus and significance of this work. The following chapter provides a more detailed insight into the

background of the study and will add to the understanding of the nursing care provided to women and their partners when presenting to non-metropolitan EDs with possible miscarriage in the first trimester.

Chapter 2: The Context

The beauty of life is, while we cannot undo what has been done, we can see it, understand it, learn from it and change. So that every new moment is spent not in regret, guilt, fear or anger, but in wisdom, understanding and love.

Jennifer Edwards, n.d.

2.1 Introduction

To fully appreciate the findings of this research it is important to understand the background. In most research, a literature review is completed prior to the research study to help contextualise the research with existing knowledge (Ramalho, Adams, Huggard, & Hoare, 2015). The use of literature has been a contentious issue in grounded theory, especially in the initial stages of the research process (Birks & Mills, 2015). The debate focuses on the researcher and their ability to not be swayed or guided by existing knowledge or theories. It is important to note that while Glaser and Strauss (1967) explicitly argued against the researcher reading about the area under study, particularly before commencing data collection or even during the later stages of the research, they did recognise that the researcher brings a level of knowledge or expertise to the process (Glaser & Strauss, 1967). Since the inception of grounded theory by Glaser and Strauss, the methodology has been expanded and it is through this process that debate has arisen. Ramalho et al. (2015) have argued that there are several benefits to an early review of literature, which include orientating the researcher to the phenomenon, ensuring the researcher understands current knowledge and identifying any gaps. Birks and Mills (2015) also have pointed out that literature has significance at all stages of a grounded theory study, and has the ability to enhance theoretical sensitivity. This chapter explores the context of this research study by exploring the challenges faced by nursing staff working in non-metropolitan EDs. The latter part of the chapter includes a published paper that draws on contemporary literature to discuss the challenges faced by women who present to non-metropolitan EDs for possible miscarriage.

2.2 Emergency Departments in Australia

Throughout Australia comprehensive ED care is counted as an integral part of the healthcare delivery system, the demand for which is increasing (Kidd, Kenny, & Meehan-Andrews, 2012).

The Australasian College for Emergency Medicine (2014) has stated that ‘an emergency department is a dedicated hospital-based facility specifically designed and staffed to provide 24 hour emergency care’ (p. 2). The ED is an area in the hospital that organises and administers healthcare to people in the community who perceive the need for, or are in need of, acute or urgent care (Australian Institute of Health and Welfare, 2014). Hospital EDs provide the community with emergency services throughout the lifespan and across a range of disciplines (Australian Institute of Health and Welfare, 2012).

The function of the ED is to assess, diagnose and manage sick and injured patients who require assessment and treatment. Patients who attend the ED are categorised by the ATS according to their acuity and urgency of the need for clinical intervention (College of Emergency Nursing Australasia, 2008). Over recent years, ED systems have evolved to manage the increasing demand on emergency services (Considine et al., 2012). Patient presentations to Australian EDs have increased to over 6.7 million per year and there has been a 17% increase in the past 5 years (Allen et al., 2015; National Health Performance Authority, 2013). Growing demand increases the pressure applied to EDs, which can affect the quality of service provision by increasing patient waiting times and the length of stay (Allen et al., 2015; Jenkins et al., 2011; Lowthian et al., 2012). The delivery of quality ED care is complex and has to be flexible to meet the needs of all communities throughout Australia (Jenkins et al., 2011). High quality emergency hospital care at any location is complex and must meet the physical, psychological and social needs of each patient who attends their local department. Meeting patients’ needs requires healthcare organisations to aspire to a high level of service quality (Clement, Sudhahar, & Selvam, 2008). According to the College of Emergency Nursing Australasia (2008), ED services must be capable of providing the following minimum emergency department services:

1. 24-hour access
2. Triage
3. Resuscitation
4. Onsite and timely care within ATS guidelines
5. Management of definitive care
6. Access to radiology and pathology services
7. Medical staffing suitable to service capability and role delineation.
8. Availability of a 24-hour nursing service
9. Referral pathway to speciality services
10. Facilities for admission transfer and discharge.

Emergency nursing care varies from place to place and also by the size and location of the ED itself. The design of services will differ among settings and locations (e.g., between different

hospitals), affecting such aspects as supply (e.g., physical and technical resources) and demand (e.g., patient numbers, demographics and needs) (Australian Health Workforce Advisory Committee, 2006; Jenkins et al., 2011; Lyneham, Cloughessy, & Martin, 2008). Aspects of supply and demand in the ED can be related to the ageing population, more patients presenting to EDs with co-morbidities, increased number of patients with chronic diseases, increased cultural diversity and increased acuity on presentation. Department specific factors such as workforce obstacles also impact on service provision, while hospital-wide factors may cause congestion in the ED (Australian Health Workforce Advisory Committee, 2006). ED hospital services are categorised according to their geographical location and also the type of service that is provided (Queensland Health, 2013). The ED categories are listed in Table 2.1.

Table 2.1: Emergency department categories (Australasian College for Emergency Medicine, 2012).

Level	Design	Service description and requirements
Level 1	Provides the minimum level of service that can be defined as an ED and provides emergency care within a designated area of a remote or rural hospital.	Provision of basic primary and secondary assessment (advanced paediatric, adult and trauma life support). Stabilisation of critically ill patients for retrieval. 24-hour access to specialty advice. Triage by credentialed clinical (nursing) staff using the ATS. ED should be part of a regional emergency medicine network with access to emergency specialist support, advice and training.

Level	Design	Service description and requirements
Level 2	ED will be part of a secondary hospital with capabilities of managing some complex cases, and would offer some sub-specialty services. This level of service should be able to provide primary critical care.	<p>Purpose-built ED (separate resuscitation area) capabilities for managing patients with life threatening conditions (invasive monitoring and short-term assisted ventilation).</p> <p>Assessment and management of a range of acute and emergency presentations (provision of primary emergency care).</p> <p>Dedicated area for the assessment and management of paediatric patients.</p> <p>Part of an emergency medicine network and if emergency specialist who is a Fellow of the Australasian College of Emergency Medicine (FACEM) led may be at the hub of that network.</p> <p>Capability of transferring critically ill patients, and access to a retrieval service.</p> <p>Capability for key participation in response to local major incidents and formal role in disaster response plans.</p>
Level 3	It would be expected that ED at this level would be part of a major regional, metropolitan or urban hospital with capabilities of managing most complex cases and have some sub-specialty services.	<p>Ability to manage a complete range of emergency presentations and provide support for other regional emergency centres as part of an emergency medicine network.</p> <p>Capability of transferring critically ill patients, and access to a retrieval service.</p> <p>Formal role in disaster response plans.</p> <p>Participate in emergency medicine training (undergraduate and postgraduate).</p> <p>Formal education programs for nursing, medical and allied health staff and students with evidence of active involvement in research.</p>

Level	Design	Service description and requirements
Level 4–6	EDs at this level are part of a large, multifunctional tertiary or major referral hospital with capabilities for managing a wide range of complex conditions, and have a significant level of sub-specialty services.	<p>Multiple resuscitation areas for major trauma and/or life threatening conditions (invasive monitoring and short-term assisted ventilation).</p> <p>Assessment and management areas for a range of acute and complex presentations (including mental health).</p> <p>Dedicated ED short stay unit with capabilities of extended monitoring and assessment.</p> <p>Dedicated paediatric areas (including a dedicated resuscitation area).</p> <p>Capable of providing tertiary level support for regional centres.</p> <p>Dedicated retrieval service or access to one.</p> <p>Key participation in a trauma service or trauma network with formal disaster response plans.</p> <p>Accredited for emergency medicine training (undergraduate and postgraduate) including formal education programs for nursing, medical and allied health staff and students.</p> <p>Active research program is in place with published articles evident.</p>

To appreciate the impact of workforce obstacles it is important to understand the general and specific nursing roles in the ED. A variety of nursing roles are incorporated in EDs to meet the explicit needs of the communities they serve.

2.3 Nursing Staff Roles and Ratios in Emergency Departments

All EDs are comprised of distinct physical facilities and organisational structures established in hospitals to deliver emergency medical care to the acutely ill and injured members of the Australian community (Schofield, 2009). A variety of roles exist within these structures to meet the specific needs of local communities. Responsibility for the management of each patient's physical care within the ED lies with the staff who fulfil these roles. The EDs must be able to provide specialist nursing and medical services and/or have the capacity to make arrangements for the transfer of patients to receive those services when needed. The EDs also require 24-hour access to pathology, radiology and operating theatres (Australian Health Workforce Advisory Committee, 2006).

There is usually a combination of staff coverage to ensure quality patient care. A mix of skills is needed in each ED to meet service demand. A range of staff, from junior through to senior,

meets this demand. Staffing of EDs tends to be tailored to the specific environment, and is based on patient attendance numbers, patient acuity levels and case mix (DeLia & Cantor, 2009). The resources of each ED vary, ranging from basic emergency facilities with designated nursing and on-call medical staff to those that provide a full range of services in metropolitan areas (Australian Health Workforce Advisory Committee, 2006). Generally speaking, staffing in the ED consists of nurses, on-site access to medical officers and on-call access to senior medical staff at all times (Australian Health Workforce Advisory Committee, 2006). Nursing staff roles may include registered nurses (RNs), nurse educators, nursing directors, nurse managers, nurse practitioners (NPs) and clinical nurse specialists/consultants (e.g., mental health [MH], paediatric and aged care). The role of nurses in the ED is to assess patients, prioritise patient care and provide ongoing nursing management for a diverse patient population (Australian Health Workforce Advisory Committee, 2006). Emergency nurses are required to possess a variety of skills, ranging from the ability to administer lifesaving interventions to the provision of health promotion and injury prevention education. This care begins as soon as the patient walks into the ED and is seen at triage (Australian Health Workforce Advisory Committee, 2006; College of Emergency Nursing Australasia, 2008; Collins, 2009).

Triage is an ED-specific role that ensures acutely unwell patients are seen before less urgent cases (Lutze, Ross, Chu, Green, & Dinh, 2014). Many patients can present to the ED simultaneously; triage aims to ensure that patients are treated in the order of their clinical urgency by the application of the standardised rating scale (Australasian College for Emergency Medicine, 2013). Triage is performed by experienced registered nursing staff using a five-point system that is determined to meet all clinical needs (Department of Health and Ageing, 2009). Administrative staff assist the triage nurse by registering patients into the ED (Australian Institute of Health and Welfare, 2012). Triage allows for the level and quality of care to be delivered in a standardised manner that ensures patient safety and equity of services within any Australian community (Department of Health and Ageing, 2009). Innovative triage staffing has been introduced in some EDs. These approaches generally involve an additional team member (e.g., another nurse or a senior medical practitioner) to assist the triage nurse, although this mainly occurs in metropolitan areas of Australia (Callander & Schofield, 2011). The presence of an experienced medical officer, clinical nurse or NP allows for many patients to be treated at triage without progressing further into the ED; this is another innovative

approach that tends to be used in metropolitan EDs (Baker & Dawson, 2013; Callander & Schofield 2011; Schofield, 2009).

Once the patient has been triaged, emergency nurses provide and co-ordinate patient care in the ED according to the triage rating scale. Nurses tend to be allocated to specific areas of the ED in which they can provide continuity of care for each patient for the duration of their care in the ED. Emergency nurses need to have a broad theoretical and skills base to care for all patients across the lifespan, ranging from obstetric to geriatric patients (Australian Health Workforce Advisory Committee, 2006; Australian Institute of Health and Welfare, 2014; Standing Council on Health, 2012). All EDs have a nursing workforce with varying degrees of experience, training, skills and expertise (College of Emergency Nursing Australasia, 2008). The role of the NP extends beyond the traditional role of the ED nurse in that they are able to assess, investigate, diagnose and treat patients with minor injuries and illnesses (Duffield et al., 2010; Schofield, 2009). They are also able to prescribe medication where needed, provide referrals and discharge patients from the ED (Schofield, 2009). The College of Emergency Nursing Australasia (2008) has defined the recognised positions of nursing staff in the ED. These are summarised in Table 2.2.

Table 2.2: Recognised emergency department nursing staff (College of Emergency Nursing Australasia, 2008).

Staff	Role
Registered nurse	Emergency RNs provide and co-ordinate patient care once patients have been triaged and allocated a bed. Additional roles include triage nurse and trauma team allocation.
Clinical nurse specialist or clinical nurse	Provides expert nursing care and is a role model and resource person for ED staff. A clinical nurse specialist practices at an advanced level and is involved in provision of education and policy development.
Clinical nurse educator/nurse educator	A senior nurse who leads and supports the nursing team through education and professional support. The clinical nurse educator is engaged in setting the education plan for the nursing staff in consultation with the clinical experts.
Nurse unit manager/nurse manager	A senior nurse who leads the nursing team and engages in the management of human, physical and financial resources of the ED. The nurse unit manager manages the department from an operational perspective. They are an expert in emergency nursing practice, who leads and manages a large team of nursing staff and possibly a number of non-nursing staff personnel.
Nurse practitioner	A senior nurse clinician recognised by the relevant registering authority as an expert in the field of emergency healthcare, who practices in accordance with relevant legislation. An NP practices at an advanced level utilising a repertoire of therapeutic responses and decision-making justified by the application of advanced knowledge.
Enrolled nurse	An enrolled nurse works under the supervision and guidance of the RN. An enrolled nurse must not work as a solo clinician, (alone or in isolation) within an ED.

Staffing requirements in the ED are determined by factors such as the level of training, expertise, seniority mix, educational and training access, and minimum standards required for both service delivery and supervision of staff. Staffing composition is also dependent upon numerous other factors, including geographical location, hospital services profiles, ED size, complexity of presentations, financial pressures and the appropriate training of staff in the ED (Department of Health and Human Services, 2014; Wise, Fry, Duffield, Roche, & Buchanan, 2014). Efficiency, patient satisfaction and cost-effective care within an ED requires the right mix of staffing ratios and skills (Collins, 2009). Nursing staff levels tend to be determined by industrial awards made in consultation with nursing unions and state and territory governments with the aim of reducing adverse patient outcomes (Callander & Schofield, 2011; New South

Wales Department of Health, 2010; Queensland Nurses' Union, 2015; Wise et al., 2014). Table 2.3 provides an overview of the recommended staffing ratios according to ED categories.

Table 2.3: Recommended nursing staffing ratios (NSW Nurses Association, 2010, pp. 8–9; Queensland Nurses' Union, 2015, p. 8).

Service Type	AM	PM	Night
Resuscitation beds	1:1	1:1	1:1
ED level 4–6	1:3	1:3	1:3
	In charge + Triage	In charge + Triage	In charge + Triage
ED level 3	1:3	1:3	1:3
	In charge + Triage	In charge + Triage	In charge + Triage
Ed level 2	1:3	1:3	1:3
Ed level 1 emergency medical or equivalent	1:3	1:3	1:4
Medical assessment	1:4	1:4	1:4
	In charge	In charge	In charge

Note: This staffing ratio applies to beds, treatment spaces, rooms and chairs where patients are receiving health services.

Unfortunately, the literature regarding effective staffing to patient ratios and skill mix in Australian EDs is limited. A study by Lyneham et al. (2008) emphasised the availability of literature exploring nurse to patient ratios in all areas of the hospital system, except in EDs. Such studies were not easily located and are, in fact, limited in number. The ED environment is complex and dynamic and requires flexibility in matching staff resources to peak periods of patient presentations (Callander & Schofield, 2011). Wise et al. (2014) found in their study that although larger metropolitan EDs had higher patient loads per day than smaller regional, rural and remote EDs, all had similar levels of busyness and skill mix requirements.

2.4 Challenges Faced by Emergency Departments in Non-Metropolitan Areas

In rural areas, nurses and midwives play a significant role in the provision of healthcare services. In general, nurses account for 60% of the rural health workforce and are often required to provide first line management in the absence of medical staff (Kidd et al., 2012). Unfortunately, nursing shortages in rural and remote Australia have been classified as 'critical'

since 2008 (Kidd et al., 2012). When additional staffing is required in an ED, nursing staff are diverted from the wards to assist with patients who present for care. Limited staffing in rural areas of Australia often impacts on staffing ratios and requires innovation and adaptation in the ED processes to ensure appropriate care is delivered. Smaller remote EDs also have fewer funded beds and tend to be staffed by RNs and on-call GPs who are called into the ED when necessary (Baker & Dawson, 2013; Tescher & Chen, 2009). In these situations, it is often considered that there is no need for an RN to be allocated to triage (Tescher & Chen, 2009).

The triage process in rural and remote EDs is heavily impacted by the limited resources available compared with metropolitan EDs (Department of Health and Ageing, 2009). Although the general principles of triage remain the same (e.g., application of the ATS), there is an ironic greater reliance on local resources. As a result of the limitations in nursing staff, during any one shift a nurse will not be allocated solely to triage. The nurse works in a roving triage position in which the nurse needs to attend patients in the ED as well as triaging patients as they arrive into the department (Department of Health and Ageing, 2009; Tescher & Chen, 2009). This then requires the nursing staff to assess patients on arrival to the ED and to commence treatment without the support of medical staff, until the local GP arrives from their general practice (Department of Health and Ageing, 2009). It is up to the nurse's discretion whether or not to contact the on-call medical officer to attend the ED to review patients (Tescher & Chen, 2009). It is important to note that in smaller towns one RN often shares the role of staffing the ward and the ED simultaneously, especially afterhours.

Nurses recruited to work in rural, regional and remote EDs are required to have a diverse range of skills and experience, ranging from novice to the more experienced nurse (Mills, Birks, & Hegney, 2010). According to Mills et al. (2010), novice nurses show higher rates of attrition as they often feel unsupported and have limited opportunities to up-skill and maintain competence. Rural and remote ED nursing staff are required to work at an advanced level both through necessity and also community expectation (Mills et al., 2010). Nursing staff often extend their practice skills to compensate for the absence of medical and allied health staff in regional, rural and remote areas of Australia (Sullivan, Francis, & Hegney, 2008). This expansion of skills enables nurses to be flexible and to meet the needs of the community in which they live and work (Sullivan et al., 2008). Advanced skills include diagnostic reasoning, critical thinking, management of patients who are unstable with emergent disease and injuries while operating with limited resources and, often, under extreme conditions (Misener et al., 2008). These skills are gained through additional study and extensive experience (Mills et al.,

2010). Once skills are gained, maintenance of these skills is important and necessary for staff working in rural and remote areas of Australia. Campbell et al. (2015) have explained that clinical opportunities are required for the maintenance of advanced skills, whereas these can be infrequent, leading to reduced confidence and competence. They also indicated that access to continuing education may be limited in rural and remote environments (Campbell et al., 2015). The types of issues that arise include difficulty in staff maintaining their critical care skills, particularly where no senior support staff are available to provide education and support; difficulty attending professional development opportunities to extend skills because of the limited availability of relief staff and the higher costs associated with travel from geographically isolated areas; and an increased need for staff to work overtime to ensure appropriate staffing levels are met (Kidd et al., 2012). Campbell et al. (2015) also found in their study that there was variation between professionals (medical, nursing and allied staff) as to how they maintained their skills, which ranged from clinical observation to the use of simulation.

Additionally, nursing staff in non-metropolitan areas tend to have heavy workloads, with greater on-call demands resulting in long hours of work that lead to a poor work–life balance and professional isolation (Conger & Plager, 2008; Misener et al., 2008). Mills, Birks and Hegney (2010) have reported that nursing staff are also less likely to receive meal breaks because of limited staff availability. High stress levels are a natural consequence of these conditions that, when combined with professional isolation, often lead to staff dissatisfaction, burnout and high staff turnover (Misener et al., 2008; Terry, Le, & Nguyen, 2016). Regardless of the location, EDs are characterised by complexity. However, in regional, rural and remote areas nurses face varied challenges and, therefore, the solutions to these issues must be similarly diverse.

2.5 Working Towards Innovative Practice

The preceding discussion has identified many obstacles in the provision of quality ED healthcare in rural, regional and remote areas of Australia. While most nurses strive to provide the best care they can, they are often faced with many challenges, including professional isolation and burnout. Meeting patients' needs requires healthcare organisations to aspire to higher levels of service provision; this starts with providing support for their nursing staff. Limited staffing numbers and working in unique—and often confrontational—environments can lead to increased stress and dissatisfaction. Sufficient dedicated and highly skilled nursing

staff need to be employed to ensure that existing rural and remote nurses are supported and provided with relief to advance and maintain their ED skills. Further, to attain and maintain the advanced skills required of nursing staff working in non-metropolitan EDs, a pool of qualified relief staff needs to be established.

The implementation of innovative professional development initiatives to improve access for all non-metropolitan nursing staff working in EDs is recommended so that a generation of highly capable staff is nurtured. Further research is required to explore the professional development capabilities and also creative approaches to reduce nursing staff burnout and professional isolation in these rural and remote communities. Lastly, there needs to be a reduced reliance on staff leaving in-patients on the ward to assist in the ED, and roving triage positions need to be re-evaluated as an acceptable standard of care. Roving triage requires staff to leave the patient they are currently caring for, to triage newly arriving patients. This care is neither optimal nor equitable, and incurs the potential for errors in patient assessment and treatment.

There is no doubt that there is increasing demand on all EDs throughout Australia. These departments need to be appropriately staffed with experienced team members and the correct nurse-patient ratios, especially in non-metropolitan EDs. Such measures are necessary to assure patient safety and satisfaction. There is limited literature available regarding staffing levels and skill mix in EDs generally, let alone in rural, regional and remote EDs. With insufficient data, it is difficult to ensure that effective staffing ratios and skill mixes are being utilised throughout all Australian EDs. Further research that identifies and addresses demographic, geographic and fiscal constraints of EDs is needed to ensure equity in the delivery of healthcare to communities in non-metropolitan locations.

2.6 Published Article

This chapter continues with a discussion paper that was published in the *Australasian Journal of Emergency Nursing* on the 9 February 2016. It is titled ‘Miscarriage in Australia: The Geographical Inequity of Healthcare Services’. This paper continues the preceding discussion by exploring the specific challenges in the provision of ED healthcare for women presenting to EDs with possible miscarriage.

2.6.1 Discussion paper 1: Miscarriage in Australia: The geographic inequity of healthcare services

Table 2.4: Declaration of authorship.

Chapter number	Publication	Nature and extent of the intellectual input of each author, including the candidate	Author
2	Edwards, S., Birks, M., Chapman, Y., & Yates, K. (2016). Miscarriage in Australia: The geographic inequity of healthcare services. <i>Australasian Emergency Nursing</i> , 19(2), 106–111.	Original and key concept ideas, writing up and revisions	Susan Edwards
		Concept ideas, contributed to drafts and critical revisions	Professor Melanie Birks
		Concept ideas, contributed to drafts and critical revisions	Adjunct Professor Ysanne Chapman
		Contributed to drafts and critical review	Dr Karen Yates



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DISCUSSION PAPER

Miscarriage in Australia: The geographical inequity of healthcare services



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2.7 Summary

Chapter Two has identified and explored the challenges faced by nursing staff working in regional, rural and remote EDs, and in particular those encountered by women who presented to non-metropolitan EDs with possible miscarriage. This chapter has also identified the place of literature in grounded theory and provided a justification for the inclusion of this information in grounded theory. The following chapter will discuss philosophy, research paradigms, methodology and its application in this research study.

Chapter 3: Methodology

Good research is systematic in that it is planned, organised and has a specific goal.

Melville & Goddard, 2001, p.1

3.1 Introduction

Choosing and applying a research methodology is essential when commencing a research study so that the aims of the research can be achieved. This chapter will discuss concepts of philosophy and research paradigms, provide a definition of methodology and argue the value of qualitative research. As grounded theory is the methodology used in this study, the reason for the choice of this approach is presented as a basis for understanding its application in this work. The history of grounded theory will be explored in this chapter, including its principles and essential methods that result in the generation of theory.

3.2 Philosophy and Paradigms

Philosophy is a system of beliefs and assumptions regarding the development of knowledge and refers to the way in which a body of data is gained, analysed and utilised (Scotland, 2012). Philosophy is concerned with views regarding how the world works and also how it is explored. Research philosophy refers to a system of beliefs and assumptions about the development of knowledge and can also be defined with the assistance of research paradigms (Wahyuni, 2012). Paradigms are a set of assumptions or overarching philosophical or ideological stances or systems of belief about the nature of the world and its application in the research setting (Scotland, 2012). Cohen, Manion and Morrison (2007) have argued that a research paradigm is a broad framework comprising perceptions, beliefs and understandings of several theories and practices that are utilised when conducting research. Paradigms consist of the following three components: ontology, epistemology, and methodology (Bunniss & Kelly, 2010; Scotland, 2012).

Ontology is the study of being and raises questions about the nature of reality and the nature of human beings in the world (Levers, 2013). Epistemology is the study of knowledge in a way of understanding and explaining 'how I know what I know' and makes meaningful sense of the world (Wahyuni, 2012). Scotland (2012) explains that differing paradigms inherently contain ontological and epistemological views that have differing assumptions of reality and

knowledge that underpin their particular approach, which is reflected in their methodology and methods. Methodology is the strategy or plan of action that lies behind the choices of particular methods and is concerned or focused on the who, what, when and how concerning data collection and analysis (Scotland, 2012). To ensure this research had a strong research design, I needed to have an understanding of research paradigms. For the purpose of this study, I explored three of the research paradigms including postpositivist, interpretivist and constructivist, as they chiefly relate to qualitative research.

Postpositivist researchers challenge the absolute truth when exploring human experiences and believe that although there is a need for rigour and logical reasoning, knowledge is fallible and is shaped by social conditioning (Levers, 2013; McEvoy & Richards, 2003). Interpretivism is different from postpositivism in that the researcher's set of beliefs about the world and how it should be understood and studied guides their research process (Scotland, 2012). The interpretivist believes that knowledge is relative to particular circumstances and interpretations are individual (Levers, 2013). To understand these interpretations, the researcher needs to understand an individual's social world and their interpretation of it (Scotland, 2012; Levers, 2013). Lastly, constructivism is conceptualised as having aspects of both the postpositivist and interpretivist, where the researcher constructs, generates or inductively generates or develops a theory or pattern of meanings (Creswell, 2003). Constructivism assumes that reality is socially constructed, and meaning is made through the individual's understanding of the world that is central to how we understand ourselves and others (Creswell, 2007). Therefore, it is important that the researcher chooses a methodology that ensures that participants can provide their views on the phenomenon being explored (Uzen, 2016).

3.3 Qualitative Research

Qualitative research focuses on determining the 'how' and 'why' a phenomenon occurs (Creswell, 2007). According to Creswell (1998), qualitative research is 'an inquiry process of understanding based on distinctive methodological traditions of inquiry that explore a social or human problem' (p. 99). Qualitative research allows the researcher to explore the personal experience of the participants and to determine how meanings are formed (Corbin & Strauss, 2008). The exploratory nature of qualitative research is especially well-suited to the investigation of phenomena that have not been previously researched (Corbin & Strauss, 2008). Charmaz (2006) has explained that through the research methodology the researcher is able to see the world as the participant does—from the inside. It provides a holistic overview of the

research phenomenon by exploring the everyday life experiences of the participants and valuing the participants' perspective, while ensuring the enquiry process is interactive and descriptive in nature (Corbin & Strauss, 2008; Marshall & Rossman, 1999).

Most importantly, qualitative research 'includes the voices of participants, the reflexivity of the researcher, and a complex description and interpretation of the problem' (Creswell, 2009, p. 53). One of the main advantages of qualitative research is its flexibility (Charmaz, 2006). Qualitative research is able to capture the complexity of a phenomenon by gaining in-depth understanding through the voices of the study participants (McCracken, 1988). McCracken (1988) has stated that the qualitative researcher 'uses a lens that brings a narrow strip of the field of vision into very precise focus' (p. 16). This allows the researcher to discover patterns within the data that explain the participants' reality of the process being researched (Cutcliffe, 2000). The aim of the current research is to understand and explain the experiences of women and their partners who present to regional, rural and remote EDs with first-trimester bleeding, and also the experiences of the nursing staff who provide the care. This area of study is, therefore, best addressed using a qualitative approach. As the research question guides the selection of methodology (Birks & Mills, 2015), it was necessary to explore various methodological options to establish which would best serve the aims of this research.

3.4 Selecting a Methodology

As defined by Birks and Mills (2015), methodology is the 'set of principles and ideas that inform the design of the research' (p. 4). A methodology refers to a model in which research is conducted within a particular paradigm, and comprises an underlying set of beliefs that guide a researcher (Wahyuni, 2012). Therefore, the core concept for research is its methodology, whereas the research method must be designed into the research so that the product of the research is reliable and credible (Jones & Alony, 2011).

The choice of an appropriate methodology and method can be guided by the application of three questions, as described by Rice and Ezzy (2000):

1. What is the substantive issue being addressed?
2. What are the desired outcomes of the research?
3. What is the theoretical framework of the research?

In choosing the most appropriate research methodology for this study, the researcher needed a process for collecting and analysing data that was flexible and open to gain an in-depth understanding of the research topic.

Creswell (2013) has explained that there are five qualitative approaches: ethnography, narrative inquiry, phenomenology, case study and grounded theory. These approaches all have similar data collection techniques (observation, interviews and reviewing text); ultimately, it is the purpose of the study and the phrasing of the research question that differentiates them. Ethnographic research involves the immersion of the researcher in the participant's environment to understand the goals, cultures, challenges, motivations and themes that emerge (Sangasubana, 2011). Ethnography has its roots in anthropology where researchers place themselves within a culture and, rather than relying on interviews or surveys, the researcher observes and at times interacts with people in the culture in which she or he is placed (Creswell, 2013; Sangasubana, 2011).

Phenomenology is a school of thought that focuses on people's experiences and interpretations of the world and seeks to describe and understand the meaning participants place on the phenomenon being studied (Creswell, 2013). Phenomenology starts from a perspective that is free from hypotheses or preconceptions (Chan, Fung, & Chen, 2013). There are at least two distinctive forms of phenomenology: descriptive and interpretive. The former is used in nursing research to illuminate pure description of people's experiences, whereas the latter seeks the 'hidden' meaning and interpretation of these experiences. Further, descriptive phenomenology deals with epistemology and interpretive with ontology (Mutua & Van Der Walk, 2015).

The narrative approach retells someone's story across time to weave together the sequence of events (Wang & Geale, 2015). Robert and Shenhav (2014) have explained that humans have a natural affinity to tell stories and that narrative inquiry allows an individual to tell their story from their personal and social perspective. Narrative research can be based on either individual or organisational cases. Wang and Geale (2015) have explained that the narrative approach acknowledges that human experiences are 'dynamic and are in a constant state of flux' (p. 195). Narrative inquiry seeks to understand human experiences and/or social phenomena through the form and content of stories analysed as textual units (Wang & Geale, 2015). This approach enables the researcher to provide a rich description of the participant's experience through narrative and allows an exploration of the meaning applied to these experiences by the

participant (Wang & Geale, 2015). The researcher relies on the participants' own perspectives to provide insight into their motivations (Wang & Geale, 2015).

Case study is aligned to narrative in that it is organised into a case structure. The case study presents a detailed analysis of a 'case' where the focus is on one specific facet, such as a person, group process or activity (Zucker, 2009). It allows the researcher to understand the nature and complexity of the process taking place and is concerned with 'how' and 'why' things happen (Noor, 2008). A case study may be exploratory, descriptive or explanatory (Baxter & Jack, 2008; Bryant, 2008). The processes involved in preparing a case study are interdisciplinary, so a variety of different theories and concepts can emerge when it comes to the final interpretation (Creswell, 2013).

While the above methodologies focus on description and/or interpretation of an entity or event, grounded theory looks at providing an explanation of phenomena that is grounded in the data (Creswell, 2013). Grounded theory was found to fit perfectly with the direction of this research, as it allowed for exploration of human–context interactions (Glaser, 2008; Glaser & Strauss, 1967). In terms of exploring human social interactions, such as the interactions between the women, their partners and the nursing staff in this study, grounded theory had the potential to provide insight into this complex phenomenon (Charmaz, 2006; Glaser, 1998). Grounded theory is useful when the goal is to explain human behaviour in context through the development of a theory or framework (Wuest, 2012). Grounded theory was considered the most appropriate approach for this study, as it emphasised *explaining* the experiences of the participants rather than simply *exploring* them.

3.5 Grounded Theory

Grounded theory is 'a qualitative strategy of inquiry in which the researcher derives a general, abstract theory of process, action, or, interaction grounded in the views of participants in a study' (Creswell, 2009, p. 13); that is, a theory that is grounded in the words of the participants and is rooted in the edicts of symbolic interactionism (Glaser & Strauss, 1967). However, it is important to note that GT has evolved from these historical edicts according to Chamberlain-Salaun, Mills and Usher (2013). Symbolic interactionism is a micro-level perspective in sociology that addresses the manner in which individuals create and maintain society through face-to-face, repeated and meaningful interactions (Cater & Fuller, 2015). Glaser (2005)

believed that SI is not a GT method nor is it required to be used as a basis or a foundation of GT, although SI can be used as a sensitising perspective by researchers in their particular field.

Grounded theory was first defined and utilised by Barney Glaser and Anselm Strauss in 1967, in their study called *The Awareness of Dying*. Glaser and Strauss were unhappy with the way existing theories dominated social research; they argued that researchers needed a research pathway that would allow them to move from data to the development of a theory (Oktay, 2012). These theories would be specific to the context in which they had been developed, and they would be grounded in the data from which they emerged (Oktay, 2012). Therefore, grounded theory was designed to open up a space for the development of new contextualised theories. The aim of grounded theory is the 'discovery of theory from data' by developing a higher level of understanding of social phenomena (Glaser & Strauss, 1967, p. 1). Grounded theory was intended to move beyond descriptive studies of research towards identifying theories that explain processes in which the theory could be tested or utilised to provide a basis for action and/or further research (Charmaz, 2006); that is, gaining a deeper understanding that is 'grounded' in and/or derived from a systematic analysis of data (Lingard, 2008). The theory that emerges offers an explanation of the phenomenon being studied.

Grounded theory provides a detailed, rigorous and systematic method of data collection and analysis, which has the advantage of reserving the need for early hypothesis development, and is accepted as naturalistic, holistic and inductive (Jones & Alony, 2011). Grounded theory still maintains many of the traditional stages of research, which include planning, data collection, data analysis and reporting, although the process of grounded theory method is not entirely linear (Egan, 2002). The research design incorporates cycles of simultaneous data collection and analysis, which then informs the next cycle of data collection, guided by the emerging theory (Lingard, 2008). This means that data collected from the participants determines what is explored, the literature that is researched and the number of participants in the study (Chiovitti & Piran, 2003). Therefore, grounded theory explores the fit between the initial research interest and the emerging data, where the process is not preconceived; rather, the data leads the investigation. Birks and Mills (2015) have explained that grounded theory is appropriate to use when there is little known about the area of study and the generation of a theory is required that has explanatory power. It was for these reasons that grounded theory was chosen.

Grounded theory aims to explain, understand and reveal the ‘invisible’ by reflecting on the unconscious choices that the researcher makes while being immersed in the simultaneous data collection and analysis (Star, 2007). The two key characteristics of grounded theory research design are constant comparison of data and theoretical sampling that maximises the similarities and differences within the collected data (Creswell, 2007). According to Charmaz (2000), the strategies utilised in grounded theory include: a) the simultaneous collection and analysis of data, b) the data coding process, c) comparative methods, d) memo writing aimed at the construction of conceptual analysis, e) sampling to refine the researcher’s emerging theoretical ideas, and f) the integration of the theoretical framework.

So far in this chapter, grounded theory has been discussed as a methodology, but it is important to note that some confusion exists about whether grounded theory should be regarded as a methodology, a method or both. While Strauss and Glaser both described grounded theory as a methodology, the Grounded Theory Institute (run by Glaser) has asserted that grounded theory is an ‘inductive methodology and while many call grounded theory a qualitative method, it is not ... It is a general method that systemically generates a theory from systematic research’ (Grounded Theory Institute, 2013). Therefore, it is understandable how confusion exists, particularly as its founder has stated that grounded theory works both as a method as well as a methodology (Cho & Lee, 2014). In recognition of this duality, the essential methods that comprise grounded theory (Birks & Mills, 2015) will be considered in this chapter.

