A STUDY TO DESCRIBE AND ANALYZE THE POSTPARTUM HOME VISIT MADE BY PUBLIC HEALTH NURSES TO PRIMIPAROUS WOMEN

BY

Brenda L. Cantin

A Thesis
Submitted to the Faculty of Graduate Studies
in Partial Fulfillment of the Requirements
for the Degree of

MASTER OF NURSING

Faculty of Nursing
University of Manitoba
Winnipeg, Manitoba

ISBN 0-315-81740-2

Name _____

Dissertation Abstracts International is arranged by broad, general subject categories. Please select the one subject which most nearly describes the content of your dissertation. Enter the corresponding four-digit code in the spaces provided.

Nursing
SUBJECT TERM

0569
SUBJECT CODE

U·M·I

Subject Categories

THE HUMANITIES AND SOCIAL SCIENCES

COMMUNICATIONS AND THE ARTS
Architecture 0729
Art History 0377
Cinema 0900
Dance 0378
Fine Arts 0357
Information Science 0723
Journalism 0391
Library Science 0399
Mass Communications 0708
Music 0413
Speech Communication 0459
Theater 0465

EDUCATION
General 0515
Administration 0514
Adult and Continuing 0516
Agricultural 0517
Art 0273
Bilingual and Multicultural 0282
Business 0688
Community College 0275
Curriculum and Instruction 0727
Early Childhood 0518
Elementary 0524
Finance 0277
Guidance and Counseling 0519
Health 0680
Higher 0745
History of 0520
Home Economics 0278
Industrial 0521
Language and Literature 0279
Mathematics 0280
Music 0522
Philosophy of 0998
Physical 0523
Psychology 0525
Reading 0535
Religious 0527
Sciences 0714
Secondary 0533
Social Sciences 0534
Sociology of 0340
Special 0529
Teacher Training 0530
Technology 0710
Tests and Measurements 0288
Vocational 0747

LANGUAGE, LITERATURE AND LINGUISTICS
Language
- General 0679
- Ancient 0289
- Linguistics 0290
- Modern 0291

Literature
- General 0401
- Classical 0294
- Comparative 0295
- Medieval 0297
- Modern 0298
- African 0316
- American 0591
- Asian 0305
- Canadian (English) 0352
- Canadian (French) 0355
- English 0593
- Germanic 0311
- Latin American 0312
- Middle Eastern 0315
- Romance 0313
- Slavic and East European 0314

PHILOSOPHY, RELIGION AND THEOLOGY
Philosophy 0422
Religion
- General 0318
- Biblical Studies 0321
- Clergy 0319
- History of 0320
- Philosophy of 0322

Theology 0469

SOCIAL SCIENCES
American Studies 0323
Anthropology
- Archaeology 0324
- Cultural 0326
- Physical 0327

Business Administration
- General 0310
- Accounting 0272
- Banking 0770
- Management 0454
- Marketing 0338

Canadian Studies 0385
Economics
- General 0501
- Agricultural 0503
- Commerce-Business 0505
- Finance 0508
- History 0509
- Labor 0510
- Theory 0511

Folklore 0358
Geography 0366
Gerontology 0351
History
- General 0578
- Ancient 0579
- Medieval 0581
- Modern 0582
- Black 0328
- African 0331
- Asia, Australia and Oceania 0332
- Canadian 0334
- European 0335
- Latin American 0336
- Middle Eastern 0333
- United States 0337

History of Science 0585
Law 0398
Political Science
- General 0615
- International Law and Relations 0616
- Public Administration 0617

Recreation 0814
Social Work 0452
Sociology
- General 0626
- Criminology and Penology 0627
- Demography 0938
- Ethnic and Racial Studies 0631
- Individual and Family Studies 0628
- Industrial and Labor Relations 0629
- Public and Social Welfare 0630
- Social Structure and Development 0700
- Theory and Methods 0344

Transportation 0709
Urban and Regional Planning 0999
Women's Studies 0453

THE SCIENCES AND ENGINEERING

BIOLOGICAL SCIENCES
Agriculture
- General 0473
- Agronomy 0285
- Animal Culture and Nutrition 0475
- Animal Pathology 0476
- Food Science and Technology 0359
- Forestry and Wildlife 0478
- Plant Culture 0479
- Plant Pathology 0480
- Plant Physiology 0817
- Range Management 0777
- Wood Technology 0746

Biology
- General 0306
- Anatomy 0287
- Biostatistics 0308
- Botany 0309
- Cell 0379
- Ecology 0329
- Entomology 0353
- Genetics 0369
- Limnology 0793
- Microbiology 0410
- Molecular 0307
- Neuroscience 0317
- Oceanography 0416
- Physiology 0433
- Radiation 0821
- Veterinary Science 0778
- Zoology 0472

Biophysics
- General 0786
- Medical 0760

EARTH SCIENCES
Biogeochemistry 0425
Geochemistry 0996
Geodesy 0370
Geology 0372
Geophysics 0373
Hydrology 0388
Mineralogy 0411
Paleobotany 0345
Paleoecology 0426
Paleontology 0418
Paleozoology 0985
Palynology 0427
Physical Geography 0368
Physical Oceanography 0415

HEALTH AND ENVIRONMENTAL SCIENCES
Environmental Sciences 0768
Health Sciences
- General 0566
- Audiology 0300
- Chemotherapy 0992
- Dentistry 0567
- Education 0350
- Hospital Management 0769
- Human Development 0758
- Immunology 0982
- Medicine and Surgery 0564
- Mental Health 0347
- Nursing 0569
- Nutrition 0570
- Obstetrics and Gynecology 0380
- Occupational Health and Therapy 0354
- Ophthalmology 0381
- Pathology 0571
- Pharmacology 0419
- Pharmacy 0572
- Physical Therapy 0382
- Public Health 0573
- Radiology 0574
- Recreation 0575
- Speech Pathology 0460
- Toxicology 0383

Home Economics 0386

PHYSICAL SCIENCES
Pure Sciences
Chemistry
- General 0485
- Agricultural 0749
- Analytical 0486
- Biochemistry 0487
- Inorganic 0488
- Nuclear 0738
- Organic 0490
- Pharmaceutical 0491
- Physical 0494
- Polymer 0495
- Radiation 0754

Mathematics 0405
Physics
- General 0605
- Acoustics 0986
- Astronomy and Astrophysics 0606
- Atmospheric Science 0608
- Atomic 0748
- Electronics and Electricity 0607
- Elementary Particles and High Energy 0798
- Fluid and Plasma 0759
- Molecular 0609
- Nuclear 0610
- Optics 0752
- Radiation 0756
- Solid State 0611

Statistics 0463

Applied Sciences
Applied Mechanics 0346
Computer Science 0984

Engineering
- General 0537
- Aerospace 0538
- Agricultural 0539
- Automotive 0540
- Biomedical 0541
- Chemical 0542
- Civil 0543
- Electronics and Electrical 0544
- Heat and Thermodynamics 0348
- Hydraulic 0545
- Industrial 0546
- Marine 0547
- Materials Science 0794
- Mechanical 0548
- Metallurgy 0743
- Mining 0551
- Nuclear 0552
- Packaging 0549
- Petroleum 0765
- Sanitary and Municipal 0554
- System Science 0790

Geotechnology 0428
Operations Research 0796
Plastics Technology 0795
Textile Technology 0994

PSYCHOLOGY
General 0621
Behavioral 0384
Clinical 0622
Developmental 0620
Experimental 0623
Industrial 0624
Personality 0625
Physiological 0989
Psychobiology 0349
Psychometrics 0632
Social 0451

A STUDY TO DESCRIBE AND ANALYZE THE POSTPARTUM HOME VISIT MADE BY PUBLIC HEALTH NURSES TO PRIMIPAROUS WOMEN

BY

BRENDA L. CANTIN

A Thesis submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements for the degree of

MASTER OF NURSING

ABSTRACT

Studies documenting the content and process of nursing care are limited, particularly in the community setting. The purpose of this descriptive study was to describe and analyze the postpartum home visit made by public health nurses (PHNs) to primiparous women. Mothers' and nurses' perceptions of the visit were also examined. Symbolic interactionism (Blumer, 1969) guided this research. As well, health promotion concepts provided an organizing framework for the study. A convenience sample of five public health nurses each completed two postpartum home visits for the study. The home visits were audio-tape recorded by the nurse. Each PHN and each mother (n=10) were separately interviewed by the researcher following the visit to gather information on their perceptions of the visit. Latent and manifest content analysis was used to interpret the data.

Though nurses dominated the visit in terms of amount of time talked and number of questions asked, mothers were satisfied with the visit and found it helpful. All mothers felt they participated in the visit but their definition of participation included more than talking. Discussion during the visit fell into four categories of topics: baby, mother, services, and other. Social/emotional care needs were briefly explored. Public health nurse interactions clustered into the categories of socializing, listening actively, giving information, and taking information. Nurses spent the majority of their time taking or giving information. Findings suggest that a better understanding of the meaning clients give to interactions would allow nurses to better meet the client's needs. The results of the study support the need for continued research in areas related to community health nursing.

ACKNOWLEDGEMENTS

I would like to acknowledge the following individuals for their contribution to my graduate education.

First, I would like to thank the public health nurses and mothers who took part in my study.

I would next like to thank my committee chairperson, Dr. Karen Chalmers, for her ongoing support, and direction. Dr. Chalmers's positive manner and thoughtful comments were always encouraging. I appreciated Dr. Chalmers's prompt response to the drafts of my thesis her attention to the details of my work. I feel truly privileged to have had Dr. Chalmers guide me through my thesis.

Dr. Ina Bramadat served as my internal committee member. I thank Dr. Bramadat for sharing her expert knowledge in maternal child health. I found Dr. Bramadat's suggestions to be helpful throughout the entire process of my thesis work.

I thank Dr. Richard Stanwick, my external committee member, for the wisdom he shared from his experience and expertise in community health.

My sincere appreciation is extended to the graduate students with whom I shared this experience. Their support and encouragement will always be remembered.

Finally, I would like to thank my family. I am grateful to my mother, Julie, who filled my freezer, cleaned house, and prepared the family meals on each of her trips to Winnipeg. I thank my children, Melanie and Jeffrey, who supported my decision to enter graduate school and who rarely complained about their extra household duties or quickly prepared meals. Finally, I would like to thank my husband, John, who was my greatest source of support. John always had an encouraging word and provided invaluable assistance editing my work. John also rescued me on the computer on numerous occasions.

My thesis is dedicated to the memory of my father, Pep.

TABLE OF CONTENTS

TABLE OF CONTENTS (continued)

TABLE OF CONTENTS (continued)

LIST OF TABLES

CHAPTER ONE

Introduction

The history of home visits in nursing dates back to the late 1800s. Florence Nightingale gave impetus to visiting or district nursing in England when she and William Rathbone helped organize the Metropolitan and National Nursing Association in 1874 (Goodnow, 1944). In Canada, organized home nursing services began in 1897 with the establishment of the Victorian Order of Nurses [VON] (Gibbon, 1947).

In the early 20th century, public health units were being established in Canada (Pringle, 1988). This period saw the development of community health nursing (Jones & Craig, 1988). During these early years, community nursing practice centered around the prevention of communicable diseases and treatment of their effects, as well as, improved maternal and child health.

High infant mortality rates in the early 1900s made maternal and infant care a focus of attention (Smith, 1984). In Manitoba, the Board of Health in 1916 formed the provincial public health nursing service which included the first provincial service to rural areas (Wilson, 1945). According to Wilson, the objective of the service was "to safeguard child welfare and to protect public health" (p.3).

Infant and maternal mortality rates have dropped significantly since public health nurses (PHNs) began home visits in 1916. In 1921, the infant death rate was 83 deaths per 1,000 live births (Statistics Canada, 1977), while in 1988, the infant mortality rate in Manitoba was 7.7 deaths per 1,000 live births (Manitoba Vital Statistics, 1990). As well, the maternal death rate was 43.8 per 10,000 live births in

1921 with only one maternal death in Manitoba in 1988. Direct services for mothers and infants by nurses has been one of the influences in reducing infant mortality rates in this century (Salmon & Peoples-Sheps, 1989).

Statement of the Problem

Three major issues influence the need to examine the PHN practice of making postpartum (PP) home visits. Those issues are decreasing infant and maternal mortality rates, increasing health care costs, and the changing nature of health care problems. First, the practice of making postpartum visits has continued, though infant and maternal mortality rates have decreased dramatically. As early as 1946 provincial PHNs were directed to visit each infant at least once as soon after birth as possible with further visits made according to need (Russell,1946). This practice continues today. Currently, all primiparous mothers in Manitoba receive a postpartum home visit from a PHN.

In addition to changing epidemiologic statistics, shrinking health care dollars is a second concern that challenges nurses to justify the services they offer in a community. In 1988, there were 16,946 live births in Manitoba (Manitoba Vital Statistics, 1990). Though the number of primiparous births is not known, postpartum contact continues to constitute a substantial amount of nursing time. Nevertheless, nurse managers must be wary of discontinuing services, which may be useful but costly, without careful evaluation.

The changing nature of health problems over the years is a third reason that may make it necessary to alter the care given to clients (Kasch, 1986; Schoolcraft,

1984; Smith, 1986). Though mortality rates have dropped, it has long been recognized that the postpartum period is a vulnerable time for mothers (Rubin, 1975); that mothers have many concerns during this period (Bull, 1981; Gruis, 1977; Haight, 1977; Harrison & Hicks, 1983; Moss, 1981); and that there is a need for new learning (Butnarescu, 1978). In addition, consumers have also changed over the years with an increased interest in participating in their own health care and an increased knowledge through childbirth education classes (Templeton Gay, Estes Edgil, & Bragg Douglas, 1988).

Public health nurses should examine current practices based on the changing nature of health care problems which may involve changing consumer needs. Included in changing consumer needs may be the need for consumers to be more active in their care. Inherent in the philosophy of community health nursing in Canada is the belief that individuals participate as active partners with the nurse in promoting, maintaining, and restoring health (Canadian Public Health Association [CPHA], 1990). The nurse-client interaction is central to our understanding of nursing and will become more important in the development of health education/promotion roles for nurses and in the assistance nurses give to clients to achieve responsibility for their own health care (Clark, 1989).

The PHN has traditionally cared for women and infants in the home (Hampson, 1989), but there is not a substantial amount of research in this area. Combs-Orme, Reis, and Ward (1985) located only eight studies in their review of empirical research concerning the effectiveness of home visits by PHNs in

maternal/child health. Though research is limited, the importance of evaluation of PHN services has been recognized since the early 1960s (Archer, 1983; CPHA, 1990; Freeman, 1961; Roberts, 1962; Wright, 1984). However, difficulty continues to exist in trying to substantiate the impact of PHN service (Goeppinger, Lassiter, & Wilcox, 1982; Robertson, 1981).

Luker (1985) pointed out difficulties in evaluating health visiting practice[1] including the use of broadly defined goals that makes measuring the effectiveness of practice difficult, the difficulty with all prevention programs in measuring something that has not occurred, and the long-term nature of the work. Additional problems include the possibility of finding a negative result (Kok & Green, 1990) and the multidisciplinary nature of interventions making it difficult to isolate and evaluate the nursing component (Highriter, 1984). Further, when using an experimental evaluation design, randomization is costly, time consuming, and could be considered unethical if an established program must be withheld (Baxter, 1986).

In spite of the above concerns with evaluating practice, public health nurses must be accountable for the services they provide (American Nurses' Association, 1980; Canadian Public Health Association, 1990; Combs-Orme, Reis, & Ward, 1985; Yauger,1972). Improving infant and maternal mortality rates, rising health care costs, and the changing nature of health care problems indicate it is imperative to

---

[1]Health visitor is the British term for public health nurse. The health visitor has a similar role to the PHN. Health visitor/client contact usually takes place in the client's home. Postnatal mothers and children 0-4 years are priority care groups for health visitors.

examine the current practice of PP home visits by PHNs to justify the existing service or to recommend changes. In Ontario, the Ministry of Health has recently begun to study the delivery of postpartum follow-up services by public health nurses (Edwards, Mackay, & Schweitzer, 1992; Townsend, Edwards, & Nadon, 1992).

Evaluation research is becoming an important tool that enables managers to determine if programs produce benefits that justify their costs (Wood, 1989). According to Wood, four assumptions are implicit in the use of an evaluation research design. First, the program must have measurable objectives that can be used as a basis for evaluation. Second, the objectives can be assigned priorities and weighted in a practical sense according to their value to the project. Third, methods or tools are available to measure the variables. Fourth, adequate control subjects can be provided so statistical testing can be used to determine if a program made a difference.

Though the provincial PP home visit program has never been formally evaluated, none of the above assumptions can be satisfied. The home visit program objectives are broadly stated making measurement difficult. An appropriate measurement tool is not available. Finally, as the PP home visit is an established service, some may consider it unethical to withhold or delay service from a control group. Therefore, an experimental evaluation design cannot be used.

As it is not possible to examine the PP home visit using an experimental research design, other options must be considered. Evaluation of nursing care that encompasses process and outcome has the possibility for impact on quality of nursing care (Bloch, 1975; Wright, 1984). To prepare for process-outcome evaluation, one of

the necessary tasks is to develop a set of measurable process criteria. The value of studying process is the clues it gives to corrective nursing action. Process involves the interaction between the PHN and the client (Flynn & Ray, 1987).

Nursing, in general, has not sufficiently documented the content and process of nursing care and the majority of what is documented comes from acute care settings (Cox, 1982). In the studies reviewed by Barkauskas (1990) on home care for maternal, infant, and pediatric populations, information was limited regarding the content of home-based nursing interventions. Documentation of the content and process of nursing interventions in the PP home visit could be used as the initial step in a process-outcome evaluation study.

Purpose of the Study

The purpose of this study was to describe and analyze the postpartum home visit made by provincial public health nurses to primiparous women. A non-experimental design was used to examine the process and content of nurse/client interactions during the PP home visit and to examine nurses' and mothers' perceptions of the visit.

Research Questions

The following research questions were addressed:

1. What is the nurses'/mothers' participation in the postpartum home visit?
2. What topics are discussed during the postpartum home visit?
3. What are mothers' perceptions of the postpartum home visit?
4. Are maternal concerns addressed during the postpartum home visit?
5. What are nurses' perceptions of the postpartum home visit?

Operational Definitions

Primiparous Mother: a woman who has given birth to her first living child.

Concerns: questions, worries, areas of marked preoccupation related to the puerperium (Bull, 1981).

Provincial Public Health Nurse: registered nurse employed by Manitoba Health as a public health nurse.

Postpartum Home Visit: visit made by a provincial PHN in the home of a primiparous mother following delivery of a living infant.

Perceptions: statements made by PHNs or primiparous mothers to describe the PP home visit as elicited by a semi-structured interview conducted by the nurse researcher.

Summary

Maternal and child health continues to be an important practice area for public health nurses. Though it is difficult to evaluate an established program, it is possible to gain some insight into the process of a PP home visit. Beginning descriptions of

the content and process of PP home visits allows nurses to build a research base that permits process-outcome evaluation in the future. This descriptive study examined nurses' and mothers' participation in and perception of the PP home visit that will build a foundation for future research endeavors.

CHAPTER TWO

Literature Review

The literature review is organized under the headings: (a) health promotion, (b) health promotion-nursing's role, (c) nurse/client interactions, (d) client's perceptions of care, (e) client's satisfaction with care, (f) transition to motherhood, including postpartum maternal concerns, (g) home visits, and (h) postpartum home visits. The review begins with the broad perspective of health promotion to identify key concepts that may be common to nursing practice in general and more specifically in the areas of perinatal and child health.

Health Promotion

One of the key concepts providing a common thread to all health promotion literature is public participation. The Declaration of Alma-Ata specified a goal of health for all by the year 2000 (World Health Organization [WHO], 1978). Primary health care was identified as the key to attaining this goal. Primary health care is "essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination" (p.3).

Primary health care services will vary from country to country and community to community as services reflect the economic conditions and social values of the area they serve. Basic services include: promotion of proper nutrition and an adequate

supply of safe water, basic sanitation, maternal and child care, immunization against the major infectious diseases, prevention and control of locally endemic diseases, education concerning prevailing health problems and the methods of preventing and controlling them, appropriate treatment of common diseases and injuries, and provision of essential drugs.

Implicit in the concept of primary health care is an intersectoral approach to health using appropriate health technology. World governments were asked to formulate national policies, strategies, and plans that included primary health care as part of a national health system. Mahler has stated health workers must understand the concept of primary health care involves new roles for them (WHO, 1984a). Health workers must accept their new roles and have the necessary skills to enact these new roles. Workers must be concerned with more than disease prevention. Health promotion must also be part of the role of health workers.

Health promotion is defined by WHO (1984b) as "the process of enabling people to increase control over, and to improve, their health" (p. 3). There are five principles of health promotion. Health promotion: (a) involves the population as a whole in the context of their everyday life, rather than focusing on people at risk for specific diseases, (b) is directed towards action on the determinants or causes of health, (c) combines diverse, but complementary, methods or approaches, (d) aims particularly at effective and concrete public participation, and (e) is nurtured and enabled by health professionals-particularly those in primary health care.

In the field of health promotion, Canada has consistently demonstrated leadership (Stern, 1990). Changes to the vision of health were first documented in the Lalonde report A New Perspective on the Health of Canadians (Health & Welfare Canada, 1974). Terris (1984) called this report a worldclass document as it was the first government policy recognizing the beginning of a new era of public health, that of noninfectious diseases. Hancock (1989) noted the importance of the report as the first time in recent history that government acknowledged health care services were not the major contributor to improving people's health.

The Health Field Concept developed in the Lalonde report was divided into four elements: human biology, environment, lifestyle, and health care organization. The human biology element consists of all physical and mental aspects of health developed in the human body as a result of the basic biology of man and the organic structure of the individual. Environment includes all matters related to health, external to the body, over which the individual has little or no control. In the Health Field Concept, decisions made by individuals that affect their health and over which they have some control fall into the lifestyle category. The fourth category consists of quality, quantity, arrangement, nature, and relationships of people and resources in the provision of health care.

The Lalonde report has not come without criticism. Labonté and Penfold (1981) have stated this report created the impression health is primarily dependent on individual lifestyle choices and has resulted in victim blaming. Labonté and Penfold suggested health professionals should help people recognize their personal and

collective power to control their health through critical awareness of the social, economic, and sexist conditions that originally caused poor health. The focus on individual responsibility for achieving good health detracts from environmental and economic factors requiring social action to solve (Levin, 1987).

Hancock (1989) noted by the early 1980s the limitations to the approach of changing personal behaviours and individual lifestyles was beginning to be recognized. There was a change from risk factor reduction to a broader concept of health promotion (Spasoff, 1990). The move to examine broader socio-environmental and economic factors that shape personal behaviours was documented in Achieving Health for All (Epp, 1986) and the Ottawa Charter for Health Promotion (WHO, Health & Welfare Canada, & Canadian Public Health Association [CPHA], 1986).

The Epp report developed a health promotion framework as a means of achieving health for all Canadians. The WHO definition of health promotion is used in this document. The Epp framework identified three challenges facing Canadians. The first challenge is to reduce the inequities in the health of low-versus high-income groups. The second challenge is to find ways of preventing injuries, illnesses, chronic conditions and their resulting disabilities. The third challenge is to enhance people's ability to manage and cope with chronic conditions, disabilities, and mental health problems.

The health promotion mechanisms named in the framework are self-care, mutual aid, and healthy environments. Self-care refers to the decisions and actions taken by people in the interest of their health. Mutual aid refers to people's actions to

deal with health concerns by helping each other. Healthy environments include physical, social, economic, and political surroundings that are conducive to health.

Implementation strategies include fostering public participation, strengthening community health services, and coordinating healthy public policy. Helping people assert control over factors that affect their life is fostering public participation. Strengthening community health services means assigning greater responsibility to community-based services. Healthy public policy implies the coordination of all policies that have a bearing on health.

The Ottawa Charter for Health Promotion also built on the progress made through the Declaration of Alma-Ata. According to the Ottawa Charter, the prerequisites for health are peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity (WHO, Health & Welfare Canada, & Canadian Public Health Association, 1986). Health promotion means building public policy, creating supportive environments, strengthening community action, developing personal skills, and reorienting health services.

Terris (1989, 1990) refers to health promotion as the development of healthful living standards. Healthful living standards have a positive effect on health which includes not only a subjective state of well-being, but also has a functional component or the ability of an individual to participate effectively in society. Standard of living also plays a role in the prevention of disease and injury. Canada recognized the importance of living standards in the Epp report and the Ottawa Charter.

Becker (1986) criticized the health promotion/disease prevention movement for exacerbating such developments as: premature release of scientific finding which have often resulted in the need to reverse advice given to the public; a confused public; and an approach to health that fosters victim-blaming and ignores important social, economic, and environmental issues that impact on health. Becker believes attention must move beyond lifestyle modification to the social and economic determinants of health, disease, and wellness. This approach would start by assessing problems of daily living, move to community organization and community-based strategies, and end in efforts to reach planned social change.

Green and Kreuter (1990) agree with the earlier criticism that health promotion placed too much emphasis on the individual. Green and Kreuter define health promotion as a combination of educational and environmental supports for actions and conditions of living that contribute to health. Actions may be those of individuals, groups, communities, policy makers, employers, teachers, or others whose actions affect the determinants of life. The community is seen as the center of gravity for health promotion as the decisions on priorities and strategies for social change affecting lifestyle issues must be made collectively as closely as possible to those involved.

The influence of the social environment on health calls for a change in the health education approach from a focus on the individual to an approach that considers the social context in which people live (WHO, 1984a). Health is more than a medical

issue. Environmental, cultural, biological, social, and economic issues also must be considered as influencing health.

The Healthy Cities or Healthy Communities Project is viewed as an example of the broader approach to health promotion (Gott & O'Brien, 1990; Hancock, 1989; Minkler, 1989). Developing a healthy city requires (a) intersectoral public policies that promote and enhance health, and (b) the development of healthy and supportive physical and social environments (Hancock, 1987). Hence, community action is strengthened and public participation is encouraged. The Canadian name for this project is 'Healthy Communities' and the premise on which the project is based is that health promotion requires local action, including local government to make a more healthy community (Hancock, 1989). From a review of the newsletters of the Canadian Healthy Communities Project, it is evident there are many active community projects occurring throughout Canada. For example, in Vancouver, a new program was established called "A Health Promotion Program with Older Adults". In Edmonton, the healthy communities project has established a "Safe Meeting Place for Kids" which is a free after school program that offers a broad range of healthy lifestyle opportunities. "Reduce, Reuse, and Recycle" is the theme of a healthy communities project in Medicine Hat, Alberta.

Participation in the planning and implementation of individual health care is inherent in primary health care, the Epp framework for health promotion, and the Ottawa Charter. Community participation is defined by WHO as "the process by which individuals and families assume responsibility for their own health and welfare

and for those of the community, and develop the capacity to contribute to their and the community's development" (WHO, 1978, p. 50). In the Canadian quest for health, people form a major resource (Epp, 1986). Helping people assert control over factors that effect health encourages public participation. Self-care is one example of an initiative from the community level approach to citizen involvement (Bracht & Tsouros, 1990). "Self-care is the means whereby people take responsibility for their own health based on an understanding, in their own language, of what health is all about, how to promote it and what to do when something goes wrong" (Bracht & Tsouros, 1990, p. 206).

One method of encouraging community participation in health promotion is through the development of partnerships with groups committed to improving health. In Manitoba, the provincial health department has recognized the value of developing partnerships in the "Partners for Health" initiative (Manitoba Health, 1989). This initiative has two goals. The first goal is to encourage Manitobans to take personal responsibility for their health. The second goal is to involve the entire community in a more active and focused effort to identify and correct risks to health.

