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THE UNIVERSITY OF ALBERTA

INITIATING OUTREACH HOME VISITS: PHN APPROACHES

by

HASANA ANN BIRK

A THESIS

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The undersigned certify that they have read, and recommend to the FACULTY OF GRADUATE STUDIES AND RESEARCH, for acceptance, a thesis entitled INITIATING OUTREACH HOME VISITS: PHN APPROACHES submitted by HASANA ANN BIRK in partial fulfilment of the requirements for the degree of MASTER OF NURSING.

Supervisor

Date Feb 11, 1988

In memory of my father,

Erwin David Hickin

ABSTRACT

The initial phase of a nurse-client encounter is the time during which the foundation of a good nurse-client relationship is laid; it is the phase during which the nurse must demonstrate her credibility and the relevance of her services to the client's needs. The act of so doing is sometimes called *seeking right of entry*. The need for nurses to seek entry is particularly critical in public health nursing, where many encounters are characterized as outreach, that is, they are initiated not by the client, but by the nurse. If clients do not understand the purpose of the encounter, they may accept the public health nurse into their homes, but fail to see her services as relevant to them. The objective of this study was to describe different approaches used public health nurses (PHNs) in initiating outreach home visits and to interpret the relationship between their approaches and the concept of right of entry.

In this exploratory-descriptive study, a combination of qualitative and quantitative methods was used in order to increase the comprehensiveness and validity of the findings. Nine PHN volunteers each tape-recorded one postnatal outreach home visit, and the PHNs' approaches were categorized using a pre-established coding guide based on a conceptual framework for seeking right of entry (ROE). The nine PHNs and their 11 clients were then interviewed separately in order to elicit their perspectives on initiating oureach visits. Interviews were analysed using constant comparative techniques. Findings revealed that the PHNs' approaches differed from that of the ROE framework in that the latter appeals essentially to the client's understanding, whereas approaches used by the PHNs appealed essentially to the client's feelings. PHNs and clients described four approach types comprised of different combinations of the following three approach components: *Focusing in on the client, Socializing* and *Explaining about public health*. This research contributes a description and interpretation of an area of public health nursing practice that has as yet received little attention from nurse researchers, and lays groundwork for continuing research on the phenomenon of attaining right of entry on public health nursing outreach visits.

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Chapter I

BACKGROUND AND STATEMENT OF THE PROBLEM

The initial phase of a nurse-client encounter is the time during which the foundation of a good nurse-client relationship is laid (Orem, 1981). In this phase, the nurse's primary responsibility is to make sure that he or she and the potential client share a common understanding of the purpose of the encounter. This first phase of the nurse-client encounter has been called *attaining right of entry* (Berg & Helgeson, 1984; Dingwall, 1977; Edmonton Board of Health Nursing Division [EBH], 1984); it is the phase during which the nurse must demonstrate that she or he is a "legitimate purveyor of services that the client should reasonably require" (Dingwall, p. 97).

The need for nurses to justify their presence in the lives of their potential clients is particularly crucial in public health nursing, where many contacts are initiated, not by the client, but by the nurse. This outreach activity has distinguished public health nursing since its inception (Emory, 1945) and is linked essentially with the promotion-prevention focus of public health: to wait until people's health privations become perceived problems is neither humane nor economical (EBH, 1984). If clients do not understand the purpose of a public health nursing outreach visit, they may view it as a social encounter or as an infringement upon their privacy; in either case, nurse and client may "talk past" each other during the entire encounter. The implications are far reaching: waste of time and energy of both nurse and client, ineffective use of health care dollars, and potential degeneration of the health status of the public, resulting in an increased demand for more costly restorative health care services.

The purpose of this research was to determine how public health nurses (PHNs) go about attaining right of entry with their potential clients on outreach visits. The conceptual framework used to guide the study was the Right of Entry (ROE) framework developed by the Nursing Division of the Edmonton Board of Health (1984) and based upon the Aristotelian model of persuasion. Right of entry is not just an invitation to enter a person's

home, it is an invitation to enter an individual's personal world. The PHN *earns* right of entry through conveying to the potential client the worth of public health nursing and its particular relevance for that client. In Aristotelian terms, successful right of entry consists in the PHN's establishing the *ethos* (character) of public health nursing by appealing to both the client's emotions (*pathos*) and intellect (*logos*) (Adler, 1983).