3.6 Coding

Qualitative coding, as described by Charmaz (2006), is the first step in the analytical process, and is ‘the bones of the analysis’ (p. 45). Glaser (1978) has stated that coding generates an ‘emergent set of categories and their properties which fit, work and are relevant for integrating into a theory’ (p. 56). According to Charmaz (2006), coding filters and sorts the data so that the researcher is able to easily identify what is occurring in the data and comparisons can be made. Coding links the data and finds the relationships within the data through constant comparison (Star, 2007). It is through the coding process that the raw data and the theory are connected, so that the generated theory has explanatory power (Jeon, 2004). Through coding, the researcher defines what happened in the data and what it means (Charmaz, 2006). These codes are the ‘building blocks’ of grounded theory that answer the question, ‘what is going on here?’, through the process of analytical writing or note-taking (Jeon, 2004; Rich, 2012). In reviewing the process discussed by both Charmaz and Birks and Mills, it was decided that

Birks and Mills' (2015) process would guide the essential methods utilised in this research and provide a straight-forward approach when coding.

3.6.1 Initial coding

Initial coding as described by Birks and Mills (2015) is the first step in coding and is synonymous with that of the same name used by Charmaz (2014) and open coding referred to by Glaser (1978) and Strauss and Corbin (1990, 1998). Data analysis begins with the examination of data, line by line or by set of lines, naming the actions or events found within the data (Boychuk-Duchscher & Morgan, 2004). Early on, the data are sorted and synthesised in the initial coding process, in which the researcher labels segments of the data that identify what the data are about (Charmaz, 2006; Birks & Mills, 2015). Initial coding takes a reflexive approach in line by line coding, and this continues until categories begin to form (Birks & Mills, 2015). Line by line coding, as described by Charmaz (2006), prompts the researcher to remain open to the data and is a useful tool in the initial coding process, as it allows the researcher to become immersed in the respondents' world ideas. Also, line by line coding identifies thoughts and ideas that may have escaped the researcher's attention when reviewing the data in a general manner, and provides clues to pursue (Charmaz, 2006). The analytical coding process breaks interviews and observations into distinct units of meaning, which are labelled to generate concepts (O'Connor, 2012).

The process of initial coding examines the data without limitations in its scope or the application of filters; therefore, all the data are accepted and no data are excluded. Charmaz (2006) has pointed out that in initial coding the researcher should stick closely to the data and allow openness so that new concepts and ideas emerge freely. The researcher is then able to look for patterns that may be identified as of special interest to the research. Charmaz (2006) has highlighted the need for speed and spontaneity in this stage, as working quickly allows for fresh thought development in regard to coding. The codes need to fit the data, rather than forcing the data to fit the codes, which can be achieved by word by word, line by line and/or incident by incident coding (Charmaz, 2006).

Birks and Mills (2015) and Charmaz (2006) have explained that many grounded theorists describe line by line coding as their first step in coding; it is an enormously useful tool as ideas may present to the researcher that have been identified when reading the data in a general thematic analysis. As coding continues, the data that is collected accrues to form categories of similar patterns. The emerging categories are used to organise and group the initial codes into

meaningful clusters, which involves breaking down the interview data into discreet parts that are examined and compared for similarities and differences (O'Connor, 2012). The advantage of initial coding, as described by Charmaz (2006), is its ability to fulfil two of the criteria of grounded theory: 'fit' and 'relevance'. Initial coding allows the researcher to refrain from imputing motives, fears or unresolved personal issues into the respondents' responses, and keeps the data true and grounded. Initial coding continues until categories begin to form (Birks & Mills, 2015). Initial coding can also include 'in-vivo' coding, which is the process by which codes are applied that come directly from the interviewees and do not require interpretation by the researcher (O'Connor, 2012). As coding establishes categories, the process involves three subcomponents: naming, comparing and memoing (Locke, 2002).

3.6.2 Intermediate coding

Intermediate coding is the second phase of coding and follows on from the initial coding process (Birks & Mills, 2015). After assessing which initial codes appear most frequently, codes are then applied to large amounts of data during initial coding (Charmaz, 2006). The researcher moves between initial and intermediate coding during the process of concurrent data collection or collection and analysis, and constant comparison of data (Birks & Mills, 2015). While initial coding is said to fracture the data, intermediate coding reconnects the data. Birks and Mills (2015) have explained that 'one of the key tasks of intermediate coding is the linking together or integration of categories and subcategories' (p. 95). In the process of concurrently generating and analysing data, a large number of codes can be identified and this requires continuous organising; the grouping of these codes leads to the formation of categories by the process of constant comparison of data and their sub-categories (Birks & Mills, 2011).

3.7 Constant Comparison

One of the essentials of grounded theory is the process of constant comparison and theoretical sampling that guides the development of the emergent theory (Jones & Alony, 2011). Constant comparison names and develops concepts, which allows the researcher to gain an analytical grasp on the data (Rich, 2012). Constant comparison is the simultaneous and concurrent process of coding and analysis (Jones & Alony, 2011). The process of comparing and asking questions is embedded in the entire research process, and is fundamental in the stimulation of thinking about incidents, concepts and categories through the writing of analytical notes (Corbin & Strauss, 2008). In simple terms, constant comparison is the process of constantly

comparing instances of data that are labelled as a particular category with other instances to see if the categories fit and are workable (Corbin & Strauss, 2008).

The researcher initially makes comparisons between data to find similarities and differences, and then continues to compare 'incident to incident, incident to codes, codes to codes, codes to categories' (Birks & Mills, 2015, p. 11). As the categories accumulate and gain depth, constant comparison compels the researcher to begin to reflect on the data and to commence conceptualisation by writing memos that record the researcher's reflections and annotations of the data (Jones & Alony, 2011). Constant comparison requires the researcher to tease out the categories and their related properties (Hutchinson, 1993). According to Glaser and Strauss (1967), constant comparison provides a process for comparing incidents applicable to each category and integrates the categories and their properties. Constant comparison continues until the theory is generated with sufficient detail and abstraction (Hutchinson, 1993). The benefit of using constant comparison is that a substantive theory emerges as the research progresses through the process of memo writing (Kolb, 2012).

3.8 Memos

Analytical notes or memos are a critical element in grounded theory, in which the researcher's thoughts, comparisons and connections are made (Charmaz, 2006; Rich, 2012). Memos are the unconstrained writings that incorporate the thoughts, questions and ideas that arise when data are analysed (Charmaz, 2006; Rich, 2012). Memos allow for the elaboration of the researcher's thoughts and ideas and provide the link between the formation of codes, and continues through coding and into the development of analytical categories that arise when comparing the data (Birks & Mills, 2011; Charmaz, 2006). Memos are the theorising write-up of ideas about codes and their relationships as they strike the researcher while coding (Jeon, 2004). Oktay (2012) has explained that memos also show the changes that occur in the direction of the analytical process and the emerging perspective, as well as providing reflections on the adequacy of the research question. As a result, memos provide information about the research itself and about the substantive findings of the study (Oktay, 2012).

Memos reflect emerging ideas concerning relationships between data categories, new categories, the properties of these new categories, insights into the research process and other reflections (Sbaraini, Carter, Evans, & Blinkhorn, 2011). Memos provide a way to capture the researcher's insights into what to explore and should be utilised as a research tool that triggers

further constant comparison. Memo writing is an essentially reflective process that also provides the researcher with an opportunity to remember, question, analyse and make meaning about the time spent with the participant and the data generated. Memo writing can be a sentence, a paragraph or a few pages that exhausts the analyst's ideation, raises the data to a conceptual level, develops the properties of each category, presents hypotheses about connections between the categories and begins to locate the emerging theory (Glaser, 1978).

Memo writing leads directly to theoretical sampling and aims to conceptualise the coding process (Boychuk-Duchscher & Morgan, 2004). Charmaz (2006) has explained that the method for producing memos lies in its spontaneity and not in the mechanical nature of formal writing. Memos should be informal and free flowing, and are for the personal use of the researcher. The process of memo writing forces the researcher to stop, clarify and develop ideas in an analytical manner. In summary, memo writing helps the researcher to freely explore ideas and is the fundamental process whereby the researcher engages with and links the data, and subsequently transforms the data into theory. Lastly, the writing of memos during each analytical phase prompts the researcher to make the analysis stronger, clearer and more theoretical (Charmaz, 2006).

3.9 Theoretical Sampling

Grounded theory, as described by Cutcliffe (2000), uses a process of non-probability sampling to gain data to build the theory. Theoretical sampling is the process whereby the researcher decides what data to collect and where to find them (Star, 2007). Beyond the initial decisions concerning data collection, further collection of data cannot be planned in advance. Theoretical sampling is not just about what you do next, it is also about 'how' you do it (Birks & Mills, 2015). As such, the process of data collection is controlled by the emerging theory (Salinger, Plonka, & Prechelt, 2008). The researcher decides where to go next by coding the initial data and then looking for sources of data that will saturate the emerging codes and categories (Salinger et al., 2008).

Theoretical sampling can be employed in both early and later stages of the research, and can be utilised to narrow and refine the focus of the emerging categories (Charmaz, 2006). Theoretical sampling elaborates on the meaning of the categories, discovers the variations between them and can also define gaps that arise in the categories (Bryant & Charmaz, 2007).

It is theoretical sampling that provides the direction to fill in the gaps and ensure development of the final theory.

3.10 Theoretical Sensitivity

Theoretical sensitivity, as defined by Birks and Mills (2015), is ‘the ability to recognise and extract from the data elements that have relevance’ (p. 58) for the study. It is the researcher’s ability to conceptualise and formulate theory via the constant comparison of data (Charmaz, 2006). Corbin and Strauss (2008) extrapolated that theoretical sensitivity refers to the personal qualities of the researcher and their awareness of the subtleties gained from the collected data. Birks and Mills (2015) have also explained that Glaser and Strauss identified theoretical sensitivity in 1967 as an important attribute for researchers wanting to engage in grounded theory research. Charmaz (2006) has argued that to gain theoretical sensitivity the researcher needs to explore the studied experience from many and differing angles, follow leads, make comparisons and build on the developing ideas. Charmaz (2006) has also suggested that the researcher needs to be open to the unexpected and to possibilities so that the data gained in the research can be utilised and applied. Theoretical sensitivity can be achieved or raised by a number of sources; they include the use of literature, professional and personal experience and via the application of the analytical process itself (Birks & Mills, 2015; Corbin & Strauss, 2008).

Corbin and Strauss (2008) have clarified that having insight and understanding regarding the research phenomenon increases the researcher’s interaction with the data. The collection of data, the analysis of the data via constant comparison and the development of hypotheses raise the sensitivity of the research (Corbin & Strauss, 2008). In raising the sensitivity, the analyst is able to see the research situation and its associated data in new ways and explore the data’s potential for developing theory by establishing solid connections between what is previously known and the unknown (Corbin & Strauss, 2008). These connections are made through the writing of memos, in which the act of writing the memos and analysing the writings provides a meaningful link between personal and professional standpoints of the researcher (Birks & Mills, 2015). The analysis of the researcher’s reflective writings is known as reflexivity.

3.11 Reflexivity

Reflexivity is an ‘active process of systematically developing insight into the researcher work’ to guide future action (Birks & Mills, 2015, p. 52). In being reflexive, the researcher must

incorporate a continuous awareness of reflecting, examining and exploring his/her relationship with the research phenomenon through all stages of the research process (Mauthner & Doucet, 2003). Reflexivity begins with the understanding of the importance of one's own values and attitudes within the research process, and it means taking a critical look inward (Hesse-Biber, 2007). In general, reflexivity is the process whereby the researcher explores one's own lived reality and experiences via the careful monitoring of one's own subjectivity, and then reflects on this. Self-reflection is the key for the researcher to identify and acknowledge the limitations of the research by identifying the researcher's personal views of the phenomenon and by keeping track of insights and analytical ideas as they occur to the researcher during data collection and analysis (Hutchinson, 1986). Self-exploration allows the researcher to separate and differentiate what the researcher knows, understands and needs to know, and thence guide future research actions (Birks & Mills, 2015).

3.12 Theoretical Saturation

According to Charmaz (2006), theoretical saturation occurs when the gathering of fresh data does not identify any new properties of the core category or when no new theoretical insights can be achieved. This means that the researcher has continued to sample and code data until no new categories have been identified and no new instances of variation for existing categories have emerged. Glaser and Strauss (1967) explained that theoretical saturation is the criterion utilised for determining when to stop theoretical sampling; that is, sampling should stop when there are no new codes being identified in the later stages of data generation or collection that relate to any particular category. Birks and Mills (2011) have explained that at this stage the category is conceptually well-developed and that the categories and sub-categories are clearly integrated and connected. According to Charmaz (2006), theoretical saturation is the end goal of all grounded theory research and is the point at which the data collection and analysis cycle can conclude. Dey (1999) highlights that this does not merely mean the exhaustion of data sources, but that there is sufficiency in category development.

3.13 Advanced Coding and Theoretical Integration

Advanced coding is central to the process of theoretical integration (Birks & Mills, 2015). Theoretical coding is the final stage of coding and occurs when the core categories have become saturated (Jones & Alony, 2011). In grounded theory, there may be several theoretical codes that emerge, but eventually through coding and memoing generally one theoretical code

is chosen as the theoretical code for the study (Hernandez, 2009). The theoretical code is the relational model in which all substantive codes/categories are related to the core category. 'Theoretical codes conceptualize how the substantive codes may relate to each other as hypotheses to be integrated into theory' (Glaser, 2004, p. 143). Glaser and Strauss (1967) also explained that substantive codes break down (fracture the data), while theoretical codes weave the fractured story back together into an organised theory. Theoretical codes are not preconceived; they are generated from the data.

3.14 Generating Theory

The final product, as described by Birks and Mills (2015), is the integrated and comprehensive theory that is grounded in the data and ultimately explains the phenomenon being studied. The construction of the storyline aids in formulating the theory and highlights the relationships between the concepts that build the theory (Birks & Mills, 2015). The developing storyline allows for variation and highlights the interaction between the data and the researcher by the use of memoing to assist with conceptualisation of the theory (Glaser & Strauss, 1967; Urquhart & Fernandez, 2013). Once developed, the theory can be applied to the work of others and allows the researcher to validate, support or augment existing theories to explain or reinforce the value of the researcher's developed theory (Birks & Mills, 2015).

3.15 Summary

Choosing and applying a research methodology is essential when commencing a research study, so that the aims of the research can be achieved. This chapter provided a definition of methodology and argued the value of qualitative research. An explanation was provided for the methodological choice of qualitative research and grounded theory, and grounded theory's alignment with this research. Grounded theory was the most appropriate choice for this study as the aim was to explain human behaviour in context through the development of a theory. In so doing, it provides an explanation of the experiences of women and their partners who presented to non-metropolitan EDs with possible miscarriage and of the nursing staff who provided care in these settings. The following chapter will describe the specific research design employed in this grounded theory study.

Chapter 4: Study Design and Methods

As the social world becomes more complex, researchers have much to gain from the use of grounded theory methods, comprehensively and selectively.

Melanie Birks, 2015

4.1 Introduction

The research presented in this thesis aimed to gain an in-depth understanding of women and their partners' experiences of attending their local non-metropolitan EDs with possible miscarriage. The study also sought to explain the process from the perspective of nursing staff who provided the care for these women. The meaning of this phenomenon cannot be understood without the women, their partners and the nursing staff telling their own stories in their own words. Grounded theory was employed to achieve the aims of this study, as it is most appropriate for developing a theory that explains phenomena through the inductive use of rich data. In this chapter, the design of the research project is outlined and the application of grounded theory processes and methods to this study is described in detail.

4.2 Elements of this Grounded Theory

In this chapter, the discussion will be drawn from the approach to grounded theory described by Birks and Mills (2015). The framework enables an exploration of elements of grounded theory as they are applied to the research process. These elements include:

- What led me to the question?
- Ensuring quality processes in my research.
- Positioning myself in the study.
- Generating and collecting my data.
- Analysing my data.
- Integrating my theory.
- Presenting my grounded theory.
- Evaluating and applying my grounded theory.

The first step in this process was to develop the research question.

4.3 What Led Me to the Question?

In planning this research, I had to reflect on why I wanted to understand the experiences of women and their partners when they presented with possible miscarriage to non-metropolitan EDs. In doing this, I would be able to recognise any assumptions I had about their experiences and the experiences of the nursing staff who provided the care. I noted that my assumptions were driven by my own experiences as a nurse and an NP who cared for women that presented to the regional EDs where I had previously worked. Seeing women and their partners waiting in the ED and when triaging, I often felt I needed to apologise for not being able to provide a bed or private room in which they could wait. I also understood their frustration and distress when informing them that they needed to go to another service for diagnostic procedures or follow-up. I always wished I could do more. My assumptions focused on the organisational restrictions, such as the services that were and were not provided in regional, rural and remote areas of Australia. These were largely:

- the number of available or ‘funded’ beds
- workforce issues, such as a decreased number of nursing and medical staff, shortages of sonographers and specialist consultants
- funding
- spacing availability (access and bed block)
- difficulty in arranging follow-up care due to the limited services available.

My position drove me to want to discover how we could improve our services. To do this I needed to explore the experiences of the women and their partners who attended non-metropolitan EDs for care. I knew that I needed to understand what their experiences meant to them, and also those of the nursing staff who provided the care. In exploring possible miscarriage in the ED and being aware of my experience in EDs caring for women with possible miscarriage, I also understood that I brought a wealth of knowledge to this research. At an early stage, prior to the commencement of this study, it was important to clarify my thoughts, ideas and assumptions so as not to isolate my position and to acknowledge any possible impact it may have.

4.4 Ensuring Quality Processes in My Research

Quality in research is necessary to promote evidence-based practice, which in turn aims to improve the care provided by healthcare professionals (Darawsheh, 2014). It is important that

the researcher employs measures to ensure the quality of their research by demonstrating rigour throughout the process (Birks & Mills, 2015). Rigour is necessary to enhance the consistency and quality of qualitative research especially when methodological decisions can have an impact (McBrien, 2008). Birks and Mills (2015) have highlighted three factors that influence quality: researcher expertise, methodological congruence and procedural precision. I found that memoing was critical while I monitored my growing expertise in the methodology, ensured that my philosophical position was congruent with the research process and reinforced precision in the application of the essential grounded theory methods.

According to Birks and Mills (2015), memoing 'is the cornerstone of quality in grounded theory' (p. 39). Early in my research, memos were often just the quick jotting down of thoughts. As my research progressed, I became more reliant on memoing. Birks, Chapman and Francis (2008) explained that the researcher extracts meaning from the data using interpretation, and memoing enables articulation, exploration and questioning to occur. Further, Charmaz (2014) has acknowledged the value of memoing and its ability to initiate and maintain productivity throughout research. Memos provide the researcher with records of their developing ideas and of the connections between the codes and categories (Montgomery & Bailey, 2007). In this study, memo writing occurred from the beginning of data collection and proceeded throughout the research process.

Memoing ensured the facilitation of quality throughout the research process (Engward & Davis, 2015). Some memos were written when categories were identified, and others at times when it was difficult to develop a code or category; clarifying my thoughts assisted in the final development of codes and categories. To help with the minimising of preconceptions, I wrote memos to explore possible patterns in and between the codes and to organise my thinking (see Figure 4.1; Glaser & Strauss, 1967). Memos were also important in providing an evidence trail of decisions made when working with the research data (Birks & Mills, 2015).

Memo—Arbitrary Practice

When listening to the participants' views about the care that is provided in remote locations as being arbitrary—this was a surprise. I had not thought that in this day and age that care was so dependent on the individual providing the care. This therefore became a category—I feel this is an important aspect in the care of women who present to regional/rural and remote emergency departments. This finding has given me confidence that coding and categorising was not driven by research bias and researcher expectations.

Figure 4.1: Memo—Arbitrary practice.

Memos were also very important in capturing thoughts, ideas and questions associated with coding as the analysis progressed, which then helped in developing my codes and their interconnections (Glaser, 1998). Memos provided an overview of where the data were taking me as the researcher, and were valuable in capturing any bias (see Figure 4.2), thus preventing any preconceptions from influencing the analysis (see Figure 4.3; Birks & Mills, 2015). These steps ensured that the data guided subsequent interview questions and helped shape the emerging theory (Engward, 2013; Engward & Davis, 2015).

Memo—Past History and Related Thoughts

The Royal North Shore incident impacted on all Australian EDs, I can say this as it affected the work that I carried out in a small regional hospital. The hierarchy had sent multiple memos to staff in the ED asking for what our process was—did we meet benchmarks?—I found it interesting that changes are not usually made until an error is reported or made public. We tend to keep working under the same conditions. Often commenting to our colleagues that things need to change but insufficient time and resources make this impossible. I have always attributed the overcrowding/bed block to our problems in ED. But maybe there are other causes?

Figure 4.2: Memo—Past history and related thoughts.

Memo—Actually Listening

I find that in moving forward in this research, I am becoming more attuned to what the participants are trying to say—that is, listening to what they are saying or are not trying to say. I did come into this research with some ideas or thoughts as to what I might find. But as I progress I become more immersed or focused on what it is that the participants are telling me. Keeping an open mind throughout the interviews allowed for more ‘aha’ moments. Although at times I did need to listen more than once to the taped recordings to ensure I understood what it was they were saying. I also had to remind myself to not respond when participants were pausing. I think that as nurses we tend to ‘fill in the gaps’ for our patients and try to predict what it is they were going to say (this could be related to time constraints). I had to give myself permission to listen—no reason to rush.

Figure 4.3: Memo—Actually listening.

Memoing also assisted me in positioning myself in the study, even though I was not aware of this at first.

4.5 Positioning Myself in My Study

I found that I related to the philosophical foundations of the constructivist approach that assumes a relativist ontological position where the world consists of multiple individual realities. Constructivism was a good fit and it facilitated an exploration of the complexities of healthcare and its impact on an individual’s life. Constructivism begins with the experience and explores its meaning (Charmaz, 2006). This approach also fosters openness and empathetic understanding of participants’ views and experiences. As such, it facilitated an understanding of the women’s, the partners’ and the nursing staffs’ experiences and expectations in this research. The more comfortable I became with the processes, the more theoretically sensitive I became to what was in the data; I was then able to recognise and extract data elements that had relevance to the developing theory (Birks & Mills, 2015).

4.6 Generating and Collecting My Data

Data collection in this study was guided by grounded theory methodology and directed by theoretical sampling. The aim of theoretical sampling is to choose the avenues of sampling that can bring about the greatest theoretical return (Corbin & Strauss, 2008). Theoretical sampling, as described by Glaser and Strauss (1967), is the process of data collection in which simultaneous coding occurs via comparative analysis to direct the research to the development of a theory. I used theoretical sampling to develop and saturate the theoretically relevant

categories in terms of their properties and to also identify the relationships between concepts (Birks & Mills, 2015; Corbin & Strauss, 2008; Creswell, 2009). For example, in one interview a woman spoke of being aware that the ED staff had not acknowledged her partner. This statement led me to ask other women during their interviews if they had similar experiences, and ultimately to interview the partners to gain their perspectives. Thus, theoretical sampling led to the inclusion of the partners when the study originally intended only to focus on the women who presented to the ED and the nursing staff who provided the care. As is common in grounded theory research, this evolution of the study design required an ethical amendment.

4.6.1 Ethics

Ethical approval for this study was originally received from CQUniversity Human Research Ethics Committee (H13/02-014) in March 2013. The project was assessed as being greater than low risk, and mechanisms were put in place to offer support to participants (if required) in the form of counselling (see Appendix D). In June 2014, I transferred my PhD candidature to James Cook University. An application was made to CQUniversity Human Ethics Research Committee (HREC) and approval was given for CQUniversity to continue ethical coverage, along with James Cook University accepting this external ethical clearance. James Cook University also acknowledged the previous data collection prior to the transfer (H5843). It was at this time that an amendment was approved to include the partners of women who have suffered first-trimester bleeding and possible miscarriage in the study. Both CQUniversity and James Cook University HREC approved modifications in October 2014 and April 2015 to extend data collection until June 2016 (see Appendix B).

4.6.2 Participants

Inclusion criteria for this study included women, their partners and nursing staff who lived and worked in rural, regional and remote areas of Australia. They had to be over 18 years of age, speak English and have the desire to tell the story of their experiences. Additionally, the women and the partners needed to have presented to their local non-metropolitan ED with bleeding in early pregnancy and to have attended their local ED after 2000. This timeline was chosen to coincide with the introduction of the ATS. It should be noted that the partners who participated in this study were not those of the women who participated, enabling greater breadth of experiences to be explored.

4.6.3 Recruitment

Participant recruitment commenced with advertisements for nursing staff through the College of Emergency Nursing Australia (CENA). Emails were sent to members via their e-alert system. The initial response from the mail-out was good with 14 respondents, six of who elected to participate in the study. Recruitment for women was more difficult. The recruitment of women through the public hospital system was likely to prove a protracted process and thus initial recruitment was planned through Pregnancy Loss Australia, with advertisements in their newsletter. Unfortunately, poor timing and sporadic communication resulted in no advertising through this organisation. The second approach was to recruit women through Women's Health Centres in regional, rural and remote centres. While these organisations were very helpful, no participants were recruited through this mechanism. Ultimately, snowball sampling proved to be the most effective recruitment method for both the women and the partners in this study along with word-of-mouth. Jones, Steeves and Williams (2009) have explained that word-of-mouth and snowballing are separate strategies for participant recruitment and are particularly useful for hidden populations, of whom it may be challenging to gain access. Recruitment for the women was via social networks of mothers groups; for the men, word-of-mouth was the most effective method, which was consistent with findings by Browne (2014).

The final sample of participants is summarised in Table 4.1

Table 4.1 Participant information

Participants	Number	Aria + score	Face-to-Face interview	Telephone interview
Women	3	2 x outer regional 1 x remote	0	3
Male partners of women who have miscarried	2	1 x outer regional 1x remote	2	0
Nurses– Female	4	2 x very remote	0	4
Nurses– Male	2	1 x inner regional 1 x outer regional	0	2

Prior to the interviews, I informed the participants of their rights as study participants, including potential harms and benefits of being involved in the study. I also informed the participants

that if they experienced any emotional distress to let me know, as the interview would be stopped and, if required, referrals would be made to a free counselling service (see Appendix D). Informed consent was obtained from all participants prior to the commencement of data collection (see Appendix C). Anonymity was maintained by providing each participant with a pseudonym that was utilised throughout the research process. The information gained from participants was held in strict confidence, and consent forms were kept in a locked filing cabinet, with the chief researcher holding the key. Audio-recordings and transcripts were kept in a password-protected computer that only the lead researcher had access to. The data will be destroyed after 5 years.

4.6.4 Interview Process

To obtain information-rich data, interviews were conducted using an open-ended, semi-structured approach and were recorded then transcribed verbatim (see Appendix E). The interviews were on average between 45 and 50 minutes in length in which nine were conducted by telephone and two were face-to-face. The researcher commenced the interviews by asking the participants to tell their story regarding their experiences, allowing the participants to settle into the interview process. For the most part, interviews with the female nursing staff flowed from one topic to the next and involved a sharing of experiences. Conversely, interviews with the male nursing staff were less of a shared experience and were more to the point when discussing their experiences. Nursing staff who were new to the profession appeared to be more critical of their own practices than the experienced staff. The interviews with the nursing staff were formal in nature, especially when interviewing the male nurses.

The women in this study used descriptive and emotive words in relaying their experiences of their time in the ED, while partners who were interviewed tended to answer questions with yes or no responses. I also found that the partners did not like to be asked the same questions twice, especially when I sought to clarify their yes or no responses, and they were very forward in telling me so. This was very challenging for me until I learned to approach the interview from a gendered perspective, which enabled us both to settle into the interview. Overall, these challenges required me to become inventive in my approach when interviewing men; a process discussed in the paper 'Gender perspectives when interviewing men', which is included in this chapter.

4.7 Analysing My Data

Consistent with grounded theory methods, data collection and analysis took place simultaneously (Glaser & Strauss, 1967). Analysis of the data included three stages: initial, intermediate and advanced coding (Birks & Mills, 2015). Coding is an analytical process in grounded theory that involves taking data apart into analysable fragments, following which the researcher applies names to these fragments (Tweed & Charmaz, 2012). Initial coding generates the bones of the analysis and shapes the analytical frame from which analysis builds (Birks & Mills, 2015). Initial coding was the first step in the data analysis; it was a way to identify important words and groups of words in the data, and for these to be labelled accordingly (Birks & Mills, 2015). After the initial interview was transcribed, initial coding involved examining the transcript line by line and allocating codes. When coding, I utilised qualitative data analysis software (NVivo10), which aided in the management of the large volumes of data. Identifying codes in the data began the discovery of categories, along with their properties and dimensions (Corbin & Strauss, 2008).

When possible, in-vivo codes (verbatim quotes from the participant) were utilised. In-vivo codes helped to preserve participants' words or groups of words that were subsequently used as labels for codes or categories (Birks & Mills, 2015). Charmaz (2006) has explained that in-vivo codes keep the meanings of the participants' views and actions in the coding itself and serve as a symbolic marker of the participant's speech and meaning. During the initial coding phase, I often had to walk away from the process and have a break, so that I could then come back and continue with a clear mind. As coding continued, it provided new directions to pursue in data collection, which were then analysed through constant comparison (Charmaz, 2006).

According to Birks and Mills (2015), constant comparative analysis is the process whereby data are compared with existing data as the research continues through initial coding and into intermediate coding. Comparative analysis of the coded transcripts worked to identify patterns of similarity or anomalies within and between the texts where the code did not seem to fit—and thus required recoding (Birks & Mills, 2015; Charmaz, 2006). Memos were also written at this time and were valuable in the decision-making process. Birks and Mills (2011) have explained that while initial coding will fragment data, intermediate coding focuses on 'actualising the core category' (p. 12). Intermediate coding required decisions to be made about which initial codes made the most analytical sense to become categories (Birks & Mills, 2015). First, I compared incidents to establish the underlying uniformity and varying conditions of

generated concepts and hypotheses. I then compared incidents with codes, then codes with codes, codes with categories and categories with categories. I found diagramming to be very helpful, as it increased the levels of abstraction (Wuest, 2012). Diagramming in grounded theory can provide visual representations of ideas and concepts, and can show relationships between codes, categories and sub-categories by using graphic organisers such as concept maps and flowcharts (Birks & Mills, 2015; Charmaz, 2006). In this study, diagramming also assisted in finding holes or gaps within the developing theory and in that way guided theoretical sampling (Birks & Mills, 2015).

The most frequent and significant codes were selected and then raised to categories (Hallberg, 2006; Wuest, 2012). Data that had similar properties were assigned to each specific category (see the example in Table 4.2). Dissimilar words or phrases represented new categories. When these categories were identified, memos were written identifying their properties and through this process sub-categories were highlighted to explain the broader concept (Birks & Mills, 2015). During this process, constant comparison of the data, categories and sub-categories was required to identify their relationships (Birks & Mills, 2015).

Table 4.2: Generation of categories, group C participants (partners).

Transcription abstract	Code	Category
‘No I was there but it wasn’t directed at me um ... yeah um most of the time I was sitting there and I was not even acknowledged.’	The partner’s burden	Partner’s experiences and expectations
‘I think that (my partner) was well supported but often I think that they forget that the father is experiencing a loss as well.’		
‘Yep—it might not be a physical one but it is an emotional one. Yep ... ’cause that is our job! [being a man]. I was trying to be big and tough and strong and all that kind of thing but I tried to be nice and strong and tough and the man thing’.	Exploring support	
‘... so I was often ... you know I remember being told ... I had to take her home and look after her and understand that she was grieving and all that kind of thing but was never even asked if I needed any help.’		

Utilising an inductive process of integrating the categories allowed me to limit the scope of the emerging theory by incorporating the less abstract categories with the more abstract, and then by linking these together conceptually (Birks & Mills, 2015). Data collection continued until saturation of the categories occurred and no new insights emerged from the interviews (Glaser, 2008; Glaser & Strauss, 1967; Southern, 2010). The collapsing of categories increased the

density of the events associated with the substantive theory, and because the theory was based on the participants' experiences of the events associated with presenting to regional, rural and remote EDs with vaginal bleeding in early pregnancy (possible miscarriage), internal validity was systematically built into the theory.

The continual writing of theoretical memos was a crucial component in the formulation and refinement of theory. Theoretical memos captured the ideas and meanings of the growing theory as they occurred, to work towards identification of the core category (Montgomery & Bailey, 2007). According to Corbin and Strauss (2008) and Birks and Mills (2015), the core category is analytically powerful and has the ability to hold its place as the hub of the developing theory. Further, the selection of the core category occurs when the researcher is able to trace the connections and relationships between this central category and the other categories and sub-categories.

4.8 Integrating My Theory

The core category, as described by Strauss and Corbin (1990), 'is the central phenomenon around which all the other categories are related' (p. 116). Identifying the core category as 'providing optimal care in possible miscarriage', I was able to encapsulate the process and concepts apparent in the categories and sub-categories (Birks & Mills, 2015). The process of providing optimal care in possible miscarriage in regional, rural and remote EDs relies on nursing care that incorporates the experiences and expectations of the women and their partners, and also those of the nursing staff. Advanced coding, according to Birks and Mills (2015), is the heart of theoretical integration, allowing a clear explanation of the phenomenon being researched. These authors promote the use of storyline and theoretical coding for integrating the final grounded theory. I found that the use of storyline was valuable in simplifying the process of theoretical integration, as it allowed me to explicate relationships in the data without being influenced by external concepts or patterns that could be introduced through premature use of theoretical coding (Birks et al., 2009; Ralph, Birks, Chapman, & Cross, 2014).

Once it has been developed, Birks and Mills (2015) suggest applying the work of others to increase the explanatory, and therefore theoretical, power of the storyline as theory. As discussed in Chapter Three, this application of existing theory is known as 'theoretical coding'. Birks and Mills (2015, p. 24) suggest that these theoretical coding frameworks be drawn from

existing “literature to facilitate the interpretation of findings”. To interpret the findings of this thesis, Kristen Swanson’s middle range theory of caring will be utilised, a process discussed in detail in Chapter Nine of this thesis.

4.9 Presenting My Grounded Theory

As discussed previously, storyline was used to enhance the integration of the final grounded theory. As proposed by Birks and Mills (2015), storyline can also be a strategy for facilitating the presentation of the research findings. Ultimately, ‘storyline is an abstraction of what has been constructed through careful and grounded analysis of the data’ (Birks & Mills, 2015, p. 180). While I was challenged by some aspects of grounded theory, I found constructing the storyline relatively easy and enjoyable. I believe that nurses are natural story tellers, and listening to the participants tell their stories made me realise how special the participants experiences were, especially when talking about pregnancy loss. As a nurse, listening is important and how we retell each patient’s story is vital not only for the care we provide but also in the overall treatment of women and their partners. I think of using storyline as a way of bringing the stories of all participants together to produce a tapestry that tells the experiences of their time in rural, regional and remote EDs. Each thread in the tapestry is required to ensure that there are no gaps or holes, and together they are as beautiful as they are strong. While some of the stories, like the background colours of the tapestry, may not be as obvious or as vibrant as the bolder colours, they are still important. Ultimately, they provide a perfect collection of threads that weave together like the storyline that describes this grounded theory.

Historically, the use of storyline was not highlighted as an essential method by Glaser and Strauss (Birks & Mills, 2015), although Strauss and Corbin did expand on their description of the use of storyline in their 1990 work (Birks & Mills, 2015). Glaser (1992) has stated that the application of analytical grounded theory procedures and processes allows the story to present itself from the data. In writing the storyline, Mills and Birks (2015) have explained that the researcher is writing their theory while providing an explanation of the phenomenon being explored. In the construction of the storyline, I utilised the mnemonic TALES (see Table 4.2) devised by Birks and Mills (2015) to ensure that the storyline was an accurate reflection of the data.

Table 4.3: Guiding principles for writing the storyline.

<i>T</i> Theory takes precedence

<i>A</i>	Allow for variation
<i>L</i>	Limits gaps
<i>E</i>	Evidence is grounded
<i>S</i>	Style is appropriate

In using the above mnemonic, I ensured that the theory took precedence by allowing the storyline to present itself through data analysis. Ensuring the theory was grounded from the earliest stages of the study allowed for the theoretical constructions to be reflective of the data that were analysed (Charmaz, 2006). Breaking down the data and then reassembling them into a conceptualisation of the story (an abstract narrative) assisted in the final construction of the theory (Birks & Mills, 2015). This is not to suggest that the storyline was written on the first attempt; this took a number of revisions that were assisted by diagramming, memoing and the guidance provided by my supervisors. Allowing for variation in the storyline was necessary to increase the explanatory power of the storyline (Strauss & Corbin, 1998). Birks and Mills (2015) have explained that the advantage of using storyline is its ability to identify any gaps or holes in the theory by ensuring that there is logic, structure and flow. In writing the storyline, I was able to ensure that the theory reflected the participants' experiences, starting with the decision to present to the ED, their experiences throughout their time in the ED, and of discharge and beyond.