In this section, the health promotion literature has been reviewed. The importance of public participation in health promotion and the need to consider the environmental, cultural, social, and economic influences on health have been identified in the literature. Nursing's role in health promotion will now be explored.

Health Promotion: Nursing's Role

Health promotion has been identified as an important concept for nursing. Nursing's role in health promotion dates back to Florence Nightingale who said nursing "ought to signify the proper use of fresh air, light, warmth, cleanliness, quiet, and the proper selection and administration of diet....the same laws of health or of nursing...obtain among the well as among the sick" (Nightingale, 1946, p. 6). In Britain in the late 1800s, visiting nurses mixed curative services with teaching and prevention (Heinrich, 1983).

In Canada in the late 1800s, there were no organized home nursing services (Pringle, 1988). Lady Aberdeen, wife of the Governor-General of Canada, brought the idea of home helpers to Canada that resulted in the formation of the Victorian Order of Nurses in March of 1897. The Order covered the whole range of public health nursing including pre and postnatal care, school nursing, travelling clinics, and tuberculosis work (Goodnow, 1944).

The field of practice known as community/public health nursing was established in Canada after 1900 (Jones & Craig, 1988). Voluntary agencies, such as the VON, were the forerunners of community health nursing. The work of the community health nurse advanced with the joining of nursing services dealing with health and social matters (Allemang, 1985). Divisions of public health nursing began to form within provincial and municipal health departments in the early 1900s. The role of the PHN emphasized health teaching, case finding, and preventive care.

Nurses have always recognized and participated in health promotion (Mills & Ready, 1988). The current challenge for nurses is to extend their health promotion work to implement the principles implicit in the previously noted WHO definition of health promotion. The Canadian Nurses Association (CNA) supports reform of the Canadian health care system based on the philosophy and principles of primary health care and supports the Epp document as a beginning frame of reference (CNA, 1988).

Public health nurses are in a key position to assist in moving toward a more preventive health care system (Yiu Matuk & Chadwell Horsburgh, 1989). Much is written about the need for PHNs to focus on the health of aggregates and the influence of environmental factors on health (McKay & Segall, 1983; Salmon, 1989; Salmon White, 1982; Williams, 1977). The public health nurse, however, faces moral conflict between the individualistic ethic of professional nursing and the aggregate ethic of public health (Fry, 1983). There needs to be a clear distinction between nursing services provided in the community from those provided in other areas of service delivery as accountability to aggregates may involve overlooking individual need in favor of group need.

To focus on health promotion, nurses need "to develop new skills and specializations in enabling and empowering people for self-care, self-help, environmental improvement and in promoting positive health behavior and appropriate coping abilities of people to maintain health" (Maglacas, 1988, p.71). In a conceptual model for public health nursing developed by Salmon White (1982), determinants of health were defined as human-biological, environmental,

medical-technological/organizational, and social. Nurses support involvement in health promotion; however, the response in policy planning, education, and service delivery has been chaotic (Gott & O'Brien, 1990). Maglacas calls nursing's response to the health for all challenge fragmented, sporadic, unplanned, and uncoordinated.

Public health nursing is in a period of transition (Gebbie, 1986). Responses to funding cuts include continuing all programs but at a smaller level or reduction of programs with money saved going into programs with vocal community support. A more reasonable approach might be to organize resources around highest priority activities. The future of community health nursing will be directed by such alternative views as the struggle between classic public health programs and personal health care, systems development versus individual approaches, and traditional programs versus new initiatives. Leaders in public health nursing must face funding cutbacks with creative alternatives (Ervin, 1982). Shamansky and Clausen (1980) believe the future of community health nursing lies in primary prevention, which includes generalized health promotion and specific protection against disease.

Nurses working in the community have the responsibility to encourage individuals to be active participants in their own health care (American Nurses' Association, 1980; CPHA, 1990). Unfortunately, health professionals are socialized and educated in the expert role which is incompatible with the collaborative/partner role associated with public participation (CNA, 1988). Basic modification in roles and resocialization or reprofessionalization is needed for nurses to move from provider to partner. To establish collaborative relationships with clients, nurses may

have to redefine the form of client contact from a rigidly structured interview to a conversation, the task of the contact from one of exerting influence and decisional control to one of joint decision making, and role of nurses and clients from active-passive, to active-active (Kasch, 1986).

The discipline of nursing supports health promotion and client participation; however, this support may not be reflected in actual nursing practice. Empirical study of actual practice is needed to identify how nurses and clients interact in the natural setting. In the following section, nurse/client interaction studies are reported.

Nurse/Client Interactions

To determine effective care and shape theory, it is important to describe and analyze nurse-client interactions (Dodge & Oakley, 1989). The activities of health visitors have been documented by Wiseman (1982) but little is known about how or if PHNs incorporate client participation into their practice or how nurses and clients interact. The following studies examined nurse/client interactions but were not limited to interactions in the home and extended beyond the client group of interest to gain a broader perspective. To understand a profession with a core in practice, it is necessary to study practice within the contextual setting (Field, 1983).

Bales' interaction process analysis was used by Conant (1965) to examine nurse-patient interactions during public health nurses' home visits to 24 antepartal patients. The 12 nurses that took part in the study visited two patients twice. In visits where the nurse indicated no satisfaction, the rate of asking questions tended to be higher with a lower rate of giving responses in the social-emotional area. Visits

that were satisfying to patients showed a decrease in nurses asking questions and an increase in nurses providing answers to patient's questions.

Mayers (1973) observed 16 randomly selected nurses during their visits to 37 families. Nurses were interviewed after each visit to determine the nurse's purpose of the visit, long range goals, and perceptions of the client's concerns. The findings showed the conversations between nurse and client were dominated by such topics as general health or physical signs and symptoms. Nurses did not always share their objectives with the client, making it difficult for both to work productively together. Client concerns expressed to the researcher in the interview following the visit were not reflected in the content or process of the visit. Mayers found the nurses in the study to be patient-focused (i.e., seemed to follow client clues) or nurse-focused (i.e., usually acted from their own perspective or reacted to client clues from their own frame of reference). As the study progressed, Mayers observed the visits to be a "well-established, time-honored ritual" (p.331). Both nurses and clients seemed to react as if responses had been rehearsed many times.

In another study, the Flanders Interactional Analysis System was used to investigate verbal communication patterns between volunteer health care providers (4 pediatricians and 3 pediatric nurse-practitioners) and clients (n=68) during well-baby clinics (Kishi, 1983). Results showed the more directions and orders given by the health-care provider, the less the ratio of the mother's recall of health information given by the health-care provider during the visit. Neither a high frequency of client

questions nor a high frequency of health-provider questions were correlated with client recall.

One purpose of a study by Morgan and Barden (1985) was to examine the interactive behaviors between nurses and high-risk perinatal women. The second purpose was to test the hypothesis that there would be a significant difference in the perceptions of home visits between PHNs and high-risk perinatal patients. The convenience sample consisted of 18 nurses and 55 clients. Five forms were used by nurse-observers to collect data: nurse and client biographic data forms, Bales's interaction process analysis form, and forms to measure clients' and nurses' perceptions of home visits. Alpha reliability for the perception questionnaires was 0.71 and 0.64 respectively. Results showed that asking for and giving information accounted for more than 53 percent of the nurses' interactive behavior. The stated hypothesis was supported.

In a study of nurse practitioner's (n=35) and mother's (n=60) interactions during well-child visits, audiotaped segments of the interview were examined (Webster-Stratton, Glascock, & McCarthy, 1986). The nurse practitioners were randomly chosen from lists of certified nurse practitioners in the United States. Nurse practitioners spent approximately half of the total well-child visit time asking mothers questions about their families and children. Though 96 percent of the nurse practitioners responded to mothers' expressed concerns, only 32.8 percent encouraged mothers to call back with concerns. Little affect was expressed in the tone of the nurse or mother and praise by the nurse occurred, on average, less than once during

the 15 minute exchange. Mothers were rarely asked for their suggestions, ideas, or solutions to topics. The authors reported that the nurse practitioners studied were knowledgeable about health assessments and health teaching content but less skilled in helping clients with mutual problem solving and becoming active participants in the health care delivery system.

In another study, however, clients were found to be more active in decision making (Gulino & LaMonica, 1986). In a move to describe activities of public health nurses, 186 records of nursing home visits were randomly selected and reviewed. Antepartum and postpartum health supervision were the most frequent services requested. Client assessment, teaching, and counselling were the most frequent nursing activities performed. Counselling was defined as assisting or helping a person solve a problem or make a decision. The authors suggested the high frequency of health counselling by the nurses indicated that clients were not placed in a passive dependent role with respect to making decisions. However, this study method did not use direct observation, therefore, this conclusion may not be valid.

Family planning clinic settings were chosen by Dodge and Oakley (1989) to study nurse-client interactions during 12 audiotaped nurse-client interviews. Four major themes were identified: past self-care practice, knowledge requisite to contraceptive use, intent to carry out contraceptive use-behaviors, and decision processing. The client's side of the interaction dealt more with the past than the future. Most nurses responded to client's past or future contraceptive self-care expressions by giving information or asking questions. The authors stated the

emphasis of analysis of nurse interactions should be on the specific behavioral content and on the role of the client as both are consistent with the emphasis on client participation in care.

The purpose of a qualitative pilot study by Kristjanson and Chalmers (1990) was to provide a description of interactions between community health nurses and their clients. Five nurses were observed and videotaped during 19 nurse-client interactions in a range of care settings and contexts. Field notes and semi-structured interviews were also used to collect data. Content analysis resulted in what the authors called a conceptual map of nurse-client interactions. Interactions were classified into social, working, and closing phases. Teaching was a large part of the working phase of the interactions. The client did not have primary control in any of the interactions. In 18 out of 19 interactions, the clients were passive followers of the nurse giving an imbalance in control over the flow of interactions. Generally, nursing interventions were found to vary according to the context in which they occurred and the overall style of the nurse.

Many of the same issues in nurse/client interactions were found in studies reported in the British literature. Sources for accounts of British health visiting come from professional literature, legal and managerial structures within which visitors work, and research studies (Montgomery-Robinson, 1986). Montgomery-Robinson felt these accounts operated at a high level of abstraction. To produce a description of the reality of practice, Montgomery-Robinson audio-taped 28 primary visits of health visitors and mothers. The author argues policy makers and those making

statements about what the profession should be must have a clear description of current practice to inform their decisions. For example, Montgomery-Robinson found the health visitor is sometimes not a family visitor in that when a father was present during an interview his contribution ranged from 3-34 percent of the conversation utterances.

Tape recordings of first home visits to first time mothers (n=9) by health visitors (n=5) were used in an exploratory study by Sefi (1988). Form filling took 1/6 to 2/3 of the visit. Health visitors introduced and closed all topics and mothers rarely asked questions. Sefi noted mothers appeared quite powerless during the visits and without resources to do anything more than answer questions.

Observation and tape recording were used by Warner (1984a) to examine interactions between mothers and their children and health visitors in a child health clinic setting. Warner observed the phrase "How are you?" was used as a routine format in the opening stage of the visit. The use of the past tense was restricted to children and always produced a topic for further discussion. When used in mid-conversation, "How are you?" could be used to close the visit or as an opportunity for the mother to discuss herself. Using another example from the same study, Warner (1984b) noted achieving agreement between client and health visitor is central to health visiting practice to increase the likelihood the visit will affect client health. Health visitors involved in this study found the insight provided by the study was helpful in increasing their self-awareness which allowed them to exercise greater

control over their actions with clients. Warner concluded conversation analysis provided insight into effective health visiting practice.

In summary, research on nurse/client interactions during home visits is limited. Studies reviewed demonstrate nurses dominate interactions; however, the studies involved a variety of health professionals in a variety of settings with a variety of client groups. Only one Canadian study (Kristjanson & Chalmers, 1990) was located.

Client's Perceptions of Care

When investigating a particular service, such as home nursing visits, literature related to the client's perceptions of care should be reviewed. The client's perspective must be examined to develop client centered and effective health services (Rovers & Isenor, 1988). According to Flynn and Ray (1987), the process of health-care delivery or art of care can be judged by consumers. As only two studies were found that were related to PP home visits, studies from other practice areas are included in the review that follows.

An ethnographic method of investigation was used to examine the perceptions of nine elderly persons about their experience of being old and frail, and receiving home care (Magilvy, Brown, & Dydyn, 1988). The themes of nursing care, health problems, and independence were discovered using a multi-step process of discovering major categories and smaller categories. Further analysis of categories yielded overall themes. The role of nursing was described in the nursing care theme. Nurses were perceived as reassuring and supportive who helped clients feel better and

lifted their spirits. Monitoring medications and blood pressure were perceived as important services. Teaching was often not recognized as a nursing intervention. Type of health problem and general state of health were the two major domains in the theme of health problem. In the theme of independence, the domains of self-care, mobility, and lifestyle activities emerged. The credibility of this study was enhanced by triangulation across sources, methods, and investigators.

The Preventive Health Care for the Aging Program (PHCA) used a similar format to that used for well-child clinics (Laffrey, Renwanz-Boyle, Slagle, Guthmiller, & Carter, 1990). Clients attend a PHCA clinic for an annual assessment, or more frequently if a problem is identified. The program is carried out by PHNs and is aimed at illness prevention, early detection of disease, and health maintenance. A sample of 137 new clients to a PHCA and 360 clients who had previously attended the program were interviewed to determine reasons for seeking care in the program and how the visits had affected the client's health. Content analysis was used to analyze the data. Six reasons for initially attending the program and 22 benefits perceived from care were identified. An interrater agreement of 94 percent was achieved. The top three reasons for attending the program were: told by family, friend, neighbor, or employer; notice in paper; or referred by other health professional. Perceived benefits fell into four groups. The first was nurse-centered benefits such as evaluates blood pressure, gives support, routine check-up, and teaches. Clients noted PHNs allowed them to ask questions and to be actively involved in their care. Client-centered benefits included an increase in

knowledge/health awareness, pleasure/feeling good, and increase in self-confidence and self-care. Clinic-centered benefits included the practicality and convenience of using the program. The no benefits group was comprised of eight persons who were not aware of any ways in which the program affected their health.

Consumer perceptions of quality of care should be important to those attempting to define and measure the construct of quality (Taylor, Hudson, & Keeling, 1991). Telephone interview was used to describe the response of patients, recently discharged from an acute care hospital (n=70), and their significant other to the statement "describe what you think quality nursing care is". Content analysis resulted in descriptions of quality of nursing care falling into two major types of attributes-practice and nurse. Under practice attributes, holistic care and nurse-patient interactions were mentioned by those interviewed. Nurse attributes were described by personal qualities of the nurse, caring, proficiency, professional character, and commitment to excellence. A small number of those interviewed also mentioned practice setting attributes in their description of quality nursing care.

The following two studies pertain to mothers in the postpartum period. Mothers' perceptions of the health visiting service were examined in a longitudinal study in Britain by Clark (1984). Through tape recorded semi-structured interviews of 26 mothers, Clark found that after one year of contact with a health visitor, mothers were still not clear about the purpose of the service and how it worked. Though the study sample was small (n=26) and not representative, 18 mothers reported the health visitor was helpful. Mothers had difficulty describing the purpose

of the health visitor's visit and found the services limiting as they were only available Monday to Friday during the day.

Mothers' perceptions and use of services provided by PHNs during the PP period were studied by Rovers and Isenor (1988). Two parallel groups of rural mothers (N=50/group) were included in the study. The reported study is part of a larger research project that utilized a quasi-experimental design to gain information from the subjects for the development and evaluation of a hospital-based PP education program. There were no significant differences between the groups on demographic and other key variables. After one week at home, less than half the mothers in both groups felt quite free or very free to contact the PHN should a problem arise in the ensuing month. At six weeks postpartum, 54 percent of group one and 35 percent of group two rated the PHN visit as very helpful and reassuring. Twenty-eight percent of group one and 41 percent of group two described the visit as somewhat helpful. Weighing the baby was the predominate reason for finding the visit somewhat helpful. The best sources of information for mothers in the first six weeks were family/close friends (group one) and reading (group two). In both groups, more women, who indicated they knew their PHN fairly well or very well, called the nurse.

In summary, research on client's perceptions of home visiting is scarce making it difficult to reach any conclusions. Though the mothers in two of the PP studies found the PHN visit helpful, they were not likely to call the PHN for help in the future (Rovers & Isenor, 1988) or were not able to explain the purpose of the visit (Clark, 1984). Only one Canadian study (Rovers & Isenor, 1988) was located.

Client's Satisfaction with Care

In addition to studies focusing broadly on clients' perceptions of nursing care, some studies more specifically examined the concept of client satisfaction with care. After reviewing the literature on patient satisfaction, Pascoe (1983) concluded that such information has a role in evaluating primary health care and explaining health related behavior. Pascoe reported client satisfaction can be used as an outcome measure of the quality of patient care. As well, client satisfaction with care has been described as a health outcome in both the interaction model of client health behavior developed by Cox (1982) and the theoretical framework for collaborative decision making in nursing practice developed by Kim (1983).

The majority of research on patient satisfaction has been in relation to general health care services or medical care (Eck, Meehan, Zigmund, & Pierro, 1988). Professional perspectives of the services provided by community health nurses or nurses' report of job satisfaction can be found in the literature (Lucas, McCreight, Watkins, & Long, 1988; West & Savage, 1988); however, limited descriptions are available regarding client satisfaction with community care.

An instrument has been developed that evaluates patient attitudes toward nurses and nursing care in primary care settings (Risser, 1975). The framework that guided item development came from the literature and covered the technical-professional, intra-interpersonal, trusting, and educational aspects of nurses and nursing care. Specific items were developed from suggestions from patients, the

literature, experts in the field, and other available questionnaires. The final questionnaire is a 25-item questionnaire with three subscales (technical-professional, educational relationship, trusting relationship). Estimates of reliability using coefficient alpha for the total scale was 0.912 after two trials.

Most of the studies of patient satisfaction have been in relation to satisfaction with acute care services. For example, the Risser Patient Satisfaction Scale was administered to patients on the orthopedic units in two acute care hospitals (Ventura, Fox, Corley, & Mercurio, 1982). One unit used primary nursing and the other unit did not. The authors noted the Risser scale was adapted by Hinshaw and Atwood for use in inpatient settings. There was no significant difference in patient satisfaction between the two units on any of the subscales or the total scale at the .05 level. The small variation of satisfaction measure may be explained by reluctance of patients to express negative feelings about care providers. The lack of variability in the scales may limit the effectiveness of patient satisfaction as a criterion measure.

Client satisfaction with the nursing services of a university-based nursing center was studied by Bagwell (1987). Seventy-eight clients attending the Clemson University Nursing Center completed a 23-item questionnaire using a Likert scale to rate their visit to the nursing center. The questionnaire was reviewed by a panel of experts and validated through a pilot study. No measures of reliability were reported. Items on the questionnaire included such areas as courtesy, physical surroundings, privacy, feeling rushed, suggestions to improve health, and waiting time. Out of 66 participants who completed all 16 Likert-scale items, 18 were very satisfied and 46

were satisfied with their visit. Black clients were more satisfied than white clients with the nurse's interest in their overall health and adult clients were more satisfied than parents of child clients with courtesy of staff and the suggestions they were given to improve their health.

The following two studies relate to client satisfaction with nursing care in the home setting. The purpose of a study by Reeder and Chen (1990) was to develop a client satisfaction scale for home health care. Items for the scale were generated from three existing scales developed by Hinshaw and Atwood, Schmele, and McCusker. The Client Satisfaction Survey developed uses a Likert scale to score 35 items and the nursing process as the organizational framework. The scale was tested with a convenience sample of 48 homogeneous clients of a home health agency. Thirty-seven surveys were used in the analysis. Reliability using Cronbach's alpha was 0.93. Face and content validity for the instrument were established using available literature and experts in the field. Client satisfaction averaged 4.36 of a 5-point scale. Clients were most satisfied with how well the nurse listened to them, feeling better as a result of talking with the nurse, pleasantness of the nurse, and nursing care received. Further validation of the tool is required.

In a British study, health visitors (n=4) were interviewed before and after home visits to 100 women who were also interviewed following the visit (Watson & Sim, 1989). The purpose of the study was to determine how similar the client's view of the purpose of the health visitor's home visit was to the professional's view and to see if closeness to agreement of these views influenced client and health visitor

satisfaction. Overall, the topics which clients considered health visitors had come to discuss were similar to those mentioned by the health visitor. However, the closeness of match between health visitor and client perception of the objectives of the visit did not affect either's satisfaction with the visit.

In summary, little is known about client satisfaction with nursing home visits. From the studies reviewed, clients generally feel satisfied with nursing services; however, a standard measurement tool has not been developed and used consistently.

Transition to Motherhood

Literature describing the client group of interest, the postpartum mother, was reviewed to gain an understanding of the issues that might influence the direction of the current study. Maternal behavior following delivery has been observed and described in detail by Reva Rubin (1961a, 1961b). Rubin's early work gave initial stimulus for subsequent studies on maternal-infant behaviors and relationships (Templeton Gay, Estes Edgil, & Bragg Douglas, 1988).

The transition from pregnancy to the role of mother is also known as a developmental period for women (Benedek, 1959). The time following a delivery is often difficult for women requiring energy and emotional support to cope with a baby and adapt to a new lifestyle (Sumner & Fritsch, 1977). The development of a maternal role is one change which occurs in women during the postpartum period (Ludington-Hoe, 1977). The transition to parenthood is a time of relearning (Hrobsky, 1977; Rossi, 1968). Conceptual frameworks have been developed to study maternal adaptation (Donaldson, 1981) and factors that impact on maternal role

attainment (Mercer, 1981). As well, Affonso (1987) has developed guidelines to assess maternal postpartum adaptation.

Studies investigating maternal role and adaptation to motherhood abound (Curry, 1983; Flagler, 1988; Majewski, 1987; Mercer, 1986). The literature supports the belief that the postpartum period is a time of developmental change for women which is difficult and requires emotional support. During this period, relearning is required. As well, women have concerns related to the attainment of a maternal role and the transition to parenthood.

Postpartum Maternal Concerns

The postpartum period has been identified as a difficult time for new mothers. Care providers must be aware of the multiple variables affecting the transition to parenthood to plan appropriate strategies (Hampson, 1989). Several studies have identified maternal concerns and sources of help during the PP period and are now presented.

Sumner and Fritsch (1977) monitored spontaneous requests by parents for information and support during the first six weeks following delivery. During the study period, 270 phone calls were received. Most questions related to infant care and were related to the categories of feeding and the gastrointestinal process. Though primiparous women called more frequently than multiparous women, multiparous women asked slightly more questions per call.

In another study by Haight (1977), nurses contacted 136 families by telephone during the first week home following delivery. Most of the questions posed by

parents related to baby care. Mothers reported receiving help from the baby's father, mothers, mothers-in-law, and friends. Only seven percent of mothers reported having no help at all. A later study upheld the finding that husbands and grandparents are a source of support for PP women (Pridham & Zavoral, 1988).

Recognition of an apparent gap in health care services during the PP period led Gruis (1977) to investigate the needs and resources of mothers during the puerperium. Drawing from descriptive and empirical puerperium literature, Gruis developed a questionnaire listing potential concerns for postpartum women. A total of 40 multiparous or primiparous women were then asked to confirm, rank, or add to the list of concerns and to note resources used. Concerns related primarily to the task of physical restoration and the incorporation of a new family member. Primiparas and multiparas were found to have similar concerns, but the focus of infant concern for the primiparas was on the newborn (feeding and behavior) while for the multiparas it was on the strain a new child places on the rest of the family. Most of the women sought help from their husbands and none used the nurse. Gruis noted referrals to PHNs are often made only for "problem mothers" and mothers in the study were considered normal. Only eight of the mothers received a home visit by a PHN.

Similar results were found for multiparous women in a study by Moss (1981). Card sorting was used to have multiparous women (n=56) priorize concerns related to baby, self, or family relationships on the third postpartum day. More concerns with family relationships and fewer concerns regarding themselves or their infants

were identified by the women. However, concerns of primiparous women were priorized differently in the following study.

Bull (1981) developed a 50-item questionnaire, adapted from the Gruis checklist, containing potential maternal concerns related to the categories of self, baby, husband, family, and community. Concerns of first-time mothers (n=40) did not change in frequency or intensity from postpartum day three to after about one week at home. Changes did occur at the subcategory level. Concerns related to self and baby remained stronger than those for family, husband, or community.

Harrison and Hicks (1983) modified the Gruis questionnaire and sent it to multiparous and primiparous women (n=158) during their fourth postpartum week. Areas of concern included regulating the demands of house and family, fatigue, emotional tension, return of the figure to normal, exercise, diet, and finding time for personal interests. Multiparas had fewer concerns than primiparas. Of the six sources of support identified, husbands were used most frequently for help and nurses least though 68 percent of the women received at least one visit by a PHN. Sources of help for infant feeding and behaviors were physicians and other family members and friends. Books and pamphlets were used for fitness concerns. The authors suggest one reason for mothers not using nurses as a source of help is mothers may perceive the nurse interested in concerns about infant care and most mothers identified concerns in other areas. Similar concerns but different ranks were identified by first-time breastfeeding mothers (Graef et al., 1988). These mothers (n=32) expressed

more concerns regarding themselves and their infants and fewer about family members or friends.

It is clear from the research that PP women have concerns that require information or support. Concerns generally related to self, infant, and family members or friends. In the studies that examined sources of support, husbands and grandparents were identified most frequently. The role of the nurse was examined in only one study and the nurse was rated last as a source of support. To ascertain the role of the nurse and/or effectiveness of public health nursing interventions in the home visit, literature in this area is next examined.

Home Visits

Confusion exists in the literature over the terms home health nursing, and public/community health nursing (Burbach & Brown, 1988; Green & Driggers, 1989; Oda, 1989). Similarities in the two types of nursing include setting and the independent nature of the practice. Differences also exist. The focus of practice is on the individual for home health nursing and on the population for community nursing though services are also provided to individuals. As well, Oda pointed out home visits are not the sole domain of public health nurses. Hospital-based nurses, nurse practitioners, and home health aides are examples of other classes of workers providing services to clients in their home.

The effect of the confusion over terms becomes evident in the literature. In a review of the literature on home health care, Barkauskas (1990) included studies of pregnant women, new mothers, infants, and children. The focus of the studies related

to the care of individuals at high risk and home care of sick children. Documentation of the nature of the interventions was limited making it difficult to distinguish if the nurse played a home health care role or community health role. Confusion extends to the British literature, as well, where some community nurses are called health visitors.

Several empirical studies have been completed in North America that have evaluated the effectiveness of home visits by PHNs in the area of maternal/child health. In a double blind experimental study of black primiparous women, Lowe (1970) found no significant difference in the compliance of prescribed prenatal care recommendations among women (n=26) who were given routine clinic care and women (n=30) who were given routine clinic care plus home instruction from PHNs. Lowe suggests the findings may be a result of such problems as failure to address social/cultural gaps among the nurses and patients and an insufficient number of visits from the nurses.

Health status, knowledge, and behavior were the outcomes measured in a study by Yauger (1972). The study population was composed of maternity patients with at least one child five years or under at home. The experimental group (n=21) received a minimum of four visits by a PHN and the control group (n=26) none. No statistical differences were found in the outcomes studied. However, the content of the home visits was not standardized and no information was provided on the validity and reliability of outcome measures (Combs-Orme, Reis, & Ward, 1985).