The ROE framework was designed to ensure that both PHN and client achieve a common understanding of the purpose of a PHN-client encounter. While achieving common understanding is widely accepted among nurses as the basis of a sound nurse-client relationship (Field, 1982; Fowler, 1985; Gustafsen, 1977; Langford, 1978; Orem, 1980; Sloan & Schommer, 1975; Spradley, 1981; Sundeen, Stuart, Rankin & Cohen, 1976; Warner, 1984a), it is by no means agreed upon how common understanding can best be achieved. On the one hand, it seems irrefutable that the purpose of the PHN-client encounter cannot be adequately conveyed unless it is explicitly (i.e. verbally) referred to by the PHN, as called for in the ROE framework. On the other hand, nurses may argue that clients will be more interested in getting down to discussion of the main topic of the visit, and may be bored or irritated by an explanation of "abstract ideals". Actions are often thought to speak louder than words, and PHNs may believe that clients will be able to infer the purpose of public health nursing actions from observation of those actions. Berg and Helgeson (1984) consider that the initial phase of a home visit should consist primarily of social conversation, in order to establish "rapport".

While there is no consensus in the literature on what approaches PHNs *should* use in initiating a PHN-client encounter, neither is there evidence to indicate what approaches PHNs *do* use. To date, no research has focused specifically on the introductory phase of the PHN-client encounter, although there is some evidence indicating that PHNs devote very little time to this phase (Dingwall, 1977; Johnson & Hardin, 1962). A few studies have revealed that some clients have not understood why a PHN was visiting them, even after several visits (Bambino, 1969; Clark, 1984; Conant, 1966; Field, 1982; Luker, 1982).

Purpose and Objective

The ultimate purpose of research on right of entry is to determine which PHN approaches are most effective in attaining right of entry, in order to improve nursing practice. The objective of this study was to make a beginning step in this direction by describing different approaches used by practising PHNs in initiating outreach vists and by comparing these approaches with that represented by the EBH ROE framework. Three sets of research questions were addressed:

Set 1: Description from the Researcher's Perspective

1.1 What approaches do public health nurses use in initiating an outreach home visit?

1.2 How do the PHNs' approaches compare with the approach represented by the EBH ROE framework?

Set 2: Description from the PHNs' Perspective

2.1 What approaches do public health nurses report using in initiating an outreach home visit?

2.2 What reported factors influence a public health nurse's choice of approach?

2.3 What are the reported objectives of public health nurses on outreach visits?

2.4 What do public health nurses believe about the significance of right of entry, and how do they judge their success in attaining right of entry on outreach visits?

Set 3: Description from the Clients' Perspective

3.1 What are the reported responses of clients to a public health nursing outreach visit?

3.2 How do clients describe the approach that a public health nurse used in initiating an outreach visit, and what are their reported responses to that approach?

3.3 What reported factors influenced the responses described in (3.2) above?

3.4 How do clients conceive of right of entry, and how successful were public health nurses in attaining right of entry, as judged by clients?

Definition of Terms

Approach refers to the form (process) and content of a PHN's conversation with a potential client in initiating a PHN-client encounter.

Outreach visit refers to a PHN-client encounter initiated by the PHN.

Right of entry refers to the admittance of a PHN into a client's private world; it is granted by the client on the basis of the latter's recognizing and accepting the PHN as a "legitimate purveyor of services that the client should reasonably require" (Dingwall, 1977, p. 97).

EBH ROE framework refers to an explicit approach towards attaining right of entry developed by the Nursing Division of the Edmonton Board of Health (1984). The ROE framework and its elements are presented in Appendix A.

An **explicit approach** is one in which the PHN articulates for the potential client the purpose of a PHN-client encounter and the reasons why PHNs initiate these encounters.

An **implicit approach** is one in which the PHN does not articulate the purpose of a PHN-client encounter or the reasons why PHNs initiate such encounters. Approaches in which the PHN articulates only his or her intention to act are considered implicit.

Purpose has two components: 1) an object to be attained (a goal or aim), and 2) an intention to act.

Responses include opinions and feelings expressed explicitly.

Chapter II

CONCEPTUAL FRAMEWORK

The reason that public health nurses make unsolicited visits to people arises in the philosophic base (beliefs and values) of public health nursing: to wait until people are in need of restorative health services would negate the public health focus on health promotion and problem prevention. If nurses are unable or unwilling to convey to clients their reason for initiating contacts, the probability of establishing a relationship based on mutual understanding and acceptance is likely to be low. So while the PHN may gain entry into the potential client's home, she[1] may be denied entry into that person's private world (EBH, 1984). The onus is on the PHN to earn her "right of passage" through interpreting the purpose of public health nursing for the client. In order to do this the nurse must 1) be familiar with the philosophic base on which public health nursing rests and 2) possess the information exchange skills needed to convey her message in a manner that appeals to, rather than repels, the potential client.