The integrated storyline that summarises the findings of this study is presented in Chapter Five. Chapters Six, Seven and Eight present detailed versions of the storyline from the perspective of the women, their partners and the nursing staff, respectively.

4.10 Evaluating and Applying My Grounded Theory

Glaser and Strauss (1967) broadly discuss evaluation as judging credibility and rigour of the research strategies, techniques and methods used in producing a theory that is accurately grounded in the data. The presentation of the integrated theory should draw the reader in and provide evidence of a logical conclusion. Grounded theories are constructed through the use of methods that aim to provide understanding of a phenomenon that will ultimately inform practice in a given discipline (Birks & Mills, 2015). Further, Glaser and Strauss (1967) emphasised the need for the grounded theory to have fit within the field that is intended for

use, to be understandable by those who work in the area, and to be general enough that it can be applied while allowing the user control over its use.

In evaluating this grounded theory, I provided the participants with an abstract of the findings in the form of the storyline and diagram and asked them whether it reflected their own experiences. This process allowed for the participants to review my interpretation of their story and gave them the opportunity to provide feedback as they saw fit. Further, it ensured that the developed grounded theory demonstrated fit, was understandable, and was general enough to be flexible in its application while allowing the user control over its use (Glaser & Strauss, 1967). Glaser (1978) also highlighted that, along with there being fit, the theory needs to possess an explanatory and predictive power, thereby demonstrating relevance. The developed theory provides an explanation and understanding of the experiences of women and their partners when presenting to regional, rural and remote EDs with possible miscarriage in the first trimester. It further adds to an explanation and understanding of the nursing staff who provide the care to these women. As a theory grounded in the data generated with these participants, it has relevance for everyday use in the care of women and their partners who face possible miscarriage in non-metropolitan areas of Australia. A detailed evaluation of the grounded theory presented in this thesis is presented in Chapter T

4.11 Manuscript 2: Gender perspectives when interviewing men

The next section of this chapter includes a paper currently under review for publication, titled: ‘Gender perspectives when interviewing men’. This paper is based on the researcher’s experiences of interviewing men about pregnancy loss and nature, and provides strategies for accommodating gender differences when interviewing men regarding sensitive issues. Table 4.3 outlines the authorship details and status of the manuscript.

Table 4.4: Gender perspectives when Interviewing Men’—declaration of authorship.

Chapter number	Publication	Nature and extent of the intellectual input of each author, including the candidate	Author
4	Submitted	Key ideas, concept development, writing up, contributed to drafts and revisions	Susan Edwards
		Concept ideas and development, contributed to drafts and critical revisions	Professor Melanie Birks
		Contribution to drafts and critical revisions	Adjunct Professor Ysanne Chapman
		Contribution to drafts and critical revisions	Associate Professor Anthony Welch
		Critical revisions	Karen Yates

Gender perspectives when interviewing men about sensitive topics

Journal:	<i>Journal of Transcultural Nursing</i>
Manuscript ID	Draft
Manuscript Type:	Informational Resources
Keywords:	Language and Communications < OTHER, Instrument development < RESEARCH METHODS, Other Methods/Designs < RESEARCH METHODS
Cultural Groups:	
Other:	
Abstract:	Gender identity is shaped by society and culture leading to expectations about how men and women communicate. This paper describes the lessons learned in exploring the care of women who presented to non-metropolitan emergency departments with possible miscarriage and their male partners. The process of information gathering for this study gave rise to interviews that explored men's experiences of their partner's pregnancy loss. These interviews highlighted potential pitfalls that may impede the collection of quality data when interviewing men about topics of a sensitive nature. Through this process, strategies to enhance the interview process were identified. Data generation requires interaction between the researcher and the participant through the interview process. Various factors can impact on this process, one of which is gender. This paper adds to existing literature about the process of interviewing men and posits strategies to improve the research interview, particularly when the subject is sensitive in nature.

Interviewing men about sensitive topics

Gender perspectives when interviewing men about sensitive topics

Abstract

Gender identity is shaped by society and culture leading to expectations about how men and women communicate. This paper describes the lessons learned in exploring the care of women who presented to non-metropolitan emergency departments with possible miscarriage and their male partners. The process of information gathering for this study gave rise to interviews that explored men's experiences of their partner's pregnancy loss. These interviews highlighted potential pitfalls that may impede the collection of quality data when interviewing men about topics of a sensitive nature. Through this process, strategies to enhance the interview process were identified. Data generation requires interaction between the researcher and the participant through the interview process. Various factors can impact on this process, one of which is gender. This paper adds to existing literature about the process of interviewing men and posits strategies to improve the research interview, particularly when the subject is sensitive in nature.

Key words: *data collection; gendered communication; gendered intelligence; interviews; qualitative research.*

Introduction

Human interactions are influenced by the expressions of feelings, beliefs, values and attitudes of each individual. Qualitative research explores the complex interactions experienced by human beings, often generating data through the use of interview. Some experiences can be sensitive in nature and difficult to discuss, resulting in the study of certain phenomena being avoided. Research by Affleck, Glass and MacDonald, (2012) and Spaten, Byriatsen and Langdrige (2011) found that qualitative health researchers tend to overlook men's experiences especially when exploring sensitive topics of a deeply

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personal nature. In respect of bereavement, for example, fathers were included in only 18 percent of qualitative studies while mothers were reported in 82 percent of literature (Affleck et al., 2012; MacDonald, Chilibeck, Affleck & Cadell, 2010; Swanson, Kane, Pearsall-Jones, Swanson & Croft, 2009). Norms regarding gender identity have been largely influenced by history and culture, leading to societal expectations of both men and women. The influence of gender on the research process has been previously explored primarily concerning the experiences of women interviewing women and men interviewing men (Dixon, 2015; Ghafar, 2014; Smith & Braunack-Mayer, 2014; Walby, 2010). This paper adds to existing literature about the process of interviewing men and posits strategies to improve the research interview process, particularly when the subject matter is sensitive in nature. The discussion is drawn from the experience of a female researcher conducting a research study exploring care provided to women experiencing possible miscarriage in non-metropolitan emergency departments (EDs) and their male partners and the nursing staff who provide care in these contexts. The process of information gathering gave rise to interviews that explored men's experiences of their partner's pregnancy loss. This paper describes the researcher's experiences in conducting these interviews and highlights potential pitfalls that may impede the collection of quality data when interviewing men about topics of a delicate nature. The paper commences with an overview of the study referred to, followed by a discussion of the role of interviewing in qualitative research. The concept of gender is then examined as a basis for discussing factors that influence the interview process when interviewing men. The paper concludes with a detailed discussion of strategies that can be employed when interviewing men about topics that are sensitive in nature.

Background

A description of the research

1 Interviewing men about sensitive topics

2
3 The research referred to in this paper aimed to develop an in-depth understanding of the
4
5 experiences of women who presented to regional, rural and remote emergency departments
6
7 with possible miscarriage and their male partners. The experiences of the nursing staff who
8
9 provided the care in these settings was also explored. A grounded theory methodology was
10
11 used for the purpose of generating a theory that explained the phenomenon under study. Once
12
13 ethical approval was gained via university Human Ethics Committees (H13/02-014; H5843),
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15 data collection began using purposeful sampling followed by theoretical sampling to develop
16
17 and saturate the theoretical needs of the study (Birks & Mills, 2015). Memoing helped in
18
19 exploring possible leads in the data and also with the audit process. The participants were
20
21 located throughout regional, rural and remote Australia and interviews were conducted by
22
23 the first named author either by telephone (for those located in rural and remote locations) or
24
25 face-to-face. The interviews were conducted using an open-ended, semi-structured approach
26
27 in which the participants were invited to tell their stories. The interviews were recorded,
28
29 transcribed verbatim and then subjected to analysis using methods described by Birks and
30
31 Mills (2015). The NVivo software program was used to aid the analytical process. Rigorous
32
33 application of grounded theory methods ensured the quality of the research. The findings of
34
35 this research, "Bringing together the threads of care in possible miscarriage for women, their
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37 partners and nurses in non-metropolitan EDs" will be presented as a storyline in a separate
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39 publication.
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49 Interviewing in qualitative research

50 Qualitative research is the process of inquiry that examines people's lives and experiences
51
52 in order to gain understanding of how people experience their everyday existence
53
54 (Englander, 2012). This approach to research is an important mechanism for including the
55
56 voices of patients or consumers in the development and the provision of quality health
57
58 care, especially in the discipline of nursing (National Health and Medical Research
59
60

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Council, 2015; Zieblan & Hunt, 2014). The researcher builds a holistic picture of the phenomenon being examined and sets about exploring the participants' experiences and making meaning of those experiences (Creswell, 2007; McCusker & Gunaydin, 2015). Qualitative research cuts across disciplines, fields of inquiry and subject matter (Jacob & Ferguson, 2012). Most qualitative methodologies use interviews for data collection (Mills & Birks, 2014). Interviews are a useful and powerful way for the researcher to gain in-depth information relating to the experiences and viewpoints of a specific population concerning a particular.

Doody and Noonan (2013) suggest that qualitative research aims to expose the human part of the story through the use of interviews that allow participants to share their experiences, which may be sensitive in nature (McCusker & Gunaydin, 2015; Zieblan & Hunt, 2014). Mellon (1998) adds that human beings have a natural urge to tell stories and, with a little nurturing from the researcher, valuable information can be gained through the interview process. This process for some participants is relatively easy, while for others it can be more difficult, requiring the use of additional skills to engage with the person and to encourage them to share their experience through the process of storytelling (Birks, Chapman & Francis, 2007; Remsharst & Flowers, 2007). In order to achieve this level of engagement it is important that the researcher be cognisant of the influences that have the potential to impact on the interview process. Such factors can affect the outcome of a study and therefore need to be considered prior to commencing data collection. Gender is one such factor.

The concept of gender

Gender can be viewed as a construction in which history, culture and social relations considered central to society are continually passed onto the next generation (Nilsson & Larsson, 2005). Gender or gender identity refers to a person's perception of their sense of

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masculinity or femininity regardless of their biological sex (Pishghadam, Saboori, Samavarchi & Hassanzadeh, 2016). While a person's sex is determined by their biology and refers to the physical or physiological differences between males and females, sex does not always correspond with gender (Hyde, 2014; Oakley, 2015). From birth, gender defines almost all human experience, the way in which a person engages in socially sanctioned expressions of self and aiding in normal cognitive and social functioning (Carothers & Reis, 2013). Leaper and Brown (2008) explain that masculinity and femininity are the result of social and cultural conditioning imposed from birth by family and/or carers. These gendered identities are reinforced throughout an individual's lifespan through family, religion, educational institutions, media, peer networks and society (Leaper & Brown, 2008). Although gender is shaped by socio-cultural expectations that can differ from one society to another, there are universal expectations that are common to both men and women (Pishghadam et al., 2016).

Men are often characterised as being more aggressive, dominant, active, and competitive than women, who are considered to be submissive, passive, cooperative and expressive (Pini, 2005; Pishghadam et al., 2016; Wood, 2011). From an early stage in a young boy's life he is taught by external sources that 'men don't cry' and to 'man up' in situations that could be of a delicate nature (Affleck et al., 2012). The dominant discourse of masculinity and socialisation is influenced by some mothers, fathers and peer groups to suppress the natural male ability to express emotional sensitivity (Affleck et al., 2012; Harvey, 2013). Many boys grow up having difficulty in readily putting their feelings into words, masking their vulnerability and some generate a perception of being rational, efficient and non-emotional (Affleck et al., 2012). As a result some men tend to keep their personal feelings to themselves and believe they should cope regardless of their grief (Swanson et al., 2009). Sharing of personal feelings is not an easy thing to do particularly by some men. Stoicism,

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independence, robustness and resiliency continue to be generally accepted as traditional discourses of masculinity (Witty et al., 2014). Men learn to socialise and communicate according to masculine norms of self-reliance and emotional control and are less likely to seek help or verbalise their thoughts and emotions (Affleck et al., 2012).

Men and women differ physically and psychologically both in the way they act and the way they communicate (Merchant, 2012). Language is an innate but essential part of humanity and differences regarding the use of language are both natural and genetic, resulting in differing gender conversation characteristics and traits (Merchant, 2012; Nissan & Larsson, 2005; Tannen, 1990). In a review of the literature on factors influencing the interview process in relation to women interviewing men, there was a noticeable paucity of contemporary literature on the topic. Studies of men conducted by women have received little descriptive and analytical attention regarding the interactional dynamics during the interview process (Ryan et al., 2009). In an attempt to address this deficit, the following section discusses gender related factors that can influence the research interview.

Factors influencing the process of interviewing men

According to Birks, Chapman and Francis (2007), several factors have the potential to influence the effectiveness of the interview process. Birks, Chapman and Francis's (2007) model for interviewing people from other cultures identifies categories of influence for consideration when conducting an interview. These influences include researcher-specific, participant-specific and context specific factors (Birks, Chapman & Francis, 2007). As gender is recognised as a cultural construct (Irshad & Banerji, 2012) this framework can be effectively adapted to explore the impact of gender on the process of interviewing men for the purpose of research.

Research specific factors

1 Interviewing men about sensitive topics

2
3 Researcher specific factors play an integral part in the interview process. The social
4
5 cultural and professional role of the researcher can influence not only the interview process
6
7 but also the quality of data collected. The personality of the researcher plays a central role
8
9 in the interview process, not only to ensure acquisition of valuable data but also to ensure
10
11 that the interview maintains its focus (McCusker & Gundayin, 2015). When the focus of an
12
13 interview is on emotionally sensitive issues such as health, death and bereavement,
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15 fertility, abortion, miscarriage and terminal illness, men can often be lost for words and
16
17 less eager to discuss their emotions and feelings (Elmir, Schmied, Jackson & Wilkes,
18
19 2011). The development of trust between researcher and participant is critical for creating
20
21 the necessary safe space for talking about sensitive issues and explicating personal
22
23 experiences which may not have been shared with others (Webb, 2015). The researcher
24
25 needs to be adequately prepared for the interview, possess both an awareness of self and a
26
27 degree of gender intelligence and be skilled in communication.
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29

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33
34 Conducting research interviews is not a trivial matter and requires adequate planning and
35
36 preparation (Qu & Dumay, 2011). Successful interviews start with the development of
37
38 appropriate research question/s that will yield rich data (Jacob & Ferguson, 2012).
39
40 Preparation, according to Turner (2010), can help make or break the interview process and
41
42 can affect the ability of the researcher to achieve their overall goal. Familiarity with current
43
44 literature regarding the topic under study (in this case for example, the concept of men and
45
46 loss) can assist the interviewer in establishing a partnership with the participants,
47
48 especially from a gender perspective (Jacob & Ferguson, 2012). Where specific guidance
49
50 may be limited, the researcher can utilise information from similar populations, topics or
51
52 events to prepare for the interview process (Affleck, Glass & MacDonald, 2012; Riach,
53
54 2009). This was the case in the research exploring men's experiences of pregnancy loss
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56 from both personal and professional perspectives in the ED. While there was no specific
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1 Interviewing men about sensitive topics

2
3 literature on the topic, the researcher was able to gain a generic understanding of gender
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5 and communication that was sufficient to enable her to engage in interactions that
6
7 supported the generation of data for this study.
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10
11 Self-awareness is also important in relation to the interactional relationships between men
12
13 and women (Doody & Noonan, 2013; Ryan et al., 2009). Gender may not only influence
14
15 the way a participant responds to the researcher but consideration is needed regarding the
16
17 researcher's ability to make gender-based assumptions about the participant that can also
18
19 influence the process (Sallee & Harris, 2011). One such assumption related to an
20
21 awareness that men often felt uncomfortable when discussing sensitive topics. This is
22
23 inconsistent with research by Broom, Hand and Tovey (2009), who found that some men
24
25 are more comfortable talking to women about topics that are personal and emotive, as they
26
27 perceive women to be naturally interested in these topics. The researcher found this
28
29 assumption fitted her experience. Once the participants felt comfortable and perceived no
30
31 judgement was being made, they were willing to open up and tell their stories.
32
33
34
35
36
37

38 Facilitating effective communication requires the researcher to have an increased level of
39
40 gender intelligence to ensure the free flow of words (Gatrell, 2006). Gender intelligence
41
42 recognises, understands and appreciates the unique characteristics and natural differences
43
44 between women and men; especially the way they think and communicate (Annis &
45
46 Merron, 2014). Starting with questions that require simple responses is beneficial before
47
48 moving onto more difficult or sensitive topics, allowing for a rapport to be established
49
50 (Doody & Noonan, 2013). With this in mind, the researcher in the study referred to in this
51
52 paper began the interview first by talking about topics that were considered more
53
54 comfortable such as work, family and where they lived, allowing time for a rapport to be
55
56 built with the male participants. Allowing time for discussion that was topical and/or
57
58 relevant to the male participant gave them permission to talk freely (Broom et al., 2009).
59
60

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Throughout the interview, the researcher needs to demonstrate skills in communication. Importantly, they need to effectively convey to the male participant that what he has to say is important, thus allowing him to feel at ease and not threatened (Ahmad, 2014; Jefferson, Bloor, Birks, Hewitt & Bland, 2013; Pini, 2005). The stereotypical gender discourse suggests that women's role in conversation is to be an empathetic listener and facilitator of men's narratives (Doody, & Noonan, 2013; Pini, 2005). Pini (2005) suggests that this trait can be used to an advantage and aid the female researcher to gain valuable data. Allowing the participant to tell their story in their own way is important especially as the passivity of the interviewer can provide an environment for the male participant to talk freely (Pini, 2005). Silence provided by the researcher is often all that is needed to create a powerful dynamic in the interview process (Doody & Noonan, 2013). This strategy can be an important tool for the researcher as its use ensures the interview is not rushed; although this skill can be challenging for some researchers as it is natural for humans to fill these pauses with conversation (Qu & Dumay, 2011). When interviewing men regarding pregnancy loss the interviewer's ability to use silence was valuable as it allowed the men to make meaning of their experience and gave them time to consider the questions they were asked. While challenging for the researcher, this skill allowed the male participants to answer questions they previously had not been asked. The silence allowed the men time to explore their own feelings about matters that were not considered or deemed pertinent to men's experiences.

Participant specific factors

Communication styles of women and men can be attributed to many factors but the most influential is socialisation of gender, which leads to the differences in how they communicate (Netshitangani, 2008). Men are often less emotionally responsive, which is reflected in their communication style and purpose (MacDonald et al., 2010).

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Contentiously, it has been suggested that men tend not to have the vocabulary with which to express their feelings (Affleck et al., 2012). This lack of emotional expression has been described as a significant challenge faced by researchers in a variety of fields (MacDonald et al., 2010). In the context of an interview, particularly when the subject matter is sensitive, the different communication styles employed by men can manifest as barriers that may see the participant use patterns and strategies of communication that enable them to manage the process.

Men need (although not consciously) their actions and their language to be masculine and for women and society to perceive them as such (Martin, 2001; Merchant, 2012). The interview process can be threatening for the masculine self, because the interview requires men to relinquish control especially when having to discuss bereavement and loss (Affleck et al., 2012). The enactment of maleness or masculinity can result in a barrier to free flowing words that are required in the interview process (Gatrell, 2006, Affleck et al., 2012). Minimising responses can be a natural way to protect and maintain the masculine self by withholding information about their emotional experiences or out of fear of revealing their vulnerabilities (Affleck et al., 2012). Ahmad (2014) explains that men converse in a more abstract manner, speaking vaguely and in general terms. Men often provide one or two word answers, which may not offer revealing personal data (Affleck et al., 2012; Swanson et al., 2009). Men also prefer to discuss one topic at a time, keeping their conversation short and to the point (Wood, 2011; Ahmad, 2014). This was found to be true in the study referred to in this paper. The researcher was challenged to adapt and change the style of questioning by focusing on the logical flow of the experience and accommodating the male communication style. For example, while females build and maintain rapport throughout the interview with 'rapport talk', men prefer 'report talk' according to Jefferson et al. (2013). Rapport talk refers to the types of communications that

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builds, maintains and strengthens relationships; whereas report talk typically focuses on task accomplishment, addressing questions and the provision of facts. Report talk reflects skills of being competitive and avoiding sentimentality when discussing sensitive topics (Jefferson et al., 2013). When interviewing men regarding loss in this study, report talk proved to be a valuable tool. For example, when the interviewer asked one participant about his needs for support he reported back what he felt men needed rather than make reference to himself.

I honestly think that partners need the same level of support... um... we don't understand – we are going through it too.

As the discussion became less about process and more about emotional topics, report talk allowed the men to refocus their thoughts and feelings of discomfort and answer questions with reference to their own experience.

Patterns of speech between men and women also differ and this difference can provide insight into the communication barriers that might arise during an interview (Wood, 2011). Masculine speech tends to be linear where men get to the point straight away without elaborating details, whereas women's speech imbeds information and details that they feel add to the conversation and the relationship being established (Wood, 2011). When questions are presented to men, they prefer them to be clear and to the point (Ahmad, 2014). Conversation that is perceived as repetitive and circuitous has been found to demotivate men in responding to questions posed by the researcher (Ahmad, 2014). This was found to be true when interviewing men regarding their experience of pregnancy loss in the ED. It appeared that the interviewee often interpreted being asked clarifying questions as being asked the same question about the same topic. At these times the men were very forward in letting the researcher know that they had 'already answered this question' even when the answers provided were simply 'yes' or 'no' responses:

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Researcher: Was any information provided to you in the ED and was it helpful?

Participant: No

Researcher: When you and your wife were discharged home were you provided any information and if not... what information do you feel would be helpful?

Participant: No, you just asked me that!

The researcher needed to change her interview style by ensuring questions were logical and sequential and it was equally important that the researcher informed the male participants that questions may be repeated throughout the process to ensure clarity of the event or issue being discussed.

Considering the differing communication skills of men and women, it is necessary to understand that variations in these can lead to barriers and misinterpretation in the communication process (Affleck et al., 2012; Pini, 2005; Ryan et al. 2009). By way of an example, Affleck, Glass and MacDonald (2012) highlighted in their research that when men answered serious questions some did so with humour. This is an important point to consider especially if the researcher is studying emotionally sensitive issues with men (Hancock & Rubin, 2015). In interviewing men about their experiences of pregnancy loss, the researcher found the participants often used humour to lighten the conversation and redirect the process. For example, one male participant stated that certain events he experienced in the ED were funny and laughing was his way of adding levity to the situation:

One time we were given a book on miscarriage that had a... poem (laughing) at the back um...I can't remember the name of the poem ... 'for a few moments' or something it was called - 'I knew you for a few moments' um...its actually kind of funny (laugh) because they came back in about an hour or so later and just photocopied the back cover with the poem and took the book and gave it to another woman who had a miscarriage too as they had run out (laughing).

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At times the laughter was inappropriate and inconsistent with the serious nature of what was being discussed:

It's actually quite funny (laugh) that you... say that you say that you are looking at the support...I think that they forget that the father is experiencing a loss as well (laugh)...so I was often... you know I remember being told...I had to take her home and look after her (continues laughing).

Understanding that this laughter was used as a coping strategy allowed the researcher to acknowledge what was occurring and to remain focused throughout the interview. Humour is described by McCreddie and Payne (2011) as a complex phenomenon. This type of humour is often referred to as 'gallows humour', which is an attempt to treat painful subject matter in a light or satirical manner (Watson, 2011).

Context specific factors

Researchers need to be familiar with the context of the interview before commencement to ensure its success (Birks et al., 2007). As discussed above, the researcher and participant influence the interview process. In addition, contextual factors can also play a part. The researcher needs to be familiar with the possibility of complications that may arise because of these factors and be able to adjust their approach accordingly. These context specific factors may be intangible, such as power imbalances, or tangible, such as the physical location of the interview.

Unfortunately, different gender discourses do not have equivalent status. The tendency for masculine discourses to confer greater power than feminine discourses can be problematic for women interviewing men, as masculine discourses present men with opportunity to exert power and lead the conversation resulting in the goals set by the interviewer being lost in the process (Pini, 2005). Power differences between the researcher and the participant can be related to many factors including formal and informal roles, or to gender

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discourse (Danescu-Niculescu, Lee, Pang & Kleinberg, 2012). Furthermore race, class, family status, ethnicity, and other social identities are important sources of differential power that shape the relationship between the researcher and the participants (Elwood & Martin, 2000). Traditionally, men use language as a negotiation for power and dominance while women use language to make connections and form relationships (Merchant, 2012). In such a situation the interview can become a conversation where the relationship between those engaged is not truly equal (Ryan et al., 2009). The development of a professional partnership can mitigate this imbalance of power (Webb, 2015). The appropriate use of questions can aide the female researcher in overcoming any power imbalance through the acquisition of information, as questions require answers (Jefferson et al., 2013; Netshitangani, 2008).

The location of the interview is the physical space where power dynamics, social relations, identities and meanings unfold within the actual interview (Gagnon, Jacob & McCabe, 2015). The interview location can influence position, perspective and interpersonal dynamics throughout the interview process. Ultimately there is no 'neutral' place to conduct interviews (Elwood & Martin, 2000) although the participant's location of preference can allow them to feel more empowered in their interaction with the researcher and allow them to feel comfortable in speaking freely. The reasons behind men's choices of location are not always apparent according to Witty et al. (2014) as they found that anxiety related to possibly being noticed was one fear of men. They also noted that having an interviewer in their home could lead to anxiety. Therefore, to facilitate comfort with the interview process, the researcher and the male participant should mutually agree on the location and time of the interview.

Strategies for interviewing men

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The success of the research interview is dependent on an understanding of the factors presented in the preceding section, all of which have the potential to influence the process and outcome of the exchange. Drawing from this discussion, it is possible to summarise strategies that can be utilised when interviewing participants from a gender perspective. In the case of any research interview, there is an obligation on the researchers to ensure the effectiveness of the process. The interview is a structured conversation that should endeavour to benefit both parties. The application of the strategies contained in Table 1 can mean the difference between a stilted conversation and a therapeutic exchange.

Whitting (2008) suggests that the research interview may be the first time that a participant has had someone listen to their story and therefore it is important that their contribution is acknowledged. Rinehart and Kiselica (2010) highlight in their study that some men are often marginalised when talking about sensitive issues such as miscarriage and therefore have no avenue to talk about their experiences and feelings. The significance of men having the opportunity to tell their story should therefore not be underestimated. In the case of this study of men's experience of pregnancy loss, the significance of being able to discuss such sensitive issues were made evident by one male participant who concluded the interview by saying 'thanks,... good chat mate'.

Conclusion

Qualitative research aims to improve the human experience by gaining an in-depth understanding of the experiences and attitudes of the participants in relation to the phenomenon being explored. This paper has explored the interview process in relation to gender and challenges assumptions about interviewing men. Strategies have been presented that aim to improve the research interview by addressing factors specific to the researcher, participant and context that can influence the effectiveness of the process and enhance the experience of those involved.

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Table 1 Strategies for accommodating gender differences when interviewing men

- Reflect upon one's own communication style.
 - Explore assumptions regarding gendered communication.
 - Understand and appreciate the unique and natural gender differences in communication (gendered intelligence).
 - Establish rapport through the use of general conversation prior to the interview.
 - Commence with less complex questions to encourage the participant to relax.
 - Utilise skills and knowledge of gendered communication to keep the interview flowing and on task.
 - Accommodate the use of report talk through developing and focusing questions accordingly.
 - Keep in mind that report talk allows men time to consider and process their feelings and share these with the researcher.
 - Provide time for the participant to talk about sensitive issues.
 - Expect the use of humour or some laughing during difficult conversations and respond accordingly.
 - Ensure questions are clear and to the point.
 - Inform the participant that questions relating to the same topic may be asked repeatedly to clarify and probe for further information.
 - Ensure that the participant chooses and is comfortable with the location for the interview.
 - Arrange a time that is most suitable for the participant, to enable them to focus on the interview.
 - Expect and manage issues relating to potential power imbalance through the establishment of a professional relationship and appropriate use of questioning.
-

4.11 Summary

This chapter has described the research design for this grounded theory study, the aim of which was to develop a substantive theory of the care of women and their partners who present to non-metropolitan EDs with first-trimester bleeding and possible miscarriage. The research protocol and methods were implemented in ways that ensured quality and credibility of this research. This chapter also provided strategies for interviewing men when the topic is of a sensitive nature by using a gendered approach. The following chapter is the first of four findings chapters. Chapter Five presents an overview of the outcomes and is presented as a storyline that is currently under review for publication.

Chapter 5: Findings

The beauty of life is, while we cannot undo what has been done, we can see it, understand it, learn from it and change. So that every new moment is spent not in regret, guilt, fear or anger, but in wisdom, understanding and love.

Jennifer Edwards, n.d.

5.1 Introduction

This chapter is comprised of one manuscript, titled ‘Bringing Together the Threads of Care in Possible Miscarriage for Women, Their Partners and Nurses in Non-metropolitan EDs’ (currently under review for publication), which presents an overview of the findings of this research. The findings are presented as a storyline. Birks and Mills (2015) have explained the use of storyline as a ‘strategy for facilitating integration, construction, formulation and presentation of research findings through the production of a coherent grounded theory’ (p. 114). This grounded theory explains the experiences of women and their partners when they present to non-metropolitan EDs with possible miscarriage, and the experiences of the nursing staff who provide the care. The developed theory, ‘threads of care’, explains the five stages of the journey that women and their partners experience when being seen in rural, regional and remote EDs for possible miscarriage.

5.2 Manuscript 3: ‘Bringing together the “Threads of Care” in possible miscarriage for women, their partners and nurses in non-metropolitan EDs’

Table 5.1 outlines the authorship details and status of the manuscript.

Table 5.1: ‘Bringing together the ‘Threads of Care’ in possible miscarriage for women, their partners and nurses in non-metropolitan EDs’—declaration of authorship.

Chapter number	Publication	Nature and extent of the intellectual input of each author, including the candidate	Author
5	Submitted	Original concept, key ideas, development, data collection and analysis, writing up and revisions	Susan Edwards
		Concept development, contribution to draft, critical revisions	Professor Melanie Birks
		Contribution to draft and critical revisions	Adjunct Professor Ysanne Chapman
		Critical revisions	Dr Karen Yates

Manuscript Details

Manuscript number	COLL_2017_19
Title	Bringing together the 'Threads of Care' in possible miscarriage for women, their partners and nurses in non-metropolitan EDs
Article type	Research Paper

Abstract

Pregnancy is a significant event in a woman's life, a time of great expectation and attachment to the possibilities and dreams placed onto the new life growing inside her. Complications in pregnancy are physically and psychologically traumatic experiences that can generate high levels of anxiety. Vaginal bleeding, pain, or both in the first trimester of pregnancy are a common presentation in any Australian emergency department (ED). These EDs play an important role in the provision of healthcare, especially in regional, rural and remote areas. When experiencing possible miscarriage, the care that is provided to women and their partners presenting to their regional, rural and remote ED can have significant impact on the mindset of their current and future pregnancies. This study explores the experiences of women and male partners who present to non-metropolitan EDs with possible miscarriage, along with the experiences of nursing staff who provided care in these settings. The developed theory 'Threads of Care' incorporates five stages of their journey through a non-metropolitan ED with possible pregnancy loss: presenting as one; wanting recognition and inclusion; seeking support and understanding; leaving as one; and moving on. The recommendations from this grounded theory will inform approaches to care that aim to meet the needs of women, their partners and nursing staff who care for them.

Keywords	First trimester bleeding;, miscarriage; non-metropolitan emergency departments; nursing staff.
Taxonomy	Nursing Research Methods, Nursing Care, Nursing
Corresponding Author	Susan Edwards
Order of Authors	Susan Edwards, Melanie Birks, Ysanne Chapman, Karen Yates

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Manuscript Bringing together.pdf [Manuscript (without Author Details)]

Figure 1.pdf [Figure]

Table 1 Threads of Care.pdf [Table]

Table 2 Recommendations.pdf [Table]

Title page (with author details).pdf [Title Page (with Author Details)]

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Bringing together the 'Threads of Care' in possible miscarriage for women, their partners and nurses in non-metropolitan EDs

Abstract

Pregnancy is a significant event in a woman's life, a time of great expectation and attachment to the possibilities and dreams placed onto the new life growing inside her. Complications in pregnancy are physically and psychologically traumatic experiences that can generate high levels of anxiety. Vaginal bleeding, pain, or both in the first trimester of pregnancy are a common presentation in any Australian emergency department (ED). These EDs play an important role in the provision of healthcare, especially in regional, rural and remote areas. When experiencing possible miscarriage, the care that is provided to women and their partners presenting to their regional, rural and remote ED can have significant impact on the mindset of their current and future pregnancies. This study explores the experiences of women and male partners who present to non-metropolitan EDs with possible miscarriage, along with the experiences of nursing staff who provided care in these settings. The developed theory 'Threads of Care' incorporates five stages of their journey through a non-metropolitan ED with possible pregnancy loss: presenting as one; wanting recognition and inclusion; seeking support and understanding; leaving as one; and moving on. The recommendations from this grounded theory will inform approaches to care that aim to meet the needs of women, their partners and nursing staff who care for them.

Keywords: First trimester bleeding, miscarriage, non-metropolitan emergency departments, nursing staff.

Introduction

Fear of the possibility of miscarriage is common for women and their partners when pain and vaginal bleeding occurs in early pregnancy (Edwards, Birks, Chapman & Yates, 2016; Arcka et al., 2008).

When these symptoms occur, women and their partners have awareness that miscarriage is a possibility and the threat of loss leads to presentation to their local ED (Sejourne, Callahan & Chabrol, 2010). Pregnancy loss has been estimated to occur in 12% to 24% of all pregnancies (Indig, Warner & Saxton, 2011). Spontaneous miscarriage prior to 12-14 weeks gestation occurs in 80% of

Emergency department care of possible miscarriage in non-metropolitan areas

these cases (Sejourne et al., 2010; Wendt, Crilly, May, Bates, & Saxena, 2014). Complications of pregnancy are physically and psychologically traumatic experiences that can generate high levels of anxiety. Unfortunately, nursing and medical care does not reduce the chance or inevitability of miscarriage but the care provided can have a significant impact on the mindset of their current and future pregnancies (Edwards et al., 2016). In Australia, the ED plays an important role in the provision of healthcare, especially in regional, rural and remote areas. Access and quality of healthcare has been strained because of the unique challenges associated with the delivery of care in these locations (Wise, Fry, Duffield, Roche & Buchanan, 2015).

The provision of high-quality ED healthcare throughout Australia is complex. In non-metropolitan areas of Australia there are fewer services than in the larger cities and access to healthcare in these areas is known to be problematic. Challenges in the provision of healthcare include geographic isolation, socioeconomic inequalities and inequitable distribution of resource (Edwards et al., 2016; Wakerman, Humphreys, Lyle, McGrail & Lavey, 2015; Kidd, Kenny & Meehan-Andrews, 2012). The tyranny of distance and the lack of available transport are other major obstacles in accessing healthcare for many rural and remote Australians (Baker & Dawson, 2013; Humphreys & Wakerman 2009). As a result, most rural and remote communities have restricted access to basic hospital services with further difficulties in accessing more specialised healthcare (including travel and accommodation related costs) (Vines, 2011; Australian Institute of Health and Welfare, 2014). With increasing remoteness, the size and type of hospital services change as the ED becomes more important for people living in non-metropolitan areas of Australia (Vines, 2011; Standing Council on Health, 2012).

Lack of access to healthcare in non-metropolitan areas of Australia is frequently cited as the major reason for ED attendance, with these services often struggling to meet the physical, psychological and social needs of patients because of limited resources and less infrastructure (Biacidore, Warren, Chaput & Keogh, 2009; Standing Council on Health, 2012). Rural and remote EDs not only provide emergency care but also primary healthcare, requiring nursing staff to be highly skilled and competent when working in this arena. Nursing practice in the ED is a complex phenomenon and the overall

function and business of the ED, as managed and coordinated by nursing staff, is the driving force that shapes patient care.

This paper details the findings of a grounded theory study of the care of women who present to non-metropolitan EDs with first trimester bleeding. The purpose of this grounded theory study was to examine current approaches to care provided in this context. The resultant theory was empirically derived from these data and is presented in this paper as a storyline that articulates the experiences of participants. The significance of this study lies in the ability of the findings to inform approaches to care that meet the needs of women, their partners and nursing staff working in these settings.