McNeil and Holland (1972) found group instruction by PHNs to mothers with infants over one month of age (n=56) was more effective and less costly than home visiting (n=51). However, the content of group sessions and home visits was not matched and the test instrument used measured only one aspect of the nurses' intervention. Hall (1980), on the other hand, substantiated the hypothesis that a home nursing intervention to new mothers would promote positive healthy mother-infant relationships. The effect of a home visit using structured information on normal infant behavior (n=15) was compared to no instruction (n=15). The primiparous women in the experimental group (instruction) were found to have a significantly positive change in perception of their infants as measured by the Neonatal Perception Inventory Tool. However, Hall noted the small sample size and possible Hawthorne effect which limits the generalizability of the results of the study.

Failures in the above studies to find significant treatment effects may be the result of research deficiencies rather than an ineffective intervention (Combs-Orme, Reis, & Ward, 1985). Two major problems were identified. First, a theoretical framework was often missing from the studies linking client needs or nursing activities to the outcomes measured. Second, small sample sizes may have resulted in low statistical power.

Considering the long history of maternal/child home nursing, the number of evaluation studies is limited. The problem of few home care evaluation studies extends to the entire field of community health nursing. Highriter (1977) reviewed community health nursing research from 1972-1976. Forty-four evaluation studies

were found but most of those evaluated total programs, such as, expectant parents classes, instead of home visits.

In a later review of community health nursing research from 1977-1981, Highriter (1984) concluded there has been little substantive change in the research. Most studies remained descriptive with little discussion of theory. Evaluation remained the predominant theme, with home visit studies limited to those justifying the cost-effectiveness of home versus hospital care. There appears to be an emphasis on the evaluation of new programs leaving routine services, such as the PP home visit, without formal evaluation.

Postpartum Home Visits

Maternal and infant welfare programs dominated the practice of PHNs in the 1920s and 1930s (Novak, 1991). Today, postpartum services continue to contribute a significant part of a PHN's work. Top priority care groups for health visitors in Britain also continue to include pre and postnatal women and children 0-1 years of age (Wiseman, 1982). In an American study, Gulino and LaMonica (1986) found the most frequent service requested of PHNs was postpartum health supervision. Despite the dominance of these groups in PHN practice, there is a dearth of literature in this area. Only three evaluation studies were found that were specific to the postpartum home visit by a PHN.

In an attempt to find objective evidence to support the continuation of maternal/child health programs, Brown (1967) studied the effects of a PP home visit on maternal concerns. The experimental group of primiparous women (n=39) had

home visits by a PHN; the control group (n=40) had no visits. Concerns related to infant care were assessed in each group by questionnaire. During the study period, there were significantly fewer and less intensive concerns in the area of infant feeding in the experimental group, but in the control group there was a greater reduction in the intensity of concerns about their infant's crying.

Health outcomes were measured by post test only in home-visited and not home-visited primiparous women (Barkauskas, 1983). Dependent variables measured were the health of the mother and infant, the health services utilized, and the mother's parenting practices. Subjects were placed into study groups determined by whether they did or did not receive a home visit. In the home-visited group (n=67), instruction was the primary intervention by the PHN. The second group (n=43) received no home visit. More than 85 percent of those mothers visited felt the visit was helpful as the nurse provided useful information. However, the only significant difference in health outcome was home-visited mothers were more likely to express health concerns. The reasons for only one significant finding may be the lack of random assignment to groups and a lack of control over services provided by PHNs.

In a similar Canadian study, a questionnaire was developed to measure three PP program objectives (Stanwick, Moffat, Robitaille, Edmond, & Dok, 1982). The questionnaire was used as a post-test in PHN home-visited (n=49) and non-visited (n=107) women. Both primiparous and multiparous women were included in the study. The results of this study showed the only significant difference between visited and non-visited mothers was visited mothers had more knowledge of the timing of

immunizations. No statistically significant differences were found in other knowledge areas or in infant hygiene skills.

Postpartum home visit evaluation research is scarce but required if the PHN is to maintain a role in postpartum care in the community. It has been suggested PHNs may not be the health care professional of choice for the postpartum woman by Stanwick et al. (1982) who proposed the first well-baby visit to a physician be made earlier or trained non-medical personnel be used to assist mothers in the PP period.

Summary

The trend in health promotion is to move beyond the individual to the social and economic determinants of health. Implicit in all the health promotion documents reviewed in this paper is the importance of client participation in their own health and the health of the community. Nurses support the concept of health promotion and the principle of client participation though their practice may not reflect this support.

Research examining nursing care during home visits is limited. A considerable amount of public health nursing time continues to be spent in the area of maternal/child health; however, little is known of the postpartum home visit. Despite agreeing in principle to client participation, studies show nurses continue to dominate nurse/client interactions. It is not known if client participation is related to the client's satisfaction with or perception of nursing care during the postpartum home visit.

The postpartum period has been recognized as a difficult time for women and research has identified maternal concerns exist in the areas of self, infant, and family

members or friends. Research studies have not clearly established the PP home visit as an effective nursing intervention despite mothers reporting the visit as helpful. There are few Canadian studies related to the PP home visit by a PHN. It is clear further research in this area is required.

CHAPTER THREE

Conceptual Framework

A theoretical framework for public health nursing that incorporates nursing science and public health does not exist and this gap is reflected in nursing research studies (Combs-Orme, Reis, & Ward, 1985; Highriter, 1984). Regardless, key concepts can be identified that are mutual to both nursing and public health. The literature review identified client participation as a key principle in health promotion and community health nursing.

Inherent in the philosophy of community health nursing in Canada is the encouragement of the family and individual to participate as active partners with the nurse in promoting, maintaining, and restoring health (CPHA, 1990). As well, public participation is recognized as an implementation strategy in the Canadian framework for health promotion (Epp, 1986). From an interactionist view, the nurse must have (a) the ability to manage interactions to encourage elaboration of the client's perspective, (b) the skill to involve the patient in joint decision making, and (c) the skill to manage patients' identity which includes influencing perceptions of esteem, autonomy, and efficacy (Kasch, 1986).

Client participation was the concept of interest in this research study. More specifically, participation of the mother during interactions with the public health nurse in the postpartum home visit was examined. As human behavior in a natural setting was described in this study, the theoretical perspective of symbolic interactionism (Blumer, 1969) provided direction for the study.

According to Blumer (1969), symbolic interactionism is "a down-to-earth approach to the scientific study of human group life and conduct" (p. 47) and is based on three assumptions. First, human beings act toward things based on meanings things have for them. Things include anything a person may encounter in everyday life, such as, physical objects, other human beings, guiding ideals, institutions, or activities of others. The second assumption is the meaning of things stems from social interaction between people. The last assumption is the use of meanings occurs through an interpretive process or communication with self used by the person dealing with the thing.

An implication for research of the symbolic interactionism perspective is that to understand human behavior, it must be examined in interaction in the natural setting (Chenitz & Swanson, 1986). A description of the interactions between the PHN and mother gives nurses a better understanding of the meaning of client participation in the PP home visit. As well, a description of the mother's perceptions of the visit enriches nurses' understanding of the meaning of the visit to the client. Observation and examination of nursing practice in natural settings allows nurses to determine if and how concepts, such as client participation, that are common to many fields of study can be applied to nursing practice.

CHAPTER FOUR

Methodology

The purpose of this study was to describe and analyze the postpartum (PP) home visits made by public health nurses (PHNs). The following areas were examined in the study as they relate to the postpartum home visit: topics discussed, maternal concerns, nurses'/mothers' participation, and nurses'/mothers' perceptions of the visit. In this chapter, implementation of the research methodology is addressed. Discussion is focused on the research design, sample and setting, procedures, data collection and analysis, rigor, study limitations, and ethical considerations.

Research Design

A descriptive design using qualitative and quantitative research methods was used to conduct this study. The nurse/client interactions in the PP home visit, as well as the nurse's and the mother's perceptions of the visit were examined. Both sets of data were required to examine the influence of nurse/client interactions on the nurse's/mother's perceptions of the visit. Knowledge of mothers' perceptions of needs and services is necessary if health services are to be client-centered and effective in the PP period (Rovers & Isenor, 1988). Knowledge of nurses' perceptions of the home visit allowed the researcher to examine the data for areas of congruence or disagreement of perceptions between the nurse and mother. Exploration and description of a phenomenon must be completed before the study of relationships between it and other phenomena can begin (Brink & Wood, 1989).

Primarily qualitative methods are appropriate when little research is available on a topic (Field & Morse, 1985). Qualitative research "refers to the methods and techniques of observing, documenting, analyzing and interpreting attributes, patterns, characteristics, and meanings of specific, contextual or gestaltic features of phenomena under study" (Leininger, 1985, p. 5). The descriptive method is considered an example of a qualitative method (Parse, Coyne, & Smith, 1985).

Qualitative methods of research are required to understand the characteristics, nature, and essence of nursing knowledge (Leininger, 1985). Qualitative research uses methods which produce primarily narrative rather than numerical data (Knafl & Howard, 1984) and produces results not arrived at by statistical procedures or other means of quantification (Strauss & Corbin, 1991). However, descriptive designs can make use of both qualitative and quantitative data collection (Brink & Wood, 1989). In this study, some data were quantified but the analysis was primarily qualitative.

Sample

Convenience samples of five public health nurses and ten postpartum women were recruited into this study. In qualitative research, sample size is usually small due to the large volume of verbal data that must be analyzed (Sandelowski, 1986). Qualitative studies are not concerned with generalizability as the intent is to describe and explain phenomena (Brink, 1989). Probability sampling techniques are not required as external validity is not sought.

Public Health Nurses

Public health nurses were chosen from those who volunteered and agreed to take part in the study. A sample of five PHNs was obtained. Public health nurses included in the study:

(a) were employed by a provincial health department in an urban area,

(b) carried out PP home visits as part of their work assignment, and

(c) had a minimum of two years experience as a PHN.

A minimum number of years of experience was a criterion. Although the literature does not identify years of experience required before most PHNs are comfortable with their role, a minimum of two years experience has been used as a criterion of adequate work experience in other studies (Chalmers, 1990; Kristjanson & Chalmers, 1990).

Postpartum Women

The client population of interest was primiparous, postpartum women. A convenience sample was chosen from women who met the inclusion criteria and agreed to participate in the study. Primiparous women included in the study:

(a) resided in a urban area serviced by a provincial health department,

(b) were able to communicate in English,

(c) delivered a full term, single, healthy baby,

(d) were discharged home with their baby following a hospital stay of over 48 hours, and

(e) had their PP home visit within six weeks of the date of birth of their newborn infant.

Subjects were restricted to primiparous women as previous research has indicated that maternal concerns differ for primiparous and multiparous women which may in turn influence the nature of the PP home visit. Under normal circumstances in the provincial public health system, multiparous women usually receive a telephone call rather than a home visit. Each nurse was requested to recruit two mothers to allow the researcher to analyze the adaptations made by the nurses in their interviewing style based on the context of the interview.

Setting

The natural environment provides rich and meaningful qualitative data about people (Leininger, 1985). Natural settings are most often used in qualitative research (Field & Morse, 1985). The setting for this research study was the subject's home where each home visit with the PHN and the interview between the researcher and the mother took place. Nine interviews between the researcher and nurses took place at their place of work and one took place at the home of a PHN as this was more convenient for the nurse.

Procedures

Ethical approval for the study was received from the Faculty of Nursing Ethical Review Committee at the University of Manitoba. To gain access to the study group, formal entry was requested from the Women's Health Directorate of Manitoba Health (see Appendix A).

Following formal approval from the Manitoba Health Research Access Committee, the researcher forwarded a copy of the research purpose, research questions, and methodology to the public health nursing supervisor designated as the contact person. Initially, the researcher made telephone contact with the public health nursing supervisor and then met with her to answer any questions about the study and PHN inclusion criteria, and make arrangements to recruit five volunteer public health nurses for the study.

The supervisor provided the researcher with a list of PHNs who met the study inclusion criteria. Public health nurses were then recruited by the researcher according to the following procedure:

(1) A letter explaining the study (see Appendix B) was given to potential PHN subjects identified on the list received from the supervisor.

(2) Those nurses interested in hearing more about the study completed and detached a form requesting more information (see Appendix B) and deposited the form in a sealed box/envelope left in their office.

(3) The researcher telephoned the nurses who requested further information and explained the study (see Appendix B), answered any questions, and requested their verbal consent to participate in the study.

Three nurses responded in the manner described above. One nurse personally agreed to participate at the time the researcher retrieved the box at an office and one nurse phoned the researcher and gave verbal consent following retrieval of the boxes. Random sampling was not required as no more than five PHNs volunteered to

participate. To protect the anonymity of the PHNs, nursing supervisors were not given the names of nurses who agreed or did not agree to participate. This approach provided a method of protecting the nurse's right to consider participation without coercion.

The researcher requested that each consenting PHN approach two primiparous postpartum mothers who met the study criteria and request their permission for the researcher to discuss the study with them. Mothers agreeing to this request were telephoned by the researcher. The study was explained to the mother by the researcher (see Appendix C) and verbal permission to participate in the study was requested. At the time of the PP home visit, the subject's written consent was obtained by the researcher. This approach provided a method of protecting the mother's right to consider participation in the study without coercion.

Participating PHNs scheduled their PP home visit to consenting mothers in their normal manner but coordinated the visit with the researcher's schedule. Prior to the first home visit, the researcher provided the PHN with a tape recorder, demonstrated use of the recorder, and reviewed the procedures to be followed during the visit. The researcher then obtained the PHN's written consent to participate in the study (see Appendix D) and completed the demographic data form (see Appendix E). Each PHN received a copy of the explanation of the study and consent form. The reseacher arranged to meet with each public health nurse later in the day, following a home visit, to complete a semi-structured interview which examined the nurse's perception of the visit. Interviews were audio-tape recorded by the researcher.

The researcher met the PHN at the home of a subject at the scheduled visit time. Before the visit began, the researcher entered the home, introduced herself to the mother, again explained the study (see Appendix C), answered any questions about the study, obtained written consent to participate in the study (see Appendix F), and completed the demographic data form (see Appendix G). Mothers were given a copy of the explanation of the study and consent form. The researcher gave all mothers the opportunity to complete the interview at another time if they were too tired; however, all chose to be interviewed immediately following the home visit. When the father or another person was present, the researcher gave the explanation of the study to those present and requested their written consent. Fathers or another significant person were estimated to be present in less than 50 percent of PP home visits made in the study area (Donalda Wotton PHN, personal communication, February 6, 1992).

The researcher waited in a car while the PHN completed the postpartum home visit so as not to jeopardize the rapport that develops between the nurse and mother. The PHN recorded the visit using the tape recorder provided by the researcher. The nurse could have turned off the tape recorder at any time during the visit if she felt the client's privacy was in jeopardy or at the request of the mother. This did not happen.

Sefi (1988) noted the "audio-tape recorder is simple to operate, small and unobtrusive. It is easier to ignore than the presence of an observer and less likely significantly to affect the interaction" (p. 7). Dodge and Oakley (1989) also audio-

taped nurse/client interactions without the researcher being present. On two occasions in this study, the PHN asked the researcher for assistance with mechanical aspects of the tape recorder before the home visit started. One interview was delayed due to a mix-up in obtaining the tape-recorder; however, this delay was appreciated by the mother as it gave her the opportunity to settle the baby before the visit.

The researcher again entered the home at the end of the visit, retrieved the completed tape, and interviewed the mother. Mothers were given the opportunity to take any measures required to ensure they were comfortable and ready for the interview. This interview was audio-tape recorded by the researcher. Rationale for completing the interview immediately following the home visit was to be able to capture the thoughts of the mother while the events of the visit were still fresh in her mind.

Data Collection and Analysis

Data for this study were collected from four sources (a) demographic data forms, (b) nurse/client interactions taken from an audio-tape of the home visit, (c) a separate semi-structured audio-taped interview with each nurse and mother following the home visit, and (d) field notes recorded by the researcher.

Descriptive statistics were used to analyze the demographic data collected on mothers and public health nurses. Demographic data describing the sample are presented in chapter five.

The second source of data was the nurse/client interactions taken from the audio-tape recordings of the home visit. Audio-tape recording is becoming a common

data collection method in studies of nurse-patient interactions as it allows leisurely post-hoc analysis (Clark, 1989). As well, audio-taping allows for auditability of data to address systematic bias during data collection or analysis (May, 1991).

The steps followed in the analysis of nurse/client interactions were:

1. The tapes were reviewed once by the researcher to obtain an overview of the visit.

2. The tapes were transcribed verbatim and entered into a computer by a typist using the WordPerfect program. Transcripts were reviewed by the researcher for accuracy and any corrections made.

3. Transcribed data were manually analyzed by the researcher using the analysis procedures described below. Both latent and manifest content analysis procedures were followed (Field & Morse, 1985; Polit & Hungler, 1987; Wilson, 1985).

Analysis procedures:

(a) Latent content analysis was used to analyze the first category of "topics discussed during the home visit" and the second category of "PHN interactions during the visit" (see research question # 2). Open coding in the margins of the transcripts was carried out to identify and describe subcategories. The subcategories were not preconceived but emerged from the data. In addition, analysis was not limited to the categories of topics of discussion and PHN interactions. Additional categories were sought during the analysis, however none were found. In latent content analysis, passages or paragraphs are reviewed within the context of the interview to identify

and code the major intent of the section (Field & Morse, 1985). Units of analysis are units of information that form the basis for defining categories and subcategories. Units of analysis vary from words, phrases, sentences, and paragraphs but are heuristic, or contribute to understanding, and are the smallest piece of information that can stand alone (Lincoln & Guba, 1985, p. 345).

(b) Manifest content analysis was used to analyze the process of the nurse/client interactions (see research question #1). The units of analysis were phrases or sentences in the conversation between the PHN and client or other person present during the interview. Analysis included (i) the length of the visit, (ii) number of questions asked by the nurse, mother, or others present, (iii) amount of time talked by those present, (iv) who introduced/closed topics, (v) who ended the visit, (vi) number of open/closed ended questions, and (vii) whether or not the PHN asks about client concerns, questions, or specific areas to discuss within the first five minutes of the interview. Literature support for the items analyzed in the home visit is found in Appendix H.

A summary sheet of the process analysis of the interview is found in Appendix I. Data from the summary sheet were compiled and analyzed using descriptive statistics. In manifest content analysis, the researcher reviews the transcripts for words, phrases, descriptors, and terms central to the research topic and analyzes them using descriptive statistics (Field & Morse, 1985).

The third source of data came from semi-structured interviews between the researcher and the mother and between the researcher and the PHN. Both interviews

were also audio-tape recorded. The interview between the researcher and mother described mothers' concerns and perceptions of the visit (see research questions #3 & #4). A semi-structured format was chosen as the literature review and personal nursing experience had given the researcher an idea of the structure of the PP home visit but the mother's perceptions of the visit could not be anticipated. Literature support for each of the research questions is found in Appendix H.

The interview between the researcher and PHN described the nurse's perceptions of the visit (see research question # 5). A semi-structured format was also used. Literature support for interviewing the nurse is found in Appendix H.

The reseacher's interview guidelines are found in Appendix J (mother) and Appendix K (nurse). Probes were used as required during the interview to gather more information and/or for clarification (Lofland & Lofland, 1984). Simultaneous data collection and analysis allowed flexibility in the interview questions. The content of each interview provides insight that may require further clarification during the remaining interviews (May, 1991). For example, in this study a question was added that allowed nurses to suggest changes to the postpartum program.

The data analysis of each interview was done separately and followed the same steps as those previously described for the nurse/client interactions. The units of analysis for the interview data varied from words to paragraphs. Manifest and latent content analysis techniques were used to analyze the interview data. Categories were derived from the interview questions; however, subcategories were not preconceived and emerged from the data analysis. Analysis was not limited to the predetermined

categories and additional categories were sought. When appropriate, descriptive statistics were used to summarize data. The results of the analysis of each interview were examined for areas of congruence and/or disagreement.

When the father or another person was present during the home visit and/or interview, the data were analyzed first for the mother's input, then for the input of the other person, and then the data were merged where appropriate. The findings of the analysis of the nurse/client interactions, and semi-structured interviews are outlined in chapter five of the research report.

In addition to the main sources of data described above, field notes related to the research process were taken by the researcher. These notes documented contextual observations, occurring before or after the home visit/interviews or during the interviews, which might influence the event but would not be recorded on an audiotape. Field notes, taken by the researcher, supplement other forms of data collection and are descriptive accounts of what is happening in the setting (Field & Morse, 1985). Data from field notes were used as appropriate in the presentation of the procedures and findings of the study.

The final phase of data analysis was to identify any patterns between the responses to the semi-structured interviews and the analysis of the content and process of the nurse/client interactions during the home visit. Patterns between the participation of the mother in the visit and the mother's satisfaction with the visit were reported. When examining the analyzed data for patterns, statistical inference was not sought.

To ensure appropriateness and clarity of the interview schedule, the first two interviews were used as a pilot. Since no problems in data collection occurred, these data were included in the main data set. The following is a discussion of the procedures used to ensure the trustworthiness of the study findings.

Measures to Ensure Rigor

Trustworthiness refers to the ability of research findings to be worth consideration (Lincoln & Guba, 1985). Within a naturalist paradigm, trustworthiness is established by addressing the criteria of truth value, applicability, consistency, and neutrality. Each of these criteria are discussed in relation to the qualitative aspects of this study. Reliability of the quantitative aspects of the study is presented.

To demonstrate truth value, the researcher must show the probability that the findings of a study will be found credible (Lincoln & Guba, 1985). Credibility was addressed by triangulation of data collection methods (audio-taped home visits & interviews) and peer debriefing. According to Lincoln and Guba, peer debriefing "is a process of exposing oneself to a disinterested peer in a manner paralleling an analytic session and for the purpose of exploring aspects of the inquiry that might otherwise remain only implicit within the inquirer's mind" (p. 308). The researcher used peer debriefing as required throughout the process of the study. Categories were reviewed with the peer debriefer. Category definitions were also discussed to ensure fit and clarity.

The aim of applicability is to determine the extent the research findings can be applied to other contexts or subjects (Lincoln & Guba, 1985). To meet this criterion,

the researcher has provided clear descriptions of the sample, setting, and procedures.

The consistency (auditability) of a study ensures the findings would be similar if the study was replicated using similar subjects and a similar context (Lincoln & Guba, 1985). This criterion was met by developing detailed definitions of coding categories used in the latent content analysis of the interviews. The internal thesis committee member, an expert in maternal/child health nursing, was given a random sample of two pages from each home visit. Category definitions for each topic and each public health nurse interaction were provided by the researcher. The expert was asked to use the definitions provided and code topics discussed and public health nurse interactions found in the sample of data provided. The researcher had previously coded the same sample.

An interrater reliability of 80.6 percent was achieved in the coding of major topics discussed during the home visit. An 80 percent agreement is considered adequate for reliability (Topf, 1986). Interrater reliability was not used for the coding of nurse interactions in the home visit. Although the researcher and internal thesis committee member agreed on the coding of the majority of the major categories of interactions, it was difficult to always accurately code every interaction for several reasons.

The first reason was some subcategories were too precisely defined to code consistently and had to be combined into broader subcategories. Second, as only a sample of each home visit was given to the second reader, it was sometimes difficult to code an exchange which was midway through a conversation. Third, the second

reader, not familiar with the data, could miss coding a segment of conversation. For example in the following statements the nurse says: "Oh that's good. Have you got parents around?" The nurse gives encouragement and requests information; however, both were not coded by the second reader. In another example, the nurse responding "Ahum" was missed during coding by the second reader.

However, consensus was achieved between the researcher and the reviewer. The reviewer considered the categories generated were appropriate to the data and the definitions provided. Following coding, changes were made as required to the wording of categories and subcategories of topics discussed and nurse interactions.

Samples from seven interviews between the researcher and PHN and seven interviews between the researcher and mother were also reviewed by the internal thesis committee member to ensure accuracy in the interpretation of the data. The categories generated closely resembled the questions asked by the researcher as outlined in the interview guides (see Appendixes J & K). There was total agreement between the researcher and the internal thesis committee member on the interpretation of the data.

Reliability of the process component of nurse/client interactions in the home visit was determined by giving a random two page sample of each interview to a second reader (the chair of the researcher's thesis committee). Appropriate coding descriptions and instructions were provided to allow the second reader to code the sample provided (see Appendix L). The reseacher coded the same sample. One hundred percent agreement was achieved for coding the questions 'who ended the

visit' and 'did the nurse ask about mothers' questions or concerns in the first five minutes' (see Appendix L, Questions #5 & #7).

However, the other questions reviewed presented some difficulties using the percent agreement for reliability. Reasons for the problems were similar to those previously noted for coding nurse/client interactions. As well, the second reader made some errors in classifying questions asked as opened or closed. Second, typing styles resulted in some errors counting lines of text to calculate time talked. Third, the second reader missed counting a few questions asked by the nurse or mother. Despite the problems there was considerable agreement. The researcher met with the second reader and each sample home visit was reviewed. Consensus was achieved for all coding categories.

Neutrality or objectivity of a study establishes that the findings are related to the subjects and not the conditions of the inquiry or the interests of the researcher (Lincoln & Guba, 1985) or there is freedom from bias in the research process and product (Sandelowski, 1986). Lincoln and Guba suggest using techniques for assessing confirmability for this criteria. "Confirmability is achieved when auditability, truth value, and applicability are established" (Sandelowski, 1986, p. 33).

Ethical Considerations

Informed consent is a safeguard to protect subjects from the potential harm of research studies (Ramos, 1989). This issue was addressed by giving the nurses and mothers a detailed verbal and written description of the study and having them sign a consent which clearly outlined the research process. The process of obtaining

informed consent for this study has been presented previously. Nurses and mothers were made aware that they were free to withdraw from the study at any time without threat to future care (mothers) or position as a PHN. None of the subjects chose to withdraw from the study.

To protect the anonymity of the PHNs, nursing supervisors were not informed of nurses who participated or did not participate in the study. To protect the confidentiality of subjects, no specific information about the home visit was communicated to the nursing supervisors. Information from the PHN's interview was not shared with the mother nor was information from the mother's interview shared with the PHN. However, should the mother have exposed information during the visit requiring referral to the PHN or physician, the researcher would have referred the client to the PHN or doctor or informed the nurse directly if the mother gave consent to do so. This procedure was not required.

Participants were not expected to suffer any risks as a result of taking part in this study. However, to protect the mother from disclosure of any extraneous personal information, both the PHN and mother were informed that they had the right to stop the audio recorder at any point during the home visit. However, this did not occur during any of the home visits. The mother or nurse could choose not to answer particular questions asked by the researcher during the semi-structured interview. Subjects answered all questions asked by the researcher.

To protect the identity of nurses and mothers, subjects were requested to use first names only during the home visit and interview. Code numbers were used to

identify tapes and transcribed notes. Only the researcher had access to subject names, addresses, phone numbers, and code number information which was kept in a locked cabinet, separate from the tapes and transcripts. Tapes, transcribed notes, demographic data forms, and consent forms were also kept in a locked area. Only the researcher's thesis committee had access to the raw data. Raw data will be destroyed after 10 years.

The typist was advised of the confidential nature of tapes and transcripts and was advised not to transcribe subjects' names but to use the subjects' identification numbers provided by the researcher.

Limitations

Several limitations of the study's methodology were identified. One limitation is that the full range of the home visit was not recorded on the audio-tape as the PHN did not start the recording until the more formal part of the interview began. An alternative method would have been to have the researcher set up the recorder while she was explaining the study to the mother and obtaining her written consent. This method was viewed as less satisfactory as it would have meant the researcher was determining the seating arrangement which is best decided by the nurse and client.

In two cases, the physical examination of the baby was not recorded as it took place in another room and the nurse did not move the tape recorder. As well, latter portions of the end of the interview may have been missed if the nurse turned off the recorder and then added additional information.

Although each PHN completed two client home visits in order for the researcher to examine the nurse's interview style in the context of the visit, the small sample size (n=2) did not permit detailed comparisons. However, it was possible to see patterns of nurse interview style emerge.

Summary

In this study, a descriptive research design was used to describe and analyze the postpartum home visit made by public health nurses to primiparous women. Five public health nurses audio-tape recorded the home visit of ten mothers. Nurses and mothers were separately interviewed by the researcher following the visit. Latent and manifest content analysis was used to analyze the data.

In this chapter, implementation of the research methodology was discussed. Issues pertaining to the rigor of the study and ethical considerations were addressed. Finally, limitations of the study's methodology were presented. In the following chapter, findings of the study are presented.

CHAPTER FIVE

Findings

The purpose of this study was to describe and analyze the postpartum home visit made by provincial public health nurses. A non-experimental design was used to examine the process and content of nurse/client interactions during the home visit and to examine nurses' and mothers' perceptions of the visit. In this chapter, demographic data describing the public health nurses and the postpartum women who took part in the study are presented.

The findings of the study are presented in sections related to the research questions. The first research question presented is: What is the nurses'/mothers' participation in the postpartum home visit? The next findings are outlined as related to the question: What topics are discussed during the postpartum home visit? As well, mothers' and nurses' perceptions of the home visit are described. Finally, patterns between the content and process of nurse/client interactions and the responses to the interviews are presented.

Demographic data-public health nurses

All public health nurses (PHNs) who took part in the study were female and had a baccalaureate degree in nursing. Nurses' ages ranged from 32 to 52 years with a mean age of 39.6 years and a median of 39 years. Years of experience as a PHN for the subjects ranged from 6 to 19 years though some of this was part-time. The mean years of experience was 12.8 with a median of 12 years.

Demographic data-postpartum women

The mothers in the study sample ranged in age from 19 to 32 years, with a mean age of 27.2 years and a median of 28.5 years. The date of the postpartum (PP) home visit ranged from 8 to 19 days from the date of birth (DOB) of the baby (DOB=day 0). Two visits occurred in the first 10 days, five from day 11-15, and three from day 16-19.

Two mothers did not attend prenatal classes, although one of these mothers had prenatal teaching on a one-to-one basis from a nurse midwife. The average number of prenatal classes attended by the mothers was 6.5. All mothers except one completed high school. One mother had some post secondary education and four mothers completed post secondary education. All mothers had been employed, at least part-time, shortly before or during their pregnancy. The majority of mothers held professional or semi-professional positions and lived in single family dwellings. All mothers resided in well maintained suburban areas in homes which were clean and adequately furnished.

Fathers were present and actively participated in three of the home visits (one did not stay for the interview with the researcher). In addition, one father came home mid way though the visit but did not participate. The mother of one subject was present for a visit and one mother-in-law was present during another home visit. The mother-in-law did not participate in the visit as she spoke limited English. Therefore, in 50 percent of the visits another person was present.

Research Question: What is the nurses'/mothers' participation in the postpartum home visit?

In this section, the findings are outlined as related to the research question: *What is the nurses'/mothers' participation in the postpartum home visit?* Nurses' and mothers' participation in the home visit was summarized using a summary sheet (see Appendix I). A composite of findings from all the home visits is found in Table 1. To protect the anonymity of the subjects, results presented as 'other' are combined to include the subject (postpartum mother) and father or grandmother.

The variables examined included the length of the visit, the number of questions asked and by whom, the number of open/closed-ended questions asked by the nurse, amount of time talked by those present and the number of times they introduced a topic, who ended the visit, and whether the nurse asked in the first five minutes of the visit if the mother had any concerns, questions, or specific areas to discuss. The findings related to each of the variables are outlined below.

The length of the visits was calculated and found to range from 49 to 100 minutes with a mean length of 70.6 minutes and a median of 70.

Table 1

Summary Home Visit Process

Mother # PHN #	1 1	2 1	3 2	4 2	5 3	6 3	7 4	8 4	9 5	10 5
Length of Visit (minutes)	49	49	87	78	61	60	100	77	63	82
# Questions: PHN Mother/Other	 72 5	 79 5	 68 17	 78 43	 53 24	 71 14	 36 56	 56 28	 52 2	 77 59
Time talked: PHN Mother/Other	 301 366	 509 115	 663 333	 831 249	 458 201	 447 238	 708 173	 853 196	 456 59	 892 338
# Times introduced topic PHN Mother/Other	 35 6	 31 7	 20 9	 21 7	 24 7	 38 6	 28 14	 25 4	 10 0	 18 17
Ended Visit: PHN Mother	 *	 *	 *	 *	 *	 *	 *	 *	 *	 *
Open quest.: Closed quest.: (PHN)	13 59	12 67	3 65	6 72	3 50	4 67	3 33	6 50	5 47	8 69
Concerns identified first 5 minutes	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Home visit audio-tapes were reviewed to determine if mothers were given an opportunity early in the visit to express their concerns. In seven out of ten of the visits, once the tape recorder was turned on, the nurse took direction from the mother for the home visit. Within the first five minutes of these seven home visits, mothers were asked by the nurse if they had any questions or concerns, or were asked for general comments. The interview then proceeded from that perspective. For example, one nurse started by saying "...first of all did you have any questions that you were wondering about, anything that you've been thinking about or something that's come up?" and another nurse began with "Anyway, tell me how you've been?" or "How have the first two weeks been?"

In one visit, the interview began with the nurse and mother deciding together to start the visit with an examination of the baby and in two visits the same nurse started the interview by asking about the mother's delivery experience. In this research study, the nurses did not turn on the tape recorder before entering the mother's residence. What occurred before the recorder was started is, therefore, unknown.

Though not all visits commenced with the mother's concerns, at some point in all visits but one, mothers were asked about their concerns or if they had any questions. Reasons for the differences in the opening direction are not known. It may be possible that a nurse used information gathered from a telephone contact or from the un-recorded portion of the visit to direct the opening approach. Regardless,

all mothers were given the PHN's phone number and were encouraged to call if any questions or concerns surfaced in the future.

In addition to nurses having primary control of the opening of visits, all visits were terminated by the nurse. However, seven mothers were given the opportunity to ask final questions before the nurse left. Other ways of terminating the visit included: the nurse entering into a social conversation, the nurse stating she would turn off the tape recorder: "okay, I suppose we can turn this off now it's over", or the nurse reminding the mother where to call: "Okay, my card is here. Just call anytime something comes up, any concerns or questions."

Another approach to ending a visit was to offer a summary. In this study, a summary of the visit was given to six mothers. Summaries given were usually very brief: "He's healthy and he's growing well and you're doing well." Summaries also appeared at various times throughout the visit but related to only part of the visit, for example, "at the present time you're supplying very well, he's gaining, and he's eating fairly frequently" or "well little man, you're doing amazingly well, you're a beautiful little boy, nice and pink, you sure are."

In addition to controlling the termination of the visits, nurses generally controlled the visit both in the amount of time talked and number of questions asked. Time talked by each subject during the home visit was roughly estimated by counting lines of text in the transcript. Despite this crude measure, it was obvious nurses dominated the conversation in all but one home visit. On average nurses consumed

611.8 lines of text compared to an average of 226.8 for mothers/others (see Table 2 for medians and ranges).

Table 2

Descriptive Statistics Home Visit Process

	Mean	Median	Range
Time talked: PHN Mother/Other	 611.8 226.8	 586 219.5	 301-892 59-366
# Questions: PHN Mother/Other	 64.2 25.3	 69.5 20.5	 36-79 2-59
Open-ended Questions PHN	 6.3	 5.5	 3-13
#Times Intro.Topic: PHN Mother/Other	 25 7.7	 24.5 7	 10-38 0-17

In all but one home visit, the nurse asked more questions than the mother. Nurses asked an average of 64.2 questions compared to an average of 25.3 questions asked by mothers/others. However, mothers may have expressed a concern but not necessarily in the form of a question, for example, "I'm worried about the sun and everything." Some mothers offered information that suggested a concern: "He's full of phlegm first thing in the morning..."

The example of the mother/other asking more questions and the example of the mother/other talking more than the nurse did not occur in the same home visit. Both examples were reviewed for possible reasons; however, no links were found. Both mothers attended prenatal classes and were similar in age (27 years and 29 years). In one case, the father was present and in the other case the father was not present. Therefore, the father's presence did not necessarily influence the amount of time talked or number of questions asked.

Nurses used few open-ended questions during their visits with the mothers. Open-ended questions were defined as "...those that can't be answered in a few short words. Typically, open questions begin with what, how, why, or could" (Ivey, 1983, p. 41). In this research study, questions starting with such phrases as how long, what color, how much, and what kind were defined as closed questions as they were typically answered in a few short words. An example of an open-ended question was "How do you feel about breastfeeding?"

Only 9.8 percent of the questions asked by the nurses were open-ended in nature. Despite the closed-ended nature of the questions asked by the PHNs, the mothers frequently answered in great detail. On the other hand, open-ended questions were sometimes answered with a brief response. For example, one nurse asked: "How did you feel with a male student nurse?" The mother responded: "He was wonderful." In another visit the nurse asked: "How did you find your prenatal classes?" and the mom answered: "Oh, I liked them."

In addition to asking few open-ended question, nurses seemed to direct the flow of conversation by their control over the introduction of topics. Nurses introduced topics on average 25 times. Mothers/others introduced topics on average 7.7 times. However, mother #7 and mother #10 introduced topics 14 and 17 times respectively (see Table 1). Who ended each topic was not counted as there was not a formal closing to topics. Topics seemed to close by the introduction of a new topic. In each of these home visits the mothers also asked more questions (56 & 59 respectively) than the average number of questions (25.3) asked during a visit.

Data from the home visits were examined to determine if the presence of the father or another person influenced the process of the home visit. As only three fathers were present during home visits, it was difficult to draw many conclusions. Fathers talked less time than mothers in all three visits and in two visits asked fewer questions. Grandmothers made no significant contribution to the home visits.

The researcher was also interested in examining any patterns that occurred in a nurse's interviewing style. However, as only two home visits for each nurse were observed, it is difficult to draw conclusions. Few similarities emerged in nurse interview style between the two visits. Nurses seemed to adapt their home visits to the needs of the mother/father. Although one nurse started both visits by asking about the labour experience, no other patterns were noted.

The findings from most of the visits were fairly consistent. In only one case did a mother/other (mother #9) ask considerably fewer questions, talk considerably less, and introduce considerably fewer topics than the average mother/other. This

mother (#9) attended prenatal classes, was 31 years of age (median age 28.5 years), and did not appear to have any other demographic characteristics that differed from the other mothers. In only one visit, the mother/other talked more than the nurse but the number of questions asked by this mother/other was less than the average for other mothers/others. One mother/other asked more questions than the nurse; however, the nurse still talked more.

In summary, PHNs dominated the home visit both in amount of time talked and number of questions asked. In the majority of visits, nurses took early direction for the visit from the mother; however, nurses seemed to direct the flow of conversation by controlling the introduction of topics. Most of the questions asked by nurses were closed-ended and there did not seem to be a relationship between the type of question asked and the length of response by the mother/other. Nurses terminated all visits. Grandmothers present during the home visit did not make any significant contribution to the conversation. Fathers who were present asked questions and contributed information to the conversation with the nurse. No significant patterns were found in nurses' interviewing styles.

Research Question: What topics are discussed during the postpartum home visit?

In this section, findings are discussed as related to the research question: *What topics are discussed during the postpartum home visit?* Public health nurse interactions during the visit are also presented.

During data analysis of the transcripts of the postpartum home visits, four categories of discussed topics emerged. Public health nurses' discussion related to

baby, mother, services, and other. Each topic consisted of many subtopics which are presented in Table 3 and described further in this section. From the sum of the number of lines of text in the transcripts, nurses spent the majority of their time discussing topics related to baby and mother. Topics related to 'services' and 'other' took up a very small portion of time during the home visit.

In all visits, nurses addressed the topic areas of baby, mother, and services. However, not all visits covered the same subtopics or the same intensity of discussion by the nurse. Need for discussion or depth of discussion was often judged by the nurse asking such questions as "...or are you well informed in that?" Pamphlets were sometimes used to guide a nurse's discussion. One nurse stated: "I brought you some pamphlets here and I'll just sort of go through them here just to show you what I brought."

The baby was examined in all visits but not all examinations were tape recorded. In the examinations that were recorded, no pattern of examination emerged though areas examined were similar. For example, all babies did not have their temperature taken but the umbilical cord was examined in all visits.

Some form of assessment was done on all mothers by the nurse asking mothers verbal questions. As in the assessment of babies, areas of verbal examination were similar but not all nurses covered the identical subtopics. Common areas of assessment included bowels, bladder, episiotomy, and lochia.

Table 3
Topics Discussed: Home Visits

BABY	*1.NUTRITION/ELIMINATION*: feeding issues (breast, bottle, feeding patterns, supplements, solids, juices, vitamins), bowels, bladder, burping, vomiting, fussy periods (crying, gas, colic, soother, gripe water,spoiling).
	2.DAILY CARE ISSUES: bathing, cord care, nail care, eye care (tear ducts), sleep patterns, effects of temperature (clothing for heat, cold, sun, wind), taking baby out (company in).
	3.SKIN: color, rashes, dry skin, diaper rash.
	4.GROWTH & DEVELOPMENT: baby's age, weight gain, growth spurts, reflexes, fontanelles, hips, breast characteristics, vision (eye color), hearing, issues related to assessment of baby.
	5.SPECIAL CARE ISSUES: immunization, signs and symptoms of problems, thrush, fever (taking temperatures).
	6.SAFETY: sleep (crib, bassinet, sleep position - SIDS, bedding) house, car (seats).
MOTHER: Physical	*1.BREAST*: nipples (tender, cracks, shields, clogged ducts), mastitis, engorgement, expressing, techniques of feeding.
	2.PERINEAL CARE: episiotomy, lochia, peri care, kegal exercises.
	3.NUTRITION/ELIMINATION: appetite, diet, bowels, bladder, hemorrhoids.
	4.LABOR & DELIVERY
	5.LIFESTYLE: smoking, work outside the home, exercise, sex & birth control, weight, sleep/rest, finances, blood pressure.
	6.PROBLEMS: signs and symptoms of problems (infection), diabetes, sore back, vaginal itching, headaches, low hemoglobin.
MOTHER: Social/ Emotional	*1.COPING*: postpartum stress,
	2.SUPPORT: family, friends, husband (sharing work, relationship questions)
SERVICES	*1.PHN*: card/call, Child Health Clinic, Parent Time, follow-up
	2.POSTPARTUM STRESS PROGRAM
	3.PHYSICIAN FOLLOW-UP
OTHER	*1.SPECIAL INTEREST PHN*

The only area that was consistently addressed in all home visits was breastfeeding. At the time of the visit, all mothers were breastfeeding. Breastfeeding was discussed from the perspective of the mother (latching, expressing, nipple care) or from the perspective of the baby (feeding patterns, supplements, introducing solids). Both perspectives were not necessarily reviewed during the visit. In some visits, the nurses covered breastfeeding in great detail and in other visits the topic was only briefly mentioned. The following is a conversation exchange illustrative of a brief discussion on breastfeeding from one visit:

PHN: How's breastfeeding?

Mother: Going really well, yeah. It's going really well. He's, I'm enjoying it and he is doing really well.

Father: He's hungry.

PHN: He's hungry.

Mother: He's feeding a lot for a good long stretch in the day he's feeding every two hours. And then he'll have a couple of sleeps where he's down to about four hours.

PHN: That's good. That's a real normal schedule.

Patterns of addressing topics by the PHN did not emerge from the data. For example, birth control was not covered in all visits and the amount of information given was not always consistent with a mother's expressed needs. One nurse asked:

One other thing that I wondered about was family planning. I know it seems a bit early to be talking about but do you have any questions about that,

anything you were wondering about that as far as contraceptives or that kind of thing. Or are you well informed in that?

As the mother responded that she felt she had sufficient information, no further information was given by the nurse.

In another visit, the nurse asked: "Have you given any thoughts to birth control other than or is it fair to ask at this stage?" Though the mother responded: "Not yet I haven't." and gave no indication of interest, the nurse continued to present birth control information.

An in-depth discussion of each topic area is found in the following section.

Topic: Baby

All issues related to the topic of baby centered around physical care of the infant. Issues discussed were classified by the subtopics of nutrition/elimination, daily care issues, skin, growth and development, special care issues, and safety. A description of each subtopic is found in Table 3. Nurses' discussion of a specific area was not necessarily related to an expressed concern by the mother and often occurred during the baby assessment.

Nutrition/elimination included such topics as feeding issues, bowels, bladder and fussy periods. All mothers were breastfeeding at the time of the home visit. Feeding was discussed in all visits regardless of whether a mother had a question or concern. Many questions asked by mothers surrounding breastfeeding related to the baby getting adequate milk intake. Examples of questions asked by mothers are "Can you overfeed them?" and "I'm feeding her roughly 15 minutes each side, is that OK?"

Mothers asked about the wisdom of using gripe water and soothers and recognizing colic. Nurses assessed elimination by asking questions about the frequency and description of bowels and bladder. In some visits, nurses, in teaching mothers how to assess if a baby's intake was sufficient, related frequency of elimination to feeding patterns.

Daily care issues covered such areas as bathing, umbilical cord and eye care, and sleep patterns. During several visits, mothers had questions about the effects of room/outside temperature and how to adjust the baby's clothing, for example: "In hot weather, do I still have to wrap him up?" Some mothers also expressed concern about the effects of taking their babies outside the house or to events where there would be many people. Nurses would often respond by giving general advice a mother could apply to different situations, for example: "Sort of a little tip I give moms is, I usually say, maybe put one extra layer of clothing on your baby than you have."

Discussion of skin included such areas as rashes, dry skin, and diaper rash. Nurses assessed jaundiced babies for improvement in skin color, and at the same time, might teach mothers how to assess improvement. One baby had a diaper rash and again appropriate treatment was described by the nurse.

Growth and development included areas surrounding the baby assessment, such as reflexes, fontanelles, and dislocation of hips, as well as such issues as weight gain. Nurses frequently used this time to teach mothers about what would be considered

normal. Mothers were also interested in eye color, vision, and hearing and asked, for example: "When do their eyes start to focus?"

Special care issues included such areas as immunization, fever, and thrush. Some babies had their temperature taken and nurses used this opportunity to ask if mothers had a thermometer and knew how to take a temperature. For example a nurse asked: "Do you have a thermometer? (Mother responded: "Uh huh") Good, and when you take her temperature it should be under her arm."

Immunization was not covered in all visits and the information that was given was brief. The researcher was given the impression that immunization was the responsibility of the physician. For example, a nurse commented, "You're first one is two months and Dr. R. will probably call you in at that time." One nurse indicated PHNs did little immunization during Child Health Clinics but that their strength was developmental assessments. Another nurse stated "It's (Child Health Clinic) a supplement to your doctor visits...".

The subtopic of safety included discussion of such issues as house, car, and/or sleep safety. Some mothers were interested in sleep position as a article on the topic had recently appeared in the newspaper. Nurses had not yet received updated pamphlets on the topic, so one PHN had copied information from a local newspaper to give to mothers. Another nurse explained the principle of tethering a car seat during both home visits. Some nurses would visually inspect cribs and car seats. Not all nurses reviewed any or all safety issues; however, the mother may have been

given pamphlets on the topic or safety may have been discussed during the baby examination which was not tape recorded.

Topic: Mother

Both physical and social/emotional topics were addressed in the category of mother. Physical care topics dominated the discussion. Crossover occurred between the social/emotional subtopic and the nursing interaction called "socializes" (see Table 4). In this study, social topics discussed by PHNs during the home visit have been classified as a nursing interaction.

Physical aspects covered areas such as breast, perineal care, nutrition/elimination, labour and delivery, lifestyle, and problems. Depth of discussion of breast care seemed to be determined by concerns or problems of an individual mother. If a mother was having problems with sore nipples, the nurse may discuss feeding position or a nurse may ask to observe a mother breastfeeding.

One mother had her breast examined by the nurse for reddened areas. When the area was located, the nurse had the mother view the reddened spot in the mirror. In this case, the nurse also observed the mother breastfeeding and made appropriate suggestions. Another mother was using a breast shield for feeding, so the PHN spent time explaining how and why it was important to wean the baby off the shield.

Discussion surrounding perineal care and nutrition/elimination was frequently guided by the nurses asking assessment questions, for example:

> And how about the rest of you physical recovery now. You had a regular vaginal birth and a bit of a tear. How's that healing?...and how about bowel

or bladder. Any trouble going to the bathroom?...and with your lochia or the blood discharge, are you having any large clots?

The conversation would then stem from the answer the mother gave.

The labour and delivery experience was not addressed in all visits. During those visits in which the delivery was mentioned, usually the more technical or physical aspects were reviewed. The emotional aspects of labour and delivery were examined in one of the visits. One nurse asked: "What about your labour and delivery, how long was it?" and another asked: "What did you use for breathing levels?"

Lifestyle issues included such areas as smoking, returning to work outside the home, exercise, sex and birth control, weight, and rest/sleep. One mother had her blood pressure taken. Finances were addressed in only one visit. The nurse asked: "So you're not worried about having enough in terms of things for baby between family and?"

Problems were identified by both nurses or mothers. Some mothers were experiencing specific problems and initiated discussions with the PHN. One mother offered: "That's another thing to talk, I'll ask you about this now since, I have had a lot of --" (topic not identified to protect anonymity of mother). One nurse asked about a problem that had been noted on the Postpartum Referral Form. Also included in this subtopic were discussions, where nurses took the opportunity to teach the mother general signs and symptoms, about problems such as infection. One nurse

gave a mother information on the signs and symptoms of bladder, breast, and episiotomy infections.

Social/emotional subtopics included coping and support. Assessment of social/emotional needs was briefly explored. Emotional status was mentioned in all but one visit. One nurse described postpartum stress during both home visits and left a pamphlet on the topic but did not ask the mothers about their personal emotional status. Common questions were: "As far as your sort of emotional status, any tearfulness or sort of ups and downs?" or "Have you experienced what we call the baby blues, teariness or anything?" or "How do you find you're coping?"

Mothers' adjustment to parenthood was not verbally assessed in any visit. Only two nurses asked about fathers who were not present and one mother volunteered information about how her husband was reacting to the baby. One nurse asked: "How's your husband adapting to parenthood?" and another "Did your husband have any questions?" Specific questions on the husband's role in baby care were rare.

Nurses appeared to assess support in all home visits. Most nurses used the following types of questions: "Grandma and grandpa been over to help out or?" or "Who have you got to help you when things get kind of rough?" In some visits, family support was visible by the presence of the grandmother and confirmed by mothers expressing how they appreciated the help.

Topic: Services

Information on services included those of the PHN, postpartum stress program, or physician. In all visits, mothers were given the name and phone number of the nurse and were encouraged to call if questions or concerns developed at a future time. For example, one nurse ended the home visit with the statement: "Okay, my card is there, just call anytime something comes up, any concerns or questions." All mothers were informed of Child Health Clinics or Parent Time which are both services offered by Manitoba Health.

Most mothers were given a pamphlet about postpartum stress; however, not all nurses specifically mentioned the program offered by the Women's Health Clinic. One mother was not given any resource information but the PHN suggested the mother contact the PHN about resources if required. In the majority of visits, nurses were able to gather information about physician follow-up. Mothers offered information about physician appointments, or the nurse asked when an appointment was scheduled. In some cases, the nurse would remind the mother to see the physician.

Topic: Other

There is only one example of the topic 'other'. One nurse discussed a health topic in both home visits that was not directly related to the mother's postpartum recovery or baby care. The exact topic is not identified to protect the anonymity of the nurse.

In summary, topics discussed during home visits related to baby, mother, services, and other. Not all visits covered the same subtopics or the same intensity of discussion. All babies were examined and all mothers were assessed through verbal questioning by the nurse. All issues related to baby centered around the physical care of the infant. Social/emotional aspects of the mother were only briefly explored. All mothers were given the name and phone number of the nurse and encouraged to call the nurse with questions or concerns.

Public health nurse interactions

During data analysis, several types of interactions between public health nurses and those present during the home visit emerged. An interaction was defined as verbal or assessment behavior between the nurse and any other person present during the postpartum home visit. Public health nurse interactions clustered into four categories: socializes, listens actively, takes information, and gives information. All nurses displayed some component of each category of interaction during every home visit. Taking information and giving information were the dominate activities in all home visits. A description of each interaction is presented in Table 4.

Interaction: Socializes

The interaction labelled "socializes" refers to nursing activities or verbal exchanges not directly related to health care topics. In each home visit, nurses spent some time socializing with the mother and/or baby or others present at the time. Some social aspects of the opening or closing of the visit may not have been recorded. Some socializing may have occurred before or after the nurse turned the tape recorder on or off. One nurse expressed concern that the opening of the visit was not recorded. The nurse described the opening as "sort of the niceties that get, that you have to be comfortable with each other."

Table 4
Public Health Nurse Interactions: Home Visits

SOCIALIZES	***1.ACKNOWLEDGES***: baby (admires/talks to baby, dresses/changes baby), others present during visit, pets.
	2.DISCUSSES SOCIAL ISSUES: specifics of family business, attenders of prenatal classes, home furnishings/baby apparel, views photographs.
LISTENS ACTIVELY	***1.ACKNOWLEDGES***: repeats what mother/father/other stated, responds (OK, Alright, Yes, Ahum), confirms heard/understood what was said.
TAKES INFORMATION	***1.REQUESTS***: input (any questions/concerns), direction (check baby now/where to check/where to wash).
	2.COLLECTS INFORMATION/DATA: asks questions, determines need to give information or leave pamphlet (based on knowledge/interest of client), examines mother/baby.
GIVES INFORMATION	***1.EXPLAINS***: addresses a question or concern, describes what would occur during visit, teaches, provides information on a topic, demonstrates, summarizes progress of baby/mother, closes (gives opportunity to ask last questions, reminds mother where to call for help, states will be leaving, states will turn off tape recorder).
	2.PROVIDES: suggestion, advice, opinion, direction/solution/action to take, general information mother can apply to various situations, positive feedback (encouragement, progress/events normal, baby gaining, confirms mother's/father's actions were okay).

Crossover occurred between interactions called "socializes" and the social/emotional aspects of topics discussed with mothers (see Table 3). In this study, social topics discussed by PHNs during the home visit have been classified as a nursing interaction.

Social interactions took a variety of forms. Nurses often talked to or admired the baby. The following conversations are examples of a nurse talking to a baby: "Hello sweetheart, you were awfully patient for that assessment, yes you were." and "Oh, oh you're going to spend a lot of time on grandma's shoulder today, eh." During the physical assessment of the baby, some nurses would undress/dress the baby or change a diaper.

At times, nurses commented on home furnishings or baby apparel. Nurses viewed baby pictures or discussed common areas of interest. In some visits, nurses acknowledged the presence of pets, for example, "So I see you have a budgie." In other visits, nurses would talk socially with others who were present during the home visit. For example, one nurse made the following comment to a grandmother who was visiting from out of province: "Maybe you'll get some good Manitoba sun." Some nurses opened and/or closed the visit by social conversation.

Interaction: Listens Actively

The next interaction category was called "listens actively" which was defined as verbal acknowledgement given by the nurse to a statement made by any person present during the home visit. This interaction did not take up a great deal of nurses' time. Many nurses made comments such as "ahum", "yeah", or "okay" continually while mothers were speaking. As well, some nurses would confirm that they

understood what the mother was saying or would repeat what the speaker had just said. Nurses appeared to listen actively throughout the entire visit.

The following is an example of a nurse confirming she understood what the mother said:

Mother: "And, ah for the first two nights at home it was hard, couldn't relax enough to sleep. Now I can."

Nurse: "Now you're sleeping. Okay. Try and catch those naps during the day even if it's just half an hour."