Methods

This study was undertaken using grounded theory methodology for the purpose of generating a theory that comprehensively explains the phenomenon under study (Birks & Mills, 2015). The research involved in-depth semi-structured interviews with three participant groups: women who present to non-metropolitan EDs with first trimester bleeding, their male partners, and the nursing staff who provide care in these settings. Once ethical approval was gained via the university Human Research Ethics Committees (H13/02-014; H5843), initial purposive sampling was undertaken followed by theoretical sampling that ensured the aims of the study could be met. Theoretical sampling as described by Birks and Mills (2015), is characteristic of grounded theory as the researcher strategically decides what or who will provide the best source of data to meet the analytical and theoretical needs of the study. Theoretical sampling was utilised to develop and saturate the theoretically relevant categories in terms of their properties and to also identify the relationships between concepts (Corbin & Strauss, 2008). Memo writing was an important component in the process as it helped the researcher map the possible sources and follow the leads in the data while simultaneously establishing an audit process (Birks & Mills, 2015). Eleven participants consented to take part in the study, three women who experienced a miscarriage between 2007 and 2012, two men whose partners had experienced miscarriage and six registered nurses.

Data Collection and Analysis

Interviews were conducted by the first named author who invited participants to talk about their experiences. Nine interviews were conducted by telephone, as these participants were located throughout Australia in various regional, rural and remote locations. Two interviews were conducted face-to-face as the participants lived in a regional area closest to the first named author. Individual interviews were audio recorded and transcribed verbatim. Transcripts were subjected to analysis using the methods described by Birks and Mills (2015). A qualitative data analysis software program (NVivo10) was used to assist in the analytical process. The approach to grounded theory research proposed by Birks and Mills (2015) emphasises the use of storyline as an analytical technique. These authors also promote storyline as an effective mechanism for articulating processes that characterises a phenomenon from the perspective of those who experience it (Birks & Mills, 2015).

Quality was ensured throughout the research design through the rigorous application of grounded theory methods, including the use of memoing along, with oversight of the analytical processes by co-investigators. An abridged version of the following storyline was also returned to the participants for comment before the theory was finalised. The findings described in the following section reflect the grounded theory that was developed as a result of these processes. These findings are presented as a storyline that follows the journey of the participants and describes the threads of care that characterise their experiences.

Results

Provision of optimal care in early pregnancy loss

Threads of Care: A grounded theory of regional, rural and remote ED care for women with possible miscarriage focuses on the experiences and expectations of women, their partners and nursing staff in the context of regional, rural and remote Australian ED practice (Figure 1, below).

The process of providing optimal care in possible miscarriage in regional, rural and remote EDs relies on nursing care that incorporates the experiences and expectations of both the women and their partners and also those of the nursing staff providing that care. The categories and sub-categories generated from this study are summarised in Table 1 (below) and discussed in detail in the sections

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that follow. While this process is not entirely linear, as is characteristic of most social processes, it can be effectively articulated as a storyline reflective of the experiences of these participants.

Presenting as one

The first stage of the process of seeking care in possible miscarriage sees the woman and her partner *presenting as one* to the ED. In *making the decision* to attend the ED, the women tended to consult with their partners regarding their *developing awareness* of a possible problem with their pregnancy.

The decision was compounded by pain and their fear of possible pregnancy loss. While both the women and their partners presented together, the care clearly focused on the woman while the partners were not even acknowledged by staff. This resulted in *the ED experience* for the partners to be one of observation and created a clear division where the nursing staff consulted with the women and the women then conversed with their partners. The pregnancy meant that the couple were both going to be parents, however from the perspective of the nursing staff, it was the woman who was pregnant and was experiencing the complications that required health care.

Presenting to triage the women felt an initial sense of relief that they were in the right place, although their anxiety continued, as they feared the unknown. When *presenting to non-metropolitan EDs*, the decision is further complicated by the limited options for healthcare that are available to them.

Establishing patterns of presentation in non-metropolitan EDs is largely associated with geography.

Women often present to a local ED near where they live or they are transferred in from outer rural and remote communities. If there is a concern that a woman is possibly experiencing an ectopic pregnancy or is haemodynamically unstable, these women are transferred to the closest metropolitan ED for care. Otherwise women and their partners present to their ED within a town closest to their home. Here the women were required to line up at the triage desk in order to talk to the nurse. It was at this time that the women felt there was *limited privacy and confidentiality* especially when having to provide information over the counter to the triage nurse.

... you know how you have to line up, and you know yourself and people who line up in front of you that you can hear what they say... so if people are behind you or in the waiting room... it is so quiet there that you can hear everything that is said... (woman)

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The women felt anxious and exposed as all the patients waiting in line and those seated in the waiting room could hear what they were saying. During this time, the partners were *experiencing triage* in a different way, witnessing the care that was or was not provided to the women. The partners felt that the nursing staff were impersonal both through the language they used and the way they responded to the women and themselves.

I found that actually they were almost the same person...it was like they were reading from a script...um it didn't feel personal at all...honestly I don't know if they [the triage nurse] even looked up. (partner)

The nurses in this study explained that *the triage process* is complex and that the role is dynamic and demanding, especially in non-metropolitan EDs. The triage nurse needs to ensure the safety of each patient who presents to the ED, especially in non-metropolitan EDs, as there are limited physical and human resources available.

In a small, in a small ED I think it can make it a lot more difficult when we have, during the day, we have three nursing staff and so to put one in triage, then on the floor like we've got two so that makes, that makes the work load a lot bigger. In [our facility] we're kind of to and froing between this system of having a full time triage and... a roving triage [where] anyone triages basically. (nurse)

The nursing staff working in non-metropolitan EDs are often required to perform two or more roles such as having to both triage and treat each patient who presents to the ED, which becomes more complicated the busier the ED becomes. *Highlighting the differences* was an important component for the nurses, in this study as they felt there needed to be awareness of the increasing complexity of their role.

It's a small town and it's generally a quiet ED but you know when you know you've got a bunch of category threes come in, then all of a sudden people are waiting you know long, long times like five six or seven hours or eight hours even. If they stayed away most people would just leave. That happens, that happens, frequently as well, every few days so it's kind of just the luck of the draw on the day really. (nurse)

The role demands the nursing staff be skilled in their ability to assign an appropriate triage category for each patient who presents to the ED. Women who present with possible miscarriage and who are haemodynamically stable are assigned a lower triage category. In assigning this category, the triage nurse highlighted that the woman would need to wait to be seen by a doctor, as there was not much that could be done medically for these women. In recognising the need to wait, the nursing staff felt

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they needed to apologise to the women as they understood their anxiety, but there was little they could do.

Wanting Recognition and Inclusion

The next stage of the process uncovered in this study is that of *wanting recognition and inclusion*.

Feelings of resentment arose at the *burden of having to wait* for extended period of time as they sat in the ED waiting room to be seen.

I spent hours in the waiting room... it was horrible, then I went up and I had friend with me and she went up and asked what was happening... then she had to go and then my partner came and sat with me but he had to go...cause I sat there for ages... I was in pain... I just wanted to go and lay down... I felt I could have laid on the floor I was in so much pain...I just wanted to curl up into a ball basically. (woman)

Other women spoke of having to wait in pain, which added to their sense of urgency and anxiety especially as the waiting was the longest aspect of their visit. They felt that their presenting condition was not considered worthy of requiring health care in the ED and that they did not belong; especially when informed by the triage nurse “that there was nothing that could be done”; a statement that ultimately increased their anxiety and despair. *Remaining unheard* was the biggest concern for the women who felt the triage nurse did not listen to what they were saying and did not respond to their calls for pain relief. They believed that the nursing staff did not understand or acknowledge the magnitude of what was occurring to them. The possible loss of their child as well as pain and concern regarding their body were not being acknowledged or respected.

Throughout this process *the partner’s burden* included feelings of exclusion. In *not being acknowledged* the men’s anxiety increased and they became angry towards staff.

No, I was there but it wasn’t directed at me um... yeah um most of the time I was sitting there and I was not even acknowledged. (partner)

As they witnessed their partner’s pain, it appeared to them that the nursing staff showed no empathy regarding the possibility that they could be losing their baby.

At this stage, the women were *noticing their partner’s distress*. Noting that the staff did not acknowledge their partners, it fell to the women to pacify them while having to cope with their own pain and anxiety. The partners were getting angry that nothing was being done for the woman and their baby. They tried to be supportive during this time but the longer the women had to wait the more

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their anger and anxiety grew.

Because he was like... "what the hell is going on?" and while I understand that they can't do much... (inaudible)... yeah so it wasn't nice... that fact that you have to sit and wait with everybody else while you know that you know that you are losing your baby. (woman)

When staff did communicate with the partners they were often *provided meaningless words*, which they felt did not provide any comfort for themselves or the woman. The men in this study noted that while they thought the staff may have been trying to be compassionate when they provided such comments as "it's probably for the best" or "you can always try again", nonetheless they felt these words were meaningless. For two of the participants who already had children, staff often made comments such as that they should be "thankful that they have one child".

The partners were also uncertain as to why they needed to wait to be seen as they felt that their partner's (the woman's) presentation was urgent. They were angry that they were not provided with any information which made them feel insignificant, as if miscarriage was not considered as a loss or a priority. While the nurses *recognised the woman's needs* and tried to address these, they understood that the anger they faced related mostly to the amount of time that the women were *needing to wait*. The frustration experienced by the partners led to anger that was often directed towards the nursing staff. This situation added to the already stressful nature of the triage nurse's role as they found themselves *facing partner agitation*, often in the form of verbal abuse. While such behaviour was not welcomed, it was often expected. Nurses too felt frustration in relation to the *restrictive practice* associated with working with such presentations in non-metropolitan area of Australia. These restrictions (e.g. limited physical resources such as private rooms; limited human resources such as reduced access to specialist staff) impacted on the care they were able to provide each woman who attended the ED.

Seeking Support and Understanding

Seeking support and understanding is the next stage of the process experienced by participants. While waiting in the ED, the women knew logically that they were most likely experiencing the loss of their pregnancy and fear that they would end up *paying the ultimate price* of losing their baby. They still hoped that something could be done and thus were *assuming the worst but wishing for the best*.

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Unfortunately, for two of the women, the long wait in the ED culminated in them *miscarrying in the ED waiting room toilet*.

Um... and... that's when I went up and said I think I've had it in the toilet... I think I have had a miscarriage... at that stage I was there by myself and was pretty sure I had just had the miscarriage and I just wanted to go home to the comfort of my own bed and my partner. (woman)

Not only was this a devastating experience for the women, it was also a very lonely experience as they were separated from their partner during this time. Losing their baby in the public toilet meant they were faced with the horrible decision of whether or not to flush the toilet. The women's pain continued and they spent an additional period on the toilet crying for their loss while not knowing what to do next. They did not want anyone else seeing their baby in the toilet but they also did not want to flush their baby down the toilet. They were also unsure if the nursing and medical staff needed to see what they women had passed. This experience was devastating for these women; not having the support of either their partners or the staff added to an already difficult situation.

Um...yeah I had the worst treatment I thought. I left and...like even now still after the treatment I was given...I can accept having a miscarriage but the treatment was worse...if that makes sense. (woman)

Many of the issues that were faced by staff in providing care for the women arose from the *arbitrary practice* that had to be relied upon by nurses in non-metropolitan EDs. *Being aware of women's distress* made nurses keen to provide the best care possible in the circumstances. Nurses' knowledge of one well-known event that had impacted on the care of a woman who presented with vaginal bleeding in early pregnancy in an Australian metropolitan ED heightened this awareness. This event occurred at the Royal North Shore Hospital some years earlier, where a woman miscarried in the ED waiting room toilet (see Joseph & Hunyor, 2008, for further information). The Royal North Shore (RNS) incident and subsequent inquiry lead to changes in the ED processes in the care of women who presented with possible miscarriage. The consequences of this incident affected not only the metropolitan EDs but also non-metropolitan EDs. In *remembering the RNS incident* the nursing staff in this study spoke of the need to be aware of the woman's distress and the changes that had been made since the incident.

I guess my time, my experience has differed based on I'm not sure if you are aware of the Royal North Shore incident that happened in Sydney when someone gave birth/ miscarried in the toilet or something like that and since then obviously it has become a bit of a hot topic on about how we manage these patients. So then I guess the management changed a bit after that incident. (nurse)

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Even though changes were made to policy as a result of the RNS incident, the nursing staff at triage in non-metropolitan EDs often *felt unsure and frustrated* as they were limited in what they could do for the women in their care. The nursing staff faced a number of restrictions that related to organisational, physical and time constraints associated with working in non-metropolitan EDs. While in larger metropolitan EDs nurses would be able to consult with the more experienced staff, the more rural and remote the facility the less senior staff were available. It was during these times that the nursing staff were often *relating back to personal experience*. While they understood that compassionate care was required, it was difficult for them to remove their own personal experiences from the care they provided.

I didn't feel it was, you know, terribly concerning and that after three I still had a normal pregnancy and a normal delivery and I got my second daughter. I probably feel less personally affected by it because I am quite - not blasé it's not the right word - but a little bit resigned to whatever happens in that first 12 weeks is kind of inevitable. (nurse)

This attitude was not lost on the partners, who while desperately *exploring support* for themselves and their partners nonetheless experienced a number of *unfortunate events* that resulted from the insensitive manner of the staff.

It's like that emotional that you've been slapped but it also... it also seems... yeah I guess it comes across as clinical... quite removed... it's almost like they don't want to say that you're losing the baby or anything. (partner)

While the nursing staff were aware that they were perceived as being uncaring, they felt constrained in what they could do to address this situation that had resulted from the constraints and restrictions of their practice context. Personal development opportunities were inadequate, with limited funding and lack of available relief staff to enable them to access professional development courses offered in the larger metropolitan hospitals. As a result, often *care depending on personality* of both the medical and nursing staff was provided.

There doesn't seem to be a standard approach. And it seems that it's very much directed by whichever doctor happens to be on at the time. Whether it's within hours or after hours, whether it's a weekend and that can range from you know, doing nothing other than providing reassurance and saying you know just wait and see what happens. (nurse)

The nursing staff spoke of the need for rural and remote communities to rely on their local General Practitioners (GPs) who had to run their own GP clinics and also cover the local ED. This practice again added to the stressful role of the triage nurse, as they needed to have the necessary skills and

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knowledge to know when to contact the GP depending on the urgency of the patient's condition.

When reflecting on and exploring the support provided to the women, the partners felt the physical care was appropriate but that their treatment was rushed and compounded by them being given *limited to no information* throughout the experience of being in the ED.

Leaving as one

As their experiences of the ED came to an end, participants described *leaving as one*. However women were left without closure, *being unsure* of their pregnancy status. Invariably, after *finally being seen* after waiting so long in the ED waiting room, there was a sense of relief for both themselves and their partners. The women felt at this time they would finally be listened to. However, after being seen by the medical officer and having blood tests taken and sonography ordered, the women and their partners were informed that they were being discharged. When the nursing staff spoke about activities involved in *preparing for discharge* of these women, this included providing *thoughts on education and information*. Four of the nursing staff felt that education was important while two felt it was not their role, or that there were certain populations (e.g. women from remote Aboriginal communities) who would not refer to the literature even if they provided it.

We do have, there's a package that I know, again its New South Wales, I don't know how it relates [to rural and remote Australia] but it's called 'When things go wrong in early pregnancy' or something like that. (nurse)

I think sometimes the information which... which a lot of the time says we really can't change the outcome at this early stage isn't so reassuring either. (nurse)

Upon discharge, the women and their partners left the ED together (as one). They left as one entity, still unsure about what was to happen if their pregnancy was intact; or the processes that were to follow if they had miscarried. They were as one with their feelings of dismay, frustration and fear. It was also at this time that in *arranging follow-up care* the staff provided the women with details for either being seen by their local medical officer, referred back to the ED for a planned review or alternatively to the nearest referral hospital. The option of *referring to metropolitan hospitals* provided access to a wider variety of services including obstetrics and gynaecology services, pathology, sonography and social worker services. While some of these services are available in some of the regional communities, they are limited and only offered intermittently in rural and remote

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centres.

Following discharge, only one of the women was happy with the information provided while other women and their partners left without knowing what was going to happen next. Women were *going home and hoping for the best*, wishing that they were still pregnant but uncertain of their pregnancy status. The partners noted the only time they were addressed by the nursing staff was upon discharge where they felt pressured into *being supportive* and *assuming a role* that of being 'the man' as they were informed their energies should be spent being supportive and caring for their partners. The men felt the nursing staff had made *assumptions regarding loss* of their baby and were pressured to take on a more masculine role and disguise their feelings in order to support, protect and care for their partners.

[The loss] it might not be a physical one but it is an emotional one. Yep cause that is our job [being a man]. I was trying to be big and tough and strong and all that kind of thing but I tried to be big and tough and the man thing. (partner)

For the women *being referred* to the larger metropolitan EDs meant they needed to travel some distance with time away from their family, all of which added to their emotional and financial stress. When attending their follow-up appointment (either locally or upon transfer) the women spoke of *receiving the bad news* and learning they had lost their baby, which was not only a physical experience but also a very emotional one. During this time the men were trying cope with their own feelings while supporting their partner.

I was devastated and I was very upset...Obviously you go why this does happen and you just kinda feel sad. (partner)

The women felt unprepared regarding what they needed to do next, a feeling that was also experienced by the men, especially those not provided with any information or education regarding pregnancy loss. Women and their partners spoke in particular of the terminology utilised by the healthcare staff as being very cold and clinical. The women, at this time were trying to make sense of why this had happened to them, running through a mental checklist of the 'do's and don'ts' of pregnancy (such as whether or not they smoked or consumed alcohol).

Yeah...yeah well I don't know what I could have done-I didn't drink or smoke throughout my pregnancy but if it was my body that didn't let them survive...so I was blaming myself in some way shape or form I guess. (woman)

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Meanwhile the men played the 'what if' game, such as "what if there is a problem with my sperm?" or "what if I have damaged myself that time...?" or other similar questions. This period of *self-blame* and uncertainty led to communication difficulties that added to their feelings of loss. For one of the women and her partner, the loss eventuality ended with the breakdown of their relationship.

Moving on

The final stage of the process saw participants *moving on* from their ED experience. Upon retelling their stories the partners felt it was important to provide their thoughts on improvement in respect of how care can be improved in non-metropolitan EDs. While there was an understanding that the services provided in non-metropolitan EDs were limited as a result of their location, both the women and their partners felt that there were some aspects of care that could be improved. *The women's preferences* arose from them being left *wanting more* than the care they received in the ED. In particular, they articulated a need for *including their partners* in their care as well as the provision of education/information. Men too had thoughts on improvements, suggesting that *necessary changes* in care included: the need for staff to show more compassion, to recognise and acknowledge their presence and the provision of education and information that explains the process of miscarriage, the physical effects for the woman and what to expect at the home in the following days, weeks and months.

The nursing staff also acknowledged that some changes were required in the provision of care. Largely relying on *working it out ourselves*, they acknowledged the importance of *creative practice* that involves the use of innovative local solutions for the challenges faced by healthcare staff working in regional, rural and remote Australia. According to the nursing staff in this study, *making improvements* would require the development of policies based on individual service areas. The nursing staff also suggested increasing the number of staffed beds in the ED to ensure patient privacy and adaptations of the early pregnancy assessment clinics that can be staffed by the nurse practitioners, midwives and nurses and working in the ED. Lastly, the nurses also felt having a full time triage position would improve the care of patients who present to regional, rural and remote EDs.

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Nursing staff want to abolish arbitrary health care practices in rural and remote EDs by improving staff development possibilities. They also advocated for creative and innovative practice to be recognised and accepted to ensure that local problems could be solved with local solutions.

Discussion

Women and their partners who experience first trimester bleeding in pregnancy face concerns about the wellbeing of their baby (Warner, Saxton, Indig, Fahy & Horvat, 2012). At these times they often present to their local ED for help and although miscarriage is a relatively common experience, it can still result in significant loss (Zavotsky, Mahoney & Keeler, 2013). The women and their partners in this study not only faced the possibility of pregnancy loss but also additional stressors associated with living in rural, regional and remote areas of Australia. These additional stressors included the need to travel further distances to receive healthcare and the financial burden that this creates (Birks & Mills, 2015).

On presentation to the ED, women and their partners are often found to be hyperaware of staff attitudes and the willingness to provide care that is supportive (Evans, 2012; Geller, 2010). The women in this study needed the support of nursing staff while the men wanted acknowledgment and inclusion. Nursing staff need to be aware of not only the physical aspects associated with miscarriage but also the psychological impact (Cumming, Klein, Bolsover, Lee, Alexander, Maclean & Jurgens, 2007). When nursing staff fail to acknowledge these effects, it provokes anxiety, depression and dissatisfaction with the care provided (Geller, 2010). Furthermore, a lack of empathy and recognition can have profound effects on women's and partners grief and can also lead to dissatisfaction in the care received (Adolfsson, 2006).

Dissatisfaction with care has been well documented in literature, along with evidence supporting the effects of nursing care and its impact on an individual's experience and ultimately their recovery (Geller, 2010; Adolfsson, 2006; Evans, 2012; Radford & Hughes, 2015). Reports of dissatisfaction usually transpire after an incident has occurred, for example, the Royal North Shore incident (White & Bouvier, 2005) led to an inquiry that resulted in widespread reform not only in New South Wales but throughout Australia. Unfortunately, people living in rural and remote areas of Australia were not

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able to benefit from these reforms. For example, Early Pregnancy Assessment Units evolved from the inquiry and, while these units work well in metropolitan areas of Australia, this service is not available for women living in regional, rural and remote areas because of limited speciality staff and funding.

Women facing miscarriage want to feel they are in the right place to receive care and that they will receive that care from nursing staff. For men, the emotional burden of early pregnancy loss is commonly unrecognised by not only the nursing profession but also society in general (McLean & Flynn, 2012). It is important that nursing staff not only acknowledge the partner but also have an awareness of their emotional wellbeing and their role beyond being merely a support person for the woman (Canario, Figueiredo & Ricou, 2011). Not acknowledging the partner combined with having to wait to be seen can lead to agitation and anger from the men (partner's) as they are not only concerned about their baby, but are also worried about their partners wellbeing (Huffman, Schwartz, & Swanson, 2015).

Gender specific communication is needed at this time to ensure that both the women and their partners receive information in a manner that is appropriate for them both (Liuccio, 2015). Women want the opportunity to be able to discuss their feelings, whereas men require the facts and to be spoken to as a father (Puddifoot & Johnson, 1997; Lok, Yip, Lee, Sahota & Chung, 2010). Studies by Kong, Chung, Lai and Lok (2010), Beutel, Wilner, Deckardt, Von Rad and Weiner (1996) as well as Johnson and Puddifoot (1996) support the inclusion of men in this dialogue. Their research refutes the assumption that men do not bond with their unborn child and therefore cannot experience grief and loss after miscarriage. This communication is valuable, especially for men and women living in rural and remote areas of Australia, as they can experience increased difficulty in finding and receiving support.

Nursing staff need to ensure that when communicating with both women and their partners, they do not make comments that minimises the woman's or partner's emotions such as the use of 'meaningless' words, as found in this study. These experiences highlight the importance of therapeutic communication where nurse-patient interaction helps the nurse to build positive

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relationships warmth, respect, compassion and empathy (Geller, 2010; McLean, & Flynn, 2012).

Additionally, ED nursing staff need to ensure that communication is open and non-judgemental with the focus being on both the woman and her partner (Evans, Veitch, Hays, Clark & Larkins, 2011; Jansson & Annsofie, 2011).

Quality communication is not only important while in the ED but also upon discharge. The education and take-home information should focus specifically on information that is designed to meet the needs of the woman (including follow-up instructions) and also her partner. Education and information needs to include facts concerning what may or may not occur next, about the feelings they may experience and where they can go for help (Lok et al., 2010). Research has shown that providing gender specific information assists in reducing blame and self-blame that may occur later in the grieving process and that may contribute to a breakdown of the relationship (Canario et al., 2011; Olson, 2013).

Non-metropolitan communities face significant disadvantages in the provision of healthcare especially for women requiring obstetric and gynaecological services (Edwards et al., 2016).

Additional education is needed to assist nursing staff to improve their knowledge and skill base so that they do not have to rely on personal experience or instincts when providing care (Olson, 2013). For nursing staff who live and work in non-metropolitan EDs, the additional knowledge and skills will help ensure a service equitable to that provided by a multidisciplinary healthcare team (Edwards et al., 2016). Ultimately, there is a need for nursing staff to recognise that women and their partners 'present as one' to the ED when seeking care for possible miscarriage and that they will 'leave as one'. The care they both receive during their time in the ED can have a significant influence on how they 'move on' from this experience.

Implications for Clinical Practice and Research

The findings in this study highlight the needs and expectations of nursing care for women and their partners who present to regional, rural and remote EDs with first trimester bleeding with possible miscarriage. The following recommendations (Table 2, below) are drawn from these findings and can be implemented to mitigate the challenges faced in these contexts.

While these findings are significant, it is important to acknowledge the limitations of this study. The ability to recruit to a study of this type can be difficult given the sensitive nature of the subject matter. This limitation applies to the recruitment of male participants in particular. Also the dispersed nature of the regional, rural and remote population can limit recruitment. Nonetheless, the number of participants in this study was sufficient to capture a broad range of experiences. In addition, the rigorous application of grounded theory methods ensured the quality of the theory presented in this paper.

Further research needs to focus on the experience of women and their partners from different backgrounds presenting with possible miscarriage in non-metropolitan areas of Australia. Only Caucasian Australians living in regional, rural and remote locations participated in this study. As we live in a multicultural society it is important to ensure that all Australian women and their partners are able to provide their voice regarding the care they receive in the non-metropolitan EDs. Further research should also focus on Aboriginal and Torres Strait women and their partners, along with those who come from non-traditional family structures including lesbian, gay, bisexual, transgender, questioning and asexual (LGBTQA) families.

Conclusion

ED care of women and their partners' experiencing possible miscarriage in non-metropolitan areas of Australia is understood to be influenced by many factors. 'Threads of care: a grounded theory of regional, rural and remote ED care for women with possible miscarriage' was generated from analysis of the rich data gathered in this research study. The process of providing optimal care relies on the provision of nursing care that incorporates the experiences and expectations of the woman and their partners as well as those nursing staff in this context. This study has identified a number of recommendations for education, practice and policy that aim to enhance the provision of care for women and their partners who present to non-metropolitan EDs.

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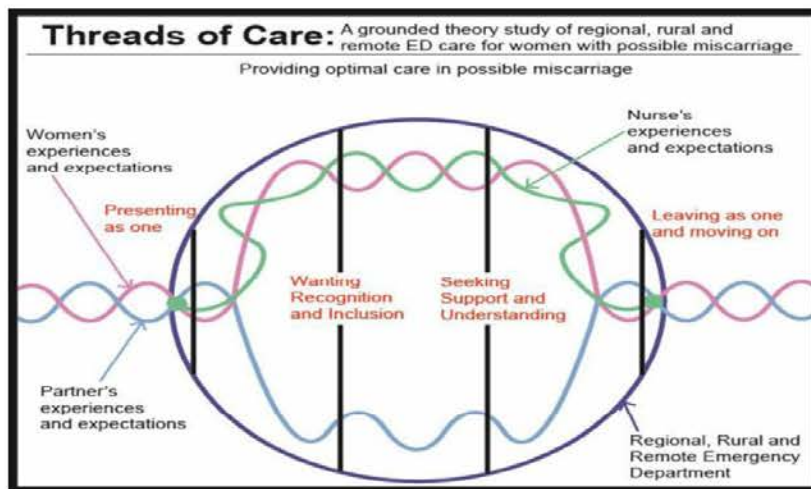


Figure 1: Threads of care: A grounded theory study of regional, rural and remote ED care of women with possible miscarriage.

Table 1: Threads of care: A grounded theory study of regional, rural and remote ED care for women with possible miscarriage.

Category	Participants/ code	Sub-categories	Codes
Presenting as one	Women	Making the decision	Developing awareness Presenting to triage Limited privacy and confidentiality
	Partners	The ED experience	Experiencing triage
	Nurses	Presenting to the non-metropolitan EDs	Establishing patterns of presentation The triage process Highlighting the differences
Wanting recognition and inclusion	Women	Feelings of resentment	The burden of having to wait Remaining unheard Noticing their partner's distress
	Partners	The partner's burden	Not being acknowledged Provided meaningless words
	Nurses	Recognising woman's needs	Needing to wait Facing partner agitation Restrictive practice
Seeking support and understanding	Women	Paying the ultimate price	Assuming the worst but wishing for the best Miscarrying in the ED waiting room toilet
	Partners	Exploring support	Unfortunate events Limited or no information
	Nurses	Arbitrary practice	Being aware of women's distress Remembering the Royal North Shore incident Feeling unsure and frustrated Relating back to personal experience Care depending on personality
Leaving as one	Women	Being unsure	Finally being seen Going home and hoping for the best Being referred Receiving the bad news
	Partners	Being supportive	Assuming a role Assumptions regarding loss Self-blame
	Nurses	Preparing for discharge	Providing thoughts on education and information Arranging follow-up care Referring to Metropolitan hospitals
Moving on	Women	Women's preferences	Wanting more Including the partner
	Partners	Thoughts on improvement	Necessary changes
	Nurses	Working it out ourselves	Creative practice Making improvements

Table 2: Recommendations for nursing education, practice and policy.

Context	Recommendations
Nursing education should include:	<p>The psychosocial aspects of miscarriage.</p> <p>The provision of gender-based knowledge relating to care.</p> <p>Therapeutic communication strategies that focus on the emotional care of women and men in pregnancy loss.</p>
Nursing practice should provide care that:	<p>Is sensitive and attentive, gender and culturally-specific with emphasis on consistent verbal and written information regarding miscarriage.</p> <p>Ensures access to detailed information for women and their partners regarding resources and access to services and facilities specific to the non-metropolitan locations.</p> <p>Enables accessible support upon discharge, either locally or via online services.</p>
Policy must:	<p>Reflect community-specific, innovative and creative practice that focuses on local resources (both human and physical).</p> <p>Focus on management that is specific to the regional, rural and remote location rather than metro-centric or arbitrary in nature.</p> <p>Implicitly state the minimum follow-up requirements for both women and their partners that focuses on their emotional well-being.</p> <p>Stipulate the minimum requirements to support nursing staff to participate in professional development opportunities.</p>

5.3 Summary

This chapter has provided an overview of the developed grounded theory, which was presented as a storyline. ‘Threads of care’ explains the experiences of women and their partners who present to regional, rural and remote EDs with possible miscarriage. Their stories are reflected throughout the five stages of the ED journey explicated by this grounded theory. The following chapter explores the woman’s experiences and expectations of the care they received in the ED in more detail.

Chapter 6: Findings: Women's Experiences

Just those few weeks when I lost you,
I lost a lifetime of hopes, plans, dreams and aspirations ...

Susan Erling Martinez, 1984

6.1 Introduction

The purpose of this study was to examine the current approaches to care provided to women who present to rural, regional and remote EDs with first-trimester bleeding. Miscarriage is a common occurrence in women's reproductive lives and, statistically, early pregnancy loss (less than 14 weeks gestation) is as high as 20%. Women often present to their local non-metropolitan ED with either one or a combination of symptoms, including abdominal pain, cramping, vaginal bleeding or spotting, and also concern that their pregnancy may be in danger. Unfortunately, miscarriage is not triaged at a high acuity level and, therefore, is not classified as an urgent case. For women who are possibly experiencing a miscarriage there is a sense of urgency that is incongruent with how they are triaged and how they are prioritised through this process. This urgency is primarily related to the possibility of the loss of their pregnancy and, ultimately, their baby. This study also investigated the experiences of women who presented to their local non-metropolitan emergency department and the care that was provided to them in respect of adequacy, quality and expectations of ED care. Through the use of storyline, this chapter will provide an overview of the women's experiences as they progress through the ED and on to discharge (see Figure 6.1).

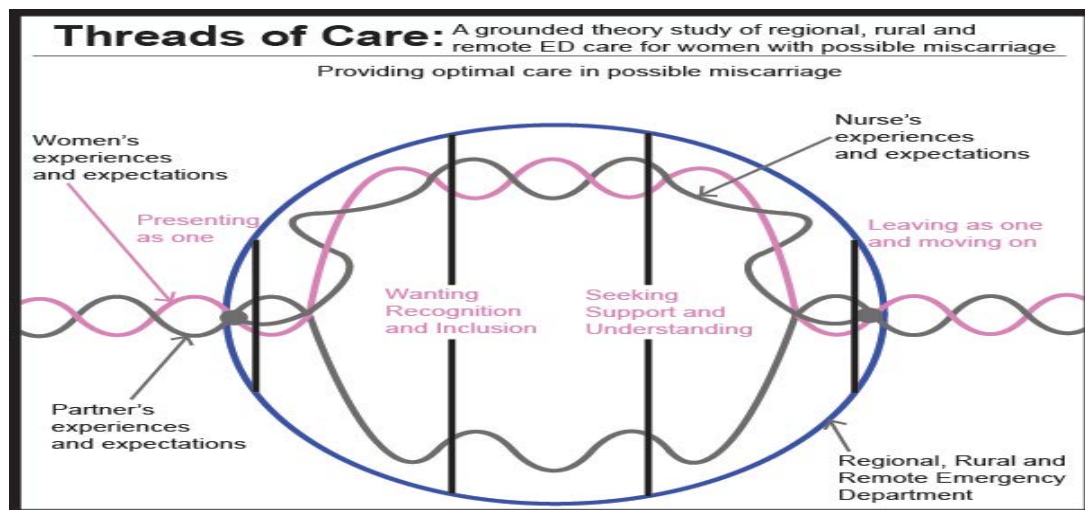


Figure 6.1: Threads of care: Women's experiences and expectations.

6.2 Women's Experiences and Expectations

This chapter discusses one of the three components of the grounded theory that was generated from the research data. 'Women's experience and expectations' is a major category of the theory, which explores the models of care provided to women who present to non-metropolitan EDs with vaginal bleeding in early pregnancy. The core category of 'providing optimal care in possible miscarriage' refers to the care that both women and their partners require and expect when they present to non-metropolitan EDs and also the experiences and expectations of the nursing staff who provide the care.

Table 6.1: Women’s experiences and expectations when presenting to non-metropolitan EDs with vaginal bleeding in early pregnancy.

Core category: providing optimal care in possible miscarriage		
Context: regional, rural and remote EDs		
Process: women’s experiences and expectations		
Category	Sub-categories	Codes
Presenting as one	Making the decision	Developing awareness Presenting to triage Limited privacy and confidentiality
Wanting recognition and inclusion	Feelings of resentment	The burden of having to wait Remaining unheard Noticing the partner’s distress
Seeking support and understanding	Paying the ultimate price	Assuming the worst but wishing for the best Miscarrying in the ED waiting room toilet
Leaving as one	Being unsure	Finally being seen Going home and hoping for the best Being referred Receiving the bad news
Moving on	Woman’s preferences	Wanting more Including the partner

Each woman’s story is reflected in the categories and sub-categories and codes (see Table 6.1) that are used to construct the following storyline.

6.3 Presenting as One

‘Presenting as one’ incorporates the women’s decisions to present to their local ED with concerns of possible miscarriage. In making the decision to present to the ED, both the women and their partners ‘presented as one’, with their main focus being the health of their baby and the health of the woman. All the women felt a sense of relief in presenting to the ED, especially as they were experiencing an emergency themselves—that being the possible loss of their baby.

6.4 Making the Decision

‘Making the decision’ to attend the local ED resulted from the woman experiencing a ‘developing awareness’ that something was wrong with their pregnancy. This developing

awareness initiated their fears and concerns for their baby and their own well-being. These fears and the symptoms the women were experiencing led them to consult with their partners in an effort to interpret the seriousness of the physical symptoms. The women and their partners needed to discuss the feasibility of attending their local ED because of their rural and remote location, which often resulted in these women feeling more frustrated. Ultimately, a joint decision was made with their partner to attend their local ED out of concern for their baby. In presenting 'as one' with their partners, the women also talked of their experiences of 'presenting to triage' and 'feelings of having limited privacy and confidentiality' at triage.