In the following example, the nurse repeated what the mother stated to confirm her (nurse) understanding of what was said:

Mother: "... the only bad part was when they started inducing but..."

Nurse: "Oh they did induce? Augmented you eh, like you were in labour, or they..."

Mother: "I was in labour for about, well from 1:30 in the morning and they finally induced me about 8 or 9 at night."

Interaction: Takes Information

The major focus of nurse/client interactions was taking information and giving information. "Takes information" was defined as nurses collecting assessment data from those present during the home visit. "Gives information" was defined as nurses providing some form of teaching to those present during the home visit. Nurses moved back and forth between taking information and giving information. Therefore, assessment and teaching did not occur as distinct and separate phases of the home

visit. Nurses seemed to shift back and forth between assessment and teaching continually throughout the entire home visit.

In the category takes information, nurses occasionally sought input from mothers by asking if they had any questions or concerns. Some nurses asked mothers more than once during the visit if they had any questions. One nurse asked a mother if her husband who was not present during the visit had any questions. As well, nurses often asked for mother's permission before examining the baby. For example, "I wonder if I could take a look at him? ...Can I wash my hands in your bathroom?"

For the most part, however, nurses controlled the direction of the interview by asking for and then giving information. Nurses continued asking questions to complete their assessment of the mother/baby or to determine the need to give information. The physical assessment of the mother and baby were classified as a component taking information.

In the following example the nurse continued asking questions until she had determined the mother's lochia was normal:

Nurse: "How's your flow?"

Mother: "Good. Some days it's heavier than others but"

Nurse: "What color is it?"

Mother: "Red"

Nurse: "Bright new blood or darker, older?"

Mother: "Sometimes well, this morning, was it this morning or last night, it seemed really bright but that might have just been maybe because there was a lot there, like..."

Nurse: "How many pads a day?"

Mother: "Ummm"

Nurse: "More than eight?"

Mother: "No"

Nurse: "Soaked?"

Mother: "They seem to be very full when I change them."

Nurse: "But not soaked heavy. Ok, it sounds like you have a moderate flow but not too heavy."

At other times nurses would determine the need to give information by asking the mother if she required the information. For example:

Nurse: "Did they talk to you about the signs and symptoms of infections or hemorrhage at hospital and things to watch for?"

Mother: "No"

Nurse: "The things to watch for mainly..."

In the following situation, the nurse ascertained a pamphlet was not required:

Mother: "I have it."

Nurse: "Oh, do you have one?"

Mother: "They gave it to me when I was there Wednesday."

Nurse: "Excellent....I'll recycle this one."

Interaction: Gives information

The final category of interaction was termed "gives information". Gives information was defined as nurses providing some form of teaching to those present during the home visit. Gives information included two subcategories: a more

professional teaching component, where nurses provided explanations or teaching; and a more personal teaching component, where nurses provided suggestions and positive feedback to mothers.

Taking information and giving information were not distinct phases but rather nurses moved back and forth between both categories of interactions as required throughout the entire visit. Though the topics discussed by nurses during the "gives information" interaction were similar, a pattern of how, when, or if the topics were discussed was specific to each individual visit.

In the first subcategory where more professional teaching was done, the nurse's decision to give information was stimulated by a variety of sources. At times, the need to give information was determined by a question or concern expressed by the mother, for example the mother asking: "She's got little hangnails. Do I cut them or leave them?" At other times, nurses would determine the need to give information by questioning the mother. In the following example, the nurse asked the question "Did you get any information in hospital about that?" to determine the need to teach postnatal exercises.

However, an assessment of the need to teach or give information was not always completed before information was given. At times, nurses automatically gave explanations or provided information on a topic. As well, some nurses used pamphlets, brought to the visit, as a method of organizing a portion of their teaching.

Nurse: "I brought you information on postpartum exercises, as well. Did you get anything in hospital?"

Mother: "Yeah, we went to, I went to one of the classes. I knew most of them like the kegal and pelvic..."

Nurse: "Yeah. Okay, if you can find time now in your routine to work that in that's a good idea. I brought you some information on safety too for your baby. In our society, children are more at risk from accidents than they are from infection or disease because we have a fairly high standard of living and we live in a complex society."

Another nurse commented: "I brought some pamphlets here and I'll just sort of go through them here and show you what I brought."

The second subcategory of "gives information" was on a more personal level where nurses provided mothers with suggestions or directions. Suggestions came from nurses' professional and/or personal experience. For example, one nurse suggested: "If this gets any worse you might want to switch to a cream with zinc oxide base like zincofax." In another situation, the nurse gave a suggestion from her personal experience with breastfeeding: "One tip and this is a personal tip, but I was like that too and what I did, I took one of those little bags and masking tape, put the bag over my nipple taped it underneath, taped it across the top and I would literally drip in an ounce." Some mothers asked nurses if they had children; however, none of the mothers commented that it was important for nurses to have had personal experience with children.

An important component of the more personal level of giving information was the positive feedback nurses gave to mothers. Nurses frequently assured mothers that events were normal, for example:

Mother: "He's feeding a lot, for a good long stretch in the day he's feeding every two hours, and then he'll have a couple of sleeps where he's down to about four hours."

Nurse: "That's good, that's good. That's a real normal schedule."

In the following example, the nurse confirms the baby is progressing normally: "She looks so content and she's alert and good color, so nothing to worry about there at all."

Nurses also confirmed that mothers' actions were okay and gave mothers encouragement. An example of a nurse confirming that a mother's actions are okay follows:

Mother: "Yeah, well, I had cereal this morning ..."

Nurse: "That's a good thing to have."

In the following example, the nurse encourages the mother to continue with the support system the mother has developed with a neighbour:

That's wonderful, that's the nicest thing, other than all the family support is to have someone close by if you need to get out for a half hour appointment or whatever. You'll be able to switch back and forth and have time together and that's really special to provide support or whatever, that's wonderful.

In summary, nurses' interactions in the postpartum home visit fell into the categories of socializes, listens actively, takes information, and gives information. Nurses spent the majority of their time during the visit taking or giving information. The category of gives information included two subcategories. The first subcategory of gives information was a more professional teaching component where nurses

provided explanations or teaching. The second subcategory of gives information had a more personal teaching component where nurses provided mothers with suggestions and positive feedback.

Nurses moved back and forth between taking information and giving information throughout the home visit. A typical interaction seemed to start with the PHN taking information followed by a response by the mother. The nurse would then give information or continue to take information until she had gathered enough data (information) to respond (give information).

Research Question: What are mothers' perceptions of the postpartum home visit?

To determine mothers' perceptions of the home visit, the researcher interviewed each mother immediately following the home visit using a semi-structured interview guide (see Appendix J). The findings are presented below.

Mothers were first asked by the researcher how they felt the visit generally went. All mothers responded positively to this question. General terms mothers used were "really well/good". Some mothers expressed that they enjoyed the visit. Most mothers noted that the visit was very informative and that they had their questions answered. One mother responded:

> I asked quite a few questions and got, you know, answers that I was satisfied with. And the information that I was given was sometimes eliminated the need for me asking any questions, not some information but from a real person sitting in my livingroom I think adds to it from just reading brochures in hospital.

Only one couple had previous personal contact with the PHN as she was the same nurse who was their instructor at prenatal classes. The nurse commented that this home visit was easier for her because the couple knew her and were more comfortable. The nurse felt trust had already been established. Although this couple also found it helpful to have known the PHN, none of the other mothers commented that they were uncomfortable because they had not previously met the PHN.

Other types of contact between the nurse and mother prior to the home visit were also limited. One nurse had received a referral from a physician's office regarding one couple she was to visit. Another nurse had received a prenatal referral concerning one mother and had made one prenatal telephone contact based on that referral.

All nurses made a telephone contact with the mother prior to the home visit to make an appointment for the visit. Some nurses used this call to make a quick assessment of how the mother and baby were doing or answer any questions the mother might have. Some nurses suggested the mother record her questions for the nurse to answer during the visit.

Not all mothers were sure of the purpose of the nurse's visit. Though some mothers stated they received a pamphlet in hospital informing them of the PHN visit, other mothers did not realize that they would be getting a home visit until the nurse called to arrange a time for the visit. Even when mothers were aware of the purpose of the visit they were sometimes concerned about how the visit would progress:

> I was told it would be to answer any questions and to have a look at the baby. But I almost had the feeling that it was more of an inspection than an

> assistance....I wouldn't say apprehensive. I just wondered if I was going to be scrutinized.

One mother remarked: "I had no idea, I didn't know, I knew that they would come out and check the baby and check the crib but that's all that I knew that they were doing." Another mother commented:

> I know a lot of people, they think that a PHN is coming to check up on my house and blah, blah, and there was a girl in our prenatal class and she was defensive, you know, she was saying that they just come in and want to check you out...

After asking mothers for their general comments about the visit, the researcher asked mothers if they found the visit to be helpful. All mothers stated they found the visit to be helpful even though seven out of ten of the mothers had talked to and/or seen a physician. Two mothers saw a physician for a two-week check of the baby though the mothers did not describe having any particular problems with the baby. One mother made the following comment regarding telephone contact she had with a physician on call at a hospital:

> He wasn't very helpful and I might even write him a letter because he upset me....He made it sound like...by waking him up or you know, I was bothering him....he just didn't seem to care and I was really upset at this point.

When the researcher asked if she had considered calling the PHN the mother replied: "Actually I did but it was so late, like it was one in the morning and I couldn't do that to her so I figure that's what the doctor is there for..." Another mother

commented that now that she had met the nurse she would feel more comfortable calling her in the future: "...because there's a face now. Face to the name."

Most mothers found it was helpful to have their questions answered by a professional and to receive the written material. The following comments from two mothers summarizes the feelings of many mothers who were interviewed:

> Just to have a source in-person to ask some questions. To have somebody else look at the baby and tell whether what you're seeing is what you think you're seeing.

and

> Well, it was really informative. I had lots of questions and she answered all the questions I had and gave me a lot of pointers and tips. I feel confident that I'm doing okay, because everything that I've done, she says is okay so far, so I feel happy about that.

Mothers found it helpful to be assured by a professional that the baby was normal and that what they were doing was appropriate. One mother commented: "Just the reassurance. Again the reassurance of a professional."

No mother found any part of the visit to be not helpful. Even mothers who stated they read a great deal found the repetition of information to be helpful. One mother stated: "No, there was nothing (not helpful). All the information, even if I had heard it before, was still reinforcing what I'd heard..."

Mothers were also asked to describe how the visit was satisfying. Some mothers were not able to distinguish between what they found helpful about the visit and what they found satisfying. All mothers stated they were satisfied with the visit.

Some mothers stated they were instilled with confidence: "I feel confident that I'm doing everything okay." However, another mother made the same comment when asked how the visit was helpful: "It gave me peace of mind that I was doing a good job." One mother commented that the following was satisfying: "really positive reinforcement about what's happening with, how we're handling things, how he's growing."

One mother stated it was satisfying to have her husband present during the visit as he was involved in the care of the baby and had some concerns. For this mother, hearing the information first hand from the nurse was seen as preferable over the mother having to repeat what was said during the visit. This mother suggested it would be helpful for visits to be in the evening so both partners could be present for the visit. One father stated that for him it was important to have his questions answered and have the nurse see the baby.

As well, some mothers described the nurse's manner as satisfying. Some mothers found the nurse's friendly, approachable manner as satisfying while others noted their competence as professionals: "...she was pleasant, you know, you could talk to her, I felt comfortable around her....She gave me the information that I needed and she was pleasant." One couple found the nurse's interaction "professional but also personal at the same time."

Another mother commented: "...she's very caring and seems to be a very gentle person and knows her profession..." Finally, one mother stated:

> The personality that, the in-person visit from somebody in your home with you rather than being at a doctor's office or in the hospital where you don't feel

it's one on one. I like to think that the whole time she was here she was thinking about my baby and me.

Mothers were asked to identify their sources of help. Mothers named family members, especially mothers, mothers-in-law, or siblings as sources of help. Friends or neighbours were also found to be helpful if they had recent experience with children. As well, physicians were named as a source of help and one mother named the ladies from her church. Some mothers found reading to be helpful.

Public health nurses were not specifically named as a source of help; however, all mothers recognized nurses as helpful during the home visit and respected their professional opinion. One mother commented:

> My mom is from a different generation and I take everything she says and I wonder now if everything is still like that or is that a universal thing good for all time. Now I know that the public health nurse or any nurse would be more current and more objective and professional.

Another mother agreed: "...you hear it from other people but to hear if from a nurse you feel better. Like knowing that's the way you're really supposed to do it."

In addition to commenting on sources of help, mothers were asked to describe how they felt they participated in the home visit. Most mothers responded that they participated by answering the nurse's questions and also recognized that they had an opportunity to ask questions. All mothers stated they were satisfied with their involvement in the visit.

Mothers did not describe they felt like they were being formally interviewed by the nurse. Mothers used words like "chatted", "yakked", or "carried on a

conversation" to describe their interactions with the nurse. One mother described participation in the following words: "It was just basically just talking. She didn't make me feel like she was here to tell me, you know, like we were just discussing things together." One couple felt the visit was more like a conversation: "It was more a conversation than an actual interview you know....It was an interactive discussion or conversation."

However, for one mother, participation also meant listening:

> I had a few questions ready. I jumped in at certain points with questions that the information that I was being given reminded me of. I like to listen though so...I felt if I had more questions more than the ones I did then I would have had the opportunity to ask them. The fact is that a lot of them were answered by listening to what she was telling me.

Another mother who stated she did not have a lot of questions also felt listening was helpful:

> I didn't have a lot of questions so her (PHN) explaining everything answered what questions I did have. So I found that she (PNH) carried on the conversation. She explained everything in full detail. So I thought it was good.

Another component of participation was the ability of the nurse to put the mother at ease to enable her to feel she was able to participate. One mother stated: "She made me feel comfortable so I was able to (ask questions). I didn't feel like I couldn't ask questions even if I did have them." This mother asked five questions during the home visit.

Mothers were asked if they could think of something else that would have been more helpful than a home visit. Mothers liked the idea of a nurse coming to the home for three reasons. First, a home visit was more convenient as it meant that the mother did not have to take the baby out. Second, the atmosphere at home was more relaxing. The third reason was it meant the nurse could visually inspect items, for example the crib or car seat, to ensure they met the safety standards. One mother liked the individual contact the home visit provided but also noted that she and her husband appreciated prenatal classes as an opportunity to talk with other people sharing a common experience.

When the researcher asked mothers if they would attend a support group for mothers, most felt that such a group would be helpful for women who did not have family or friends or if they developed problems such as postpartum stress. One mother commented that she might attend a support group if "I felt that I was in this baby blues situation and if I didn't have my mother here." Although some mothers would consider going to a support group, they still felt the home visit was helpful for the reasons previously stated.

In addition, the timing of the visit was significant to one mother who appreciated the nurse visiting within the first week the mother was home because "little things creep up in your mind."

The final comments made by the mothers were reserved for the public health nurses. Words such as "kind", "cheerful", "gentle", "caring", and "knowledgeable" were used to describe the nurses. Mothers appreciated the nurses' friendly and approachable disposition: "She (PHN) was really nice. I was comfortable with her."

Other mothers commented that it was good to know everything was normal. One mother summed up the visit by stating:

> It was like positive reinforcement and things are going well....I was very scared about bringing a baby home. So it helped in that, in just saying that things are well....Basically it was positive all around but I guess everything is pretty normal too. We're progressing fairly, just at the right speed I guess. So that's good too.

However, even after the positive experience of having a public health nurse visit their home, some mothers were still not sure if they were prepared to call the nurse in the future: "I would probably call her (baby's) doctor first just because I really trust him." Another mother commented: "...if I felt there was something wrong and I needed information right away, I'd probably phone my sister first." One mother commented that she would use the PHN as a backup to calling the doctor or might use the nurse for general questions like weaning.

In summary, all mothers found the home visit to be helpful as their questions were answered and they were reassured that the baby and their postpartum recovery were normal. All mothers stated they were satisfied with the visit. Some mothers stated they were instilled with confidence as the nurse confirmed that their actions to take care of themselves and the baby were okay. Mothers found the nurse's manner during the visit as friendly and approachable. All mothers respected and valued the nurse's professional opinion. Mothers described the nurse's interactions during the visit as more like a conversation or discussion than an interview. Most mothers preferred a home visit over other options for a variety of reasons. Support groups

were viewed as appropriate for mothers who did not have family or for mothers who were having problems.

Research Question: Are maternal concerns addressed during the postpartum home visit?

All mothers were asked if they had any concerns that they wanted the PHN to address during the home visit. As well, PHNs were asked if they felt the client had any concerns that needed to be addressed during the visit. Most mothers identified having concerns and in most cases PHNs identified similar concerns to the mother.

Nurses were seen to help alleviate concerns by verbally answering questions or providing information, giving reassurance, giving hints or advice, and providing written information in the form of pamphlets. As well, some mothers noted because the nurse was present, she was able to visually inspect an area of concern before giving advice, for example, a baby's diaper rash or a mother's concern regarding improvement in the baby's jaundice.

In one visit, the mother did not identify having any particular concerns. The PHN agreed, but correctly noted, concerns arose as the nurse and mother talked during the visit. This nurse commented: "...I try to touch on every area so that if there is a concern it would come to light."

In another visit, the mother stated she had no concerns. This mother only asked two questions during the entire visit and both questions arose only because the nurse was in a particular topic area. The mother stated her neighbour answered all her questions before the nurse arrived. However, this mother still found the visit helpful and stated: "It makes me feel better knowing that she's (baby) fine and just

her (PHN) bringing all that information and explaining it all. That, you know, I mean, you read it in books and everything, but you didn't get as much as someone talking to you."

Most mothers felt they learned from the nurse and could repeat specific information learned, such as, tethering a car seat. A mother's comment that she learned something during the visit was not restricted only to areas where she had expressed a concern. Mothers also learned new information that was not related to their expressed concerns.

At the time of the phone call to book a time for a home visit, some public health nurses suggested mothers keep a written list of their questions which could be answered during the visit. A number of mothers made a written list while some mothers kept a mental list. However, one mother noted that the nurse answered most of her questions during the conversation before she was required to ask the question.

A couple of mothers stated that they came up with more questions as they were talking with the PHN. These mothers found it helpful for the nurse to review areas even though they had not expressed a concern. These mothers remembered or thought of questions as the nurse was discussing a certain topic.

Though mothers may not have identified a particular area of concern when questioned, the researcher noted a mother may have offered information about a topic during the home visit that could be considered an area of concern. For example, during the following conversation exchange regarding a mother's lochia, the mother does not express any concerns or ask any questions but offered information that could be considered a concern: "The blood's actually almost gone...but if he starts crying

or something like that and I get tensed up then the blood flow comes back as soon as I'm a little on the excited side."

Generally, nurses felt they were able to address the concerns of the mother by sharing their professional knowledge or giving advice. However, one nurse noted that a mother's questions do not end with the visit but change over time. Another nurse agreed by commenting that a mother who is visited later in the postpartum period tends to have fewer questions. This nurse commented that it is important for PHNs to get referrals quickly from the hospital. The nurse can then make a phone call to the mother soon after she arrives home from hospital and from that phone call assess how quickly a home visit should be made. The nurse suggested that all referrals should be faxed to the PHN office from the hospital.

In summary, most mothers had concerns that were addressed by the public health nurse providing information or giving reassurance. Nurses felt they addressed concerns by sharing their professional knowledge or giving advice. Mothers sometimes offered information during the visit that was not overtly expressed as a concern but that could be considered one. Some mothers felt it was helpful to have nurses review topic areas as this process reminded them of questions or stimulated questions.

Research Question: What are nurses' perceptions of the postpartum home visit?

Data on the public health nurses' perceptions of the home visit was also gathered from a semi-structured interview between the researcher and the public health nurse following each home visit. The interview guide found in Appendix K was used to guide the process. The following comments were elicited from the nurses.

Nurses were asked how they felt the visit generally went. All nurses felt the visits went well. Most nurses commented they were able to establish a relationship with the mother and/or the mother was receptive to the visit. One nurse commented:

> The mother was comfortable enough to ask a lot of questions. I felt like I was meeting her needs rather than coming there and going through my agenda which sometimes happens on a visit.

The opening of a visit was important to one nurse who thought it was important to start the visit with positive topics. This nurse felt one of her visits started poorly as the nurse had to give advice which was in conflict with that given at the hospital. However, the mother did not find this to be a problem.

Nurses were asked to describe their objectives for the visit and if they felt they were able to meet those objectives. Nurses had three objectives that did not fall into any particular order of importance. All nurses did not have the same three objectives. One objective was to assess the wellbeing of the mother and baby which included supports available to the mother, bonding, and coping skills. Another objective was to inform mothers of the services provided by the PHN and possibly become a future resource to the mother. The third objective was to meet the needs of the mother which also included teaching and highlighting information that mothers may not be aware of, for example, new infant sleeping position. Nurses' objectives were consistent for both the visits they completed; but as one nurse noted, the focus of teaching during the visits changed to meet the needs of the mother. All nurses felt they were able to meet their objectives.

In addition to their objectives, some nurses recognized it was important to establish a rapport with the mother. One nurse stated she tries to "go gently into the house, not bounce into the house", smiles and nonverbally tries to let mothers know she is happy to see them. This nurse noted she likes to initially see the baby and make some positive comment. Another nurse made the following comments related to how she established rapport:

> ...being pleasant and friendly-I like to compliment her and the baby. I like to make her feel positive about herself and her baby and I want to establish a positive tone to the interview....trying to answer their questions.

One nurse commented that she could judge if she had established a rapport when a mother began to ask more questions, became more talkative or willing to share information, used more eye contact, or suddenly offered coffee. Another nurse recognized the importance of having some degree of trust with the mother and believed that trust could be lost by talking about things that did not interest the mother.

Conversely, one nurse indicated that it is hard to know if you have developed a rapport or will become a resource to the mother. As well, it is difficult to accurately judge who will call in the future or attend Child Health Clinics. This nurse noted some possible reasons for a mother's decision to continue or not continue use of PHN services could be related to the mother's trust in the nurse or the mother's belief that the doctor is more important than the nurse. Another nurse suggested mothers who attend Child Health Clinic are motivated, enthusiastic, excited, and want the best for their child. This nurse also noted that mothers who

phone the public health office with questions often like to talk to the nurse they know and with whom they have developed a rapport.

Meeting the needs of the mother was seen as an important part of the visit by many of the nurses. Though the provincial agency provides nurses with a Postpartum/Newborn Nursing Database form, no nurse appeared to follow the form directly when completing their assessments of the mother and baby nor did they view completion of the form as an objective of their visit. Some nurses were asked by the researcher about the relevance of the form. These nurses replied that they used the form as a general guideline indicating areas that are important to review during the postpartum period. These nurses stated that meeting the needs of the mother during the visit was more important than completing all parts of the form. One nurse commented:

> I'm more concerned with what are the mom's needs. If it means that we skip over an area entirely and come back to it at a later point, that's just fine with me. It doesn't all have to be dealt with in one visit.

In addition to asking nurses to describe their objectives, nurses were asked how they felt mothers participated in the visit and if they were satisfied with the mother's participation. Nurses felt all mothers participated. Although participation meant talking and asking/answering questions, it also meant sharing feelings. One nurse commented that a mother had to first feel comfortable before she was willing to talk about her feelings and "share things she wouldn't normally share with a person on the street." A mother's body language was included in some nurse's description

of the meaning of participation, for example, a mother sitting back comfortably on the couch, eye contact, or fidgeting.

One nurse described a home visit as a "rote motor kind of thing" if the mother did not participate:

> ...for everybody it's different but sometimes you get into a situation where the mother or the woman is very quiet, doesn't state any concerns and you just sit there and you do all the talking...and then you come out of it and you don't really, you really wonder whether you've met her need or answered her questions.

Nurses mentioned things such as a mother's culture or how she is feeling physically could influence the way she participates in a visit. Nurses noted the meaning of participation could not be generalized to all visits and a nurse's expectations and interviewing style may need to change depending on how a mother participates in the visit.

As well, nurses were asked if they were satisfied with the visit. All nurses felt they were satisfied with their visits and described satisfaction from two perspectives. From the first perspective, some nurses were satisfied when their assessments failed to identify any problems. For example, one nurse commented: "The fact that I see a happy mom. I see a healthy baby." The same nurse commented: "Well, I always get excited when I see a highly motivated couple....there is a good bonding going on....parents are utterly enjoying their role as parents."

From the second perspective, most nurses described satisfaction as having the mother respond positively and participate in the visit or being able to meet the

mother's needs. Nurses made the following comments: "mom seemed satisfied with the information I had to give her....she was open" and "...we related to each other well...she responded well to the encouragement" and "because we dealt with a lot of concerns" and "I felt like it was a two-way dialogue...she's (mom) looking for some help or some guidance or some direction from public health..."

Nurses identified a link between a client's participation and a nurse's satisfaction with the visit. A nurse who found it satisfying to find a healthy family during a home visit stated she would find it less satisfying if a mother did not participate. The nurse may not be able to collect enough data to complete her assessment of the family and would likely have to follow up with another visit. The following nurse's comments highlight the relationship between a mother's participation and a nurse's satisfaction:

> I think what made it satisfying is that she was prepared....Also the fact that as I was going through different things...I suppose some of the things I wanted to know, she would interject. She would say, 'Oh, you just made me think of another question'....they feel they can interject. That's another indication sometimes that someone's actually involved in the visit and they're not just sitting there and listening and maybe not even paying any attention.

One nurse commented that she would have liked to discuss some lifestyle factors with the mother but realized that the postpartum home visit was not the appropriate time. However, the nurse left the visit wishing she could have helped in that area.

Although nurses generally found their visits satisfying, they were able to comment on what was not satisfying from past experience. Examples such as being rejected by a client, a defensive client, and having distractions such as visitors or television interfere with the visit were seen as not satisfying. One nurse described identifying any kind of a problem during the visit as not satisfying.

None of the nurses planned a follow-up visit for the mothers they visited. Follow-up was required if problems were identified during the initial visit. The severity of the problem seemed to indicate whether follow-up required a phone call or visit. Follow-up may also be required if the mother felt there was a need or if it was not possible for the nurse to collect enough data to complete an assessment of the mother and/or baby. Two nurses planned phone follow-ups. One nurse suggested that a follow-up phone call to all mothers may help eliminate the perception the nurse does the visit and leaves -"never to be seen again."

Finally, some nurses were asked for suggestions that might enhance services to the postpartum family. Some nurses felt the father should be welcomed as part of the postpartum home visit. A father's presence was seen as especially important in some cultures where males tend to ask most of the questions or if the nurse wanted to assess family dynamics. Expanded service hours was suggested as a solution to allow more fathers to be involved in the visit and to allow the nurses to meet more of the public's needs. To promote their services, nurses suggested that they needed to increase the visibility of the public health nurse.

Nurses stated it was important for them to provide well-baby care which included immunization to all healthy children. Nurses have run into situations where

mothers took their child to the physician for an immunization in the morning and then attended Parent Time in the afternoon with questions for the nurse. This situation was seen as poor use of health care dollars.

In summary, all nurses were able to describe their objectives for the home visit which were consistent for both visits. Objectives included assessing mothers and babies, informing mothers of the services of the public health nurse, and meeting the needs of the mother. Nurses also stated it was important to establish rapport and gain the mother's trust. Nurses felt all mothers participated which meant not only talking but also sharing their feelings. Satisfaction was linked to a mother's participation in the visit. Nurses were able to make suggestions to enhance services to the postpartum family.

Patterns Between Home Visits and Interviews

The final phase of data analysis was to identify patterns between the content and process of nurse/client interactions during the home visit and responses to the interviews. Findings from the comparisons are reported in this section.