6.4.1 Developing awareness

In 'developing awareness', the women explained their feelings of concern for their pregnancy that were related to the symptoms they were experiencing and their knowledge of possible complications in pregnancy. Pain was one of the main reasons why the women in this study presented to their local ED. The pain triggered awareness that something was physically wrong within their body and/or their pregnancy. There was recognition that these symptoms were not normal in pregnancy and they called upon the support of their partners at this time:

I was getting like bad cramping and I started spotting and um because I had a previous pregnancy, previous to this one ... yeah it was not normal. [W1]

Well um...just before presenting I had spotting...so I just had some spotting and that's where it lead to get to the emergency department. [W2]

The decision to attend the ED was made harder because of their rural and remote location and the need to travel to their closest ED. Even this obstacle was overridden by the fear that something was wrong. Pain was a warning for the women that something was not quite right and such action was needed to ensure not only their own safety but also the safety of their baby. The descriptions of the pain they experienced ranged from mild cramping to stabbing and excruciating pain:

I was in a lot of pain ... and ... I was having trouble walking and then I went to A&E ... um ... and told them and I said I was pregnant and that I think I am having a miscarriage and um ... I was in excruciating pain. I couldn't stand up straight um ... it felt like everything was going to fall out but there was like a stabbing pain. Yeah, that I couldn't ... stand up ... [W3]

Along with the pain, the women also experienced symptoms such as spotting, bleeding and abdominal cramping and these symptoms intensified their fear. On presentation to the ED the women and their partners presented to triage (as one).

6.4.2 Presenting to triage

On ‘presenting to triage’ the women were seen by the triage nurse, who then asked a series of questions regarding their presentation, such as: how many weeks’ gestation are you? Do you have pain? There was a feeling that this was routine for the staff and that they were going through the motions of their daily work with no acknowledgement of what the experience was like for the woman and her partner. The triage nurse did not acknowledge the physical manifestations of the women’s symptoms. Being informed that even if they were miscarrying ‘there was nothing that could be done’ added to the woman’s anxiety:

We went to the triage desk and obviously to get triaged ... assessed what had happened at this stage and how many weeks’ pregnant um ... And they then said, ‘Well, what’s your pain level?’ [W1]

I think I was having a miscarriage and they asked how far along you were and stuff and she said to me she said, ‘If you are, we don’t do anything under the twelve weeks’ and I said you know I understand that but I am in pain. [W3]

Not only was there no acknowledgement from the staff, the women also had a sense of there being ‘limited privacy and confidentiality’ while talking to the triage nurse.

6.4.3 Limited privacy and confidentiality

The women who presented to triage experienced ‘limited privacy and confidentiality’. They felt that everyone in the ED could hear what they were saying when they were talking to the triage nurse. Hospital EDs need to ensure the safety of all individuals—that is, both the staff and the patients who are there to receive healthcare. A majority of EDs have a window or barrier that separates patients from the triage staff. This barrier is in place to ensure the safety of the staff, as often there are patients who become disgruntled at having to wait. The barrier is often made of glass, with a small space for staff to talk to the presenting patients, which can make hearing difficult for both the staff member and the patient. The women in this study were required to talk in a loud voice so that the triage nurse could hear what they were saying.

Unfortunately, everyone else in the ED could also hear what was being said, as this woman described:

Yeah it's not very private, you do feel like everyone can hear you and knows what is happening ... she spoke over the counter... so if people are behind you or in the waiting room ... it is so quiet there that you can hear everything that is said ... [W1]

Having to deal with such a personal, private and emotional experience in such an impersonal forum was a challenge for the women in itself. This participant described how this experience made them feel insignificant in regard to the magnitude of what they were experiencing:

I still hadn't ... like I was still around everybody ... it's not very confidential and private sort of thing or comfortable but like everyone around you is in there for different reasons ... then we had to just go and wait just like everyone else. [W3]

Once the women were seen at triage they were assigned a triage category by the triage nurse and informed that they had to wait.

6.5 Wanting Recognition and Inclusion

'Wanting recognition and inclusion' for these women explains their need for recognition and inclusion by nursing staff as a patient in the ED worthy of their attention and care. Once seen at triage and having been assigned a triage category, the women were told they had to sit and wait. It was at this time that the women were resigned to being treated like all the other patients in the ED, with no recognition of the enormity of what they were experiencing. The longer the women waited and the more they were ignored, 'feelings of resentment' towards the triage nurse grew. These experiences led to women having feelings of being brushed aside and being unnoticed by the nursing staff.

6.6 Feelings of Resentment

Initially, the women felt frustrated with the care they received at triage, which then led to 'feelings of resentment'. In exploring the women's feelings of resentment, they explained that these feelings related to the 'burden of having to wait', 'remaining unheard' and 'noticing their partner's distress'. Frustration grew the longer they had to wait, which intensified their feelings of anxiety and fear regarding the possible loss of their baby, along with their associated hopes and dreams for their future. Resentment eventuated, as the women had to face these challenges

in such a public forum and they felt the staff were not listening to them. Further, the women became aware that the staff did not acknowledge their partners at this time. While the women felt the nursing staff were not being intentionally rude, they did notice growing tension between their partners and the nursing staff.

Having to wait then became a burden for these women, as their growing anxiety and concern became unbearable.

6.6.1 The burden of having to wait

Having to wait to be seen by the medical staff was at times a long and gruelling process for the women. The waiting seemed endless, and the longer the women waited the more anxious they became. The women experienced increasing confusion and uncertainty, as they did not know why they had to wait for so long, or what was happening with their body and with their pregnancy. The uncertainty and the anxiety heightened their sense of urgency:

‘What the hell is going on’ and while I understand that they can’t do much ... [inaudible] ... yeah so it wasn’t nice ... that fact that you have to sit and wait with everybody else while you know that you know that you are losing your baby. [W1]

Um...I got seen around midnight and I went home about 3...I was sitting in the A&E for hours...I was up at the hospital for six to eight hours. [W2]

Adding to this burden was that the women had to wait in the ED waiting room with all other patients who needed to be seen. It was as if being placed with other patients waiting to be seen belittled their own experience of the possible loss of their baby. Not having the privacy they desired was an overwhelming experience for the women. They had feelings of being exposed emotionally as they tried to process what was occurring to them in front of other patients:

I think that being put somewhere separate would’ve been nicer than to sit with everybody else with knowing that you are going through this emotional time of knowing that you are going to lose the baby um ... I think that um ... being separated in a private room would have been nicer and I know it is probably not a possibility ... that would be nice. [W1]

Then we just had to go and wait ... and we actually had to wait for a fair bit ... umm I’m pretty sure the waiting part was the longest part of it. [W1]

... sat there for so long [W2]

Like I said even though there isn't obviously ... there was nothing they could do at that stage ... but it was just uncomfortable. [W3]

While waiting, the women tried to make sense of why they had to wait so long, considering the possibility of the ED being short staffed that day or there being an emergency in process that took the staff away from their normal roles:

There was no one at the triage counter for ages and ages um ... but ... you didn't get much just that there was an emergency ... but you know emergencies happen ... obviously they were short staffed that day ... [W2]

In addition to the 'burden of having to wait', the women also had to cope with 'remaining unheard' while waiting in the ED.

6.6.2 Remaining unheard

While having to wait in the ED, the women felt that the ED staff were not acknowledging them. Not only did they have to wait, which impacted on their emotional health, they thought they were not being listened to. The physical and emotional manifestations of what the women were experiencing did not appear to be of importance, and their presentation was not a priority for the staff in the ED. The women had an understanding that miscarriage was not recognised by the ED staff, and even their pain was not worthy of the staff's attention. When the women felt that they were not being listened to, they then enlisted the help of family and/or friends to voice their concerns to the triage staff. This ultimately led to further frustration and then anger from not only the women but also their support people when still nothing was being done to help. Regrettably, there were no words of comfort or offers of pain relief provided by the staff:

I spent hours in the waiting room ... it was horrible, then I went up and I had [a] friend with me and she went up and asked what was happening ... then she had to go and then my partner came and sat with me but he had to go ... 'cause I sat there for ages and I was the last person in the waiting room. And they were like... It must have been around midnight by this time ... I was in pain ... I just wanted to go and lay down ... I felt I could have laid on the floor I was in so much pain ... I just wanted to curl up into a ball basically. [W3]

... so they just said um ... they just said they would go up and ask the nurse what was going on and keep telling them you were in pain ... I think they were getting angry and snappy at the nurses. [W3]

As far as it goes... not really...but no they sort of said urine sample, we'll get it tested for the hormones or whatever it is... um and then it is just basically go sit in the waiting room [W1]

In the end, the women felt that the triage nurse was brushing them aside. Their own sense of urgency was incongruent with how they were triaged and treated by the staff, especially in relation to the pain they were experiencing:

I sat there for ages, like my friend went up a couple of times and said, 'She is in pain, what is happening?' And she said what the pain level is [sic]. They said check she has had Panadol. 'Cos she can only have Panadol if she is pregnancy [sic] ... I had already had it at home [Panadol] and that was that the triage nurse said. I said that I would go through childbirth again before I would go through that pain, 'cos it was horrible. [W3]

The actions of the staff were as important as their inactions for the women. Assumptions were made regarding the age of the nursing staff in relation to their perceived experience and their ability to provide competent and caring healthcare. At times, the women felt that they were being a burden, and they did not feel welcome. There was an understanding that there was nowhere else to go. The decision to go to the ED was in fact one of the only options they had to receive healthcare, as they were located in non-metropolitan areas. The perceived unhelpful attitude of the triage nurse was one of the memories the women had of their ED experience, and this also related to their perception of professionalism of the nursing staff and their ability to provide appropriate care. This was not only frustrating for the women, but also disheartening:

I just assumed that they were experienced—the nurses were older than what I am at the time and so I am sure that they have been through it all with other women. [W1]

I have experienced that [incompetent staff] ... some staff are so brilliant and others are incompetent. [W2]

Yep ... she seemed like she did not want to be there and all we wanted to do was get out of her hair. [W2]

In having to wait for so long the women became aware of their 'partner's distress'.

6.6.3 Noticing their partner's distress

Having their partner present was important for the women during their time in the ED, especially when they had to wait to be seen by medical staff. The partner provided support for

the women at this time, as it was perceived that the healthcare staff were not being supportive. Two of the women noticed throughout the visit that their partner was becoming increasingly distressed. The distress eventually turned to anger as they continued to wait. This distress eventually increased the tension and anxiety that the women were experiencing, and added another layer to an already difficult experience:

[My partner] was getting quite upset and angry and he thought something should have been done a lot sooner ... [Partner] was getting cranky ... he said, 'Why aren't they doing anything?' [W1]

So he was clearly more distressed than what I was because I had been through a pregnancy and I knew the dangers and the facts that you could lose it and everything ... and he was like, like, 'Why aren't they doing anything?' [W3]

The women then explained that in 'noticing their partner's distress' they also thought about what the women needed from the nursing staff and what they were not receiving—that is, support and understanding.

6.7 Seeking Support and Understanding

The women in this study felt they had received little to no emotional or physical support from the nursing staff while in the ED, and the only support they had received was from their partner. The women felt that while their partner had some idea of what was occurring on an emotional level, there was limited understanding about the physical aspect of possible pregnancy loss. Therefore, the women needed professional support, understanding and guidance that only the nurse could provide. Unfortunately, such support, guidance and understanding was not forthcoming. Eventually, the women in this study ended up 'paying the ultimate price' of actual miscarriage during their time in the ED.

6.8 Paying the Ultimate Price

Unfortunately, having to wait in the ED to be seen can result in this as the location where they end up 'paying the ultimate price'. While waiting, the women spent their time in a constant mental battle by 'assuming the worst but wishing for the best'. Unfortunately, for two out of the three women in this study, this culminated with a 'miscarriage in the ED waiting room toilet', an event that would further impact on what was already an intensely emotional experience for the woman.

6.8.1 Assuming the worst but wishing for the best

While waiting, there was a constant battle between the reality of what was occurring physically and what the women were wishing and hoping for. Mentally, the women ran through a checklist of the symptoms they were experiencing and those that they were not. During this time, as one woman described, there was constant battle between hope and despair:

I think that you pretty much know what is going on but something [inaudible] ... but not too sure like—I think it would have been nice to know if I had lost it or if we still had the baby ... Um ... Well, sort of still hoping for the best at that stage [inaudible] even though I was still secretly hoping even though it wasn't to be. [W3]

Unfortunately, 'miscarrying in the ED waiting room toilet' would eventually occur for some women.

6.8.2 Miscarrying in the emergency department waiting room

In having to wait for so long to be seen, two of the women in this study would ultimately experience 'miscarrying in the ED waiting room toilet'. This was a lonely experience for the women, which was made worse when they were not acknowledged by the triage staff and could not have their partners or support persons with them when this occurred:

Well I just had a big pain ... and then I was walking to the toilet ... and then started to bleed a lot ... and was pretty sure I had just had the miscarriage ... between going back and forth ... I had actually had gone to the toilet and had the miscarriage there in A&E—waiting to be seen ... in the toilet there. [W1]

Um... then I went up and told them that I think that I had miscarriage in the toilet and then I was sitting still. [W3]

Not only did the women have to deal with miscarrying in the ED waiting room toilet, alone, they also had to face the dilemma of whether or not they should flush the toilet. Therefore, their greatest concern was having to dispose of their baby by flushing it down the toilet:

Yeah ... cos like I didn't know like cos if I couldn't ... but I went to the toilet and miscarried I couldn't ... well I have to sort of flush it 'cos I couldn't leave it for someone else to walk in my friend came in; and my partner came in ... and yelled out and made sure I was okay. [W3]

... at that stage I was there by myself and was pretty sure I had just had the miscarriage and I just wanted to go home to the comfort of my own bed and my partner. [W1]

On presentation to triage the women had initially been asked to collect a urine sample. For the women who had experienced their miscarriage in the ED waiting room toilet, collecting the sample was not the only challenge they faced; getting the sample to the nurse at triage was also a dilemma. Walking through the waiting room in front of all the people who were also waiting was a humiliating experience for these women as the sample they had collected contained blood and the possible remnants of their baby. As described by this participant, this alone was often the most horrible experience they had encountered:

She got me to do a urine sample and I believed the foetus actually fell out into the sample jar ... because there was this big yucky thing ... um and I took it back to her and then we just had to go and wait ... and we actually had to wait for a fair bit ... um [my partner] was getting quite cranky ... [W1]

Um ... walking through the waiting room with that in your hand is pretty horrible ... that was not a nice feeling I have to say ... yeah we went back in there and handed it to her and told her that something fell out and she had a look in the jar and she (the nurse) said we would send it off to get tested. She said it had blood in it and I said 'I know' and even though I was still secretly hoping even though it wasn't but then at that stage it all sort of turned to anger more than anything. [W1]

Women were often left feeling that the treatment they had experienced from the triage staff was ultimately worse than the experience of miscarriage:

The treatment ... was the worst ... I was falling asleep in A&E and telling them numerous times and then ended up having the miscarriage in the toilet in A&E. [W3]

Eventually, the women were finally seen by medical staff and after a short time were prepared for discharge.

6.9 Leaving as One

'Leaving as one' incorporates the time the women were seen by medical staff and then discharged with their partners from the care in the ED. They presented 'as one' to the ED, having concerns about their baby and eventually left 'as one', still focusing on their pregnancy. The women in this study voiced their concerns and surprise regarding the amount of time they

were seen by medical and nursing staff in comparison to the amount of time they had to wait. The women spoke of ‘being unsure’ of what to do next and also, in some cases, what their final diagnosis was upon discharge.

6.10 Being Unsure

‘Being unsure’ explains the women’s feelings and concerns regarding finally being seen by medical staff, including a sense of hope that still persisted regarding their pregnancy. The women explained their surprise at receiving limited or no discharge information. This included information regarding what they should expect physically and emotionally in the following days and weeks, and also about their follow-up care. The women felt that not being provided detailed follow-up instructions added to their anxiety levels, especially for those who needed to be referred to the larger hospitals. Being unsure also incorporates the woman’s experience of ‘finally being seen’, ‘going home and hoping for the best’, ‘being referred’ and, in some, instances finally ‘receiving the bad news’.

6.10.1 Finally being seen

After waiting so long in the ED waiting room, the women were ‘finally seen’ by the medical staff. A sense of relief was felt, with the relief linked to the perception that they would finally find out what was happening, could finally receive additional pain relief and that something could be done for their pregnancy. At these times the women still experienced a sense of hope that their pregnancy was okay and that the symptoms were related to some other condition. When women are seen for possible miscarriage in the ED, they are often seen in a private room with a lockable door to ensure their privacy—if there is a room available:

... um they took us to a room with a bed. It wasn’t curtained it was an actual room. Um ... we sat down and waited for the baby doctor—um ... [laugh] I can’t recall the name right now to come down and talk to us ... um ... we were waiting there quite a little while ... um ... and he then sat me down and explained ... um ... who ... I suppose she just said ... you know ... she had the story and we had to retell the story to be honest ... and I was quite upset ...
[W2]

If a private room is not available the women are often seen in a curtained cubicle; although this is not optimal, it does at least allow for a physical assessment to be performed with some semblance of privacy:

Ah ... just in one of those curtained areas, it wasn't ... there was no door, it was curtained off ... not private. No, no um I stayed in the one spot ... um I can't [remember] if they did an internal or checked me later and then I think they just gave me pain killers and sent me home ... um. [W1]

During the consultation, the women had to retell their story to the medical officer and answer questions regarding their current and previous pregnancies and their surgical and medical history. The women were also provided further pain relief at this time. A physical assessment was performed, after which the women were told they could go home, but that they needed to come back the next day for follow-up or to attend their local GP:

Um yes, I do think they took blood ... I know they did a urinary test and then I'm pretty sure they took bloods um ... but yeah um I'm sure that's all they did and they gave me some pain relief for the cramping and um ... that was it. [W1]

On reflection, as described by this participant, there was a feeling that the waiting was the longest part of their ED visit, as their consultation with the ED doctor was quite short:

Um, I'm pretty sure the waiting part was the longest part of it. [W1]

I remember it didn't take long to see the doctor ... um because [my partner] was going off that we waited so long just for to find out that [follow-up with the GP] ... so we weren't in there for that long I don't think. [W1]

Being informed that it was time to go came as a surprise. The women were discharged from the ED with instructions for follow-up the next day. The women found themselves 'going home and hoping for the best'.

6.10.2 Going home and hoping for the best

Prior to discharge from any ED, women are provided with education and information regarding their diagnosis, referral to sonography services and information regarding follow-up arrangements. Follow-up arrangements may include referral to obstetrics and gynaecology services (this may require transfer to a larger service), referral back to the local ED or to their GP. Women who were not referred to metropolitan services for follow up were informed to return the following day for ultrasound or told to present to their GP. The women talked of a common response provided by staff upon discharge: 'to go home, rest and hope for the best'.

This was concerning, as they were being discharged and they still did not know if they were having a miscarriage:

Well, actually they said um ... that they didn't know if I had lost it or not um because like [my partner] and I were like well is it still there or is it gone? And there ... like well we don't know ... you will have to go get tests for the next three days to see ... I was pretty much well I was pretty much told to go to my GP Monday and get blood tests for the next three days ... Um ... they sent my blood work to the GP. That was it and then I had to go and make the appointment and um ... tell them what was going on. [W1]

... she said um ... just go home and take it easy ... she said do nothing and put your feet up and relax that sort of thing and we'll just have to hope for the best sort of thing and um ... and knowing that we were sort of prepared or as prepared as you can be for a miscarriage um ... she didn't give me any pamphlets. [W3]

Unfortunately, the women stated that they were not offered literature, such as pamphlets or fact sheets, to take home. Not being provided with information to take home to read meant the women felt a sense of nervousness in regard to not knowing what to expect next:

We sort of left feeling a little confused and sort of didn't know what was really going on ... [W1]

As far as information goes not really ... well obviously you know that you're having a miscarriage or there is something wrong with the baby ... but no they sort of just said urine sample we'll get it tested for the hormones or whatever it is ... but ... umm ... I am going to say no ... um ... she didn't give me any pamphlets ... [W3]

Well they have never given me an explanation as to what happened ... I am assuming that that is what happened [a miscarriage] ... [W3]

When describing their experience, the women tried to rationalise why they had not received any literature from the staff:

No really no ... but I do understand that they were really busy that night that I went in, but yeah no but we didn't receive any information; we didn't get any pamphlets to take home um ... nothing like that. [W1]

Also, the women who had experienced a previous miscarriage were told that as they had this experience they should know what to expect:

[We were told] we had been through it before—we were well experienced and to go home and let it happen. [W3]

After discharge the women were informed that they would need to be seen the next day for medical follow-up, either by being referred to a larger referral hospital, by seeing their GP or by returning to the ED after they had their ultrasound.

6.10.3 Being referred

Women who live in rural and remote communities often required referral to larger regional or tertiary centres for further investigations and also treatment. Even some regional centres do not have the same services as those provided in tertiary hospitals. 'Being referred' often requires the women to travel from their hometown to reach their referral hospital. The women in this study felt that this was an additional stress for them. Travel meant time away from their family, and added financial stress. The experience was painful for the women, and while they wanted to do all they could for their pregnancy, they also needed the support of their family:

I did not want to go down to Melbourne ... I want to go home and be with my partner. [W3]

Another issue facing the women who live in regional, rural and remote areas of Australia is the limited services, such as sonography services, that are available. This limitation requires the women to wait for services or be referred to a larger tertiary hospital or a privately run service located outside the hospital precinct:

So I went back at nine o'clock in the morning because that is when the ultrasound place opened and they told me that they can't fit me in today ... um and I said well the doctor was concerned that it was an ectopic pregnancy ... so, so and they said 'Oh well go across to the private hospital and see if they can fit you in case we can't fit you in for two days.' [W3]

I sort of had to go from one [hospital] over to the other [hospital] ... and then to get the ultrasound and then go back ... and sit there again to be seen by the doctor. [W1]

Once the women had their ultrasound they then needed to either return to their GP or their local ED. The women who returned to the ED to get their diagnosis had to again be registered with triage and wait until they were called by the medical staff. This process was daunting for the women, as they had to repeat the whole experience again to confirm what they most probably already knew. This replay of their story often resulted in the women stating that they would not present to their local ED if they experienced another miscarriage in a future pregnancy, as they

did not want to go through that whole process again only to be informed that they had lost another pregnancy:

No because I didn't think that it was worthwhile going ... we didn't think that it was worth sitting there for hours to wait to see a doctor to be told that the third one was gone. [W1]

The ultimate outcome of this experience for the women was 'receiving the bad news'.

6.10.4 Receiving the bad news

'Receiving the bad news' was not only a physical experience but also an emotional experience for the women. While the medical officer should inform women that they have had a miscarriage, there are times when the women have learned their diagnosis prior to this. In receiving the news, the women felt that the overall experience was very clinical and the use of medical terminology felt foreign. There are a number of healthcare staff who can inform women that they have miscarried or were experiencing a miscarriage; these include: 1) staff in the ED itself, 2) the sonographer, while performing the ultrasound, 3) the obstetrics and gynaecology team, and 4) the local GPs. The women in this study were informed by one of the above-mentioned healthcare staff. Each of these healthcare workers may provide the diagnosis differently, but the overall impact was the same—and was met with sadness and devastation:

They sent me for an ultrasound and the lady said that um ... that she couldn't find any heartbeat anymore and you could see on the screen that it wasn't defined as it was previously um ... I was devastated and I was very upset ... Obviously you go why this does happen and you just kinda feel sad ... they told me to go back to my doctor ... at that point in time they basically had told me that my babies had died. [W2]

Um ... she you know ... let us know. Or she gave us time [to] talk about it. I believed that she actually walked so [my partner] and I could discuss our options ... and I don't think I could bear to see that or to flush it down the toilet so I went with the D&C ... um ... and she [the doctor] did say, sorry at that point right well we will be able to get you in tomorrow. So I was able to get in straight away. So I was really lucky ... cause the whole feeling knowing that you have got something inside you that is not quite right. [W2]

Yeah, we got the test done to confirm that it was all gone and you know they told us they had to scrape everything out. [W1]

The women talked about having a sense that a miscarriage was an eventuality especially when they noticed the actions of the staff, such as being told that they were taking blood samples to confirm their blood group in preparation:

They took us to the back room ... when there they took my obs and ah ... and the gentleman actually took some blood that point ... um 'cos he said that he may as well do it now so we have your blood group organised. Um ... you know I knew it was going to happen. [W2]

Unfortunately, the women did experience a period of self-blame. After receiving the news that they had lost their pregnancy, the women ran through a list of the known 'dos and don'ts' of pregnancy, such as no smoking and no drinking of alcohol. For these women, there was a realisation that although they had strictly followed these rules (the dos and don'ts of pregnancy) they still ended up miscarrying and losing their baby. Eventually, the women tried to find a reason as to why they had lost their pregnancy, which resulted in confusion and led to feelings of guilt:

... yeah well I don't know what I could have done ... I didn't drink or smoke throughout my pregnancy but if it was my body that didn't let them survive ... so I was blaming myself in some way shape or form I guess. [W2]

In discussing their experiences, the women also talked about what their preferences would be in regard to improving care in the ED.

6.11 Moving On

'Moving on' provides insight into the women's needs regarding their physical and emotional care while in the ED and also awareness of how this care impacts their ability to move on from their experience of possible and ultimate loss. The women voiced the need for understanding and support while in the ED and also for the inclusion of their partner in their care. There was a strong feeling that their ability to move on was impacted not only by their understanding of miscarriage, but also by their partner's understanding, as the effects of miscarriage placed additional strain on their relationship. The women believed this related to their partner's level of understanding and expectations of what was occurring to them. Overall the 'women's preferences' provide an overview of what their needs and requirements were in being seen in regional, rural and remote EDs.

6.12 Women's Preferences

'Women's preferences' incorporates the women's thoughts on how nursing care in the ED may be improved. The women talked about 'wanting more' from the nursing staff for themselves regarding their care while in the ED. They also highlighted their need for 'including their partner' in care provided in the ED.

6.12.1 Wanting more

The women felt that the ED care of women who present to non-metropolitan EDs with vaginal bleeding could be improved. While there was an understanding that non-metropolitan EDs have limitations in the services they can provide, there was a sense that changes could be made to improve the overall experience for women who present to the ED with possible miscarriage:

I am not sure what more they could have done ... I was happy with it [the care] but I do believe it was brief. Sometimes the doctors seem a little bit impatient but I suppose they've got a lot ... [W1]

There was a strong feeling that women need to be acknowledged and listened to. For the women who experienced pregnancy loss in the ED waiting room toilet, there was a sense that if they had been listened to they possibly would not have experienced the loss of their baby in the way they had. Overall, the women felt that the attitude of staff was an area of concern. Being made to feel insignificant and like they did not belong in the ED was especially confusing, as this was the one place people went when they needed urgent healthcare. The importance of being provided a separate room and having the ability to express their emotions in privacy was a common priority for these women:

I think that um ... being separated in a private room would have been nicer and I know it is probably not a possibility ... that would be nice. [W1]

The women felt that being seen quickly would also be beneficial, as having to wait was agonising:

I think it would be nice um for then to kind of push you through, I mean I know that heart attacks trump it ... you know you see colds going though and I know that they have probably been in earlier but you are sitting there losing your baby and you just want to go home ... yeah. [W1]

... 'cos the whole feeling knowing that you have got something inside you that is not quite right. I'm not sure that I could have coped [having to wait longer]. [W2]

A clear follow-up plan and information that they could take home and read later was also an important aspect of care for the women, and could improve the women's understanding of what was happening and what to expect.

Lastly, 'including the partner' was seen as very important, as the women felt their partners were also experiencing the possible loss of their baby.

6.12.2 Including the partner

The inclusion of their partner was a very important aspect in the care for the women. There was an understanding that, although it was their body experiencing the pregnancy, the baby was the result of two people and they both would feel the loss of the pregnancy. The women regretted that their partners were not acknowledged by the ED staff or provided with any information regarding miscarriage, concerning either the physical process or the emotional impact:

I think that the one thing that I would like to say is that when a woman is having a miscarriage they probably focus on her ... I sort of noticed with [my partner] that he probably needed to be spoken to as well as he was going through it as well as this was his first baby and he lost it and ... it was focused on me and like it is his baby as well ... and that is probably the only other thing. [W1]

Unfortunately, effects of not being acknowledged or provided with information upon discharge from the ED were felt to be one of the main reasons for the eventual breakdown of the women's relationships with their partners. Limited knowledge led to misunderstanding and miscommunication within the relationship, which ultimately led to feelings that their partners blamed them for the loss of the pregnancy:

Yeah and then I felt like it was my fault and thought that he blamed me and it was just ... I just got too upset and left it too long then ... because my partner and I didn't talk for a month or so really like it put a big hole in our relationship. [W3]

Unfortunately, another result of the partners not being included or provided with information regarding miscarriage in the ED was the expectation for women to 'very quickly ... bounce

back, forget, move on'. This expectation was difficult for women to meet, as they often struggled to move forward without the understanding of their partners.

6.13 Summary

When women experience signs of miscarriage (14 weeks' gestation and under) in regional, rural and remote areas of Australia, they often present to their local ED. Unfortunately, women who present with signs and symptoms of miscarriage (who are hemodynamically stable) are not triaged as a high acuity patient, and while the presentation is not a physical emergency for the staff who work in the ED, it is an urgent event for the woman and her partner who fear the loss of their baby.

This chapter described the experiences of women who presented to their local non-metropolitan ED with vaginal bleeding in early pregnancy. These experiences were described as 'presenting as one', 'wanting recognition and inclusion', 'seeking support and understanding', 'leaving as one' and 'moving on'. The stories of each of the participants create a picture of the experiences of these women. In the following chapter, the 'partner's experience and expectations' regarding the care provided to women who present to non-metropolitan EDs with vaginal bleeding in early pregnancy (14 weeks' gestation and under) will be discussed.

Chapter 7: Findings: Partners' Experiences

You were, just those few weeks, my little one you darted in and out of my life too quickly.
But it seems that's all the time you needed ...

Susan Erling Martinez, 1984

7.1 Introduction

The purpose of this study was to explore the approaches to care provided to women who presented to their local non-metropolitan EDs with bleeding in early pregnancy (less than 14 weeks' gestation). The partners of women who presented to the ED with possible miscarriage were included in the research, as they played an important role in the experience of these women. This chapter will present a discussion of the partners' experiences and expectations as the women progressed through the ED and onto discharge (see Figure 7.1).

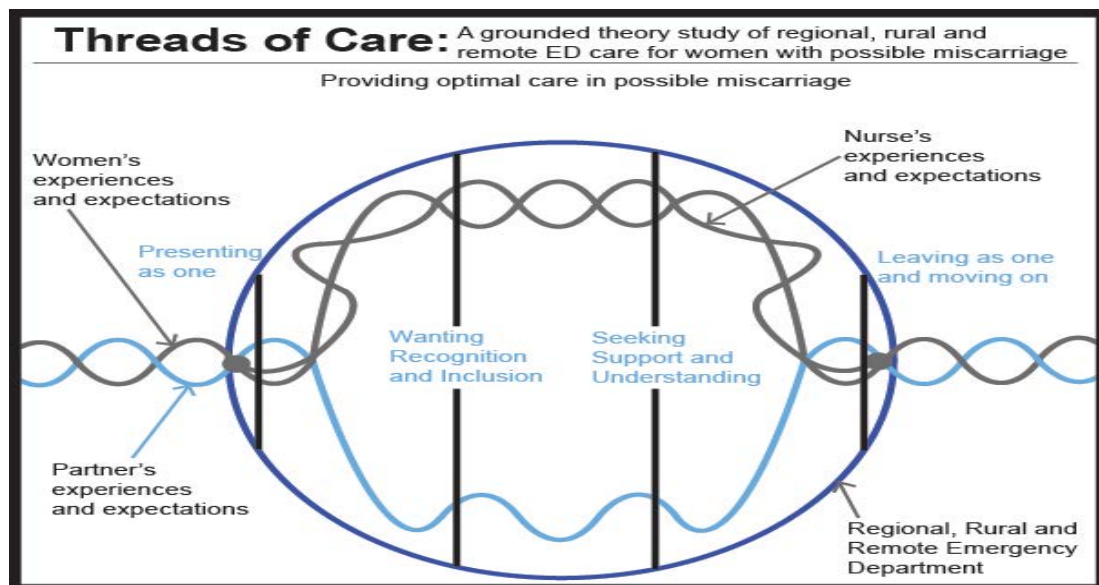


Figure 7.1: Threads of care: A grounded theory study of regional, rural and remote emergency department care for women with possible miscarriage.

7.2 Partners' Experiences and Expectations

The 'partner's experience and expectations' when a woman presents to their local ED is discussed in the following four categories: 'presenting as one', 'wanting recognition and inclusion', 'seeking support and understanding', 'leaving as one' and 'moving on'.

These categories and their sub-categories are provided in Table 7.1 below, and will be discussed in the sections that follow.

Table 7.1: Partners' experiences and expectations when presenting to non-metropolitan emergency departments with vaginal bleeding in early pregnancy

Core category: providing optimal care in possible miscarriage		
Context: regional rural and remote EDs		
Process: partner's experiences and expectations		
Category	Sub-categories	Codes
Presenting as one	The ED experience	Experiencing triage
Wanting recognition and inclusion	The partner's burden	Not being acknowledged Provided meaningless words
Seeking support and understanding	Exploring support	Unfortunate events Limited or no information
Leaving as one	Being supportive	Assuming a role Assumptions regarding loss Self-blame
Moving on	Thoughts on improvement	Necessary changes

7.3 Presenting as One

Seeking help from a regional, rural and remote ED for the men in this study occurred out of concern for both their partner and their baby. The men explained that the decision to attend the ED was jointly made with their partners and they 'presented as one' to the ED. On arrival in the ED, the men and their partners presented to triage and this began their 'ED experience'.

7.4 The Emergency Department Experience

'The ED experience' for the partners of women who presented for care with possible miscarriage began with 'experiencing triage' as they presented with the woman. Anxiety levels for the men at this time were often elevated because of their concern for their partner and their baby, and also as a result of the hospital environment, which often felt unfamiliar and intimidating.

7.4.1 Experiencing Triage

In presenting to triage with their partner, the men were introduced to the triage nurse and the triage system. After enquiring about the reason for their presentation to the ED, the triage nurse performed a set of observations including vital signs and sought to gain specific information relating to their partner's pregnancy, such as how many weeks pregnant she was and what her symptoms were. At this time, the men stood beside their partners and witnessed the care provided to the women and offered support when they could:

We were triaged and the woman said to us that 'it is not a priority' and 'we're very busy tonight' and it could be 'two or three hours'. [P1]

It was during this time that the triage nurse informed the women and their partners that 'miscarriage was not considered a "priority" in the ED' and that they would need to wait. The men expressed feelings of irritation towards the triage nurse when hearing this, and felt that he or she was cold and clinical at this time:

No not at all ... we were just told it is not a priority [being seen in the ED]. So you don't say that and to the person there at the window it is an emergency it is a priority. [P1]

It's like that emotional that you've been slapped but it also ... it also seems ... yeah I guess it comes across as clinical ... quite removed. [P2]

Further, the men felt that the experience was impersonal. While they understood that such presentations were most likely an everyday occurrence for the healthcare staff, it was not an event that was a daily occurrence for them. This feeling was reinforced when the triage nurse did not make eye contact during their encounter:

I found that actually they were almost the same person ... it was like they were reading from a script ... um it didn't feel personal at all ... honestly I don't know if they even looked up. [P1]

After triage, the men waited in the ED waiting room with their partners. While waiting, the men felt anxiety and concern, not only for their partner's well-being but also for their baby, although the greater concern was for their partner's health. Not knowing what was happening was the biggest source of stress for the men, as there was a paucity of information provided. During this time, the partners tried to provide comfort and support for the women; they tried to

stay positive as they did not know what else to do. But the more they waited, the more their anxiety and anger grew:

We were left sitting in the corner of the waiting room ... even the staff left us sitting in the waiting room for three hours. [P1]

Rather than being made to wait, the men 'wanted recognition and inclusion' in the care provided to their partner in the ED.

7.5 Wanting Recognition and Inclusion

'Wanting recognition and inclusion' incorporates the needs of the men in this study to be acknowledged and included in the nursing care provided to their partners while they too faced the possible loss of their baby. Not having the recognition and inclusion of the nursing staff became a burden for these men as they tried their best to cope with what was occurring; their continual requests for assistance were often ignored. These experiences, along with limited acknowledgement, resulted in increased anxiety and anger that was directed to these staff.

7.6 The Partner's Burden

'The partner's burden' relates to how the participants felt when they were sitting in the ED with their partner and of their experience of 'not being acknowledged' by the staff in the ED. Unfortunately, while they initially felt a sense of relief, it was immediately replaced by anger, as the partners were 'provided meaningless words' by the ED staff.

7.6.1 Not being acknowledged

When pregnancy ends in miscarriage, it is not only the woman who experiences the loss, but also her partner. Physically, the manifestations of miscarriage occurred within the woman's body; therefore, it is understandable that the ED staff's attention was on the women. Despite this focus, the men felt that they were not even recognised by the staff as being present. There was an understanding by the men that although it was the women who were physically experiencing the miscarriage, both felt the effects of the loss. There was a feeling that the staff tolerated their presence as the support person for their partners:

Um ... it's actually quite funny that you say that ... you say that you are looking at the support and that and I think that (my partner) was well supported but often I think that they forget that the father is experiencing a loss as well. [P1]

No ... I was there but it wasn't directed at me um ... yeah um most of the time I was sitting there and I was not even acknowledged. [P2]

Ultimately, the partners were disappointed with not only the ED system but also the healthcare system. As a result of this, the men put aside their own grief to support their partners' emotional needs, as they felt that this was what was expected of them and also because of the perceived limited support being provided by the staff. The men felt there was ambiguity in what the healthcare system and the staff classified as a justifiable loss. Unfortunately, miscarriage is still not considered an event for men, and they are often considered by society as the caretaker of their partner. Therefore, their grief and loss go unnoticed, and the long-term effects can be profound, leading to misunderstanding and relationship breakdown. Partners felt they should be included to gain an understanding of what is happening and what to expect, as they were concerned about both their partner and their baby:

That's what I think is funny ... so if the baby was 17 weeks old or seven weeks old like after birth the level support or the level of care would be so different for both people in the relationship but because its ... hasn't put its feet on the ground yet ... so to speak ... it seems to be dismissed ... and to me I don't think [my partner] and I both talked about this ... level of grief and the level of loss wouldn't be much different if it was a child or a toddler even ... it's still the same level of grief and you're expected to deal with it differently and the nurses expect you to deal with it differently. [P1]

In 'not being acknowledged' by the staff, the men felt unsure of what to do and how to support their partners:

I didn't know what was going on. I knew I was scared stiff ... and yeah I mean my wife was in tears and ... Honestly it feels really physical ... I mean we did we knew what was going on ... we were losing it ... um it's like a physical hit ... even though you know that you don't want to hear that. [P1]

As the men felt that they were 'not being acknowledged' at this time, they also felt they were being 'provided meaningless words'.

7.6.2 Provided meaningless words

While there was an understanding that the ED and the staff in the ED were busy, the men reported distress and anger at the lack of compassion displayed by the staff, especially when they were 'provided meaningless words'. This anger resulted from the platitudes provided by

the staff. There was also a feeling that their presentation was insignificant and that their possible loss was being minimised. The words provided by the staff were not considered helpful or caring by the partners, especially when they were being told that they could ‘always try again’ and ‘it was probably for the best’. There was a sense that the staff were not being compassionate during their ED visit, and as a result the men then took on the role of protector. They tried to buffer the situation so that the meaningless words and perceived staff attitude did not distress their already anxious partner:

Not to worry too much because we can always try again ... and all that kind of ... it’s all crap—it is—I don’t think I would say that to someone in my life. We were told that all the time. [P2]

For one couple who had previously had a child or children, the staff informed them that they ‘should both be thankful as they have one child’:

Things like ... these are the things that I remember—‘that we should be thankful that we have one’ which is always helpful. [P1]

The men stated that they had an understanding that the staff were most likely trying to say the right words and to be supportive, but unfortunately these words were misinterpreted as being unsympathetic and insensitive:

Yeah ... by the fourth time we were a mess and um and you know it’s kind of um its ... its ... and everybody tries to say the right thing but they’re always saying the wrong thing. [P1]

They also noted that when the staff made these comments their partner’s stress and anxiety level intensified, which made the whole experience even more uncomfortable. Their own sense of urgency was at odds with the attitude and actions of the staff, and there was a feeling that they did not belong in the ED.

This ultimately left the partners ‘seeking support and understanding’ from the nursing staff who provided the care in the ED.

7.7 Seeking Support and Understanding

‘Seeking support and understanding’ explores the level of support provided to men while attending their local ED with their partners. On presentation and throughout their time in the ED, the partners sought the support and understanding from the nursing staff. Questions were

often met with a blunt response, or no response at all, which resulted in the men experiencing feelings of inadequacy. This inadequacy impacted on their ability to fully understand miscarriage, including the physical and emotional aspects that would affect themselves and their partners.

7.8 Exploring Support

‘Exploring support’ highlights the experiences of the men in this study regarding the level of support they and their partners received while they were in the ED. The men spoke of ‘unfortunate events’ they experienced, along with the ‘limited to no information’ they received.

7.8.1 Unfortunate events

While in the ED, the men talked about ‘unfortunate events’ that had occurred while their partners were being seen for possible miscarriage. These unfortunate events were occasions that the men felt could have been prevented. For example, the matter of fact manner in which they were informed that their partner had miscarried bewildered these men:

You know whatever ... we were just told in passing which you know doesn't help my wife ... it doesn't help me you know. You feel like in the emergency department you feel like you are taking them away from real emergencies. [P2]

I mean he [the medical officer] was ... particularly the last two ... he was a little bit more blasé about it [providing the diagnosis] ... you know that you don't want to hear that in that way. [P1]

The partners provided a number of examples of how the staff were being insensitive during their time in the ED with their partners. In one example, the staff had provided them both with a memorial booklet, which contained a poem and prompts for the couple to explore their feelings regarding their pregnancy and the loss of their baby. The couple had enough time to flip through the booklet, then another staff member entered the room and asked for the memorial booklet back. The nurse stated that they needed the booklet to give to another lady who was experiencing a miscarriage. The partner explained the disbelief that they felt. Not only had they lost their baby, but they had also lost the memorial booklet, which provided them with something both beautiful to remember their baby and something to walk out of the hospital with, instead of two pairs of empty hands:

One time we were given a book on miscarriage that had a beautiful poem at the back um ... I can't remember the name of the poem ... for a few moments or something it was called—I knew you for a few moments um ... its actually kind of funny because they came back in about an hour or so later and just photocopied the back cover with the poem and took the book and gave it to another women who had a miscarriage too as they had run out. We kept the poem and that was the only time we were ever given any information. It affected my wife. [P1]

For the women who experienced an incomplete miscarriage, an admission into hospital was required for a planned dilatation and curettage. Unfortunately for women who live in rural and remote areas of Australia, this may require transfer to a larger hospital with appropriate services. One of the men felt that the need to travel placed additional stress on their family and their partner. At times, when beds are limited in the hospital, women can be admitted to the women's health unit (maternity ward). The men felt this was a very inappropriate place for their partners to be admitted, and also saw the irony in the admission. They remembered the look on their partner's face and felt their distress in being placed in a ward with newborn babies, and having to listen to them cry:

I find it funny ... we're in the middle of a miscarriage and we're up in maternity with crying babies everywhere ... that is like a big lump in throat even thinking about now still does that ... just the look on [my partner's] face and she's cramping in the wheel chair and then even before she um ... went to get the D&C ... instead of going to the day surgery she was popped in maternity. [P1]

The men stated that the admission was very difficult for their partners and that the event was often one of the main memories of the loss of their baby. When the medical staff eventually saw the women, the men had a sense of relief, as their partners would finally be provided with a diagnosis.

7.8.2 Limited or no information

Prior to discharge the women were provided with follow-up instructions, which provided some sense of ease for both the women and their partners but for some of the participants this was all the information they were provided with. There was 'no information' regarding miscarriage and what to expect for either the woman or her partner, which further agitated the partner. This ultimately resulted in the men being overprotective of their partners as they did not know what

to expect. They were unsure of what was normal or abnormal. Overall, this caused an increase in anxiety both for the partners and also for the women, as described by this participant:

Thinking back to the first time even – you feel that you aren't able to support your wife with the information that you had at that time. [P1]

I was just a panicked father...I was freaking out...you know I didn't let her get up, I didn't let her walk around. [P1]

The men who had previously experienced miscarriage with their partners felt that staff did not provide education or information to take home because they were seen to be experienced and so knew what to expect. These men explained that each miscarriage for them was different and that they needed to be provided with written information that they could take home and review when necessary.

Because we had a history it was like oh 'you know what is going to happen'... and then just you know 'go away and see what happens'. [P2]

Because you know...yes I have been through it but they are all slightly different and you are so wrapped up in your own grief that you are not really taking notes of the whole process... [P1]

The men felt that as a result of not being provided with education or information they had to go home and find the answers to their questions themselves with the use of the internet. Some of the men explained that the one time they were given information was after their partner had been admitted to hospital for a dilatation and curettage. The men explained that upon discharge from day surgery they were provided with ample information and so were able to support their partners.

I was given plenty of information about post op care – when she came home from the D&C because it was day surgery... [P1]

Unfortunately, along with not being provided with information the only time the ED staff acknowledged the men was upon discharge. It was at this time the men were informed that they needed to go home and *be supportive* of their partners.

7.9 Leaving as One

'Leaving as one' incorporates the time women were seen by medical staff in the ED before being discharged 'as one' with their partners. During this time, the men in this study continued

to bear witness to their partners' experiences in the ED and voiced their concerns and surprise regarding what was and was not provided to the women and themselves upon discharge. During this time, the men also felt that assumptions were made regarding their role as a partner and their level of loss while being told of the importance of 'being supportive'. Upon discharge, the men were left feeling a sense of unity with their partner regarding their uncertainty, fear and hope towards the pregnancy.

7.10 Being Supportive

Being told to be supportive was a common instruction provided to the men in this study when their partners were discharged from the ED. This comment and others like it left the men feeling as if there was limited understanding of what they were experiencing regarding possible loss of their baby. While they were 'leaving as one' with their partner, their experience in the ED left them feeling unsure, unsupported and needing to 'assume a role' that they thought was expected of them.

7.10.1 Assuming a role

While being seen in the ED, the men felt the pressure of needing to take on the stereotypical 'male' role. While the men stated that they did feel the loss of the pregnancy, they endeavoured to disguise their feelings so that they could be supportive for their partner:

Yep—it might not be a physical one but it is an emotional one. Yep ... 'cos that is our job [being a man]! I was trying to be big and tough and strong and all that kind of thing but I tried to be nice and strong and tough and the man thing. [P1]

Unfortunately, the men felt there was a perceived expectation from the staff to take on this role, as the only time they were acknowledged by the staff was to be informed that they needed to be supportive of their partner, as it was their partner who was grieving the loss:

... so I was often ... you know I remember being told ... I had to take her home and look after her and understand that she was grieving and all that kind of thing but was never even asked if I needed any help. [P1]

I should go home and look after her and make her feel better ... I guess we tried to tip toe around it for a while because we did not want to upset each other. [P2]

For the men, miscarriage was a difficult time. There were times when their partner was crying and they did not know what to do. They had no information to guide them, just the words of the ED staff telling them to be supportive. Their partner's reaction to the miscarriage also affected their own reaction. They were concerned for their partner, both for her physical and emotional welfare. This concern superseded their own feelings, as they acquired the role as her protector and support person.

Overall, the men felt some anger towards the staff, as they were being informed that they needed to be supportive of their partner without being provided with the tools and/or information to take on the role. This anger towards the staff extended through to discharge, when the men stated they had not been offered any counselling services. Further, they also stated that they would not have accepted the offer of counselling even it had been offered. Additionally, the men in this study felt they would have encouraged their partner to utilise the counselling services if they had been offered.

During this time the men felt that 'assumptions regarding their loss' made by the staff were a major cause of their dissatisfaction with the care provided.

7.10.2 Assumptions regarding their loss

Throughout their time in the ED, the men felt that the staff made 'assumptions regarding their loss'. They thought the assumptions mainly related to their level of knowledge and their ability to support their partners. In addition, the men felt the staff made assumptions regarding their level of grief in comparison with their partner's level of grief. There was a feeling that the words and actions of the staff supported these assumptions. Moreover, there was a perceived pressure to go home and cope with what was occurring, as this was the message they were receiving from the staff. This was especially the case if they had experienced a miscarriage previously with their partners:

... we had been through it before ... we were ... experienced and to go home and let it happen.
[P2]

We were told ... um ... to go home and 'what would happen would happen' and 'we knew the drill' and the midwife said that my wife would either lose it or she won't. [P1]

These assumptions made by the staff had further consequences because of the limited information provided; the men went through an unnecessary period of 'self-blame'.

7.10.3 Self-blame

‘Self-blame’ is common following miscarriage, and the men in this study went through a period of self-degradation. These men stated that their main concern was the viability of their sperm. They felt they had spent a large amount of time playing the ‘what if’ game:

Blaming it was probably me ... I was like what if it was me? What if there are some issues with me ... what if is not going to happen ... what if it’s me ... what if my sperm’s a problem ... what if it’s ... you know ... um ... I got hit playing cricket has caused some damage ...what if and it’s all internal ... [P1]

What followed was a period of guilt based on not knowing what caused the miscarriage. There was no blame placed on their partners, just an overall feeling of helplessness.

Lastly, the men provided their ‘thoughts on improvements’ they feel are necessary within the ED to improve satisfaction and to assist both the woman and her partner in ‘moving on’ from their experience.

7.11 Moving On

‘Moving on’ incorporates the effect of experiences the men underwent while in the ED with their partners. These experiences encouraged the men to provide their thoughts on the changes they feel are necessary to improve the care provided to women and their partners where there is possible miscarriage. Ultimately, these changes would work towards improving their understanding and ability to move on, regardless of the end result.

7.12 Thoughts on Improvement

In recounting their stories, the men provided their thoughts on how they felt the nursing care of women and their partners could improve in the ED. The partners highlighted what they felt were the ‘necessary changes’ to increase overall satisfaction.

7.12.1 Necessary changes

For care to improve in the ED, the men felt that the staff needed to show more compassion and recognise and acknowledge them during the ED experience. They believed they should receive the same level of emotional support as their partners. There was a strong feeling that education

and take-home literature was also very important. In particular, the men felt that they needed specific formation regarding how best to support their partners when they were discharged:

Well um I think it should be the same ... the partner is working through the same ... what I really think the partners well if not exactly the same but close ... so I guess yeah its 50/50 there ... it takes two of you to put it together ... so and I think that it takes the two of you to get over the loss ... So that you can work through it together ... more than provide support yeah ... [P1]

I honestly think that partners need the same level of support as the person um ... we don't understand—we are going through it too and um more of that support type services like SANDS or SIDS or I don't really know but only when they are ready ... [P1]

I think that men, the fathers should be included... I would be the father... I am the husband... [P2]

These changes described by the men would assist both themselves and their partners in moving on from this experience. Further, they would ultimately improve the overall nursing care provided to women and their partners when they present to their local ED with possible miscarriage.

7.13 Summary

Pregnancy loss has traditionally been considered 'women's business'. Men have been excluded from the process, being considered a support for the woman who was experiencing miscarriage. The stories revealed in this chapter provide an overview of the experiences of men who presented with their partners to their regional, rural and remote EDs with vaginal bleeding in early pregnancy. These experiences were explored throughout the processes of 'presenting as one', 'wanting recognition and inclusion', 'seeking support and understanding', 'leaving as one' and 'moving on'.

The following chapter explores the nursing staff's experiences and expectations regarding the care provided to women who present to non-metropolitan EDs with vaginal bleeding in early pregnancy (14 weeks' gestation and under). With the perspective of the women and their partners already presented, this next chapter pulls together the final threads of care described in this study.

Chapter 8: Findings: Nursing Staff Experiences

There is no foot too small, that it cannot leave an imprint on this world.

Unknown

8.1 Introduction

Emergency nursing staff are the frontline carers for women and their partners who present to the ED with possible miscarriage. Working in non-metropolitan Australian EDs provides a markedly different environment and experience than working in metropolitan EDs, especially when caring for women who present with first-trimester bleeding. Clinical nursing staff are required to possess a greater diversity of skills in an often resource-poor workplace. The aim of this study was to gain an in-depth understanding of the experience of women and their partners who attend non-metropolitan EDs with first-trimester bleeding, along with the experiences of the nursing staff who provide care in these settings. This chapter will provide an overview of the participants' experiences and expectations and their approaches to care as they nurse women who present to ED through to discharge (see Figure 8.1).

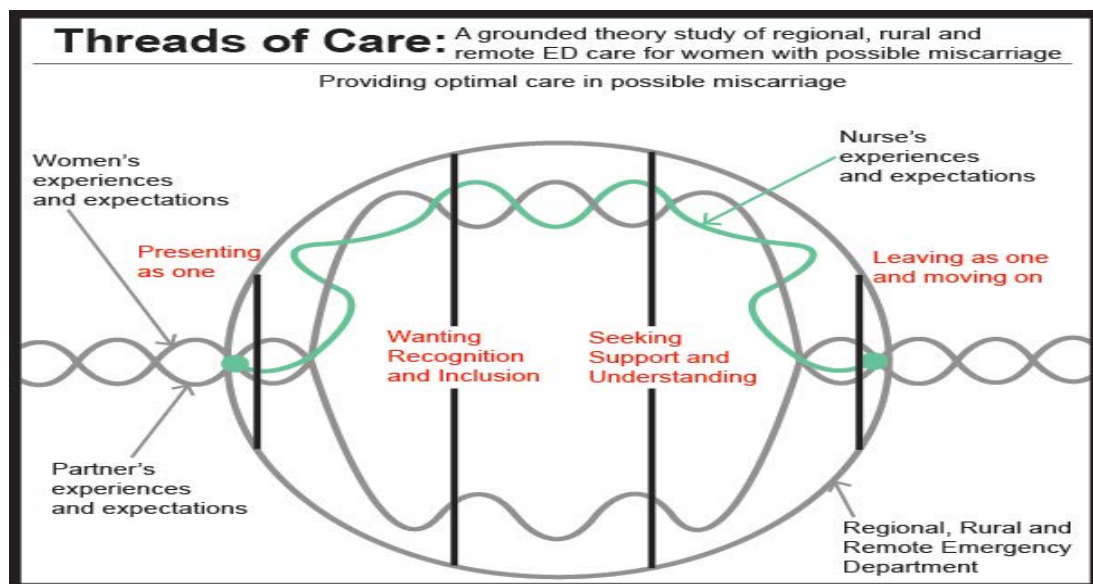


Figure 8.1: Threads of care: Nursing staff's experiences and expectations.

'Nursing staff experiences and expectations' is one of the key components of the theory that explains the care provided to women and their partners who presented to non-metropolitan EDs with vaginal bleeding in early pregnancy. Clinical nursing staff are required to obtain a greater

diversity of skills to enable them to work in an environment that is often resource-poor. In the following discussion, these experiences are once again discussed as occurring in the phases of the process as ‘presenting as one’, ‘wanting recognition and inclusion’, ‘seeking support and understanding’, ‘leaving as one’ and ‘moving on’ (see Table 8.1).

Table 8.1: Nursing staff experiences when presenting to non-metropolitan emergency departments with vaginal bleeding in early pregnancy

Core category: providing optimal care in possible miscarriage		
Context: regional, rural and remote EDs		
Process: nursing staff experiences and expectations		
Category	Sub-categories	Codes
Presenting as one	Presenting to the non-metropolitan EDs	Establishing patterns of presentation The triage process Highlighting the differences
Wanting recognition and inclusion	Recognising the woman’s needs	Needing to wait Facing partner agitation Restrictive practice
Seeking support and understanding	Arbitrary practice	Being aware of the woman’s distress Remembering the Royal North Shore incident Feeling unsure and frustrated Care depending on personality Relating back to personal experience
Leaving as one	Preparing for discharge	Providing thoughts on education and information Arranging follow-up care Referring to metropolitan hospitals
Moving on	Working it out ourselves	Creative practice Making improvements

8.2 Presenting as One

The nursing staff who participated in this study highlighted the differences in service provision between metropolitan and non-metropolitan EDs and how these differences impacted on the care provided. Such differences can be observed in the approach to care for couples presenting

with threatened miscarriage. In the preceding chapters, women and their partners spoke of presenting as a single unit to the ED. However, nursing staff noted that while women and their partners presented ‘as one’, the care they provided as nurses focused solely on the women, with little acknowledgement of their partners.

8.3 Presenting to Non-Metropolitan Emergency Departments

On presentation to non-metropolitan EDs with first-trimester bleeding, the couple are met by the triage nurse and this begins the ED experiences of all three parties involved in the process. What follows is ‘establishing patterns of presentation’, ‘the triage process’ and ‘highlighting the differences’.

8.3.1 Establishing patterns of presentation

There are differing patterns of presentation for women who seek care for possible miscarriage in non-metropolitan EDs. The nurses in this study felt that the geographic location of the ED was one of the main contributing factors to how women present. Women either presented to the ED from the town in which they lived or they were transferred in from outer communities. Transport was either by car or plane. The women retrieved from outer rural communities were either taken straight to their nearest metropolitan hospital service or directly to their local non-metropolitan ED.

Vaginal bleeding was considered the main reason why these women presented to their local ED. Once the woman and her partner presented, they were introduced to ‘the triage process’.

8.3.2 The Triage Process

‘The triage process’ is dynamic according to the nurses in this study. It is also a demanding and complex role for any nurse. Triage sets the overall priority with which patients are seen within the ED, and has three main functions. The primary triage role is assessment and allocation of a triage category. The second role is to provide the initial treatment, such as pain relief, education and support. The third role is to provide continual assessment of those patients who are deemed not to require urgent care and are seated in the ED waiting room. The triage nurse must be skilled and must have the ability to assign an appropriate triage score for each patient in a timely manner. To establish which patients are seen first, the triage nurse needs to assess each patient and then assign a triage score depending on the patient’s need for care or urgency of care:

Basically when they present it's just it's just their triage category is ... I mean, it's determined by their pulse rate and their extent of bleeding so basically whether they're haemodynamically stable and their level of pain. [FN3]

If the woman presents to triage with heavy bleeding, pain and unstable observations, the triage nurse will assign a higher triage category and place the woman in a bed in the main department. Once women were assigned a bed they were automatically assigned a nurse to care for them during their time in the ED, a process described by this male nurse:

I know I have triaged many women who have quite heavy bleeding, I have had to give them a category two because they are so unstable and shocked even and so you know had to be escalated ... [MN1]

Yes, they are they are brought in, um ... provided there is rooms um ... if there um ... a bit more of a medical emergency obviously things might be different. They would go to the resus room or whatever it might be. Um ... but those who are relatively stable it's the waiting room. [MN1]

For the women who were assessed as being haemodynamically stable, there was often some indecision in assigning a triage score. The indecision related to knowledge that in assigning a lower triage acuity score the woman would need to sit and wait in the ED waiting room. Even when providing the women with a lower triage score the nurses often tried to get the women into the main ED department so that they could wait with some sense of privacy. This attempt was often fruitless because of limited physical spaces and the busyness of the ED:

If they weren't bleeding heavily, they didn't have very much pain, and they seemed to be coping okay they would likely be placed in a waiting room ... [although] I try really hard to get them into the department. [FN3]

Overall, the women's care in the ED was significantly influenced by the general business of the ED, that being, the prioritisation of patients regarding their need for medical intervention:

If I have a lady present with known pregnancy and PV loss um but no pain, I hate to say it but ... I don't like to generalise across a group of patients suffering a complaint but yeah um ... yeah I'm not in as much of a hurry and it also depends on the blood loss as well, so lots of factors that I try to take into account. [FN2]

Once the triage category was assigned the women were either allocated a bed in the department or informed to wait in the ED waiting room. While this is the normal process for EDs

throughout Australia, differences do occur for nursing staff working in non-metropolitan EDs. In ‘highlighting the differences’ between ED care in metropolitan and non-metropolitan EDs, the nursing staff also provided insight into the challenges faced by women in rural and remote locations throughout Australia.

8.3.3 Highlighting the Differences

Differences in non-metropolitan EDs relate to all aspects of healthcare provision, including staffing numbers, skill and ability levels and the everyday functioning of the ED that directs the type and level of care that could be provided:

In a small, in a small ED, I think it can make it a lot more difficult when we have, during the day, we have three nursing staff and so to put one in triage, then on the floor like we’ve got two so that makes, that makes the work load a lot bigger. But then again we kind of also at the same time we forget about maybe the triage is probably a third of your work anyway so you kind of ... it should be a third of your work if you’re doing all of the follow-ups and the monitoring. [MN2]

The more rural and remote the location of an ED, the more complex it becomes to provide efficient and effective ED care. Therefore, changes in processes are common, especially because of the reduced number of nursing staff working in the ED. As a result, some functions need to be absorbed, with nursing staff having to perform two or more roles. In metropolitan EDs a triage nurse is assigned for an entire shift, which means the nurse is able to focus on triaging the patients who present; but for staff working in remote EDs there are no nursing staff allocated to the triage role on any shift. This role then becomes a ‘roving position’, so any nurse on shift can triage a patient who presents to the ED:

It’s a roving position because we’ve only got the two on. We don’t, we don’t designate someone to, I mean you know we work as a team so whenever someone buzzes whoever’s not busy goes and answers the triage bell. [FN3]

The nursing staff also explained how not having an allocated triage nurse affects the overall function of the ED. There was a greater feeling of pressure in providing care especially for women who present with possible miscarriage, as this often required the nursing staff to ‘triage and treat’ their patients:

But more often than not I have to interrupt, go [to] triage quickly and come back out to that woman but you know that that issue is not isolated just to the early pregnancy loss; you know ... you know it's with doing anything ... [FN1]

The nursing staff explained the complex role of the GP in rural and remote areas of Australia and their need to split their time between private practice and the ED. In non-metropolitan areas of Australia GPs need to cover the ED 24-hours a day. This provides challenges for the nursing staff, who need to have the knowledge and skills to assess patients and predict when the medical staff are required:

And we have a medical officer assigned. He's present through the day until four and then after that it's like most rural hospitals [inaudible] hospital and we call our doctors as we need them. [FN3]

Some of the ED staff voiced their concern regarding the limited number of available GPs. The nursing staff felt stressed in having to work in an environment with limited resources. Decisions regarding the allocation of a triage score were relatively easy for patients who required urgent care, as they notified the GP for immediate assistance. For women who presented with possible miscarriage and who were haemodynamically stable, their care became more complex. The complexity related to the many factors that required consideration of how medical cover is provided, including when and where the women would be seen. Specialist services, such as early pregnancy assessment clinics that are provided in metropolitan EDs, utilising a multidisciplinary team approach, were not able to be provided in non-metropolitan areas because of limited funding and resources (both human and physical). If the women wanted these services, they needed to travel to their closest tertiary hospital to receive specialised care:

So there is no like an early pregnancy assessment. I know this seems like a ... for smaller areas there's no funding for that. [FN3]

In making the decision to assign a lower triage score the nursing staff understood that the woman would need to wait.

8.4 Wanting Recognition and Inclusion

'Wanting recognition and inclusion' describes the ability of nursing staff to recognise the needs of women who present with possible miscarriage. The nursing staff demonstrated a range of awareness in identifying the needs of women and those of their partners. The nursing staff also

explained their need for patients to recognise the limitations placed on them as staff working in regional, rural and remote locations.

8.5 Recognising the Woman's Needs

Unfortunately, even in 'recognising the women's needs' the staff were unable to address their psychological or emotional requirements because of the organisational workings of the ED. The nursing staff discussed how they understood the woman's and her partner's concerns regarding the need to wait, but felt there was not much they could do as they were restricted from a triage perspective, and this constraint influenced the care they were able to provide.

8.5.1 Needing to wait

The ED nurses recognised that there were times when patients needed to wait, especially when triaged at a lower acuity level. This was reinforced by the notion that there was not much medically that could be done for women who were possibly experiencing a miscarriage and were medically stable. The need to wait was not only influenced by the woman's presenting symptoms, but also by the overall business of the ED.

It depends on who is on in the night, how many people are in [needing to wait]. [FN1]

The lower end probably perhaps they could wait um an hour or two ... but the less serious patients, no there's often a wait. [FN4]

When informing the women that they needed to wait in the ED waiting room, the nursing staff felt it was necessary to apologise at the same time. There was an understanding by the staff, as stated by this nurse, that the women were already anxious and having to wait in the ED waiting room would add to the women's anxiety.

Um... [sigh] I, I feel bad for them if they have to wait. You know they're already coming in anxious about losing, potentially losing their baby. [MN1]

Um... well I guess obviously I'm apologetic to them on behalf of the service. [MN1]

Meeting the emotional needs of the women was difficult for the triage nurses in this study. When women were allocated a bed in the department they were assigned a nurse who would be able to meet the needs of the women from a holistic perspective. The women who were triaged and left to sit in the ED waiting room were felt to be at a disadvantage, as a holistic

approach to nursing care could not be provided. This often left the staff feeling frustrated, as a patient's physical needs always superseded a patient's emotional needs. Providing emotional care was, therefore, beyond what the triage nurse was able to provide.

As the women were required to wait, the nurses noted that their partners were anxious and that some became increasingly agitated the longer they had to wait.

8.5.2 Facing partner agitation

The nursing staff felt that the partners of some of the women were agitated and that they were angry because their partners had to wait. While acknowledging their agitation, the nurses talked of having to calm them down, which seemed to be met with more agitation the longer they had to wait:

Yeah so the partners can get um ... quite irate actually, they don't understand why, why their wives or girlfriends have to wait to be seen and for them it is a matter of urgency that they get seen by a doctor so um yeah a lot of the job does involve calming the husbands and boyfriends down ... [FN4]

The ED staff commonly experienced verbal abuse, but the anger never manifested in the form of physical or verbal abuse. Informing both the women and their partners that there was nothing that could be done and that they needed to wait was further met with partner agitation and displays of anger towards the ED staff. While staff felt they understood why the partners were angry, there was not much they could do, as the dominant discourse of the ED was focused on patient acuity levels and those that needed urgent medical care. Partner anger, while not acceptable to the triage nurse, was often expected, especially when the department was busy. While the nursing staff felt bad for the women and, to a lesser extent, the partners, they believed it was the woman who needed the care in the ED. In addition, these staff felt they were too time poor to provide the requisite care and that there was not much they could do to support the partners at the time—and did not know how to ameliorate the situation.

Further frustrations related to the 'restrictive practice' associated with caring for women in non-metropolitan areas of Australia.

8.5.3 Restrictive practice

Working in an environment that has many constraints was challenging for nursing staff. The restrictions they faced impacted on the care they were able to provide each woman who

attended their ED. Limited physical resources in the ED meant the women could not be placed in a private room or, at times, even a bed; there may not have even been an area that would provide privacy for the woman if she felt the need to cry. Limited specialist staff resources also caused restrictions in practice and this usually required the women to be transferred to the larger hospitals to be seen:

Yeah I mean ideally we would have somewhere to put them ... um ... where they could sit you know and have a cry with their partner or um ... not feel embarrassed about frequently going to the toilet and having to change their pads or um ... that would be ideal and I do think that we try and see them as soon as possible ... um ... whether or not the statistics reflect that or not I'm not quite sure. [FN4]

Other restrictions related to the limited equipment and human resources after hours and over the weekend. Staff working in regional, rural and remote EDs each day faced this challenge. If a woman needed an ultrasound during these hours they would have to wait, unless it was considered an emergency. The lack of resources caused frustration for staff, as the women became more anxious the longer they had to wait. On most occasions, the women had to wait until the next day or until after the weekend for an ultrasound:

So if have a lady come in, you know on a Friday night then she is not going to get see anybody possibly until the Tuesday ... of the following week, so that's difficult. So there is a gap there where women fall through over the weekend I think where they're left to sit at home and ... and um anxiously wait ... and all they really want to know is whether or not they're still pregnant. [FN4]

Environmental restrictions also meant that individualised care was not possible for those requiring attention to specific cultural and/or religious needs, for example, Aboriginal, Torres Strait Islander or Muslim women who required assessment by female staff. The ability to provide an all-female service was not always possible in non-metropolitan EDs, and this was frustrating for the nursing staff who participated in this study:

We you know, we're not able to provide always able to provide an all-female staff for patients and Indigenous women do prefer females and we do have a small Muslim population here as well too and we're not always able to provide a female staff member for them. [FN3]

Having to rely on medical staff was another restriction that the nursing staff spoke of in regard to caring for women in rural and remote communities. There was also increased pressure on the nursing staff because the GP relied on their assessment abilities in order for them to provide

medical care, as medical orders such as pain relief and sonography orders were often provided over the phone or via fax.

These restrictions left nursing staff feeling unsupported in their roles as nursing staff working in non-metropolitan EDs. They also felt they had limited understanding in the challenges they faced in their nursing practice.

8.6 Seeking Support and Understanding

‘Seeking support and understanding’ highlights the professional needs of nursing staff as they face the challenges of working in regional, rural and remote EDs. Some nurses emphasised their need for additional training in the care of women with possible miscarriage, especially for nursing staff new to the nursing profession. These staff in particular often relied on their own personal experience to provide nursing care to women facing pregnancy loss in their first trimester. Nursing staff identified that ‘arbitrary practice’ is problematic in rural and remote EDs, and these practices impact on the care provided to women.

8.7 Arbitrary Practice

Although nursing staff were ‘aware of the woman’s distress’, they felt they were unable to adequately address this, which left them ‘feeling unsure and frustrated’. The complexity of human nature often impacts on healthcare and can lead to arbitrary practice occurring in both metropolitan and non-metropolitan EDs throughout Australia. ‘Arbitrary practice’ explains how the provision of nursing care can depend upon past history (‘remembering the Royal North Shore incident’), personal experiences (‘relating back to personal experience’) and personality (‘care depending on personality’) when nursing staff have limited knowledge, skills and experience.

8.7.1 Being aware of the woman’s distress

Although the nursing staff recognised the woman’s distress, they felt they were limited in what they could do. The context of triage was a process that focused on the medical management of patients and, therefore, the patients who required urgent care were seen and triaged at a higher triage category. If women presented who were physiologically stable but emotionally distressed, they were not considered to require urgent care. In these circumstances, the triage nurse needed to follow process and triage women with a lower triage score. This resulted in

frustration, as the triage nurse felt stretched in terms of what options were available for providing the women with support:

Um ... to try to keep them comfortable while they wait um ... and I just say to them to let me know if um ... anything changes or if your bleeding heavily or you know if you've got more pain. [MN1]

I try and give them some pads as well and what I am doing is trying to maintain some privacy and some confidentiality for the patient. Um so reassurance, information, providing them with pads. [FN4]

There was also an understanding that some of the women who presented to the ED with vaginal bleeding in early pregnancy would continue on with their pregnancy until full term. Therefore, the nursing staff felt that providing reassurance was an important component of the care provided:

I guess you try and reassure them that some people have bleeding and everything's fine um ... because often they say I'm miscarrying and their crying um ... I guess you try and reassure them that it's okay. [MN1]

There was some understanding that different women required differing levels of support. Unfortunately, even in recognising this, the triage nurses felt restricted in what they could do for these women, apart from providing reassurance and trying to be as sensitive as they could:

Umm ... yeah then again with the reassurance. If I have a mum who is very anxious, that will affect and come into play so um ... [MN1]

But certainly we've um ... a young woman who is coming in, and looks like she is most likely having a miscarriage ... I certainly try and be more sensitive to their needs. [FN4]

Some of the nursing staff acknowledged that they felt that building rapport with the woman was a key component in the provision of care, but also recognised that this connection requires time, whereas, for the triage nurse, time is often a scarce resource:

Look you know it comes in really good, you know developing a rapport with those women ... good explanation of what goes to happen and what the anticipated outcomes is, you know, I think you know and I think if you can get that in and get your assessment in. [FN1]

Nursing staff also spoke of the need to be empathetic and to attempt to understand the woman's concerns from her perspective, although some of the staff spoke of not knowing how to respond at times—a common response for the male nurses who participated in this study:

I found it difficult for me to know how to respond to them so I just tried to I suppose keep a cool face and just look and just treat what I saw. I don't know I kind of just tried to get through it. [MN2]

Often the nurses felt that no matter what support they provided or how much they tried to be empathetic, the women continued to be anxious. Some of the nurses also felt that all nurses need to be aware of each woman's cultural requirements so that they can provide culturally specific care:

Yeah, and then to complicate things you know there's the Indigenous factor as well too and that's you know the vast majority of our women here as well. [FN3]

The nursing staff all felt the triage nurse's job was one of the most stressful in the ED. Being able to assess and prioritise patients in a short amount of time was an important skill for triage nurses. The triage nurse was very aware of the importance of their role and when they talked of triaging women with possible miscarriage they were all very aware of the incidents that have occurred in the past.

One of the most memorable incidents was the 'Royal North Shore incident'.