Nurses' interactions in the home visit seem to have an influence on mothers' perceptions of the visit. The finding that public health nurses controlled the home visit both in amount of time talked and number of questions asked did not seem to influence mothers' satisfaction with the visit. All mothers reported they were satisfied with the visit. Satisfaction for the mother related to the nurse's friendly manner and the nurse providing positive reinforcement both of which related to nurse interactions in the home visit. Mothers also noted nurses alleviated concerns by providing information and giving reassurance, both of which are also nurse interactions.

In addition, the nurses' questioning techniques (open versus closed-ended questions) did not seem to influence the mothers' perception of their opportunity to participate in the visit. Despite nurses asking more questions than most mothers, some mothers described the visit as a conversation rather than an interview. All mothers were satisfied with their participation in that their questions were answered by the nurse. Mothers also considered listening to the nurse as a component of satisfaction.

In the post visit interview with the researcher, mothers did not make any comments regarding topics discussed during the home visit. Mothers did not seem to be concerned if nurses reviewed a topic area even if the mother did not express a concern in the area. In fact, some mothers commented that it was helpful for the nurse to review topics as questions may be stimulated during the process. Though nurses addressed only the physical aspects of baby care, some nurses commented they made assessments of bonding behavior between the mother and baby.

Nurses' comments on the importance of meeting the needs of the mother were consistent with nurses' interactions during the home visit. As noted from the analysis of nurses' interactions, nurses moved back and forth between taking and giving information to meet the mothers' needs for information as well as to complete their nursing assessment of the mother and baby. One nurse explained:

> ...I do a lot of teaching as I go...if I pick up on anything that I sensed may be a problem...I don't overload them with information, I just, if they've got a question that's when I'll teach or if...it's a need for them to know...

Nurses did not report any relationship between their questioning techniques and the taking or giving of information. Some nurses noted the establishment of rapport and a mother's comfort were often related to a mother's participation in the home visit. Though nurses recognized a mother's participation meant talking and answering questions, a mother's body language could also indicate she was participating in the visit.

In summary, the nurses' interactions in the home visit seemed to have an influence on a mother's perception of the visit. Nurses' interactions in the home visit were consistent with the value they placed on meeting the needs of the mother. Nurses did not report a relationship between their questioning techniques and the interactions of giving and taking information.

Summary

The sample for this study consisted of ten primiparous mothers and five public health nurses. Postpartum home visits were taped recorded and nurses and mothers were interviewed separately following each home visit. The content and process of each home visit was analyzed. Findings indicate the nurses dominated the home visit both in amount of time talked and number of questions asked.

During data analysis, four categories of topics discussed during the visit emerged: baby, mother, services, and other. Nurses spent the majority of their time talking about areas related to baby or mother. In addition, four categories of nurse interactions in the home visit emerged: socializes, listens actively, takes information, and gives information. Nurses spent the majority of their time taking or giving information.

Findings from the interviews with nurses and mothers indicate both parties were satisfied with the visit and were able to describe what made the visit satisfying. Mothers reported having their concerns addressed by the nurse who provided information or gave reassurance. Mothers felt they had an opportunity to participate in the visit. Nurses described their objectives for the visits and stated their objectives were met. Nurses' and mothers' perceptions of the home visit seemed to relate to the interactions between the nurse and mother.

CHAPTER SIX

Discussion

In this chapter, a discussion of the research findings is presented in three sections. Findings of the study are discussed and related to other literature in the first section. In the second section, the findings are discussed in relation to the conceptual framework, symbolic interactionism, used in the study. Finally, in the third section, implications for nursing education, practice, and research and limitations of the study are presented. The chapter concludes with a summary of the research study.

Discussion of Findings

Nurses' and mothers' participation

The first research question examined the nurses' and mothers' participation in the postpartum home visit. These findings are discussed and mothers' and nurses' perceptions of the visit are integrated into the discussion where appropriate.

The nurses in this study controlled the postpartum home visit; both in amount of time talked and number of questions asked. Although the majority of nurses took early direction for the visit from the mother, nurses introduced most topics and ended all visits. Other researchers have described similar findings in studies of community nursing. As early as 1965, Conant reported nurses ended most home visits. Webster-Stratton et al. (1986) found nurse practitioners gave mothers in well-child clinics an opportunity to ask questions early in the visit but the nurse practitioners spent approximately half of the visit asking mothers questions. Sefi (1988) reported health visitors controlled the first home visit to first time mothers by opening and closing all topics. Kristjanson and Chalmers (1990) also reported public health nurses

had primary control of all interactions in the various nurse/client situations the researchers observed.

There may be several reasons for the nurse's apparent control over the home visit. In situations, such as the postpartum home visit, where data collection and assessment are a primary component of the nurse's role, it is appropriate for nurses to ask questions. Heavy workloads and time pressure may compel nurses to guide questioning to obtain the information needed to complete their assessment as efficiently as possible. As well, mothers who are not given direction by the nurse may offer information that is not congruent with the nurse's data collection agenda.

Though nurse control of nurse/client interactions has been recognized, research in this area is limited. Waitzkin (1979) suggested professional (physician)-client relationships are linked to social class relationships that develop in everyday life. Danziger (1978) suggested patients may assume a more passive manner and allow physicians to take a more active role in controlling or structuring the course of patient/physician interactions. Perhaps mothers in this study expected the visit would be controlled by the nurse as the nurse was viewed by the mothers in this study as the expert.

In addition, mothers themselves may have contributed to the nurses' apparent control over the home visit. As mothers in this study were primiparous women, their experience in self and baby care may have been limited. Though the majority of mothers attended prenatal classes and had family and friends whom they considered to be sources of help, mothers still indicated they were seeking reassurance from a professional. Mothers may have felt they had received adequate information on self

and baby care and only needed to have the nurse confirm their interpretation and implementation of the information was correct. As the mothers reported satisfaction with their involvement in the visit, it may be possible they did not want greater control.

Health care consumers have changed over the past several years and many are more interested in becoming active partners in their health care. Most mothers in this study stated they had concerns that they wanted the PHN to address during the visit. Nurses were seen to help alleviate concerns by verbally answering questions or providing information, giving reassurance, giving hints or advice, and providing written information in the form of pamphlets. The majority of mothers in this study were fairly well educated, and had been active in preparing for their child by attending prenatal classes. This group of mothers may have been more willing to assume greater control over the visit had it not been satisfying than mothers of lower socioeconomic status or mothers from other ethnic groups.

As well, nurses' use of open or closed questions did not always influence the mother's response to a question. Open questions are used to encourage others to talk and provide the listener with maximum information (Ivey, 1983). Open-ended questions did not always elicit a detailed response by mothers and the reverse was also true. To some degree mothers may have controlled the visit by the information they gave or did not give in response to the nurse's questions. In summary, providing first time mothers have an opportunity to have their questions answered in the postpartum home visit, the control the nurse exerts over the visit may not be an issue. The most important task for nurses may be to reassure mothers that the baby

and their postpartum recovery are normal and their actions to care for the baby and themselves are appropriate.

At first glance, the control displayed by the nurses during the visit does not appear to support the current health promotion literature. This literature emphasizes the importance of public participation in planning and implementing health care services (Epp, 1986; WHO, 1978; WHO, Health & Welfare Canada, & Canadian Public Health Association, 1986). However, this perception deserves a more detailed examination. Though community nurses support the concept of individuals being active participants in their care (American Nurses' Association, 1980; CPHA, 1990), little research is available describing what participation means to clients and how clients perceive participation. During this study, participation had a variety of meanings to the mothers. Clients in this study felt they participated in the home visit and were satisfied with their participation. Nurses also reported mothers participated in the visit.

Most mothers described their participation in the visit as answering the nurse's questions or by having the opportunity to ask their own questions. However, participation was not restricted to talking. Listening to the nurse was also considered participation. As well, mothers recognized that a component of participation was the nurse's ability to establish a climate which made mothers comfortable enough to ask questions. Nurses felt a mother's body language contributed to her participation in the visit as it gave the nurse some indication of the mother's interest and comfort with the process. Some nurses noted that the culture of the mother may influence how much she participates in the visit. Nurses in this study reported their satisfaction with

the visit was linked to the mother responding positively to and participating in the visit. Studies describing client participation in nursing situations are limited. However, in one study elderly clients described participation as having the opportunity to ask questions and being encouraged by the nurse to talk (Laffrey, et al., 1990).

In summary, the findings from this study suggest the meaning of participation in the postpartum home visit should not be restricted to active involvement by the client, for example, talking. Listening and body language can contribute to the meaning of participation. Participation may adopt different meanings in the various settings and with the varied client groups which constitute a nurse's practice. Nurses can promote client participation by creating a climate that facilitates client involvement in the visit.

In addition to increasing awareness of the meaning of participation, findings from this study provided insight into the collaborative relationship which develops between the public health nurse and a client. All mothers in the study stated it was important the information given to them during the home visit came from a professional source, in this case the nurse. At the same time, some mothers commented the nurses were friendly and approachable and the home visit was more like a conversation or discussion than an interview. Nurses in this study recognized the need to develop rapport with the mother. Hence, the nurses in this study seemed to have maintained their professional role during the home visit yet, at the same time, developed a collaborative climate.

Health professionals are said to be educated and socialized in the expert role which is considered incompatible with the collaborative/partner role (CNA, 1988). Kasch (1986) suggests nurses must move from rigidly structured interviews to conversations to establish collaborative relationships with clients. Findings from this study appear to dispute the incompatibility of the role of expert and collaborator. These nurses seem to have developed interviewing techniques that have allowed them to maintain their role as expert, yet have enhanced the development of a collaborative relationship with the mother.

In addition to mothers' participation in the home visit, their satisfaction with the visit was also explored in this study. Little is known about client satisfaction with home visits by nurses and a standard measurement tool has not been developed. In this study, mothers reported being satisfied with the home visit regardless of the control the nurse seemed to hold over the process of the visit. Mothers appeared to associate satisfaction with three behaviors of the nurse: nurse's manner, the nurse's professional competence, and/or the nurse's skill in providing the mother with confidence in her ability to care for the baby. If these qualities of the nurse are valued by the mother, nurses may need to re-evaluate their approach to the home visit. Perhaps nurses should give more thought to the processes they use to assess and teach mothers during the visit. Nurses may wish to take a less structured and more informal approach during the postpartum home visit. When culturally appropriate, mothers could be asked to verbalize their perceptions of their postpartum progress and their areas of concern. This process would give the nurse an opportunity to give mothers positive reinforcement when appropriate and provide the

required teaching based on the needs determined by the mother. Teaching done by the nurse should strengthen the mother's understanding and ability to recognize normal versus abnormal signs and symptoms.

Other studies have also found that the personal qualities of the nurse were associated with client satisfaction. Elderly clients reported being most satisfied with nurses whom they considered listened attentively to them and the pleasantness of the nurse who delivered their home health care (Reeder & Chen, 1990). Perinatal clients who were visited in their homes perceived the nurse to be friendly and reported to be satisfied with the visit (Morgan & Barden, 1985). Client descriptions of quality of nursing care in hospitals has, in part, been related to both the personal qualities of the nurse and professional proficiency (Taylor et al., 1991).

Satisfaction has also been linked to the opportunity clients are given to ask questions. Although the nurses in this study asked many questions, mothers also reported they had an opportunity to ask questions and their questions were answered. Conant (1965) found antepartal patients reported to be satisfied with their home visit when there was a decrease in the number of questions asked by the nurse and increase in nurses providing answers to questions. Elderly clients attending a preventive health care program viewed the opportunity they were given by the public health nurse to talk as a benefit of the program (Laffrey et al., 1990).

In this study mothers' perceptions of the helpfulness of the visit were also examined. Mothers' perceived the home visit to be helpful as nurses were viewed as experts in postpartum care. Mothers trusted the reassurance they were given by the nurse that the baby and their postpartum recovery were normal. Mothers also found

it helpful to have the nurse confirm their actions to care for themselves and the baby were appropriate. Some mothers in this study commented it was helpful for a nurse to review a topic area even if the mother had not expressed a concern in the area. Mothers found during this process they might remember questions or the nurse may offer new information. As well, mothers felt it was important to have information they may have read or heard confirmed by a professional.

Similar perceptions of helpfulness have been found in previous research. Primiparous women in a study by Barkauskas (1983) reported PHN visits were helpful as they were provided with information and access to a health care worker, had the baby checked, and were provided with general support and reassurance. Clark (1984) reported mothers found it helpful to have the health visitor give practical advice and tell them they were doing things properly. Other studies also reported clients found general reassurance and/or information from the nurse to be helpful (Laffrey et al., 1990; Magilvy, Brown, & Dydyn, 1988; Rovers & Isenor, 1988).

In summary, studies of client satisfaction reported clients appreciate the opportunity to talk and have their questions answered by a professional. The personal qualities (friendly, pleasant) of the nurse also seemed to influence a client's satisfaction with care. Though nurses in this study spent some time giving mothers positive feedback and confirming events were normal, they did not identify these activities as an objective of their visits. By paying greater attention to confirming normality and giving positive feedback, nurses may enhance the usefulness of the visit to the mother. The use of a conversation-like approach by the PHN in the home visit and the incorporation of positive re-enforcement into the professional expertise nurses

share during their assessment and teaching may strengthen the helpfulness of the visit to the mother.

Content and process of the home visits

In this study, data were analyzed to determine topics discussed and nurse/client interactions that occurred during the postpartum home visit. Issues surrounding maternal concerns also were examined. These findings are discussed in the following section.

Topics discussed by nurses in this study fell into the categories of baby, mother, services, and other. These topics were compared to the maternal concern literature to examine if nurses in the study addressed the areas of concern identified in the literature. Bull (1981) developed a comprehensive concern questionnaire adapted from the work of Gruis (1977). Categories of potential maternal concerns identified by Bull were self, baby, husband, family, and community. Other researchers also identified infant care as the prime area of concern (Haight, 1977; Sumner & Fritsch, 1977).

The majority of concerns reported by Bull were identified within the subcategories of topics discussed by the nurses in this study. Areas identified by Bull as potential concerns but not addressed by the nurses in this study, for the most part, related to the emotional issues surrounding mother, husband, and community. Bull (1981) described emotional self as concerns related to fatigue, emotional tension, inability to concentrate, feeling tied down, baby blues, time for personal interests, and being a good mother. Bull reported that the frequency and intensity of concerns related to physical discomfort decreased after one week at home and the intensity and

frequency of concerns related to emotional self increased after one week at home. Nurses in this study did not verbally address such areas as feelings of being tied down, feeling comfortable handling the baby, relationships with husband, and change in relationships with family and/or friends.

In this study, not all subtopics (see Table 3) were discussed in each home visit. This seems to be an appropriate decision by nurses as previous research reported mothers rank concerns by frequency and intensity (Bull, 1981; Gruis, 1977; Harrison & Hicks, 1983; Moss, 1981). Nurses should be aware of the common postpartum concerns and adapt their discussion in the home visit to meet the individual needs of the mother.

Most topics discussed during the home visit related to issues surrounding the postpartum period. However, one example surfaced in the category of "other" in this study. In this example, the nurse took the opportunity of the visit to discuss another health related topic with the mother. Community nurses have many opportunities to promote health during their interactions with clients, for example, by promoting a smoke-free environment or maintaining a healthy weight. Nurses should take advantage of these opportunities when appropriate and if the client is open to the discussion.

Some nurses and mothers in this study commented that the timing of the postpartum visit was significant. Nurses felt it was important to contact the mother as soon as possible after discharge from hospital or noted mothers' questions change over time. One mother commented she was glad the nurse came the week after the birth (baby was eight days at time of visit) as the mother was wanting confirmation

from a professional that "everything is okay." Previous research suggests mothers have more problems the first week following discharge (Haight, 1977; Rovers & Isenor, 1988) and the frequency of questions parents ask by phone decrease over time (Sumner & Fritsch, 1977). Domke (1986) found there was a change in some concerns expressed by primiparous mothers from the second or third postpartum day (greatest concern about physical aspects of baby) to one month postpartum (greatest concern about the husband).

Nurses should make every effort possible to visit mothers the first week they are home as this seems to be the period mothers have the greatest concerns and need the most reassurance. To expedite the process, hospitals could fax postpartum referrals to the appropriate health office. By keeping abreast of the current literature on maternal postpartum concerns, nurses could incorporate the appropriate research into their practice to assist them in priorizing the issues discussed in the home visit.

An area of concern arising from this study is the nurses' limited discussion of areas related to the emotional issues surrounding the postpartum period. Wotton (1992) reported a similar finding in a study of the postpartum telephone interview and suggested general questions about postpartum adaptation would not identify the significant concerns of mothers. The reasons why nurses did not explore the emotional aspects of care in more detail could not be determined from the data collected during this study. Possibly, nurses made the assumption that these areas were not of concern if the mothers did not verbalize problems, there were no visual cues of problems, and mothers did not indicate they had any feelings of "baby blues"

when asked by the nurse. As well, nurses may be less comfortable with their ability to assess emotional aspects of care as they are less concrete than physical needs. Nurses may have the impression emotional issues are not of great importance as a very small area is allocated to mother's adjustment on the Postpartum/Newborn Nursing Database form. However, the postpartum period has been recognized as a difficult time for women and emotional support is required. The emotional concerns of new mothers have been found to increase after one week at home (Bull, 1981).

Baby blues usually occurs within four days of delivery and lasts approximately four days (Chang & Renshaw, 1986). Research reviewed by Gjerdingen, Froberg, and Wilson (1986) suggests postpartum blues occurs in 50-80 percent of women who have given birth. During the period mothers experience postpartum blues, they often begin to question their adequacy (Petrick, 1984). The incidence of postpartum depression in the literature reviewed by Handford (1985) varies from 10.8 to 24 percent. A frequent onset time for postpartum depression is the mother's return home following the delivery of the baby (Vandenbergh, 1980). Conflicts toward the role of motherhood and a mother's own internal feelings are associated with the onset of postpartum depression. The postpartum period has been found to the time of highest risk of serious emotional disorder with a peak in the rates of mental illness in the first four weeks postpartum (Casiano & Hawkins, 1987). It seems essential that nurses be aware of and assess the presence of the factors associated with these conditions and implement appropriate interventions, such as reassuring mothers of their ability to care for themselves and the baby. Nurses must examine methods to enhance their discussion surrounding emotional issues in the postpartum period.

In addition to service delivery, a traditional public health nursing role is case finding (Jones & Craig, 1988). In this study, no problems were identified that warranted the mother or baby be added to the nurse's caseload. In Manitoba, data are not available on the number of mothers/babies identified as being at risk following the postpartum home visit. However, the postpartum home visit provides an ideal opportunity for nurses to observe high risk mothers and children, for example the potential for child abuse. Colicky or irritable children or children who are rigid or non-cuddly are considered to be at risk for abuse (Manitoba Association of Registered Nurses, 1988). In Ontario, a screening tool consisting of criteria identifying risk factors in postnatal multiparas was developed as part of a larger study of the accuracy of screening clients in need of home visiting (Townsend, Edwards, & Nadon, 1992). Comprehensive guidelines to assist nurses to identify clients at risk during the postpartum period are not available. Development of such guidelines could assist nurses in their role in case finding.

In addition to finding limited discussion of the emotional aspects of care, this study revealed few fathers were present during the home visit. Only three fathers were present and actively involved in the postpartum home visits studied. In all cases, the father talked less than the mother. Montgomery-Robinson (1986) also found fathers usually talked less than the mother in the postpartum home visit. In many nursing models, such as the McGill model, the individual and family are viewed as an open system in constant interaction with one another (Gottlieb & Rowat, 1987). If nurses are to assess family adjustment to parenthood as indicated on the Postpartum/Newborn Nursing Database form, it seems imperative that methods to

enhance fathers' presence and participation in the visit be developed. Nurses' working hours may need to be extended to enable nurses to make home visits when fathers are home from work. As well, nurses may need to develop their skills in assessing the father's adaptation to parenthood and facilitating fathers' contribution to the discussion that occurs during the postpartum home visit.

An additional area of assessment omitted by some nurses was that of safety. Not all nurses addressed safety issues nor did all nurses make a visual safety inspection of the home and baby equipment. In community health nursing, the influence of the environment is a crucial determinant of health and a required component of a family assessment (Reutter, 1984).

In summary, community health nursing is based on the belief the individual (family/community) is a composite of physical, psychological, social, cultural, developmental, and spiritual characteristics (CPHA, 1990). As well, community nurses have the opportunity and responsibility to view the client within the family context. In this study, nurses did not always assess the emotional aspects of care. Family assessments of adaptation to parenthood were not always completed as fathers were not present in the majority of home visits and nurses did not always talk about the father's adjustment. Nurses must address these issues to clearly establish their unique role in the community. If the postpartum home visit is viewed as only an assessment of the physical recovery of the mother/baby, and family and visual safety assessments are not completed, the door is open for other types of service providers to deliver care, such as, the postpartum home visit.

In this study, the major focus of nurse interactions was taking or giving information. Nurses moved back and forth between taking information and giving information throughout the entire visit. Though the mean length of visits in this study was 70.6 minutes, most nurses spent a small portion of that time in the "socializes" category of interactions. The majority of the nurse's time in the home visit was spent taking or giving information. Similar findings have been in other studies. Morgan and Barden (1985) found over half of a nurse's time in a home visit was spent asking for or giving information. Kristjanson and Chalmers (1990) found assessment occurred at any point during nurse/client interactions and that teaching was a large part of the working phase of interactions. Assessment and instruction have been identified as the primary services provided by nurses during home visits to primiparous women (Barkauskas, 1983). Mothers reported being satisfied with the visit and found the nurse to be helpful. In a review of health records, public health nurses were found to routinely assess clients during home visits in order to plan interventions which included teaching (Gulino & LaMonica, 1986). Asking questions and providing information were also found to be the primary nursing actions in a family planning clinic (Dodge & Oakley, 1989). In all of the home visit studies reviewed, nurses seem to spent the majority of their time assessing and teaching.

Home visits in this study did not appear to follow any particular routine unlike those described by Mayers (1973) as a "well-established time-honored ritual" (p. 331). Mothers described the visits as discussions or conversations. Though the topics discussed were similar from visit to visit and nurse to nurse, no pattern was identified in the order or the depth of discussion in any area. Kristjanson and

Chalmers (1990) also found nurse interactions varied according to the context of the interaction and style of the nurse. Sefi (1988) reported nurses spent time during home visits asking standard questions or form filling; however, the differing style of the nurses gave different patterns to the visit.

A typical nurse/client interaction pattern in this study seemed to start with the PHN taking information followed by a response by the mother. The nurse would then give information or continue to take information until she had gathered enough data (information) to respond (give information). Sefi (1988) described a similar interaction pattern in her study of health visitors. Health visitors asked a question (topic opening), mothers answered, then health visitors made a topic closing move. Sefi noted the pattern could be expanded through a sub series of questions and answers but the pattern remained essentially the same.

The findings from this study support the beginning theory described by Chalmers (1992). Chalmers suggests the health visitor and client "selectively 'gives' and 'receives' in order to manage the health visitor-client encounters. What gets offered and how the offer is received is a complex process involving many factors related to both the health visitor and the client and the particular context in which the interaction takes place" (p. 319). In summary, the finding that nurses in this study spent the majority of their time taking and giving information is supported by other research. Though patterns of taking and giving were identified, the finding that nurses varied their discussion of topics suggests nurses are concerned about meeting the individual needs of the client.

Issues related to the health care system

Several areas emerged from the findings of this study that related to the structure of the services being offered to mothers. These areas are discussed below.

Though mothers' appeared to be satisfied with the postpartum visit and found it to be helpful, it is interesting to note mothers do not necessarily plan to continue to use the services of the PHN. As well, nurses were not identified by any of the mothers as a source of help. This finding is consistent with that of other researchers who have reported mothers tend to use physicians, family, or friends as a source of help (Gruis, 1977; Harrison & Hicks, 1983; Rovers & Isenor, 1988).

Despite nurses stating one of their objectives for the postpartum home visit was to establish themselves as an ongoing resource to the mother, they do not seem to have made any headway in this area. One is left to wonder what the result would be if nurses did not make postpartum home visits; especially, as the majority of mothers in this study had already established a relationship with a physician by the time of the home visit. Would mothers be satisfied with the information, reassurance, and support given by the physician, family, or friends?

There may be several reasons for mothers limited continued use of public health nursing services. If participation is a process by which individuals assume responsibility for their own health (WHO, 1978), it may be that in the situation of the postpartum home visit, the nurse has been successful. By giving the mother the reassurance she needs, the nurse has facilitated the process of the mother assuming responsibility for the care of herself and the baby. As well, changes within the

structure of the health care system may be required to facilitate mothers' continued use of public health nurses.

Physicians are accessible to mothers 24 hours a day via hospital emergency departments and the doctor-on-call system. Mothers may be using this system for problems that could be effectively resolved by a nurse. As PHNs are not available, the more expensive services are used. Mothers in this study valued the professional opinion of the public health nurse. Perhaps if nurses were more accessible, for example through an on-call system, mothers would be willing to use their services. The need for more accessible services was also identified previously in this study in the finding that only three fathers participated in the postpartum home visit as visits are made when fathers are at work.

An unexpected finding from the study was that 70 percent of the mothers had phoned and/or visited a physician prior to the visit by the public health nurse. One nurse indicated she knew of cases where a mother may visit the physician in the morning to have the baby immunized and then attend Parent Time (an education, baby assessment, and immunization program offered by public health nurses) in the afternoon. In this period of restraint in the health care system, possible duplication of any service warrants investigation. Nurses in Canada are prepared to assume greater responsibility for primary health care and have recommended that nurses become points of entry to the system for assessment, care, and referral (Canadian Nurses Association, 1988). However, in Manitoba, the physician has been described as the "gate keeper" to health services (Manitoba Health, 1992). Changes to the structure of

the health care system would be required if nurses were to take a more active role in well-baby care.

Some nurses in the study indicated a desire to improve the service they provided to encompass all well-baby services, including immunization. An audit of immunization services indicates that from July 1, 1987 to the end of December 1988, 77 percent of newborns in Manitoba received their first immunization from a physician (Manitoba Health, 1991). In some provinces in Canada, nurses are providing immunization and well-baby care. A study in Saskatoon reported the majority of parents received well-baby care, including 90 percent of all immunizations to infants, from community health nurses (Hemmelgarn, Edouard, Habbick, & Feather, 1992). However, parents in the same study also attended private physician practices for well-baby services. Presently in Manitoba, the concept of nurse-run clinics is being investigated. Well-baby care and immunization may be a feasible and possibly cost effective area for a nurse-run clinic; however, guidelines would have to be established to avoid potential duplication of service with other health care professionals.

In summary, findings from this study suggest there may be some overlap in well-baby services between the physician and public health nurse. Mothers may be willing to use nurses for well-baby care if nursing services were more accessible to them.

Conceptual Framework

Client participation is a key principle identified in the health promotion and community health nursing literature. This literature implies the meaning of

participation is restricted to active interaction or verbal communication. In this study, mothers' participation in the postpartum home visit was examined. Symbolic interactionism guided this study. According to this perspective, human beings act toward things based on the meaning things have for them and the meaning of things is derived from social interaction.

Findings from this study support the importance of examining human behavior on more than a superficial level to interpret the meaning a subject attaches to the behavior observed. In this study, the content and process of the home visit was first examined. If the analysis was limited to this procedure, the researcher would have concluded nurses dominated and controlled the interactions in the home visit by the amount of time talked, the number of questions asked, introduction of topics, and the ending of visits. However, the study also included an examination of both nurses' and mothers' perceptions of the visit.