8.7.2 Remembering the Royal North Shore incident

All the nursing staff in this study remembered the Royal North Shore incident in which a woman miscarried in an ED waiting room toilet. The incident led to a government inquiry, and influenced the practice of EDs in metropolitan areas and, to a lesser extent, non-metropolitan EDs throughout Australia:

Um ... I guess they usually present with PV-bleeding um ... and then I guess my time, my experience has differed based on I'm sure, if you are aware of the Royal North Shore incident that happened in Sydney when someone gave birth/miscarried in the toilet. [MN1]

Since then obviously it has become a bit of a hot topic on about how we manage these patients. [MN1]

When I started at my emergency department, there'd been um... at another local hospital had been exposed for leaving a patient had a miscarriage in the um... waiting room toilets so as a result they released new protocols. [FN3]

The practice pre and post the Royal North Shore incident saw a move away from sitting women in the non-metropolitan ED waiting rooms to trying to place the women in a private room in the department. Although the staff noted that this was not always possible and a majority of the women triaged at a lower acuity level were still placed in the ED waiting room:

Say before the Royal North Shore incident, if they were haemodynamically stable and I guess their pain was not too bad or they weren't bleeding too heavily, they could probably sit in the waiting room to see the doctor like other people presenting with different issues um... and then and that would normally be the process. I think after the Royal North Shore incident there was I guess a bit of a change in process, I'm not sure if it happened in writing or not but there was a bit of a push with all people, sorry women presenting with um ... PV-bleeding in pregnancy you would not put them in the waiting room, there was a sudden increase to um ... to get them inside um ... and put them in a private room and document about um ... the social work involvement and things like that. I guess that there was a push to prevent something like that happening again. [MN1]

Although some of the nursing staff in this study could not remember the name of the incident, they were aware of the incident and were aware that it was the instigator of change in the way women were triaged with first-trimester bleeding in metropolitan EDs:

Look, I guess it's pretty good I think you know certainly it's you know you know we're all aware you know of the terrible things that have happened, you know. You know that women have gone to toilets while they're waiting in ED departments and you know have lost their you know lost their products in the toilet so we are all, so we really do try and get those women in very quickly. [FN3]

Other staff talked about the incident or similar incidents being 'hyped up' by the media and that the ED was doing exactly what it was meant to do in caring for women with possible miscarriage.

I mean I know there's a whole lot of media stuff about women, you know, miscarrying in the toilets and things like that and I can I feel like there's a bit of a media beat-up in a way. [FN2]

When talking about the 'Royal North Shore incident', the nursing staff also spoke of the importance in recognising the needs of women when presenting to the ED with possible

miscarriage. Unfortunately, there were times when nursing staff were not able to meet these needs and were left with limited options in caring for women with possible miscarriage, which led to 'feelings of frustration' in non-metropolitan EDs.

8.7.3 Feeling unsure and frustrated

There was a feeling of frustration by the nursing staff, especially as the women were being seen in an environment that is largely focused on medical management and was often arbitrary in its approach to care. The staff felt they were limited in what they could do for the women because of the physical and organisational constraints of the ED:

I feel that I get frustrated as a triage nurse that you can't sometimes um ... I guess make it go any faster, depending on what's going on in the department or maybe there's no beds or there's a huge queue. [MN1]

Time was one of the main constraints in the ED, and insufficient time led to feelings of frustration. Having insufficient time to review policies was one of the main causes of concern for staff who did not have the experience of caring for women with possible miscarriage. On these occasions, the nursing staff referred to the most senior staff for advice. When senior staff were not available, some of the staff talked of having to look confident and care for the women the best they could:

You know, I mean as soon as these cases come in where I kind of scratch my head a bit. I should be going straight on to the online [state government] website and looking up the guidelines just to give me a basic idea of what I should be looking for and the protocol that I should be going through. I think it's just a, it's a behaviour that I've never really I've never really established I suppose. I guess I feel like I'm so stretched where it is and that time of going online and looking it up and reading through it and then establishing that I guess for me I feel like sometimes I feel like that's time I don't have, but sometimes I just need to do it. [MN1]

The knowledge deficit noted by some of the nursing staff was the cause of inconsistency in the level and type of care provided to the women. Frustration resulted from the lack of time to support junior nursing staff. There was recognition that additional education was required, although to access this the staff needed to travel to the larger cities, and there was often a lack of relief staff and funding to support their professional development:

My knowledge is very similar when it comes to anything kind of peri-natal, I suppose. I know I've not much experience and it kind of scares me a little ... I don't feel like I had enough knowledge at all. I think it would definitely ... I would change my practice if I knew about it. [MN2]

Feeling unsure about what type of care to provide women and also not having personal experience to fall back on was a concern for some male nurses in particular. With their inexperience they stated further that they thought that it should be a female nurse who saw women with vaginal bleeding in early pregnancy.

Yeah, I don't know but it probably would have been better if it came from someone a bit more experienced and definitely a woman. I think would have helped a lot more or a man I think if he was more able to yeah I guess to have that discussion with a woman about her experience ... I guess a bit more at ease to give her more information about what was happening in the situation. [FN4]

Feeling unsure was not the only experience that nursing staff spoke of, they also explained that 'healthcare often depended on personality'.

8.7.4 Care depending on personality

Though medical management was the central component in the care of the women, the nursing staff felt that the type of care provided depended on the differing personalities of both the medical and nursing staff. For example, the ordering of investigations such as pathology testing or transabdominal or transvaginal sonography depended on the personality of the staff providing care at that time. Even the delivery of education and information was determined by the medical officer or nurse working in these EDs:

What I've found is that the care that's provided or the interventions that are provided are very arbitrary. There doesn't seem to be a standardised approach. And it seems that it's very much directed by whichever doctor happens to be on at the time whether it's within hours or after hours, whether it's a weekend and that can range from you know, doing nothing other than providing reassurance and saying you know just wait and see what happens ... come back if you're concerned, to doing you know everything from bloods and PV exams and ultrasound, admissions or transfers. [FN2]

Some of the staff were primarily focused on the physical aspects of their patients and did not focus on the emotional aspects of what the women were experiencing, while others were very

compassionate and took on a more holistic approach in providing medical and nursing care for the women:

Depending on the doctor that they get ah they're either dealt with very compassionately or it can be or the doctors can be quite abrupt with them. In so far as suggesting um ... that you going to have a miscarriage it going to happen so go home and get on with it essentially.
[FN4]

Personal experience was another influencing factor that impacted on the care provided to women in the ED. Staff often referred back to their own 'personal experiences' to guide the care they provided to women.

8.7.5 Relating back to personal experience

When some of the nursing staff in this study had adequate theoretical knowledge but limited nursing experience caring for women with first-trimester bleeding, they described 'relating back to personal experience' to provide care. Their lack of clinical expertise in providing care to women experiencing miscarriage in these cases was shaped by their own personal history:

Yep, Um ... I hadn't prior to starting in the ED despite having kids of my own; I hadn't had a lot of experience with miscarriage not having had much um ... gynaecological nursing experience ... apart from having my own babies. [FN4]

I guess I have a little bit more experience now that we've gone through it ourselves, me and my partner. [FN4]

Like I know that when I did miscarry in the hospital it was in the toilet 'cause that's where you go. But I did have a bed. [FN2]

The staff who had experienced a previous miscarriage or bleeding in early pregnancy, were able to empathise with the women and have an understanding of the anxiety they experienced. Unfortunately, for some of the nursing staff, their own personal feelings were difficult to escape when providing nursing care, and at times this was perceived as being uncaring:

I probably feel less personally affected by it because I am quite—not blasé it's not the right word ... but a little bit resigned to whatever happens in that first 12 weeks is kind of inevitable. [FN2]

Personal experience for the nursing staff not only related to experience with possible miscarriage but also experience with caring for the women who present to the ED. Past experiences also lead to some of the staff in this study making assumptions about the women who presented for care:

I mean I guess I had three miscarriages between my two girls so I kind of feel maybe I'm a little bit less sensitive because I wasn't overly damaged by it myself. [FN2]

Once medical staff had seen the women, they were prepared for discharge. Preparation for discharge was an important component of the care for women according to the nursing staff who participated in this study.

8.8 Leaving as One

Although the nursing staff made note that the women were often discharged with their partners and thus 'leaving as one', the focus of their care was again on the women. In 'preparing women for discharge', the nursing staff explained the process of discharge planning for women with possible miscarriage in regional, rural and remote areas of Australia. The nurses spoke of the frustration they faced in gaining services for these women on discharge, which often resulted in women being referred to larger metropolitan hospitals for specialised healthcare.

8.9 Preparing for Discharge

In discussing 'preparing for discharge', the nursing staff in this study provided their thoughts on education and information for women and their partners and the process involved in arranging follow-up care.

8.9.1 Providing thoughts on education and information

The provision of education and information for the women to take home and read is inconsistent in rural and remote nursing practice. Some of the nursing staff in this study regularly provided education and information to women, as they felt that this was an important aspect of care for the women. Other nursing staff did not regularly hand out literature to women to take home, as they felt it was not their job, believing it was up to the GP to provide this information:

Any miscarriage kind of education information material ... I've never given it. [MN4]

I think that um education ... is the responsibility for that education probably lies with their GP. [FN4]

Overall the nursing staff were satisfied with the literature they handed out to women, as it explained what may be happening, what to expect next and what they needed to do next, especially if they experienced complications. The nurses working in the more remote areas of Australia explained that the literature they handed out to women was from various sources, such as their tertiary referral hospital, Up-to-Date or other organisations (such as Pregnancy Loss Australia, who provide miscarriage packs):

Generally we'll get something off ... off you know off Up-to-Date or one of the ... you know ... like the some information from some of the bigger hospitals ... At least it gives them a bit of a framework to take home. [FN3]

There was concern noted by some of the nursing staff that the discharge literature utilised in some of the regional, rural and remote centres was taken from the larger metropolitan hospitals. This information related to the services provided in those EDs and some of the nurses thought that the information would not be appropriate for women living in non-metropolitan areas of Australia, as they did not have the same resources as those larger referral hospitals:

And then because, you know we don't you know we just don't have the resources to do things specific to this hospital. That's why we use a lot of that you know, a lot of the handouts and written information we give particularly to paediatrics and I think you'll find these obstetric point of view, too. [FN3]

Surprisingly, a small number of the nursing staff did not know where the literature was situated in the ED. In addition, some of the staff made assumptions regarding which women they would provide literature to on discharge and which women they would not. There was a feeling that some of the literature was not consumer-friendly towards some of the population of women they cared for, although they did not work to resolve this situation:

We rarely ... we rarely hand out pregnancy printed information to the Indigenous women. It's and you know because English is probably their third or fourth or fifth language up here. I know this is, it sounds, now that I'm saying it, it sounds incredibly discriminatory but you know, if they asked for it, we would certainly be happy to give it to them. But generally, it's and a lot of those Indigenous women that come in from out of town we would probably have them stay with us anyway, like they would stay in hospital to see what because we won't send them back out to a community out of town, back out, you know, 300 k [kilometres] in

case you know they did have you know a big bleed. So a lot of those women stay, and yeah, we always try to explain to them that it's a waiting game, we can't you know there's no guarantees and that. You know we need to do the, we need to do this blood test again in 72 hours and we'll wait and see and certainly women who want written information we do give that. [FN3]

Another concern of some of the nursing staff was that the women or patients in general were provided too much information; they felt that if the women really wanted to know something that they would either ask or search for it themselves at home via the Internet:

You know often I feel that women are bombarded with so much information and they often have questions down the track. [FN1]

Upon discharge women were generally provided with information, which included follow-up arrangements.

8.9.2 Arranging follow-up care

Follow-up care was arranged either by the medical officer or the nursing staff in the ED upon the woman's discharge. Follow-up usually occurred in one of three places: either returning to the ED for a planned review within the following 48 hours, by the GP, or referral to the nearest referral hospital. If women were seen in the ED over the weekend and were referred to see their GP for follow-up care, they then had to wait until the clinic opened at the start of the working week. At these times the nursing staff felt for the women, as they would have an anxious few days where they did not know what was happening to themselves or their pregnancy:

Most often they just get sent home and get told to either make another appointment with their GP or if they have one to keep it if it's within the week or to come back to the ED. And that if anything changes in the meantime ... if the pain gets worse or their bleeding gets heavier ... to come back again. [FN2]

Some of the women who were referred to the larger tertiary hospitals could be seen in the specialist clinics that are not offered in the more rural and remote areas of Australia.

8.9.3 Referring to the metropolitan hospitals

Within the larger metropolitan hospitals there is a wide variety of expertise, including obstetrics and gynaecology services, and also the extensive use of pathology and sonography services (24-hours a day). The larger tertiary services also have greater access to social workers to

provide women with the emotional support they needed. Because of these services, the nursing staff believed that referral to the larger centres would be beneficial for the women, but they also understood that being transferred required the women to be separated from their family and their support:

So our district hospital um ... we have a midwifery run birthing service um ... but we don't have an obstetrics or gynaecology, so um ... that along with a few other specialities need to be referred to the tertiary hospital. [FN4]

Where the early pregnancy assessment units/clinics get booked out the women may need to wait longer to be seen. According to the nursing staff, women usually do not want to be referred to the larger tertiary hospitals. Another concern is access block, which is the lack of inpatient beds. This impacts on the ED's ability to admit patients, and patients become backed up in the ED. Although this affects the larger metropolitan hospitals, there is an effect on the ability of regional, rural and remote to refer patients for additional services:

She did not want to go down to Melbourne and I don't know if I could have sold her and that another thing how do you sell 'em down to Melbourne ... and you know for me to transfer a patient down to Melbourne, if I can barely sell a fractured NOF [neck of femur] let alone an early pregnancy lady, it's very hard in fact I wouldn't be able to. [FN1]

While this is just one of the obstacles faced by nurses working in rural, regional and remote EDs, in general they have a 'never give up attitude' as they strive to provide the best care possible.

8.10 Moving On

'Moving on' explains the passion that regional, rural and remote nursing staff have in providing healthcare in their community, even though they are often faced with many challenges. Through determination and innovation, the nurses prided themselves on being able to work through any situation and providing the best care possible. The nurses spoke of having a 'can-do' attitude, but also wanting acknowledgement of their ability to 'work it out'.

8.11 Working it Out Ourselves

Challenges faced by nurses working in regional, rural and remote areas relate not only to limitations in services, resources and workforces, but also geographical and professional isolation. 'Working it out ourselves' explores how these nurses cope with the challenges they

face and how they overcome these challenges through ‘creative practice’. This includes their thoughts on ‘making improvement’ to the care provided to women who present with possible miscarriage.

8.11.1 Creative practice

‘Creative practice’ was common in the provision of healthcare in regional, rural and remote areas of Australia. The nursing staff in this study felt that creative practice was and is a necessary process in providing care. There was a strong feeling that local solutions should be provided for the local challenges faced by the people living and working in non-metropolitan locations of Australia. Unfortunately, the nursing staff felt that policymakers would often reject formal submissions that involved creative practice, leaving them feeling unsupported and frustrated. Creative practice is, therefore, rarely reflected in standard policy and procedures:

Sometimes not even having a bed to put them in, so we had to get creative on how we, how we um ... help those patients when they presented. [FN4]

So it’s not a protocol. The protocol is that if we’re concerned about anything they have to go to [the referral hospital] for assessment but often we’ll use our midwives because they’re there. [FN2]

Generally, the policy and procedures utilised in rural and remote EDs are developed by the larger metropolitan hospitals or the state and territory governments as clinical guidelines:

Policies comes from the bigger the big hospitals ... down south so we use the Royal Children’s and the Royal Women’s—yeah, we use their sites. [FN3]

While these policies and guidelines are suitable for the larger centres, they are commonly not suitable to the unique contexts in which regional, rural and remote EDs function. This situation drives the nursing and medical staff to creatively use what resources they have available to provide the best healthcare possible for all patients, such as described by this participant:

I’m also a midwife so if I’m on I generally like you know and we only have a staff of two on each shift so if I’m on I generally see those women and mostly you know I’ll talk to them at triage. [FN1]

We can call the midwives down and they’ll do a foetal heart assessment and a basic maternal assessment. [FN1]

In addition to creatively providing care for women who presented with first-trimester bleeding, nursing staff were also happy to provide their thoughts on whether improvements needed to be made.

8.11.2 Making improvements

The nursing staff in this study had many ideas for the improvement of care for women, many of which related to addressing the limited resourcing within which they had to operate. Suggestions made by the nursing staff for ‘making improvements’ included increasing the number of beds and staffing numbers in departments, having a separate room for women, and the provision of an adapted version of the early pregnancy assessment services that are provided in metropolitan hospitals. Participants suggested that such services could be staffed by local nurses and that midwives could be supported by telehealth. They also spoke of utilising policies and protocols that allowed for a standardised approach, and reducing the possibility of arbitrary practice:

I think it would be good in the service that I’m in if there was some kind of protocol that we followed so that everybody got the same. So that it wasn’t dependent on which doctor was on or whether ultrasound is available or not. That it was a standardised approach to everybody. [FN1]

An allocation to full time triage I think. That’s the best way to go. [MN2]

A small number of the nurses in this study felt that the current system worked well, especially since the addition of the NP role:

Um ... yeah it can make it difficult in that sense but I wouldn’t say that they are not managed well. I think that the system does work well um ... especially with the nurse practitioners that definitely makes it um ... quicker cause they would um ... pick them up over the medical doctors anyway generally as they would see them on the triage screen. [FN1]

8.12 Summary

Working in regional, rural and remote Australian EDs can provide challenges in the provision of healthcare that are not experienced by health professionals who work in metropolitan EDs. Emergency nursing staff are required to possess a greater diversity of skills that enable them to work in an environment that is often resource poor. The ED care of women experiencing miscarriage in early pregnancy is influenced by a complex interplay of both internal and

external factors. This interplay is even more complex in non-metropolitan EDs because of the limitations in service provision that affects the overall ability of nursing staff to provide care for these women.

This chapter has described the experiences of nursing staff who care for women who present to regional, rural and remote EDs with first-trimester bleeding. These experiences were explored through the possesses of ‘presenting to non-metropolitan emergency departments’, ‘recognising women’s need’, ‘arbitrary practice’, ‘preparing for discharge’ and ‘working it out ourselves’ as participants provided care for women who present to ED and progress through to discharge.

Chapter 9: Discussion

When a child loses his parent, they are called an orphan. When a spouse loses her or his partner, they are called a widow or widower. When parents lose their child, there isn't a word to describe them.

Ronald Reagan, October 1998

9.1 Introduction

The aim of this study was to examine approaches to care provided to women who present to regional, rural and remote EDs with first-trimester bleeding and possible miscarriage. Three participant groups were included: the women who presented for care, their partners and the nursing staff who provided the care. Multiple participant views informed the development of the theory entitled, 'threads of care'. This theory explains the adequacy, quality and expectations of the care provided. The provision of optimal care in possible miscarriage emerged as the core category in this grounded theory. The following discussion focuses on the key components of this theory that includes the experiences and expectations of the three participant groups. The purpose of this chapter is to present the findings of this research in the context of existing literature, and to highlight the theory's unique theoretical contribution to nursing knowledge using Swanson's middle range caring theory as a theoretical coding framework.

9.2 Providing Optimal Care in Possible Miscarriage

Women and their partners in this study attended their local ED in the hope they would receive the best care possible. Their presentation was often related to uncertainty associated with symptoms they experienced and their perceived meaning in respect of their health and the health of their pregnancy. According to Indig, Warner and Saxton (2011) and Warner et al. (2012), the most common presenting symptoms in miscarriage include abdominal pain, vaginal bleeding and an overall concern for their pregnancy. Complications in early pregnancy are usually both physically and psychologically traumatic experiences that can generate high levels of anxiety (Kersting & Wagner, 2012; Limbo, Kobler, & Levang, 2010; Wright, 2011). This anxiety often relates to the threat of loss, the uncertainty of the outcome and not knowing whether to remain hopeful or if they should begin to grieve (Thorstensen, 2000). Women and their partners experiencing this possible pregnancy loss require specialised care, as the nature

of this loss is unique. In perinatal bereavement, parents not only lose their baby but also their dreams and joy at the prospect of a new life, which ultimately turns into despair (Callister, 2006). Lovell (2006) wrote that miscarriage, especially in early pregnancy, is located at the bottom of the 'bereavement heap', resulting in an inequality in the way society and health professions provide care. Unfortunately, this inequality is still evident in today's society and in contemporary nursing practice.

Women experiencing the possibility of miscarriage in the non-metropolitan EDs are often disadvantaged because they are placed in an environment that has limited resources, both physical and human (Indig et al., 2011; Bourke & Wood, 2009; Warner et al., 2012). In addition, the business and busyness of the ED is not an ideal environment when caring for women who are experiencing possible pregnancy loss. A study by Jansson and Adolfsson (2010) found that women experiencing the possibility of miscarriage require their feelings and fears to be recognised by the nursing staff in the ED. Unfortunately, this can be difficult for nursing staff in the ED, especially non-metropolitan EDs where staff are working roving triage positions (Indig et al., 2011; Jansson & Adolfsson, 2010). Triage staff have a limited amount of time to spend with each patient, and this can often be perceived by women and their family as being insensitive (Frost et al., 2007; Indig et al., 2011). Further, limited privacy and confidentiality has also been shown to increase women's anxiety and stress (Bourke & Wood, 2009; Geller, Psaros, & Kornfield, 2010; Indig et al., 2011; Warner et al., 2012). Warner et al. (2012) add that having limited to no privacy or confidentiality tends to leave women feeling as though they do not belong in the ED. A study by Zavotsky, Mahoney and Keeler (2013) found that staff in the ED often find it difficult to help women and their families deal with the psychological trauma associated with early foetal demise. This difficulty arises as emergency nurses are used to dealing with rapidly changing life and death situations (Zavotsky et al., 2013). Overall, the hospital experience for women and their partners has been shown to be an important component in their miscarriage experience and the woman's and her partner's ability to move forward (McLean & Flynn, 2012; Rowlands & Lee, 2010).

The core category, providing optimal care in possible miscarriage, denotes the care that both women and their partners require and expect when they present to non-metropolitan EDs. Optimal care delivery in possible miscarriage in regional, rural and remote EDs recognises the needs and expectations of both the women and their partners, and is reliant on the experience of the nursing staff providing the care. To explain the relationship between this core category and all other categories, theoretical coding has been utilised.

Theoretical coding is ‘the use of advanced abstractions to provide a framework for enhancing the explanatory power of the grounded theory’ (Birks & Mills, 2015, p. 181). In achieving this, it is important for the researcher to understand that substantive codes ‘break down or fracture the data’, while theoretical codes ‘weave the fractured story back together’ into an organised theory (Glaser, 1978, p. 72). Further, Birks and Mills (2015) have clarified that in applying the work of others to the developed storyline, the researcher is able to validate, support or augment existing theories in nursing to explain or reinforce the value of the researcher’s developed theory. Glaser (2005) has explained that using theoretical codes in this way ensures that the process is a reciprocal one, with the shared aim of expanding knowledge.

The application of previous theoretical knowledge provides a theoretical framework to interpret, describe and explain the grounded theory (Birks & Mills, 2015; Hernandez, 2009). Swanson’s middle range caring theory will be applied to this study’s findings as a theoretical coding framework that will expand and explain the concept of optimal care delivery in possible miscarriage. Caring is central to nursing practice and Swanson’s middle range caring theory provides a link between this process and patient well-being (Bacidore et al., 2009; Swanson, 1991; Tonges & Ray, 2011).

9.3 Swanson’s Middle Range Caring Theory

Kristen Swanson’s middle range caring theory in nursing practice describes nursing as being informed care for the well-being of others (Swanson, 1991). Swanson’s caring theory postulates that nurses need to demonstrate compassion in the care they provide patients, and this compassion is as important to patients’ well-being as the clinical activities that are required to be performed (Swanson, 1991; Tonges & Ray, 2011). While this theory was developed in 1991, there has been a resurgence in its use, as it has been shown to be an effective and sensitive guide for nursing staff in the care of women who have experienced miscarriage (Jansson & Annsofie, 2011; Swanson, Karmali, Powell, & Pulvermakher, 2003). In 2011, the theory was revitalised and used in a study by Jansson and Annsofie (2011) to improve the care of women in Sweden who had suffered early miscarriage where it was shown to be an effective theory for practice.

In her original work, Swanson studied the experiences of women who miscarried, parents whose children required neonatal care and women who experienced high-risk pregnancies (Swanson-Kauffman, 1986; Swanson, 1991, 1993; Swanson et al., 2003). Swanson’s middle

range caring theory inductively provides a link between the caring process and patient well-being (Tonges & Ray, 2011). In caring for women who present to the ED with possible miscarriage, it is important that nursing staff know and understand what women and their partners need in regard to the care they receive. Swanson's theory encompasses five processes of caring, which include 'knowing', 'being with', 'doing for', 'enabling' and 'maintaining belief' that leads to client or patient well-being (Jansson & Annsofie, 2011; Swanson, 1991). While the five processes are discussed individually, none are mutually exclusive, in the same way that one pattern of knowing in itself will not uncover all knowledge required (Tonges & Ray, 2011). Swanson's theory will now be compared with the findings from this study. Figure 9.1 provides a diagram that illustrates Swanson's concepts and their relationship with the theory of threads of care. This application of extant theoretical knowledge provides a framework to interpret, describe and explain this grounded theory (Birks & Mills, 2015; Hernandez, 2009).

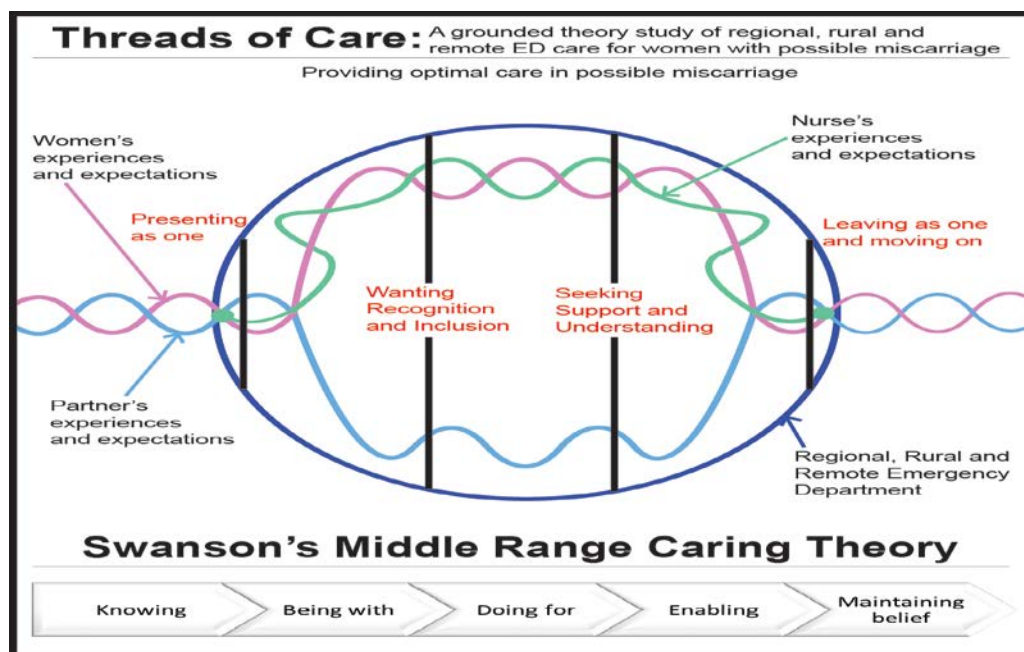


Figure 9.1: Threads of care grounded theory and Swanson's middle range caring theory.

9.4 Presenting as One and 'Knowing'

'Presenting as one' for the women and their partners in this study incorporates the joint decision to present to their local regional, rural and remote ED with concerns of possible miscarriage. Both the women and their partners presented with fear and anxiety that something was with

wrong with their pregnancy. Upon arrival to the ED they hoped they would be met by staff who were compassionate and understanding. According to Swanson, ‘knowing’ illustrates the woman’s desire to be understood by nursing staff regarding the significant loss in her life (Swanson, 1991). Swanson identified ‘knowing’ as first in the caring process that highlights the woman’s desire to be understood for her experience (Swanson-Kauffman, 1986; Swanson, Connor, Jolley, Pettinato, & Wang, 2007; Swanson et al., 2003). How care is provided to women and their partners by nursing staff is crucial to their overall experience and their ability to move on from their loss (Frost et al., 2007; Geller et al., 2010). The attitudes, behaviours and helpfulness of the nursing staff is often related to the women’s perception of how well they have been cared for (Geller et al., 2010).

Women do not want to be made to feel that what they are experiencing is routine, and that the magnitude of their loss or potential loss is ignored and ultimately not worthy of acknowledgement by nursing staff (Frost et al., 2007; Geller et al., 2010; Stratton & Lloyd, 2008). ‘Knowing’ enables women to feel they are not alone and that they are in the right place where their needs are just as important as other patients in the ED. A study by Geller et al. (2010) found women often felt dissatisfied with their ED experience, especially when having to wait, and they perceived this as the nursing staff being insensitive to their needs. Both the women and their partners need understanding and reassurance that they are in fact in the right place and they are not considered a burden (Thorstensen, 2000).

For women, ‘knowing’ ensures that nursing staff understand that their loss or their potential loss was more than just an embryo or foetus—it was her baby (Adolfsson, Tullander-Tjornstrand, & Larrsson, 2011). Geller et al. (2010) found in their study that the attitudes of staff and their level of helpfulness has been shown to directly impact on the woman’s perception of the care she receives and how well the providers acknowledge the magnitude of what she is experiencing. Further, the loss of an infant during pregnancy clearly distresses the woman and can ultimately place a strain on her relationship with the father (Kersting & Wagner, 2012). McLean and Flynn (2012) reported in their study that women felt unsupported by healthcare professionals and these feelings have been identified in other research (Rowlands & Lee, 2010; Séjourné, Callahan, & Chabrol, 2010a). Importantly, in this study it was not only the women that felt misunderstood and unsupported, but also their partners.

Unfortunately, miscarriage is often not seen as an issue for partners (the men) especially as ED nursing care focuses on the care of the woman (Douglas & Fox, 2009; Rinehart & Kiselica,

2010), as noted in this study. Therefore, 'knowing' needs to extend to the partner, in which their experiences and expectations are recognised along with the woman's, as they are both experiencing the loss or possible loss of their baby (Séjourné et al., 2010a). Kersting and Wagner (2012) have explained that the loss of a child is recognised as difficult and unique, with complicated grief reactions affecting the psychological and physical well-being of an individual. Perinatal loss, although relatively common, is often not acknowledged by society and health professionals, and even less so for men (Rinehart & Kiselica, 2010). O'Leary and Thorwick (2006) have explained that men often do not outwardly show or display signs of grief, as they tend to be less expressive, less self-disclosing and less interdependent than women. This tendency can be a result of biology and/or societal expectations (O'Leary & Thorwick, 2006). Additionally, societal pressures result in men being expected to recover quickly and be a support for women (Kersting & Wagner, 2012; O'Leary & Thorwick, 2006). According to Rinehart and Kiselica (2010), men also feel they should abandon their sense of loss and grief so that they can better support their partner. 'Knowing' focuses on the provision of the individualised care that is particularly important for men at this time, as their feelings are overlooked, even though they are equally deserving of care (O'Leary & Thorwick, 2006).

For nurses, 'knowing' encompasses the provision of woman-centred, individualised and continuous care, along with maintenance of nursing knowledge and skills (Jansson & Annsofie, 2011; Swanson, 1991). 'Knowing' also incorporates knowledge-based observations, careful systematic research and/or repeated clinical experience that incorporates empathy, understanding, patient-centred care and the avoidance of preconceived ideas that are not helpful for women or their partners (Jansson & Annsofie, 2011). Lastly, Swanson (1991) has highlighted that it is the care provider who plays an important role in the care of both women and their partners in alleviating the experience of miscarriage. Reflection on their role in this process brings nursing staff closer to an understanding of what is known and not known and ensures the provision of the best possible care (Jansson & Annsofie, 2011).

9.5 Wanting Recognition and Inclusion and 'Being With'

The process of wanting recognition and inclusion for the women in this study incorporated a necessity for nursing staff to recognise their needs and expectations while in the ED. According to McLean and Flynn (2012), women often feel they are not acknowledged or supported by the nursing staff during their time in the ED. These feelings often resulted from a limited lack of compassion and sympathy (Callister, 2006; McLean & Flynn, 2012; Séjourné, Callahan, &

Chabrol, 2010b). Swanson (1991) has explained that 'being with' is a process that illustrates the woman's need to have others feel 'with' her and not 'for' her. Women have reported dissatisfaction with their overall care and a perceived discrepancy between their own feelings and that of the nursing staff (Olson, 2013). This perception results in disconnection between the nursing staff's sense of what is important and that of the woman in relation to her possible miscarriage and sense of loss (Olson, 2013). McLean and Flynn (2012) found that women felt that nursing staff played an important role in how their miscarriage experience was shaped—specifically, that the more compassion, sympathy, acknowledgement and offers of support that were provided, the better the woman's experience was. Unfortunately, medicalisation of women's health has resulted in miscarriage being seen as a brief event that may or may not need intervention (especially in the ED, McLean & Flynn, 2012). A study by Frost et al. (2007) found that this medicalisation removes or detracts from the psychological complexity of miscarriage and reduces the social, emotional and practical consequences beyond the physical needs of the woman. In addition, there is reduced ability of staff in the ED to 'be with' a woman because of ED processes. This ultimately leads to women feeling excluded or unrecognised in her own care (McLean & Flynn, 2012). Unfortunately, as discussed in Chapter Six, this was the case for women in this study who felt that they were not recognised or included in their own care.

'Being with' is also an important component of care for men, especially given they are often disregarded by both the health profession and society. O'Leary and Thorwick (2006) found in their study that society tends to marginalise the father's role in not only childrearing but also pregnancy loss. Unfortunately, in being marginalised, men have no socially acceptable outlet for their very real emotions regarding their loss (Rinehart & Kiselica, 2010); these findings were also highlighted in the preceding chapter. Puddifoot and Johnson (1997) found that male partners were overlooked in the event of miscarriage and that their role was that of support to the woman. Studies by Kersting and Wagner (2012), O'Leary and Thorwick (2006) and Stratton and Lloyd (2008) have found that these expectations persist, as men are still delegated the role of 'support person', and while men do not outwardly display grief, their experience is no less than that of a woman. While it is recognised that men and women grieve differently and are faced with differing societal and cultural expectations, men still require recognition and support from the nursing staff in the ED (Bryant, 2008). This failure to be recognised when women present to the ED with their partners can lead to men feeling excluded, diminished, disregarded and disenfranchised with the healthcare system (Bryant, 2008; Rinehart &

Kiselica, 2010). In being treated this way by nursing staff, the partners were left anxious and angry, and often this anger was directed towards the nursing staff—a situation that was borne out in this study. Ultimately, emotional support is a key component in the provision of optimal nursing care for women experiencing pregnancy loss, and the provision of such support and understanding to the partner will ultimately assist the woman when they are discharged from the ED, especially in non-metropolitan areas of Australia (Warner et al., 2012).

According to Swanson, ‘being with’ involves the nursing staff being emotionally present when caring for patients (Jansson & Annsofie, 2011). When nursing staff are ‘being with’ a woman, there is an assurance that the woman’s reality is appreciated and that the nurse is ready and willing to be there for her (Swanson, 1991). In the ED, care focuses on the woman’s physical condition and her diagnosis (Jansson & Annsofie, 2011). However, to be with someone is to give time, authentic presence, attentive listening and contingent reflective responses (Swanson, 1991). ‘Being with’ requires effective communication, including the ability to listen (Swanson, 1991; Swanson et al., 2003). To actively listen, the nurse needs to not only hear, but also interpret what is being said, and to be sensitive to both vocal and non-vocal cues (Randolph, Hruby, & Sharif, 2015). For both the women and their partners the possibility of loss was often devastating, as it signified the death of their child and it is at this time that women and their partners need to feel that someone understands and is there to support them both (Abboud & Liamputtong, 2003; Indig et al., 2011; Murphy & Philpin, 2010; Petrou & McIntosh, 2009).

‘Being with’ is an important component of nursing care. The results of this study support the importance of this process, as possible miscarriage is an unanticipated event during which both women and men need nursing staff to provide both care and support (Lok & Neugebauer, 2007; Luczak-Wawrzyniak, Czarnecka-Iwanczuk, Bukowska, & Konofalska, 2010). Regardless of the number of miscarriages that a woman and her partner have experienced, there is a need for comfort to be provided, especially when both are feeling that they are unprepared for the experience (Brier, 2008). Unfortunately, as was found in this study, nursing staff can often be time and resource poor, which ultimately affects their ability to ‘be with’ the woman and their partner, especially at triage. Further, this study highlighted a disconnection between the women, their partners and the nursing staff. Overall, the women in this study required nursing staff to not only ‘be with’ them but also to ‘be with’ their partners, as they both were anxious and concerned about the life of their baby (Callister, 2006; Geller et al., 2010).

9.6 Seeking Support and Understanding and ‘Doing For’

Women attending their local ED not only require medical and nursing care, but also support and understanding when they experience possible miscarriage. Randolph et al. (2015) found that these women find empathy, sympathy and reassurance invaluable. Unfortunately, women find that their treatment in the ED lacks compassion and regard for their emotional needs (Anderson & Malone, 2014; McLean & Flynn, 2012). Swanson (1991) explained that ‘doing for’ includes the provision of comfort and dignity while anticipating the nursing care necessary for women who present to the ED. ‘Doing for’ also incorporates the ability to provide empathy, sympathy and reassurance, for which effective communication is necessary (McLean & Flynn, 2012). A study by Rowlands and Lee (2010) found that women sought sensitive and supportive care that included the provision of timely information. Overall, women want care provided by competent staff with an attitude that is helpful, supportive and without the provision of any insensitive comments (Geller et al., 2010). The importance of sensitivity when communicating has been found to be highly valued by both women and their partners, especially while in the ED (Mulvihill & Walsh, 2014). The women in this study took notice of the way the staff communicated with them and how they answered their questions. Poor communication between the women and the staff who provided the care often resulted in the women feeling that the nursing staff were not compassionate, empathic or understanding (McGee, 2013). Mulvihill and Walsh (2014) and Rowlands and Lee (2010) found in their studies that staff who were sensitive gave women a sense of belonging, while simultaneously preventing them feeling alienated.

Gender impacts on the provision of healthcare and affects the way nursing staff communicate and provide nursing care (Liuccio, 2015). Unfortunately, as has been a common theme in this discussion, miscarriage is not considered an event for men, who are often considered by society as the caretaker of their partner (Rinehart & Kiselica, 2010). Therefore, their grief and loss go unnoticed, and in turn the effect can be profound, leading to misunderstanding and relationship breakdowns (Douglas & Fox, 2009). In ‘doing for’, nursing staff should not overlook the men during this time of possible loss. They need to ensure that the men are treated with the dignity and respect they deserve as the woman’s partner and the father of the baby. ‘Doing for’ should incorporate the provision of support and understanding by the nursing staff through effective gender-specific communication (O’Leary & Thorwick, 2006). Nursing staff need to recognise that the partner’s struggle to remain strong and unemotional can lead to displays of aggression resulting from cultural conditioning by society and their feeling of a lack of control (McCreight,

2004). Providing information that is factual can assist the partner in understanding what is occurring and that their feelings of loss are normal for both themselves and the woman (O'Leary & Thorwick, 2006).

'Doing for' is an important process in caring for the women, as it is an active task. According to Swanson (1991), the key skills of 'doing for' include comforting, communicating, anticipating, performing competently/skilfully, protecting and preserving the dignity of women. These skills also ensure that nursing staff are able to provide appropriate care (Swanson, 1991). The maintenance of knowledge and skills is very important in caring for women and their partners (Swanson, 1991). Some of the nursing staff in this study experienced discomfort in caring for women with miscarriage, which, according to Evans and Read (2015), can be described as 'role uncertainty'. This uncertainty, especially for junior nursing staff, left them feeling incompetent in their ability to care for women and their partners during their time of loss (Evans, 2012; Wallbank & Robertson, 2008).

Understanding the emotional impact and significance of first-trimester bleeding and loss can assist the health professional in meeting the needs of women and their partners (Thorstensen, 2000). It was clear from this study that although nursing staff were aware of the psychological impact that miscarriage has on women, there was an obvious inability by them to meet these needs, for a variety of reasons. This inability affected the nursing staff's ability to 'do for' the women and partners who presented to their EDs. Further, inexperience led to staff utilising their own personal experience to influence the care they provided. Murphy and Merrel (2009) have explained that staff often utilise their own perceptions of miscarriage to influence the care they provide. According to Séjourné et al. (2010b), support techniques should include cognitive behavioural therapy, including cognitive reframing. Experiences of grief may be further impacted by nursing staff who mean well but often say something that may be perceived as insensitive. These insensitive statements may lead to women experiencing feelings of anger, frustration, isolation and rejection (Douglas & Fox, 2009). Further, nursing professionals working in non-metropolitan EDs need to assume various roles in the ED when caring for patients, especially those who have experienced a loss or possible loss in pregnancy (Bryant, 2008).

9.7 Moving On and Maintaining Belief

‘Moving on’ identifies the woman’s and her partner’s ability to move forward from their experience of loss. Their capacity to move on is influenced by their experience in the ED, the nursing care that is provided, their understanding of miscarriage and their ability to grieve both as individuals and together as parents. ‘Maintaining belief’, according to Swanson (1991) and Jansson and Annsofie (2011), means that the woman and her partner have the capacity to pass through the experience and see the future as meaningful. ‘Maintaining belief’ is the foundation of nursing practice in which nurses strive to ‘know’, ‘be with’, ‘do for’ and ‘enable’ (Swanson, 1991).

For optimal care to be provided in the context of this study, each woman and her partner need to have their expectations met (‘doing for’, enabling and ‘maintaining belief’) and for their experiences to be acknowledged (‘knowing’ and ‘being with’). In providing the optimal care in non-metropolitan EDs, nursing staff must have awareness of these experiences and expectations so that they can provide the best care possible. The fifth process of ‘maintaining belief’ is a fulfilment of these expectations that can only be achieved if they are realistic and achievable.

9.8 Summary

Pregnancy loss is an experience that can have emotional and psychological consequences for women and their partners. Therefore, it is important that the nursing care that is provided meets their expressed and unexpressed needs and expectations. Swanson’s middle range of caring theory addresses the need for nurses to be emotionally present, respectful, competent and focused on meeting the needs of women and their partners. The provision of optimal nursing care requires nursing staff to have the knowledge, skills, understanding and ability to provide the best care they can by acknowledging and respecting the needs of women and their partners during their time of loss.

Chapter 10: Conclusion

Without change there is no innovation, creativity, or incentive for improvement. Those who initiate change will have a better opportunity to manage the change that is inevitable.

William Pollard (1828–1893)

10.1 Introduction

Grounded theory gives the researcher the ability to tell the story of the participants and their lived experiences regarding the phenomenon being explored. In nursing, research provides opportunity to accumulate knowledge that can influence and improve practice. The purpose of the research presented in this thesis was to explore and explain the experiences of women and their partners who present to regional, rural and remote EDs with possible miscarriage, along with the perspectives of the nursing staff who work in that context. The grounded theory developed as result of this study is evaluated in this final chapter to reinforce its contribution to existing knowledge. The implications of the findings, limitations of the research and recommendations for further study are also presented for consideration.

10.2 Returning to Where it Began

Looking back to the beginning of this study, I set out to examine the experiences of women and their partners who presented to non-metropolitan EDs with possible miscarriage. Adequacy and quality were examined in relation to current ED models of care, along with the expectations of these participants. Experiences of the nursing staff were compared with those of the women and their partners; differences were highlighted and a grounded theory was developed that explains the experiences of women, their partners and the nursing staff who provide the care.

The research was guided by the following questions:

1. How do women and their partners experience current approaches to care when presenting to non-metropolitan EDs with first-trimester bleeding?
2. How do staff experience caring for these women and their partners?
3. What factors influence expectations and experiences of the women, their partners and nursing staff in these circumstances?

The above questions were addressed in the findings presented in the preceding chapters. In the following discussion, the quality of the processes and products of this research will be considered to reinforce the value of these findings.

10.3 Evaluating the Quality of This Research

When examining the quality of grounded theory research, consideration should be given to the audience for which it is intended, as they will judge its usefulness and quality of the final product (Charmaz, 2006; Elliott & Lazenbatt, 2004). According to Charmaz (2006), the evaluation process incorporates an exploration of where the grounded theory journey has taken the researcher and what has been gained as a result. The criteria for this evaluation depend on who forms them, and for what purpose (Charmaz, 2006). Creswell (1998) has suggested that rigorous enquiry, systematic procedures and specific methods underlie the generation of a grounded theory. The theory should relate to the phenomenon being explored, clarify the categories that emerge during analysis of the data and indicate the relationships between them (Creswell, 1998). Birks and Mills (2015) have suggested that being rigorous in conducting the research is necessary to ensure that the outcome is credible. These authors proposed that a number of factors influence the quality of grounded theory research, including researcher expertise, methodological congruence and procedural precision. The following discussion will reflect on the process of this research using these criteria, augmented by consideration of credibility and auditability.

10.4 Researcher Expertise

There are a number of conditions that foster quality research, including the personal and professional characteristics of the researcher (Corbin & Strauss, 2008). Birks and Mills (2015) have added that ‘self-awareness, clarity of purpose, commitment to hard work and internal motivation’ (p. 35) are examples of the personal and professional characteristics that foster quality in research.

My area of interest has always been focused on emergency nursing and providing quality care. For quality nursing care to be provided, there must be evidence to support practice. Therefore, my transition from nursing practice to nursing research was logical. While this shift in focus sounds relatively easy, it has involved considerable work and, at times, has necessitated that I overcome self-doubt. From the day I first commenced this study, I have endeavoured to read widely and extensively to gain an understanding of grounded theory and its essential methods.

Understanding and applying the essential methods of grounded theory was necessary to ensure that I developed a theory that would be useful for those who could benefit from it most. Drawing on questions posed by Birks and Mills (2015), Table 10.1 summarises how researcher expertise is demonstrated in this grounded theory study.

Table 10.1: Evidence of researcher expertise.

Quality question	Evidence supplied
Does the researcher demonstrate skills in scholarly writing?	This is evidenced throughout, and particularly by the peer reviewed papers in earlier chapters of this thesis.
Is there evidence that the researcher is familiar with grounded theory?	Evidence is provided in Chapters Three and Four and in the generation of theory with explanatory power presented in Chapters Five through Nine.
Has the researcher accessed and presented citations of relevant methodological resources?	Citations of relevant methodological resources are provided through this research, most particularly in Chapters Three and Four.
Are limitations in the study design and research process acknowledged and addressed where possible?	Limitations in the study design and the research process are discussed later in this chapter.

10.5 Methodological Congruence/Credibility

Methodological congruence is the foundation for a credible research project (Birks & Mills, 2015). In this study, data gathered from the interview process were analysed through constant comparison with the construction of the categories and sub-categories. Chiovitti and Piran (2003) have asserted that letting participants guide the research process can enhance credibility. Additionally, Strauss and Corbin (1990) have stated that grounded theorists can add to the credibility of the grounded theory by using the words of the participants in the theory. This thesis provides links between the data and the final thesis through the provision of excerpts from the interviews and the development of the categories and sub-categories. These categories provided insight into the data that informed their development.

According to Glaser and Strauss (1967), credibility occurs when grounded theory is generated from data that has been obtained from those who have lived the experience. Achievement of credibility occurs when the researcher reviews the individual transcripts and looks for similarities within and across study participants (Cope, 2014; Thomas & Magilvy, 2011). Chiovitti and Piran (2003) have explained that credibility is demonstrated when participants

and readers of the research recognise the researcher's described experiences as their own. In my own research, I was able to ensure the generated theory resonated with the participants of this study by seeking participant feedback. According to Thomas and Magilvy (2011), informant feedback is the process of returning to the participants from whom the data was gained to ensure that the interpretation of their data is an accurate representation of their experiences. While no feedback was received that indicated the theory was not a reflection of their experiences, one participant did respond by stating:

I feel the model you present represents what my wife and I went through for each miscarriage and ... Hopefully this will assist nursing staff in realising that a fresh approach needs to be considered that includes both parents.

Table 10.2 summarises how methodological congruence is demonstrated in this grounded theory, again using the criteria proposed by Birks and Mills (2015).

Table 10.2: Evidence of methodological congruence and credibility.

Quality question	Evidence supplied
Has the researcher articulated their philosophical position	The researcher has outlined her philosophical position in Chapter Three.
Is grounded theory an appropriate research strategy for the stated aims of the study?	Chapter One provides the aims of the research and Chapter Three discusses the appropriateness of grounded theory to address these.
Do the outcomes of the research achieve the stated aims?	The findings are provided in Chapters Five, Six, Seven and Eight.
Is a grounded theory presented as the end product of the research?	The grounded theory is presented in detail in Chapters Five through Eight and explained through the use of theoretical coding in Chapter Nine.
Are philosophical and methodological inconsistencies identified and addressed?	Philosophical and methodological inconsistencies are identified and addressed in Chapter Four.

10.6 Procedural Precision/Auditability

Procedural precision, according to Birks and Mills (2015), is the ability to 'maintain an audit trail, manage data and resources and demonstrate procedural logic' (p. 37). Auditability, according to Cooney (2011), is the maintenance of comprehensive records regarding the methodological decisions that were made, sampling and analytical decisions. This has been

described as the ‘audit trail’ (Cutcliffe & McKenna, 1999; Cooney, 2011). Cooney (2011) has suggested that while grounded theorists do not make reference to audit trails, they do use memos to record all methodological and analytical decisions. These memos should be sufficiently detailed so that a reviewer can make judgments about components of the research process (Cooney, 2011). The use of memos is a critical element in the promotion of quality in grounded theory (Birks & Mills, 2015).

Throughout this research, I consistently used memoing to explore my thoughts and make comparisons and connections within the data. Memoing assisted in guiding my data collection, coding and analysis (Birks, Chapman, & Francis, 2008). This process also helped raise the data to a conceptual level, developing the properties of the categories and providing a record of analytical progress (Charmaz, 2006). The developed memos kept a record of my thoughts, feelings, insights and ideas in relation to the application of the essential methods in this grounded theory (Birks & Mills, 2015).

Table 10.3 provides evidence of how the criteria of procedural precision and auditability were met in this research using the final set of questions posed by Birks and Mills (2015).

Table 10.3: Evidence of procedural precision and auditability.

Quality question	Evidence supplied
Is there evidence that the researcher has employed memoing in support of the study?	Evidence of memoing is provided in Chapter Four.
Has the researcher indicated the mechanisms by which an audit trail was maintained?	Decision-making throughout the research design is presented in Chapter Four.
Are procedures described for the management of data and resources?	These procedures are described in Chapter Four.
Is there evidence that the researcher has applied the essential grounded theory methods appropriately in the context of the study described?	Chapter Three demonstrates the researcher's understanding of the essential grounded theory methods and their application is described in the context of the study design in Chapter Four.
Does the researcher make logical connections between the data and abstractions?	These connections and abstractions can be observed in Chapters Five, Six, Seven and Eight.
Is there evidence that the theory is grounded in the data?	Chapters Five, Six, Seven and Eight provide evidence of the connection between the data and abstractions.
Is the final theory credible?	The theory meets the definition of credibility proposed by Glaser and Strauss (1967) in that it is generated from data and has been obtained from those who have lived an experience.
Are potential applications examined and explored?	Potential applications are examined and explored later in this chapter.

10.7 Implications and Recommendations

The findings of this study highlight a number of issues that may occur in relation to the care provided to women and male partners when they present to EDs in regional, rural and remote areas throughout Australia with possible miscarriage. These three areas have been grouped together to facilitate an exploration of the issues that impact on the provision of nursing care to women and their partners in non-metropolitan locations. While it is acknowledged that these three areas face different challenges, the final theory generated from this research identifies the implications for nursing education, practice and policy development in non-metropolitan EDs generally. These recommendations are summarised in Table 10.4.

10.7.1 Education

The findings of this study indicate that changes need to be made to ensure optimal care for the women and their partners who present to regional, rural and remote EDs with possible miscarriage. To implement changes in practice, education is needed to focus on both nursing students and RNs. Nursing education needs to include the psychosocial aspects of miscarriage and a gender-based approach that ensures the inclusion of partners in the care provided. This education should include skills in the use of therapeutic communication, specifically focusing on the emotional care of women and men in pregnancy loss. This study found that the women and their partners felt dissatisfied with the care provided to them during their time in the ED. Male partners vocalised that there was no support or education provided for them, and stated that they were often informed by nursing staff at the time of discharge to go home and ‘support their wife or partner’. They felt that empathetic care was limited, with inadequate understanding of their individual needs. However, the nursing staff revealed a lack of confidence and knowledge regarding the care of women or their male partners who were experiencing pregnancy loss. Therefore, education should focus on gendered grief reactions to loss and how nurses can respond and care for both women and men using an empathetic and individualised approach. Nursing staff should be afforded continuing educational updates in the use of gender-specific, verbal and written education and information pertaining to the process of grief and loss.

10.7.2 Practice

The results of this study highlight the significant role that emergency nursing staff play in the well-being of women and their partners who live in non-metropolitan areas of Australia when facing pregnancy loss. To support quality practice, the inclusion of sensitive and attentive nursing care that is gender-specific and covers the gamut of emotions experienced by the women and their partners is paramount. Nursing staff themselves must be provided with debriefing and support. When communicating with women and men, nursing staff should ensure that they do not use language that minimises, reduces or dismisses their experiences or emotions. They should recognise that both men and women have different responses to grief and loss, and that within each gender there is also an array of responses. As well as providing maps or detailed directions to metropolitan referral hospitals, nursing staff in regional, rural and remote centres must provide women and their partners with local support services that

these women and their partners can access. If these face-to-face services do not exist, nursing staff must provide web-based support services.

10.7.3 Policy

The women and their partners in this research repeatedly spoke about not being provided with information that was community-specific. Policies need to be community orientated and allow for innovative and creative practice focusing on local resources, both human and physical. Therefore, policy is needed that explicitly states the minimum follow-up requirements for both women and their partners, and that specifically refers to their emotional well-being. Such policy needs to reflect the delivery of quality service provision through continuous professional development, especially focusing on the needs of rural, regional and remote staff. While the terms and conditions of employment for staff working in rural and remote areas of Australia often stipulate that nurses are entitled to support so they may attend professional development opportunities, these terms and conditions are not specific and could be open to interpretation. The findings of this research indicate that nurses were often unable to attend professional development, as relief staff were unavailable. Employment contracts and hospital policy need to specifically reflect support for professional development of nursing staff, including the provision of relief staff to attend events off-site. Webinars and other online education services may also make professional development more accessible to these nurses.

Table 10.4: Recommendations for nursing education, practice and policy.

Context	Recommendations
Nursing education should include:	<p>The psychosocial aspects of miscarriage.</p> <p>The provision of gender-based knowledge relating to care.</p> <p>Therapeutic communication strategies that focus on the emotional care of women and men in pregnancy loss.</p>
Nursing practice should provide care that:	<p>Is sensitive and attentive, gender and culturally-specific with emphasis on consistent verbal and written information regarding miscarriage.</p> <p>Ensures access to detailed information for women and their partners regarding resources and access to services and facilities specific to the non-metropolitan locations.</p> <p>Enables accessible support upon discharge, either locally or via online services.</p>

Policy must:	<p>Reflect community-specific, innovative and creative practice that focuses on local resources (both human and physical).</p> <p>Focus on management that is specific to the regional, rural and remote location rather than metro-centric or arbitrary in nature.</p> <p>Implicitly state the minimum follow-up requirements for both women and their partners that focuses on their emotional well-being</p> <p>Stipulate the minimum requirements to support nursing staff to participate in professional development opportunities.</p>
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10.8 Recommendations for Future Research

To ensure that all members of regional, rural and remote communities have the ability to voice their needs and expectations regarding care provided in these areas, it is important that further research is undertaken. The findings in this study highlight the needs and expectations of women and their partners when they present to the non-metropolitan EDs with possible miscarriage. The women and their partners who were interviewed in this study were Caucasian Australians living in regional, rural and remote areas from traditional family backgrounds. As we live in a multicultural society, it is important to ensure that all Australian women and their partners are given the opportunity to voice their thoughts, feelings and concerns regarding the care they receive in non-metropolitan EDs. Future research needs to focus on participant recruitment specifically towards Aboriginal and Torres Strait Islander women and their partners. Work is also needed to explore experiences of other non-Caucasian women and their partners. Importantly the focus of future studies should also include non-traditional families, including single, divorced, lesbian, gay, bisexual and transgender Australians presenting with possible miscarriage to non-metropolitan areas of Australia.

Challenges were also faced in this research regarding the recruitment of male participants, especially as the topic was sensitive in nature. Further research is required with a specific focus placed on the recruitment process to ensure men have an opportunity to participate in research that can be sensitive. Lastly, it was found in this study that women and their partners were not provided with follow-up information or instructions; therefore, they received limited follow-up care. Further research is needed to explore the follow-up care provided to women in non-metropolitan areas of Australia, as it is known that services in these areas are imperfect.

10.9 Summary

In summary, this chapter has brought this thesis to a close. Threads of care is a grounded theory study of regional, rural and remote ED care for women with possible miscarriage. The grounded theory was an empirically derived representation that explains the experiences of women and their partners, along with the nursing staff who provided care in these settings. The women and their partners in this study not only faced the possibility of pregnancy loss, but also additional stressors associated with living in rural, regional and remote areas of Australia. Non-metropolitan communities face significant disadvantages in the provision of healthcare, especially for women requiring obstetric and gynaecological services.

The process of providing optimal care in non-metropolitan areas is threatened because of the unique challenges with care delivery in these locations. Ultimately, there is a need for nursing staff to recognise that women and their partners 'present as one' to the ED when seeking care for possible miscarriage and, ultimately, they will 'leave as one'. The care received during their time in the ED can have a significant influence on how they 'move on' from this experience. The grounded theory generated through this research can inform the education of nursing students and nursing practice in regional, rural and remote areas of Australia. Further, it can be utilised in policy development to ensure that optimal care is provided in non-metropolitan areas of Australia for women and their partners who present with possible miscarriage.

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Appendix A: ARIA+

ARIA+ is the reviewed and improved version of ARIA

ARIA stands for Accessibility/Remoteness Index of Australia (Australian Population and Migration Research Centre [APMRC], 2012). During 1998, the Commonwealth Department of Health and Aged Care commissioned a project to measure and classify the remoteness of populated localities in relation to ‘service centres’ of various sizes (APMRC, 2012). The APMRC (2012) explained that the result was the ARIA index, which was developed by the National Key Centre for Social Applications of Geographical Information Systems at the University of Adelaide.

ARIA uses geographic information system technology to provide a measure of remoteness (from service centres) for all places and points in Australia (APMRC, 2012). ARIA defines five categories of remoteness based on road distance to service centres. The five categories are as described by the APMRC (2012, p. 1):

1. **Highly accessible** (ARIA score 0–1.84): relatively unrestricted accessibility to a wide range of goods and services and opportunities for social interaction.
2. **Accessible** (ARIA score >1.84–3.51): some restrictions to accessibility of some goods, services and opportunities for social interaction.
3. **Moderately accessible** (ARIA score >3.51–5.80): significantly restricted accessibility of goods, services and opportunities for social interaction.
4. **Remote** (ARIA score >5.80–9.08): very restricted accessibility of goods, services and opportunities for social interaction.
5. **Very remote** (ARIA score >9.08–12): very little accessibility of goods, services and opportunities for social interaction.

‘ARIA+’ is a development of ARIA proposed by the National Key Centre for Social Applications of Geographical Information Systems, as explained by the APMRC (2012).

There are three differences in methodology between ARIA and ARIA+.

The major differences between ARIA and ARIA+ is that ARIA+, as described by the APMRC (2012), include:

- Extra category of service centres.
- ARIA+ is based on road distance to service centres in the following five categories:
 - A. more than 250,000 persons
 - B. 48,000–249,000 persons
 - C. 18,000–47,999 persons
 - D. 5,000–17,999 persons
 - E. 1,000–4,999 persons.

APMRC (2012) explained that the ARIA+ index will now have values between 0 and 15 rather than a range of between 0 and 12, as with ARIA.

**Appendix B: Human Ethics Approval (CQUniversity and James
Cook University)**

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Appendix C: Consent Forms with General Information

Informed Consent for Study Participants—Women

My name is Sue Edwards, I am a lecturer in the School of Nursing and Midwifery at CQUniversity Mackay and I am currently working on my PhD. I am conducting a research study and you are invited to participate. The purpose of this study is to investigate the experiences of women who have attended a rural or regional emergency department with bleeding in early pregnancy (less than 14 weeks' pregnancy). This study will facilitate an understanding in the effectiveness of the care provided.

This study will require a personal interview that will last for approximately one hour in which you may be asked to describe your experience/s, using your own words. Your participation in this study is entirely voluntary. You will also be asked to consent to be provided for a follow-up phone call at a later date/time for clarification (if necessary), which would take approximately 15 minutes of your time. As a means of protecting confidentiality, all names and identifying information will be removed from the research data and from the research study's report of findings.

By providing your signature on the consent form, you give permission for an interview and for the interview to be audio-recorded and transcribed for use in this study. The audio-recordings of your interview will be treated as confidential, and will not be shared with any person except in connection with this research study. The digital audio files and interview transcripts will be stored in a locked filing cabinet to ensure confidentiality, and they will be destroyed at the end of the research study. Also, the transcripts and other documents made from the audio-recorded interview will not have your name or any other identifying information, in order to protect your confidentiality.

Any information gathered in this study will be used as fulfilment of doctoral dissertation requirements. There are minimal risks and no direct benefits associated with participation in this research. While you may not directly benefit from participating, you will be contributing to knowledge in this topic area. One risk of participating in this study is that you could become upset or uncomfortable while thinking about or discussing the issues involved. If you experience emotional discomfort the interview will be stopped and the interviewer will make appropriate referrals for you to receive counselling, if necessary. The counselling service is

available to you at no cost through My Psychology Corp. Alison Thwaites, Psychologist, can be contacted on 0407733609.

If you decide to participate in this study, you will be asked to sign a consent form.

If you would like further information or to discuss your participation in this study at any time, please contact me: Sue Edwards (07) 49 407 829 or Professor Ysanne Chapman, (07) 49 407 409, PhD supervisor, to discuss any concerns you may have. Please contact Central Queensland University's Office of Research (Tel: 07 4923 2607; e-mail: research-enquiries@cqu.edu.au; mailing address: Building 32, Central Queensland University, Rockhampton QLD 4702) should there be any concerns about the nature and/or conduct of this research project.

Thank you for taking the time to read this information sheet.

Sue Edwards

Consent Form—Women Participants

I consent to participation in the research project and agree that:

1. An information sheet has been provided to me that I have read and understood.
2. I have had any questions I have about the research project answered to my satisfaction by the information sheet and any further verbal explanation provided.
3. This study will require a personal interview that will last for approximately one hour.
4. In the interview I will be asked to describe my experience/s, using my own words.
5. I am aware that the interview in which I will be participating will be audio-recorded.
6. I understand that to preserve anonymity and maintain confidentiality of participants that all names and identifying information will be removed from the research data and from the research study's report.
7. I am aware that I may request a plain English statement or results to be made available to me on completion of the study on request.
8. I understand that a risk of participating in this study is that I could become upset or uncomfortable while thinking about or discussing the issues involved. I am aware that if this should occur the interview will be stopped and the interviewer, as a trained clinician, will make appropriate referrals for you to receive counselling, if necessary.
9. I agree that I am providing consent to participate in this project.

I am aware that I may also be asked for a follow-up phone call at a later date/time for clarification (if necessary). The telephone interviews will be of approximately 15 minutes' duration and will ask clarifying questions about information that you provided in the interview.

☐ I consent to be contacted about a possible follow-up phone interview

☐ I do not consent to be contacted about a possible follow-up phone interview

Signature: _____ Date: _____

Name (please print): _____

Please provide an e-mail or postal address if you wish to receive a plain English statement or results

Informed Consent for Study Participant—Male Partners

My name is Sue Edwards, I am a lecturer in the School of Nursing and Midwifery at CQUniversity Mackay and I am currently completing a PhD. I am conducting a research study and you are invited to participate. The purpose of this study is to investigate the experiences of women and their partners who have attended a rural or regional emergency department with bleeding in early pregnancy (less than 14 weeks' pregnancy). This study will facilitate an understanding in the effectiveness of the care provided and to develop a model of care that is current and meets both the needs and expectations of patients and staff alike.

Your participation in this study will involve an interview (face-to-face or by telephone) that will last for approximately one hour. During this interview you may be asked to describe your experience/s, using your own words. Your participation in this study is entirely voluntary. You may also be asked to participate in a follow-up phone call at a later date/time for clarification (if necessary), which would take approximately 15 minutes of your time.

As a means of protecting confidentiality, all names and identifying information will be removed from the research data and from the research study's report of findings.

If you decide to participate in this study, you will be asked to sign a consent form. By providing your signature on the consent form, you give permission for an interview and for the interview to be audio-recorded and transcribed for use in this study. The audio-recordings of your interview will be treated as confidential, and will not be shared with any person except in connection with this research study. The digital audio files and interview transcripts will be stored in a locked filing cabinet to ensure confidentiality and they will be kept for five years and destroyed. Also, the transcripts and other documents made from the audio-recorded interview will not have your name or any other identifying information, in order to protect your anonymity.

Any information gathered in this study will contribute to this research in fulfilment of doctoral dissertation requirements. There are minimal risks and no direct benefits associated with participation in this research. While you may not directly benefit from participating, you will be contributing to knowledge in this topic area. One risk of participating in this study is that you could become upset or uncomfortable while thinking about or discussing the issues involved. If you experience emotional discomfort the interview will be stopped and the interviewer will make appropriate referrals for you to receive counselling, if necessary. The

counselling service available to you at no cost through My Psychology Corp. Alison Thwaites, Psychologist, can be contacted on 0407733609.

If you would like further information or to discuss your participation in this study at any time, please contact me: Sue Edwards (07) 49 407 829 or Professor Melanie Birks, (07) 47 814 544, PhD supervisor or Professor Ysanne Chapman, PhD supervisor (e-mail: y.chapman@cqu.edu.au). Please contact Central Queensland University's Office of Research (Tel: 07 4923 2603; e-mail: ethics@cqu.edu.au; mailing address: Building 361, Central Queensland University, Rockhampton, QLD 4702) should there be any concerns about the nature and/or conduct of this research project, 'Emergency Department management of first trimester bleeding in rural/regional communities: Developing a model of care' (HREC approval number, H13/02-014).

Thank you for taking the time to read this information sheet.

Sue Edwards

Consent Form—Male Partners

I consent to participation in the research project ‘Emergency Department management of first trimester bleeding in rural/regional communities: Developing a model of care’ (HREC approval number: H13/02-014) and agree that:

1. An information sheet has been provided to me that I have read and understood.
2. I have had any questions I have about the research the project answered to my satisfaction by the information sheet and any further verbal explanation provided.
3. This study will require a personal interview (face-to-face or by telephone) that will last for approximately one hour.
4. In the interview I will be asked to describe my experience/s, using my own words.
5. I am aware that the interview in which I will be participating will be audio-recorded.
6. I understand that to preserve anonymity and maintain confidentiality of participants that all names and identifying information will be removed from the research data and from the research study’s report.
7. I am aware that I may request a plain English statement or results to be made available to me on completion of the study on request.
8. I understand that a risk of participating in this study is that I could become upset or uncomfortable while thinking about or discussing the issues involved. I am aware that if this should occur the interview will be stopped and the interviewer, as a trained clinician, will make appropriate referrals for me to receive counselling, if necessary.
9. I agree that I am providing consent to participate in this project.

I am aware that I may also be asked for a follow-up phone call at a later date/time for clarification (if necessary). The telephone interviews will be of approximately 15 minutes’ duration and will ask clarifying questions about information that you provided in the interview.



I consent to be contacted about a possible follow-up phone interview



I do not consent to be contacted about a possible follow-up phone interview

Signature: _____

Date: _____

Name (please print): _____

Please provide an e-mail or postal address if you wish to receive a plain English statement of results

Informed Consent for Study Participant

Emergency Department. Nursing Staff

My name is Sue Edwards, I am a lecturer in the School of Nursing and Midwifery at CQUniversity Mackay and I am currently working on my PhD. I am conducting a research study and you are invited to participate. The purpose of this study is to examine the current models of care provided to women who present to rural/regional emergency departments with first trimester bleeding. The study will investigate the experiences of these women. Patient care will be explored in relation to the adequacy, quality and expectations of care provided via current emergency department models of care. Examination of staff experiences will also be gained and compared with those patient experiences. The study will highlight any differences in care, experiences or expectations to provide a platform for the development of a model of care that is current and meets both the needs and expectations of patients and staff alike.

This study will facilitate an understanding in the effectiveness of the care provided.

This study will require a personal interview that will last for approximately one hour in which you may be asked to describe your experience/s, using your own words. Your participation in this study is entirely voluntary. You will also be asked to consent to be provided for a follow-up phone call at a later date/time for clarification (if necessary), which would take approximately 15 minutes of your time.

As a means of protecting confidentiality, all names and identifying information will be removed from the research data and from the research study's report of findings.

By providing your signature on the consent form, you give permission for an interview and for the interview to be audio-recorded and transcribed for use in this study. The audio-recordings of your interview will be treated as confidential, and will not be shared with any person except in connection with this research study. The digital audio files and interview transcripts will be stored in a locked filing cabinet to ensure confidentiality, and they will be destroyed at the end of the research study. Also, the transcripts and other documents made from the audio-recorded interview will not have your name or any other identifying information, in order to protect your confidentiality.

Any information gathered in this study will be used as fulfilment of doctoral dissertation requirements. There are minimal risks and no direct benefits associated with participation in

this research. While you may not directly benefit from participating, you will be contributing to knowledge in this topic area.

If you decide to participate in this study, you will be asked to sign a consent form.

If you would like further information or to discuss your participation in this study at any time, please contact me: Sue Edwards (07) 49 407 829 or Professor Ysanne Chapman, (07) 49 407 409, PhD supervisor, to discuss any concerns you may have. Please contact Central Queensland University's Office of Research (tel: 07 4923 2607; e-mail: research-enquiries@cqu.edu.au; mailing address: Building 32, Central Queensland University, Rockhampton QLD 4702) should there be any concerns about the nature and/or conduct of this research project.

Sue Edwards

Consent Form—Emergency Department Nursing Staff

I consent to participation in the research project and agree that:

1. An information sheet has been provided to me that I have read and understood.
2. I have had any questions I have about the research the project answered to my satisfaction by the information sheet and any further verbal explanation provided.
3. This study will require a personal interview that will last for approximately one hour.
4. In the interview I will be asked to describe my experience/s, using my own words.
5. I am aware that the interview in which I will be participating will be audio-recorded.
6. I understand that to preserve anonymity and maintain confidentiality of participants that all names and identifying information will be removed from the research data and from the research study's report.
7. I am aware that I may request a plain English statement of results to be made available to me on completion of the study on request.
8. I agree that I am providing consent to participate in this project.

I am aware that I may also be asked for a follow-up phone call at a later date/time for clarification (if necessary). The telephone interviews will be of approximately 15 minutes' duration and will ask clarifying questions about information that you provided in the interview.

☐ I consent to be contacted about a possible follow-up phone interview

☐ I do not consent to be contacted about a possible follow-up phone interview

Signature: _____ Date: _____

Name (please print): _____

Please provide an e-mail or postal address if you wish to receive a plain English statement of results

Appendix D: Pregnancy Loss Resource—My Corp Psychology



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Appendix E: Interview Guide with Demographic Questions as Warm Up

Interview Guide

Interviewer:

Thank you for participating in this study, and for taking the time to talk with me. I hope this study will prove to be helpful to women who attend regional/rural emergency departments with bleeding in early pregnancy and also I hope that talking about your experience and sharing your story will be of benefit to you. I am very interested in listening to your story and to understand how your experience is similar or different to other women.

I have worked in the emergency department for many years and while I have a nursing perspective in caring for women who present to the emergency department with bleeding in early pregnancy; it is my belief that understanding a women's perspective is imperative to providing optimal patient care.

We are going to begin today by asking you some general information and then we will move into talking about your experience. If at any stage, in the interview, you feel you need to take a break or you need to clarify any question please feel free to inform me or to ask a question.

To begin with do you have any questions?

Warm up:

- Easy non-threatening questions will be asked to break the ice and make people more comfortable such as a general discussion about the participant, e.g. marital status, number of children (if any) sex and age of children, employment etc.

Interview:

- 'I understand that you have experienced vaginal bleeding in early pregnancy, please, tell me about your experience.'

Probe question:

- A. How would you describe the care that was provided to you when you presented to the emergency department?
- B. What care do you feel that the medical and nursing staff could do to help women who present to regional/rural emergency departments with bleeding in early pregnancy?
- C. How did you feel when you were informed that you would have to wait in the emergency department prior to being seen?
- D. Do you feel the staff provided enough information to you; if yes what was included and if no what do you feel would have been beneficial?