The analysis of mothers' perceptions of the visit gave a different meaning to the word 'participation'. Mothers felt the nurse gave them opportunity to ask questions. Although mothers interpreted participation to mean answering the nurse's questions or asking the nurse a question, the amount of time talked or the number of questions asked by the nurse did not seem to influence how mothers perceived the visit. Mothers also felt that listening to the nurse was a component of participation as was the nurse's ability to set a climate that fostered the mother's comfort in asking questions.

A related finding was the importance mothers put on the professional perspective of the nurse. Although mothers found it helpful to have their questions

answered, mothers also wanted to be assured the baby was normal and to be given positive reinforcement ensuring their actions to take care of the baby were appropriate. In this study, it appears appropriate for the nurse to control the visit given the mother's issues described above are addressed.

Mothers' perceptions of their participation in the visit and satisfaction with their participation appeared to be related to the interactions of the nurse and not the process of the interaction in the visit. Participation appears to have different meanings and must be put into the context of a particular nurse/client interaction. Community health nurses may have to adapt their interviewing style to a variety of situations to meet the client's participation needs.

In summary, nurses should be cognizant that the meaning of general terms, such as participation, may not be the same in all practice situations. Nurses need to be cautious when applying a generic term to a variety of settings and with different client groups.

Implications

The study results have implications for public health nurses providing services to women in the postpartum period. Recommendations for nursing education, practice, and research will be presented as they relate to the research findings.

Recommendations for nursing education

Students develop the skills required to practice as professional nurses during their education period. Findings from research studies can be used to enhance the information and skills students should be taught to practice in an efficient and effective manner to meet the diverse needs of the clients found in clinical practice.

1. Communication plays an important role in establishing health-promoting relationships with clients (Harrison, Pistolessi, & Stephen, 1989). Communication must remain a fundamental component of theoretical and clinical courses in the baccalaureate nursing program. Educators must remain up-to-date on the current research and theories of communication in nurse/client interactions.

2. Symbolic interactionism theory suggests humans act toward things based on the meaning things have for them which is embedded in social interaction. As meaning of generic words such as, participation, may change with different client groups and settings, students should be taught to adapt their interactions to meet the needs of individual clients.

3. Nurses have the responsibility to assess all components of clients' needs. Students should be taught to value and address the often less concrete, however no less important, emotional aspects of client care.

Recommendations for nursing practice

This study has identified areas that would require structural changes at the level of the health care delivery system and the nurse practice level. The changes that have emerged from the data are summarized below:

1. Consumer needs have changed over the past few years. Fathers are more actively involved in the maternity cycle. Fathers are now encouraged by nurses to attend prenatal classes and be present during the labor and delivery of their child. Nurses should encourage fathers to continue to be involved during the postpartum period. Public health nurses are encouraged to complete family assessment; however, the system obstructs this process by not offering home visits in the evening or on

weekends when fathers are more likely to be home from work. Extended or flexible office hours should be considered so that fathers can be present during the visit.

2. Though the nurses were able to articulate their objectives for the visit, it is not known if those objectives were congruent with those of the employer. The purpose of the postpartum home visit should be clearly defined to reflect the changing needs of the health care consumer, and the nurse's role as a health promoter. Objectives should be written in a manner which could facilitate evaluation of the program.

3. Mothers in this study expressed satisfaction with the postpartum home visit and valued the reassurance and information they were given by the public health nurse. However, mothers continue to use physicians for well-baby care and immunization. As well, mothers reported using physicians for minor baby care problems as they understand it is the physician's responsibility to be available 24 hours a day. Nurses reported they were aware of cases of duplication of service between PHNs and physicians though official data are not available in Manitoba. Health care reform is currently underway in Manitoba. Nurses have indicated an interest in providing well-baby care and immunization. The feasibility and cost effectiveness of nurse-run clinics in the postpartum period should be investigated. Investigation of service delivery in this area would seem a logical follow through to the current discussion of midwifery.

As well as implications for administration, the findings of the study support the following recommendations for public health nursing practice:

1. Mothers reported they found the postpartum home visit was helpful as the nurse answered their questions. At the suggestions of the nurse, some mothers recorded their questions and mothers reported this to be helpful. At the time of the phone call to book the postpartum home visit, public health nurses should encourage mothers to record their questions or concerns so they can be addressed at the home visit. Mothers should be given frequent opportunities during the visit to ask questions that may have developed during the conversation or that the mother may have remembered as a result of a particular topic being discussed.

2. The emotional status of the mother can affect her interaction with her baby and her adaptation to the role of motherhood (Cohen, Kenner, & Hollingsworth, 1991). Nurses should be more attentive to their assessment of the emotional aspects of maternal adaptation to motherhood and to the mother's need for positive feedback and reassurance.

3. In this study, fathers were present in only three of the ten home visits. In all cases, fathers talked less time than the mothers. During the home visit, the nurse should provide the opportunity for fathers to be an active participant in the visit. Nurse should observe the interactions of the family and include an assessment of the father's adaptation to parenthood.

4. As maternal concerns appear to be more frequent and intense during the first week at home, it would seem helpful for nurses to make phone contact with the mother during the first week at home and make a home visit within one to two weeks.

Faxing of postpartum referrals from hospitals to health units would facilitate this process.

5. In this study, the nurse's use of taking and giving information seemed appropriate as mothers reported to be satisfied with the visit. However, the finding that mothers were seeking reassurance from the nurse and information regarding events being normal is worth noting and incorporating into practice. As well, mothers should be given ample opportunity to ask questions throughout the visit as some mothers reported they remembered questions or concerns as the nurse moved through topics during the visit.

Recommendations for nursing research

This descriptive exploratory study of the postpartum home visit made by a public health nurse is only a start toward practice based community health nursing research in general and the postpartum home visit in particular. Though the findings from this study are similar to those from Britain and the United States, further Canadian research is necessary. Recommendations for future research include:

1. Though historically the home visit has been recognized as a factor in the reduction of infant mortality, research in this area is scarce. In Manitoba, public health nurses have been making home visits to postpartum women since 1916 without a formal evaluation of the service. Findings from this study suggest components of the service could be evaluated without using an experimental research design or withholding the service. Further study of the content and process of the visit and client perceptions could form the basis for the development of an evaluation questionnaire. As well, audits could be completed to identify the type of problems

identified during the home visit and the number of mothers/babies added to nurses' caseloads as a result of the home visit. Statistics on the number of mothers who phone contact the PHN following the visit and the reason for the contact could also provide helpful evaluation information. A record of the number of mothers who continue to use the services provided by the agency and their reasons for using the service should be kept. This data could give program planners some of the evidence required to assess the impact of the program and to suggest changes that could be helpful in promoting and planning programs appropriate for the population being served.

2. Communication is an essential part of nursing interventions. Research examining nurse interactions in a variety of settings and with a variety of client groups would add to the knowledge base of what constitutes community health nursing practice. Client perceptions of the interactions should be examined at the same time to determine the meaning of the interactions.

3. A convenience sample of mothers and nurses who volunteered to participate was used in this study. All mothers, except one, had completed high school and lived in well maintained suburban areas in residences which were clean and adequately furnished. No mothers or babies were added to the nurse's caseload following the home visit. As the sample used in this study could be considered low risk, a similar study could be conducted using a sample of high risk women, such as, single parent or adolescent mothers, or mothers from different ethnic groups.

Limitations

A limitation of this study was the use of a convenience sample consisting of PHNs and mothers who volunteered to participate. The number of public health nurses and mothers who declined and their reasons for declining is unknown. The nurses who participated may be confident nurses who under most circumstances enjoy postpartum home visits and believe they have adequate knowledge and skills in the area being studied. As well, nurses may have only selected mothers they considered to be at low risk for problems adjusting to the postpartum period. Data from high risk mothers may be different from that collected in this study. Mothers who agreed to participate in the study may also have been confident in their ability to care for themselves and the baby and were not experiencing or anticipating any problems. With the use of a convenience sample, it is not possible to generalize study findings to other settings or samples.

Another limitation of the study was the presence of the tape recorder which may have influenced the nurse's and mother's behavior during the home visit. For example, nurses may have been particularly thorough in their assessments knowing the visit was being analyzed by the researcher. As well, mothers may have been reluctant to identify problems because of the presence of a tape recorder even though both mothers and nurses were aware the tape recorder could be turned off at any time at the request of either party. A social desirability response bias may have occurred in that during the interview with the researcher, both nurses and mothers may have responded to the questions with what they believed to be socially correct responses rather than their actual answer.

An additional limitation to the study is the techniques used to capture the nurse/client interactions did not allow the calculation of percent agreement reliability in all areas of analysis. If a more precise method of micro analysis was wanted, the researcher should have been present during the visit to observe nonverbal communication, a more sensitive tape recorder used, and more specific directions given to the typist.

A final limitation of the study is common to all interaction studies. The focus of the data collection is on micro systems (i.e., nurse/client system) and not the interaction of this system with larger systems (i.e., individual programs/total health department programs). The study findings could have been further interpreted if detailed data of the health care system had been gathered, for example, the relationship of the postpartum home visit program to the philosophy within the public health system, other programs, staffing patterns, the relationship of other agencies in the community, and so forth. Without such detailed data and analysis, the study findings stand in comparative isolation. Therefore, care must be taken in the use of the data to make recommendations for policy changes to the postpartum home visit program.

Despite these limitations, valuable data was collected that adds to the limited Canadian research on community health nursing. This study provided some insight into nurse/client interactions in the postpartum home visit, as well as, mothers' and nurses' perceptions of the visit.

Summary of the Study

Maternal and child health continues to be an important practice area for public health nurses. The purpose of this study was to describe and analyze the postpartum home visit made by provincial public health nurses to primiparous women. The process and content of nurse/client interactions during the postpartum home visit and nurses' and mothers' perceptions of the visit were examined. A descriptive design using qualitative and quantitative research methods was used to conduct the study.

Public health nurses were found to dominate the home visit both in amount of time talked and number of questions asked. In the majority of visits, nurses took early direction for the visit from the mother; however, nurses seemed to direct the flow of conversation by controlling the introduction of topics. Topics discussed during the home visit related to baby, mother, services, and other. All issues related to baby centered around the physical care of the infant. Social/emotional aspects of the mother were only briefly explored.

Nurses' interactions in the postpartum home visit fell into the categories of socializes, listens actively, takes information, and gives information. Nurses spent the majority of their time during the visit taking or giving information.

All mothers found the home visit to be helpful as their questions were answered and they were reassured that the baby and their postpartum recovery were normal. All mothers stated they were satisfied with the visit. Some mothers stated they were instilled with confidence as the nurse confirmed that their actions to take care of themselves and the baby were okay. Mothers described the nurse's manner during the visit as friendly and approachable. All mothers respected and valued the

nurse's professional opinion. Mothers described the nurse's interactions during the visit as more like a conversation or discussion than an interview. Most mothers had concerns that were addressed by the public health nurse providing information or giving reassurance.

All nurses were able to describe their objectives for the home visit which were consistent for both visits. Objectives included assessing mothers and babies, informing mothers of the services of the public health nurse, and meeting the needs of the mother. Nurses felt all mothers participated which meant not only talking but also sharing their feelings. Satisfaction was linked to a mother's participation in the visit. Nurses were able to make suggestions to enhance services to the postpartum family. Nurses' and mothers' perceptions of the home visit seemed to relate to the interactions between the nurse and mother.

Findings from this study support recommendations for nursing education, practice, and research.

References

Affonso, D. (1987). Assessment of maternal postpartum adaptation. Public Health Nursing, 4(1), 9-20.

Allemang, M. (1985). Development of community health nursing in Canada. In M. Stewart, J. Innes, S. Searl, & C. Smillie (Eds.), Community health nursing in Canada (pp.3-29). Toronto: Gage.

American Nurses' Association. (1980). A conceptual model of community health nursing. Kansas City: Author.

Archer, S. (1983). Marketing public health nursing services. Nursing Outlook, 31(6), 304-309.

Bagwell, M. (1987). Client satisfaction with nursing center services. Journal of Community Health Nursing, 4(1), 29-42.

Barkauskas, V. (1983). Effectiveness of public health nurse home visits to primiparous mothers and their infants. American Journal of Public Health, 73, 573-580.

Barkauskas, V. (1990). Home health care. Annual Review of Nursing Research, 8, 103-132.

Baxter, D. (1986). The evaluation book: A guide to assessing programmes. Toronto: City of Toronto.

Becker, M. (1986). The tyranny of health promotion. Public Health Reviews, 14(2), 15-23.

Benedek, T. (1959). Parenthood as a developmental phase: A contribution to libido theory. Journal of the American Psychoanalytic Association, 7(3), 389-417.

Bloch, D. (1975). Evaluation of nursing care in terms of process and outcome: Issues in research and quality assurance. Nursing Research, 24(4), 256-263.

Blumer, H. (1969). Symbolic interactionism: Perspective and methods. Englewood Cliffs, NJ: Prentice-Hall.

Bracht, N., & Tsouros, A. (1990). Principles and strategies of effective community participation. Health Promotion International, 5(3), 199-208.

Brink, P. (1989). Issues in reliability and validity. In J. Morse (Ed.). Qualitative nursing research: A contemporary dialogue (pp. 151-168). Rockville, MD: Aspen.

Brink, P., & Wood, M. (1989). Descriptive designs. In P. Brink & M. Wood (Eds.). Advanced design in nursing research (pp. 123-140). London: Sage.

Brown, L. (1967). Effectiveness of nursing visits to primigravida mothers. Canadian Nurse, 65(1), 45-49.

Bull, M. (1981). Change in concerns of first-time mothers after one week at home. Journal of Obstetric, Gynecologic, and Neonatal Nursing, 10(5), 391-394.

Burbach, C., & Brown, B. (1988). Community health and home health nursing: Keeping the concepts clear. Nursing and Health Care, 9(2), 97-100.

Butnarescu, G. (1978). Perinatal nursing: Reproductive health (Vol.1). New York: John Wiley & Sons.

Canadian Nurses Association. (1988). Health for all Canadians: A call for health-care reform. Ottawa: Author.

Canadian Public Health Association. (1990). Community health - public health nursing in Canada: Preparation & practice. Ottawa: Author.

Casiano, M., & Hawkins, D. (1987). Major mental illness and childbearing: A role for the consultation-liaison psychiatrist in obstetrics. Psychiatric Clinics of North America, 10(1), 35-51.

Chalmers, K. (1990). Preventive work with families in the community: A qualitative study of health visiting practice. Unpublished doctoral dissertation, University of Manchester, Manchester, England.

Chalmers, K. (1992). Giving and receiving: An empirically derived theory on health visiting practice. Journal of Advanced Nursing, 17, 1317-1325.

Chang, S., & Renshaw, D. (1986). Psychosis and pregnancy. Comprehensive Therapy, 12(10), 36-41.

Chenitz, W., & Swanson, J. (1986). Qualitative research using grounded theory. In W. Chenitz, & J. Swanson (Eds.), From practice to grounded theory: Qualitative research in nursing (pp.3-15). Don Mills, Ont.: Addison Wesley.

Clark, J. (1984). Mothers' perceptions of health visiting. Health Visitor, 57, 265-268.

Clark, J.M. (1989). Nurse-patient interaction. In J.M. Clark & L. Hockey (Eds.). Further research for nursing (pp. 113-121). Harrow, Middlesex: Scutari Press.

Cohen, S., Kenner, C., & Hollingsworth, A. (1991). Maternal, neonatal, and women's health nursing. Springhouse, PA.: Springhouse.

Combs-Orme, T. Reis, J., & Ward, L. (1985). Effectiveness of home visits by public health nurses in maternal and child health: An empirical review. Public Health Reports, 100(5), 490-499.

Conant, L. (1965). Give-and-take in home visits. American Journal of Nursing, 65(7), 117-120.

Cox, C. (1982). An interaction model of client health behavior: Theoretical prescription for nursing. Advances in Nursing Science, 5(1), 41-56.

Curry, M. (1983). Variables related to adaptation to motherhood in "normal" primiparous women. Journal of Obstetric, Gynecologic, and Neonatal Nursing, 12(2), 115-121.

Danziger, S. (1978). The uses of expertise in doctor-patient encounters during pregnancy. Social Science and Medicine, 12, 359-367.

Dodge, J., & Oakley, D. (1989). Analyzing nurse-client interactions in family planning clinics. Journal of Community Health Nursing, 6(1), 37-44.

Domke, L. (1986). Change in primiparous mothers' concerns from the second or third day postpartum to one month postpartum. Unpublished master's thesis, University of Manitoba, Winnipeg.

Donaldson, N. (1981). The postpartum follow-up nurse clinician. Journal of Obstetric, Gynecologic, and Neonatal Nursing, 10(4), 249-254.

Eck, S., Meehan, R., Zigmund, D., & Pierro, L. (1988). Consumerism, nursing, and the reality of the resources. Nursing Administration Quarterly, 12(3), 1-11.

Edwards, N., Mackay, G., & Schweitzer I. (1992). The provision of public health nursing follow-up services for postnatal clients in Ontario: A cross-sectional survey. Canadian Journal of Public Health, 83(3), 200-202.

Epp, J. (1986). Achieving health for all: A framework for health promotion. Ottawa: Minister of Supply and Services.

Ervin, N. (1982). Public health nursing practice: An administrator's view. Nursing Outlook, 30(7), 390-394.

Field, P. (1983). An ethnography: Four public health nurses' perspectives of nursing. Journal of Advanced Nursing, 8, 3-12.

Field, P., & Morse, J. (1985). Nursing research: The application of qualitative approaches. London: Croom Helm.

Flagler, S. (1988). Maternal role competence. Western Journal of Nursing Research, 10(3), 274-290.

Flynn, B., & Ray, D. (1987). Current perspectives in quality assurance and community health nursing. Journal of Community Health Nursing, 4(4), 187-197.

Freeman, R. (1961). Measuring the effectiveness of public health nursing services. Nursing Outlook, 9(10), 605-607.

Fry, S. (1983). Dilemma in community health ethics. Nursing Outlook, 31(3), 176-179.

Gebbie, K. (1986). Impact of cutbacks: Alternative futures in public health nursing. Journal of Public Health Policy, 7(1), 21-27.

Gibbon, J. (1947). Victorian Order of Nurses for Canada: Fiftieth anniversary. Montreal: Southam Press.

Gjerdingen, D., Froberg, D., & Wilson, D. (1986). Postpartum mental and physical problems. Postgraduate Medicine, 80(8), 133-145.

Goeppinger, J., Lassiter, P., & Wilcox, B. (1982). Community health is community competence. Nursing Outlook, 30(8), 464-467.

Goodnow, M. (1944). Nursing history in brief. London: W.B. Saunders.

Gott, M., & O'Brien, M. (1990). The role of the nurse in health promotion. Health Promotion International, 5(2), 137-143.

Gottlieb, L., & Rowat, K. (1987). The McGill model of nursing: A practice-derived model. Advances in Nursing Science, 9(4), 51-61.

Graef, P., McGhee, K., Rozycki, J., Fescina-Jones, D., Clark, J., Thompson, J., & Brooten, D. (1988). Postpartum concerns of breastfeeding mothers. Journal of Nurse-Midwifery, 33(2), 62-66.

Green, J., & Driggers, B. (1989). All visiting nurses are not alike: Home health and community health nursing. Journal of Community Health Nursing, 6(2), 83-93.

Green, L., & Kreuter, M. (1990). Health promotion as a public health strategy for the 1990s. Annual Review of Public Health, 11, 319-334.

Gruis, M. (1977). Beyond maternity: Postpartum concerns of mothers. American Journal of Maternal Child Nursing, 2(3), 182-188.

Gulino, C., & LaMonica, G. (1986). Public health nursing: A study in role implementation. Public Health Nursing, 3(2), 80-91.

Haight, J. (1977). Studying parents as they go - by phone. The American Journal of Maternal Child Nursing, 2(5), 311-312.

Hall, L. (1980). Effect of teaching on primiparas' perceptions of their newborn. Nursing Research, 29(5), 317-322.

Hampson, S. (1989). Nursing interventions for the first three postpartum months. Journal of Obstetric, Gynecologic, and Neonatal Nursing, 18(2), 116-122.

Hancock, T. (1987). Healthy cities: The Canadian project. Health Promotion, 26(1), 2-4, 27.

Hancock, T. (1989, March). Where the rubber meets the road. Paper presented at the National Symposium on Health Promotion and Disease Prevention, Victoria, B.C.

Handford, P. (1985). Postpartum depression: What is it, what helps? Canadian Nurse, 81, 30-33.

Harrison, M., & Hicks, S. (1983). Postpartum concerns of mothers and their sources of help. Canadian Journal of Public Health, 74(5), 325-328.

Harrison, T., Pistolessi, T., & Stephen, T. (1989). Assessing nurses' communication: A cross-sectional study. Western Journal of Nursing Research, 11(1), 75-91.

Health & Welfare Canada. (1974). A new perspective on the health of Canadians: A working document. Ottawa: Author.

Heinrich, J. (1983). Historical perspectives on public health nursing. Nursing Outlook, 31(6), 317-320.

Hemmelgarn, B. Edouard, L., Habbick, B., & Feather, J. (1992). Duplication of well-baby services. Canadian Journal of Public Health, 83(3), 217-220.

Highriter, M. (1977). The status of community health nursing research. Nursing Research, 26(3), 183-192.

Highriter, M. (1984). Public health nursing evaluation, education, and professional issues: 1977 to 1981. Annual Review of Nursing Research, 2, 165-189.

Hrobsky, D. (1977). Transition to parenthood: A balancing of needs. Nursing Clinics of North America, 12(3), 457-468.

Ivey, A. (1983). Intentional interviewing and counselling. Monterey, CA: Brooks/Cole Publishing.

Jones, P., & Craig, D. (1988). Nursing practice in the community: Primary health care. In A. Baumgart, & J. Larsen (Eds.), Canadian nursing faces the future: Development and change (pp. 135-149). Toronto: C.V.Mosby.

Kasch, C. (1986). Establishing a collaborative nurse-patient relationship: A distinct focus of nursing action in primary care. Image, 18(2), 44-47.

Kim, S. (1983). Collaborative decision making in nursing practice: A theoretical framework. In P. Chinn (Ed.), Advances in nursing theory development (pp.271-283). Rockville, MD: Aspen.

Kishi, K. (1983). Communication patterns of health teaching and information recall. Nursing Research, 32(4), 230-235.

Knafl, K., & Howard, M. (1984). Interpreting and reporting qualitative research. Research in Nursing and Health, 7, 17-24.

Kok, G., & Green, L. (1990). Research to support health promotion in practice: A plea for increased co-operation. Health Promotion International, 5(4), 303-308.

Kristjanson, L., & Chalmers, K. (1990). Nurse-client interactions in community-based practice: Creating common ground. Public Health Nursing, 7(4), 215-223.

Labonté, R., & Penfold, S. (1981). Canadian perspectives in health promotion: A critique. Health Education, 19(3,4), 4-9.

Laffrey, S., Renwanz-Boyle, A., Slagle, R., Guthmiller, A., & Carter, B. (1990). Elderly clients' perceptions of public health nursing care. Public Health Nursing, 7(2), 111-117.

Leininger, M. (1985). Qualitative research methods in nursing. London: Grune & Stratton.

Levin, L. (1987). Every silver lining has a cloud: The limits of health promotion. Social Policy, 18(1), 57-60.

Lincoln, Y., & Guba, E. (1985). Naturalistic inquiry. Beverly Hills, CA: Sage.

Lofland, J., & Lofland, L. (1984). Analyzing social settings: A guide to qualitative observation and analysis (2nd ed.). Belmont, CA: Wadsworth.

Lowe, M. (1970). Effectiveness of teaching as measured by compliance with medical recommendations. Nursing Research, 19(1), 59-63.

Lucas, M., McCreight, L., Watkins, J., & Long, S. (1988). Job satisfaction assessment of public health nurses. Public Health Nursing, 5(4), 230-234.

Ludington-Hoe, S. (1977). Postpartum: Development of maternicity. American Journal of Nursing, 77(7), 1171-1174.

Luker, K. (1985). Evaluating health visiting practice. In K.Luker, & J. Orr (Eds.), Health visiting (pp.121-153). London: Blackwell Scientific.

Maglacas, A. (1988). Health for all: Nursing's role. Nursing Outlook, 36(2), 66-71.

Magilvy, J., Brown, N., & Dydyn, J. (1988). The experience of home health care: Perceptions of older adults. Public Health Nursing, 5(3), 140-145.

Majewski, J. (1987). Social support and the transition to the maternal role. Health Care for Women International, 8, 397-407.

Manitoba Association of Registered Nurses. (1988). Child abuse: Nurses' protocol. Winnipeg: Author.

Manitoba Health. (1989). Partners for health: A new direction for the promotion of health in Manitoba. Winnipeg: Author.

Manitoba Health. (1991). Postpartum referral form report. Winnipeg: Author.

Manitoba Health. (1992). Quality health for Manitobans: The action plan. Winnipeg: Author.

Manitoba Vital Statistics. (1990). Maternal and child care vital statistics 14th update. Winnipeg: Manitoba Health.

May, K. (1991). Interview techniques in qualitative research: Concerns and challenges. In M. Morse (Ed.). Qualitative nursing research: A contemporary dialogue (pp. 187-201). Rockville, MD: Aspen.

Mayers, M. (1973). Home visit - Ritual or therapy. Nursing Outlook, 21(5), 328-331.

McKay, R., & Segall, M. (1983). Methods and models for the aggregate. Nursing Outlook, 31(6), 328-334.

McNeil, H., & Holland, S. (1972). A comparative study of public health nurse training in groups and in home visits. American Journal of Public Health, 62(12), 1629-1636.

Mercer, R. (1981). A theoretical framework for studying factors that impact on maternal role. Nursing Research, 30(2), 73-77.

Mercer, R. (1986). Predictors of maternal role attainment at one year postbirth. Western Journal of Nursing Research, 8(1), 9-32.

Mills, K., & Ready, H. (1988). Health promotion in community nursing practice. In A. Baumgart, & J. Larsen (Eds.), Canadian nursing faces the future: Development and change (pp. 150-161). Toronto: C.V. Mosby.

Minkler, M. (1989). Health education, health promotion, and the open society: An historical perspective. Health Education Quarterly, 16(1), 17-30.

Montgomery-Robinson, K. (1986). Accounts of health visiting. In A. While (Ed.), Research in preventive community nursing (pp.125-133). New York: John Wiley & Sons.

Morgan, B., & Barden, M. (1985). Nurse-patient interactions in the home setting. Public Health Nursing, 2(3), 159-167.

Moss, J. (1981). Concerns of multiparas on the third postpartum day. Journal of Obstetric, Gynecologic, and Neonatal Nursing, 10(6), 421-424.

Nightingale, F. (1946). Notes on nursing: What it is, and what it is not. London: J. B. Lippincott. (Original work published in 1859).

Novak, J. (1991). The social mandate and historical basis for nursing's role in health promotion. In K. Saucier (Ed.), Perspectives in family and community health (pp.9-16). Toronto: Mosby.

Oda, D. (1989). Home visits: Effective or obsolete nursing practice? Nursing Research, 38(2), 121-123.

Parse, R., Coyne, B., & Smith, M. (1985). Nursing research: Qualitative methods. Bowie, MD: Prentice-Hall.

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

Petrick, J. (1984). Postpartum depression: Identification of high-risk mothers. Journal of Obstetric, Gynecologic, and Neonatal Nursing, 13(1), 37-40.

Polit, D., & Hungler, B. (1987). Nursing research: Principles and methods (3rd ed.). London: Lippincott.

Pridham, K., & Zavoral, J. (1988). Help for mother with infant care and household tasks: Perceptions of support and stress. Public Health Nursing, 5(4), 201-208.

Pringle, D. (1988). Nursing practise in the home: The role of the Victorian Order of Nurses. In A. Baumgart, & J. Larsen (Eds.), Canadian nursing faces the future: Development and change (pp. 121-133). Toronto: C.V. Mosby.

Ramos, M. (1989). Some ethical implications of qualitative research. Research in Nursing and Health, 12, 57-63.

Reeder, P., & Chen, S. (1990). A client satisfaction survey in home health care. Journal of Nursing Quality Assurance, 5(1), 16-24.

Reutter, L. (1984). Family assessment - An integrated approach. Journal of Advanced Nursing, 9(4), 391-399.

Risser, N. (1975). Development of an instrument to measure patient satisfaction with nurses and nursing care in primary care settings. Nursing Research, 24(1), 45-52.

Roberts, D. (1962). How effective is public health nursing? American Journal of Public Health, 52(7), 1077-1083.

Robertson, C. (1981). 1: Measuring the effectiveness of health visitors. Health Visitor 54, 20-21.

Rossi, A. (1968). Transition to parenthood. Journal of Marriage and the Family, 30, 26-39.

Rovers, R., & Isenor, L. (1988). Mothers' perceptions and use of community health services during the postpartum. Public Health Nursing, 5(4), 193-200.

Rubin, R. (1961a). Basic maternal behavior. Nursing Outlook, 9(11), 683-686.

Rubin, R. (1961b). Puerperal change. Nursing Outlook, 9(12), 753-755.

Rubin, R. (1975). Maternity nursing stops too soon. American Journal of Nursing, 75(10), 1680-1684.

Russell, E. (1946). Public Health Nursing Manual. Unpublished manual-Manitoba Health.

Salmon, M. (1989). Public health nursing: The neglected specialty. Nursing Outlook, 37(5), 226-229.

Salmon, M., & Peoples-Sheps, M. (1989). Infant mortality and public health nursing: A history of accomplishments, a future of challenges. Nursing Outlook, 37(1), 6,7,51.

Salmon White, M. (1982). Construct for public health nursing. Nursing Outlook, 30(9), 527-530.

Sandelowski, M. (1986). The problem of rigor in qualitative research. Advances in Nursing Science, 8(3), 27-37.

Schoolcraft, V. (1984). Futurism and nursing. In V. Schoolcraft (Ed.), Nursing in the community (pp.3-22). New York: John Wiley & Sons.

Sefi, S. (1988). Health visitors talking to mothers. Health Visitor, 61, 7-10.

Shamansky, S., & Clausen, C. (1980). Levels of prevention: Examination of the concept. Nursing Outlook, 28(2), 104-108.

Smith, G. (1984). Historical foundations and trends. In V. Schoolcraft (Ed.), Nursing in the community (pp.23-40). New York: John Wiley & Sons.

Smith, J. (1986). Nursing and health care in the twentieth century: Myth, reality and dichotomy. Journal of Advanced Nursing, 11, 127-132.

Spasoff, R. (1990). Current trends in Canadian health care: Disease prevention and health promotion. Journal of Public Health Policy, 11(2), 161-168.

Stanwick, R., Moffat, M., Robitaille, Y., Edmond, A., & Dok, C. (1982). An evaluation of the routine postnatal public health nurse home visit. Canadian Journal of Public Health, 73, 200-205.

Statistics Canada. (1977). Vital statistics: Volume III deaths. Ottawa: Author.

Stern, R. (1990). Healthy communities: Reflections on building alliances in Canada. A view from the middle. Health Promotion International, 5(3), 225-231.

Strauss, A., & Corbin, J. (1991). Basics of qualitative research: Grounded theory procedures and techniques. London: Sage.

Sumner, G., & Fritsch, J. (1977). Postnatal parental concerns: The first six weeks of life. Journal of Obstetric, Gynecologic, and Neonatal Nursing, 6(3), 27-32.

Taylor, A., Hudson, K., & Keeling, A. (1991). Quality nursing care: The consumers' perspective revisited. Journal of Nursing Quality Assurance, 5(2), 23-31.

Templeton Gay, J., Estes Edgil, A., & Bragg Douglas, A. (1988). Reva Rubin revisited. Journal of Obstetric, Gynecologic, and Neonatal Nursing, 17(6), 394-399.

Terris, M. (1984). Newer perspectives on the health of Canadians: Beyond the Lalonde Report. Journal of Public Health Policy, 5(3), 327-337.

Terris, M. (1989, March). The road ahead for health promotion and disease prevention. Paper presented at the National Symposium on Health Promotion and Disease Prevention, Victoria, B.C.

Terris, M. (1990). Public health policy for the 1990s. Journal of Public Health Policy, 11(3), 281-295.

Topf, M. (1986). Three estimates of interrater reliability for nominal data. Nursing Research, 35(4), 253-256.

Townsend, E., Edwards, N., & Nadon, C. (1992). The hospital liaison process: Identifying risk factors in postnatal multiparas. Canadian Journal of Public Health,83(3), 203-207.

Vandenbergh, R. (1980). Postpartum depression. Clinical Obstetrics and Gynecology, 23(4), 1105-1111.

Ventura, M., Fox, R., Corley, M., & Mercurio, S. (1982). A patient satisfaction measure as a criterion to evaluate primary nursing. Nursing Research, 31(4), 226-230.

Waitzkin, H. (1979). Medicine, superstructure, and micropolitics. Social Science and Medicine, 13A, 601-609.

Warner, U. (1984a). Asking 'How are you?' in health visitor clinics. Health Visitor, 57, 270-272.

Warner, U. (1984b). Asking the right questions. Nursing Times, June 13, 214-216.

Watson, E., & Sim, J. (1989). The health visitor's visit. Health Visitor, 62, 214-217.

Webster-Stratton, C., Glascock, J., & McCarthy, A. (1986). Nurse practitioner-patient interactional analyses during well-child visits. Nursing Research, 35(4), 247-449.

West, M., & Savage, Y. (1988). Satisfactions of health visiting. Health Visitor, 61, 336-338.

Williams, C. (1977). Community health nursing - what is it? Nursing Outlook, 25(4), 250-254.

Wilson, E. (1945, January). History and development of health services in Manitoba. Paper presented to Women's School of Citizenship, Winnipeg.

Wilson, H. (1985). Research in nursing. Menlo Park, CA: Addison-Wesley.

Wiseman, J. (1982). What health visitors do. Nursing Times, 78(29), 113-116.

Wood, M. (1989). Evaluation designs. In P. Brink & M. Wood (Eds.), Advanced design in nursing research (pp.223-237). London: Sage.

World Health Organization. (1978). Alma-Ata 1978: Primary health care. Geneva: Author.

World Health Organization. (1984a). Education for health: In support of health for all. Geneva: Author.

World Health Organization. (1984b). Health promotion: A discussion document on the concept and principles. Copenhagen: Author.

World Health Organization, Health & Welfare Canada, & CPHA. (1986). Ottawa charter for health promotion. Health Digest, 10(4), 1-4.

Wotton, D. (1992). An exploration and description of the postpartum telephone interview. Unpublished master's thesis, University of Manitoba, Winnipeg.

Wright, D. (1984). An introduction to the evaluation of nursing care: A review of the literature. Journal of Advanced Nursing, 9, 457-467.

Yauger, R. (1972). Does family-centered care make a difference? Nursing Outlook, 20(5), 320-323.

Yiu Matuk, L., & Chadwell Horsburgh, M. (1989). Rebuilding public health nursing practice: A Canadian perspective. Public Health Nursing, 6(4), 169-173.

Appendix A

Facility Access Letter

Ms. L. Thompson
Acting Director
Women's Health Directorate
Manitoba Health
800 Portage Avenue
Winnipeg, Manitoba
R3G 0N2

Dear Ms. Thompson

As we have discussed informally in the past, I would like to conduct my Master of Nursing thesis study with Manitoba Health. The Nursing Ethics Committee of the University of Manitoba has approved my research proposal and I am including the forms required by Manitoba Health, as well as, a copy of the research proposal.

The purpose of the study is to examine nurse/client interactions during the postpartum home visit to primiparous women as well as the nurse's and mother's perceptions of the visit. For this study, I am requesting that five PHNs agree to tape record their postpartum home visit with two primiparous mothers. Immediately following the visit, I would like to interview the mother only. The nurse would be free to continue with his/her daily routine. Later in the day, I would like to interview the nurse.

To protect patient privacy and freedom of choice regarding participation in the study, I ask the PHNs who agree to take part in the study to assist me with identification of client participants. This would involve the PHN approaching primiparous postpartum mothers, who they assess as being able to participate in the study and who meet the criteria for the study, to ask their permission for me to speak with them about my study prior to inviting them to participate.

During the study, please feel free to discuss with me any concerns or questions you have. I can be reached at 253-8638. If you wish to speak with my study supervisor, Dr. Karen Chalmers, she can be reached by phoning 474-9315.

Thank you for considering my request. I look forward to hearing from you.

Sincerely

Brenda Cantin, RN, BScN
Master of Nursing Student
University of Manitoba

cc Karen Chalmers

Appendix B

Explanation of Study for Nurse Participants

My name is Brenda Cantin. I am a registered nurse and a student in the Master of Nursing Program at the University of Manitoba. As part of my nursing program, I am conducting a study in the community to learn more about nurse/client interactions in the postpartum home visit and the nurse's and mother's perceptions of the visit. The study has received ethical approval from the Faculty of Nursing Ethical Review Committee at the University of Manitoba. Manitoba Health has given me permission to carry out this study.

You are invited to participate in this study. If you agree to do so, I will collect some demographic data about yourself and ask you to tape record your postpartum home visit to two mothers who meet the study inclusion criteria and who also consent to be part of this study. I will not be present during the visit but will interview the mother to record her perceptions of the visit after you have completed your visit and have left the home. I will ask you to book about 15 to 30 minutes later in the day to answer several questions that will give me your opinion of the visit. This interview will be tape recorded by myself. I may also ask to contact you a second time by telephone in order to clarify any questions I have after reviewing the interview.

Transcripts will be made of your taped visit and my interviews and I may take short notes about the home visit and interview process. No other staff will have access to the taped visit, the transcripts, or any notes taken by the researcher. Information from your interview will not be shared with the mother nor will information from the mother's interview be shared with you.

Participation in this study is voluntary. Whether or not you participate, your position as a public health nurse will not be affected in any way. Your nursing supervisor will not be informed of whether or not you participate in the study. If you choose to participate, I will ask you to read an explanation of the study and a consent form and will answer any questions you may have regarding the study. Your signature on the consent form indicates your willingness to participate in the study. You will receive a copy of the explanation of the study and consent form.

Your taped interviews will be confidential. Your full name will not be recorded on the tape as I will ask the mothers participating in the study to address you by your first name only. I will also ask you to address the mother by first name only. Your name or identifying information will not appear on any transcripts, written notes, or in any public report of this study. Instead, a code number will be assigned to each public health nurse and client who participate in the study. The list with the coded numbers and names will be kept in a locked cabinet and will be accessible only to me. In the written research report or in any publication, information which might identify a subject will be altered or eliminated.

Appendix B (continued)

There will be no direct benefits to participating in this study but the study may help public health nurses become more aware of how they interact with clients. You may experience some loss of privacy as a result of having your home visit and interview with me tape recorded. It is expected that your participation will not involve a significant time commitment above that required for a regular home visit except for the 15 to 30 minute interview later in the day. You are free to withdraw from the study at any time.

Following completion of the study, I will be willing to do a presentation of the study findings to Manitoba Health public health nurses in the Winnipeg Region.

If you have any questions about the study, I can be reached at 253-8638. If you wish to speak with my study supervisor, Dr. Karen Chalmers, she can be reached by phoning 474-9315.

Thank you for your time and attention.

----------DETACH AND PLACE IN BOX----------

I _____(name) am interested in learning more about the study to describe nurse/client interactions in the postpartum home visit as well as the nurse's and mother's perceptions of the visit.

Please contact me at the following number _____. This is not a consent to participate in the study.

Appendix C

Explanation of Study for Client Participants

My name is Brenda Cantin. I am a registered nurse and a student in the Master of Nursing program at the University of Manitoba. As part of my nursing program, I am conducting a study of how public health nurses and mothers interact during the home visit which occurs after a woman has her first baby and how nurses and mothers perceive the visit. The study has received ethical approval from the Faculty of Nursing Ethical Review Committee at the University of Manitoba. Manitoba Health has given me permission to carry out this study.

You have already been contacted by , your public health nurse and agreed to allow her to give me your name. I would like to invite you to participate in this study.

If you agree to participate in this study, , your public health nurse, will bring a tape recorder when she comes to your home to visit you and your baby. Just before the visit begins, I will come into your house to meet you, answer any questions you may have, and ask you to sign a consent form. I will then leave the house and wait in a car while you and the nurse complete the visit. The visit will be tape recorded by the nurse. Following the visit, I will ask you to take approximately 15 to 30 minutes to answer several questions that will give me your opinion of the visit. This interview will also be tape recorded by myself. I may also be required to contact you a second time by telephone in order to clarify any questions I have after reviewing the interview.

Later in the day, I will interview the PHN about her opinion of the visit. Both the taped visit and the interviews will be transcribed, and I may take short written notes about the home visit and interview process. Information from your interview will not be shared with the public health nurse nor will information from the nurse's interview be shared with you.

Participation in this study is voluntary. Whether or not you decide to participate, your present or future care by your public health nurse will not be affected in any way. If you agree to participate, I will ask you to read an explanation of the study and a consent form and I will answer any questions you may have regarding the study. Your signature on the consent form will indicate you willingness to participate in the study. You are free to withdraw from the study at any time, without harm to you or your care. You will receive a copy of the explanation of the study and consent form.

There are no direct benefits to participating in the study but the study may help public health nurses become more aware of how they interact with clients. The home visit will not take any extra time due to the study and it is anticipated the interview will take approximately 15 to 30 minutes.

You may experience some loss of privacy as a result of having your home visit and interview with me tape recorded. You may ask to have the tape recorder turned

Appendix C (continued)

off at any time or may choose not to answer a specific question I ask during our interview. There will be no health risks to participation in this study.

You are assured of confidentiality. Your last name will not be used by the nurse or myself, therefore, will not be recorded on the tape. I will also ask you to call the nurse by her first name only. Your name or identifying information will not appear on any transcripts, written notes, or in any public report of this study. Instead, a code number will be assigned to each study participant. The list with the coded numbers and names will be kept in a locked cabinet and will be accessible only to me. When writing the research report or in any publication, information that might identify a subject will be altered or eliminated.

I will be happy to answer any questions you have about this study. I can be reached at 253-8638. If you wish to speak with my study supervisor, Dr. Karen Chalmers, you can call her at 474-9315. Thank you for your time and attention.

Appendix D

Consent Form for Nurse Participants

DESCRIPTION OF STUDY:

Brenda Cantin, a registered nurse and a student in the Master of Nursing Program at the University of Manitoba, is conducting a study of nurse/client interactions during the postpartum home visit as well as the nurse's and mother's perceptions of the visit. I am invited to participate in the study.

PROCEDURES:

If I agree to participate, my participation will include:

1. I will agree to complete a demographic data form and to ask two clients who meet the subject inclusion criteria given to me by Brenda if they will allow me to give their phone number to Brenda. Brenda will phone the perspective subjects and explain the study to them and ask for their verbal consent to participate in the study.
2. For each of the two mothers who agree to participate in the study, I will agree to tape record my postpartum home visit. Brenda will obtain written consent from the client prior to the visit but will not be present during the visit. I will return the tape and tape recorder to Brenda following the visit at which time Brenda will interview the mother to obtain her perceptions of the visit and I will be free to leave.
3. I understand that I may turn off the tape recorder at any time during the visit at the request of the mother or if I feel the client's privacy is in jeopardy.
4. I agree to book time later in the day of the visit to be interviewed by Brenda about my perceptions of the visit. This interview will take approximately 15 to 30 minutes and will be audio-tape recorded. Both the visit and the interviews will be transcribed onto paper. Brenda may contact me by telephone following the interview in order to clarify any questions she has following her review of the transcripts. Brenda may take short written notes about the home visit and interview process.

BENEFITS AND RISKS OF PARTICIPATING IN THIS STUDY:

There are no direct benefits from participating in this study but the study results may give nurses insight to their interactions with mothers during the postpartum home visit.

I may experience some loss of privacy through participation in this study as a result of having my postpartum home visit and interview tape recorded. I understand my participation will not involve a significant time commitment beyond that required for the home visit except for the 15 to 30 minute interview with Brenda later in the day. I am free to withdraw from the study at any time.

Appendix D (continued)

CONFIDENTIALITY:

I am assured of confidentiality. My full name will not be used on the tape. My name will not be used on any transcripts, written notes, or in any public report of this study. Instead, a code number will be assigned to each nurse and client participant in the study. Transcribed notes of the home visit and interviews will be saved for possible future analysis purposes but my name can not be identified with these transcripts. In the written research report or in any publication, information which might identify a subject will be altered or eliminated. Information from my interview will not be shared with the mother nor will information from the mother's interview be shared with me.

INVITATION TO QUESTION:

If I have any questions about the study, I may reach Brenda Cantin at 253-8638. If I wish to speak to her study supervisor, Dr. Karen Chalmers, she may be reached at 474-9315.

VOLUNTARY PARTICIPATION:

Participation in this study is entirely voluntary. Whether of not I decide to participate, my position as a public health nurse will not be affected in any way. My supervisor will not be told of my participation in the study. If I decide to participate and then later want to withdraw, I am free do so without any harmful effects.

My signature on this form indicates that I have discussed this study with Brenda Cantin and have read a written explanation of it, that I have read this form, and that I give my consent to participate in this study.

_____ _____

Signature of Nurse Signature of Researcher

Date:_____ Date:_____

I wish to receive a summary of the final report of this study:
Yes_____ No_____

Mail to:

Appendix E

Demographic Data

Public Health Nurses

FILL IN BLANK OR CIRCLE CORRECT RESPONSE

Q1 Nurse ID number:_____

Q2 Gender:_____female _____male

Q3 Age:_____years

Q4 Highest level of education:

1 Diploma
2 Baccalaureate
3 Masters
a nursing
b other_____

Q5 Work experience as a public health nurse:_____years

Appendix F

Consent Form for Client Participants

DESCRIPTION OF THE STUDY:

Brenda Cantin, registered nurse and a student in the Master of Nursing program at the University of Manitoba, is conducting a study of how mothers and public health nurses interact during the home visit that occurs after a women has her first baby and how nurses and mothers perceive the visit. I am invited to participate in this study.

PROCEDURES:

If I agree to participate, my participation will include:

1. My public health nurse tape recording my postpartum home visit. Brenda will not be present during this visit.

2. Following the home visit and immediately after the public health nurse leaves, Brenda will take approximately 15 to 30 minutes to ask me several questions about my opinion of the visit. This interview will also be recorded. Both the visit and interview will be transcribed onto paper. Brenda may contact me by telephone following the interview in order to clarify any questions she has following her review of the transcripts. The nurse will be interviewed by Brenda later in the day to get her opinion of the visit. Brenda may take short written notes about the home visit and interview process.

BENEFITS AND RISKS OF PARTICIPATING IN THIS STUDY:

There are no direct benefits to participating in this study but the study may help public health nurses become more aware of how they interact with mothers.

There will be no health risks to participation in this study. I may feel some loss of privacy through having the home visit and interview tape recorded. I am free to ask the public health nurse or Brenda to turn the tape recorder off at any time. I understand the home visit will not take any extra time due to the study and the interview will take approximately 15 to 30 minutes.

CONFIDENTIALITY:

I am assured of confidentiality. My full name will not be used during the time the tape recorder is recording. My name will not be used on any transcripts, written notes, or any public report of this study. Instead, a code number will be used to identify nurse and client participants. Transcribed notes of the home visit and interviews will be saved for possible future analysis purposes but my name can not be identified with these transcripts. When writing the research report or in any publication, information that might identify subjects will be altered or eliminated. Information from my interview will not be shared with the public health nurse nor will information from the public health nurse interview be shared with me.

Appendix F (continued)

INVITATION TO QUESTION:

If I have any questions about the study, I may contact Brenda Cantin at 253-8638. If I wish to speak to her study supervisor, Dr. Karen Chalmers, I may call her at the University of Manitoba School of Nursing (474-9315).

VOLUNTARY PARTICIPATION:

Participation in this study is entirely voluntary. Whether or not I decide to participate, my care will not be affected in any way. If I decide to participate and then later want to withdraw, I am free to do so without any effect on my care.

My signature on this form indicates that I have discussed this study with Brenda Cantin, have read a written explanation of it, that I have read this form, and I give my consent to participate in this study.

_____ _____

Signature of Client Signature of Researcher

Date_____ Date_____

I wish to receive a summary of the final report of this study:
Yes_____ No_____

Mail to:

Appendix G

Demographic Data

Postpartum Mothers

FILL IN BLANK OR CIRCLE CORRECT RESPONSE

Q1 Subject ID number:_____

Q2 Age:_____years

Q3 Date of birth (baby): _____ _____ ____
Day Month Year

Q4 Date of PHN visit: _____ _____ ____
Day Month Year

Q5 Education:

1 Some grade school

2 Completed grade school

3 Some high school

4 Completed high school

5 Some post secondary

6 Completed post secondary

Q6 Occupation:_____

Q7 Attendance at prenatal classes: 1 Yes; How many___

2 No

Appendix H
Research Questions: Literature Support

RESEARCH QUESTION/DATA	TOOL	ITEM/QUEST. #	LITERATURE SUPPORT
Research Data	Demographic Data - PP mothers	Q3 Date of Birth Q4 Date of PP visit	Bull, 1981; Moss, 1981; Rovers & Isenor, 1988; Sumner & Fritsch, 1977 - concerns change, more problems early in PP period
Research Data	Demographic Data - PP mothers	Q7 Prenatal classes	Gruis, 1977; Harrison & Hicks, 1983; Moss, 1981; Rovers & Isenor, 1988
Are maternal concerns addressed during the PP home visit? Research Q4	Interview Guide	Q2 Concerns Sources of help	Bull, 1981; Graef et al. 1988; Gruis, 1977; Haight, 1977; Harrison & Hicks, 1983; Sumner & Fritsch, 1977 Gruis, 1977; Haight, 1977; Harrison & Hicks, 1983; Pridham & Zavoral, 1988; Rovers & Isenor, 1988

Appendix H (continued)

Research Questions: Literature Support

RESEARCH QUESTION/DATA	TOOL	ITEM/QUEST. #	LITERATURE SUPPORT
What are mothers' perceptions of the PP home visit? Research Q3	Interview Guide	Q3 - Visit helpful	Barkauskas, 1983; Brown,1967; Rovers & Isenor, 1988
	Interview Guide	Q4 - Satisfied	Bagwell, 1987; Conant, 1965; Morgan & Barden, 1985; Pascoe, 1983; Reeder & Chen, 1990; Watson & Sim, 1989
		- PHN contact	Conant, 1965; Morgan & Barden, 1985; Rovers & Isenor, 1988
		Q5 - More helpful than visit	Brown, 1967; McNeil & Holland, 1972
What topics are discussed during the PP home visit? Research Q2	Analysis of visit	1 - Content: topics & interventions	Barkauskas, 1983,1990; Gulino & LaMonica, 1986; Laffrey et al., 1990

Appendix H (continued)

Research Questions: Literature Support

RESEARCH QUESTION/DATA	TOOL	ITEM/QUEST. #	LITERATURE SUPPORT
What is the nurses'/mothers' participation in the PP home visit? Research Q1	Analysis of visit	2- Process - Length of visit - Questions asked - Time talked, introduces/ closes topics - Ended visit - First 5 minutes, closed/open-ended questions	Conant, 1965; Sefi, 1988; Webster-Stratton et al., 1986 Laffrey et al., 1990; Sefi, 1988 Sefi, 1988 Conant, 1965 Webster-Stratton et al., 1986
What are the nurses' perceptions of the PP home visit? Research Q5	Interview Guide		Conant, 1965; Kristjanson & Chalmers, 1990; Mayers, 1973; Morgan & Barden, 1985; Watson & Sim, 1989

Appendix I

Summary Sheet Home Visit: Process

1. Length of visit:_____minutes.

   Time nurse enters home:____hours

   Time nurse exits home:_____hours

2. # questions asked: nurse_____mother_____other_____

3. Amount time talked (lines of transcript):

   nurse_____mother_____other_____

4. # times introduces topics:

   nurse_____mother_____other_____

   # times closes topics: nurse_____mother_____other_____

5. Ended visit: nurse__mother__other__

6. # open-ended questions asked by nurse:____

   # closed-ended questions asked by nurse:___

7. Nurse asked in first 5 minutes- any concerns? questions?

   specific areas to discuss? Yes__ No__

Appendix J

Interview Guide: Mothers

Q1 Can you tell me generally how the visit was for you?

Q2 Tell me about any concerns you had that you wanted the PHN to address?

If yes, PROBE-how addressed?

PROBE-other sources of help? -physician?

-hospital? -family? -friends?

Q3 Can you describe what was helpful about the visit?

PROBE-not helpful? -what was learned?

Q4 Overall, were you satisfied with the visit?

PROBE-what was satisfying?-not satisfying?

PROBE-previous contact with PHN?

Q5 Can you think of something else that might be more helpful than a home visit?

PROBE-describe

Q6 Can you tell me how you felt you participated in the visit?

PROBE-satisfaction with involvement

Q7 Is there anything else you would like to tell me about the visit before I leave?

Appendix K

Interview Guide: Public Health Nurses

Q1 Can you tell me generally how the visit was for you?

Q2 Have you had any previous contact with this mother?

If yes, explain nature of contact.

Q3 What were your objective's for the visit?

PROBE- were objectives met? if not, why?

Q4 Do you feel the client had any concerns she wanted you to address?

If yes, PROBE-how were they addressed?

Q5 Overall, were you satisfied with the visit?

PROBE-what was satisfying? not satisfying?

PROBE-how well did you know the client?

Q6 Can you tell me how you felt the mother participated in the visit?

PROBE- were you satisfied with her involvement?

Q7 Is there anything else you would like to tell me about the visit before I leave?

Appendix L

Guidelines for coding: Summary Sheet Home Visit-process

1. Length of visit - self explanatory

2. # questions asked:

nurse c beside question if closed- ended
o beside question if open-ended
mother * beside question
other ** beside question
-questions not included: directed at baby

Open-ended questions were defined as "those that can't be answered in a few short words. They encourage you to talk and provide you with maximum information. Typically, open questions begin with what, how, why, or could" (Ivey, 1983, p. 41). Ivey defines closed questions as those that can be answered with a few short words or sentences often beginning with is, are, or do. In this study such questions as "how old" "how long" "what color" "how much" "what kind" were defined as closed questions.

3. Amount of time talked: line drawn down center of page, at least a full word over the line counts as a full line (some discretion was used due to spacing or short words). Lines credited to nurse were recorded in right margin, lines credited to mom recorded in left margin, lines credited to other recorded in left margin and circled. If both mother and father talked at same time it was credited to mother.

4. # times introduces topic: new topic areas noted by a line drawn horizontally across page. When nurse reviewing pamphlets or doing examination of baby, each new topic not counted except if long discussion occurred in a certain area or if mother or father changed to an area not related to current conversation. All descriptions of subtopics on topics definitions sheet count as a new topic. Some researcher subjectivity occurred.

5. Ended visit: self explanatory, PHN may summarize briefly, give opportunity to ask last questions, remind mother where to call for help, state she will be on her way, state she will turn off tape recorder, enter into a social discussion.

6. see #2 for coding

7. Self explanatory, page and quote recorded on summary sheet. Any opening that allowed the client to direct the opening of the visit was counted. Examples: PHN5 M10 "...to start do either of you have some questions?"
PHN3 M5 "How have the first two weeks been?"