The conceptual framework used to guide this research project is a learning guide developed by the Nursing Division of the Edmonton Board of Health in order to assist PHNs in fulfilling this responsibility. Entitled *Gaining Right of Entry in Situations Initiated by the Nurse*, it is part of a larger framework intended to serve as a guide for support counselling (EBH, 1984). The Right of Entry (ROE) framework is based upon the EBH Nursing Division (1982a) model of information exchange and the Aristotelian model of persuasion, as described by Adler, 1983. In Aristotelian terms, successful right of entry consists in the PHN's establishing the *ethos* (character) of public health nursing by appealing to both the emotions (*pathos*) and intellect (*logos*) of the client.

In the following sections, the constituents (form and content) of the ROE framework will be explicated. These are: 1) The philosophic base of public health and public health nursing (the content) and 2) The information exchange model and the Aristotelian model of

[1]The use of the feminine pronoun is for purposes of style only, and is not intended to imply that only women are PHNs

persuasion (the form).

The Content: The Philosophic Base of Public Health and Public Health Nursing

The Public Health System as Health Authority

The public health system is a political institution, that is, an institution designed to serve the common good (Adler, 1971). Common good is here conceived as both a collective good and a personal good. A collective good is one that is "somehow participated in or shared by a number of individuals" (p.18). The collective good that the public health system aims at is a healthful community--a community in which both the physical environment and the actions of community members contribute positively to the health of those members. Health itself is an attribute of individuals--a personal good. This personal good is common in that it is assumed to be a natural need of *all* individuals: a constituent of human well-being, or happiness (conceived ethically as a whole life well-lived [Adler, 1970]).

According to Simon (1940, 1962), the attainment of any common good requires common (i. e. unified) action, and common action requires the unifying power of authority. It follows that a public health system is by nature a health authority. The term "authority" is one which tends to have negative connotations; it is often thought, for example, to be in essential opposition to the cherished value of liberty. Simon, however, points out that authority and liberty are really complementary notions. "It is quite clear that authority, when it is not fairly balanced by liberty, is but tyranny, and that liberty, when it is not fairly balanced by authority, is but abusive license" (p.1).

Authority, properly exercised, is a necessary means to the attainment of the common good. This is the case, says Simon, because there is always a number of excellent means of attaining the common good. Even when several people are united in their desire to pursue a common good and each person knows what the common good *is*, they are unlikely to achieve

concensus regarding the means of action, except by chance. Simon aptly illustrates this point with the analogy of an orchestra whose members see several excellent ways of interpreting a Bach concerto, and each plays according to his own vision. It is evident that, in the ensuing confusion, attainment of the common good (beauty, in this case) will be unlikely.

Choosing the means to the common good is the essential, but not the only, function of authority. Those in authority are charged with the responsibility of knowing both the form and the content of the common good (they must both want it and know what it consists in) (Simon, 1962). When community members are deficient in respect to one or both of these conditions, it is the responsibility of authorities to assist the members in repairing those deficiencies. Simon refers to this as the "substitutional" function of authority. In large communities, much of the work of authorities is devoted to substitutional functions; indeed, the professions owe their existence to the fact that individuals cannot be expected to possess the special knowledge required to overcome all the privations to which human beings are naturally prone (Castell, 1964).

In the example of the orchestra referred to above, authority is invested in the conductor. Professional public health workers are analagous to the conductor. Their authority is granted by public mandate because health is a desired good and because they possess the knowledge, attitudes and skills required for the protection and improvement of the health of the public. Whatever their specific roles, they must gain the cooperation of the "public orchestra" and to do so they must understand both the nature and functions of their authority, as well as the instrumental means by which it is exercised. Simon (1962) states that only two instrumental means are open to authorities: force and persuasion. Persuasion is the principal instrumental means used in public health work. This point will be explicated in the following section.

Public Health as a Persuasion System

The public health system is designed to induce change in the knowledge, attitudes and behavior of individuals and the public; as such, it is a persuasion system (EBH, 1982b). Persuasion here refers to a mode of social intercourse characteristic of beings "capable of conscious determination of ideal ends" (Whitehead, 1933, p. 86), and is devoid of any connotation of deceitful manipulation. The "way of persuasion", says Whitehead, is "one of the gentler modes of human relations" (p. 64); he holds with Plato that the progress of civilization represents a victory of persuasion over force.

Like authority, persuasion has acquired a "bad name" in contemporary society. Those who reject the use of persuasion offer the following grounds for objection: first, that persuasion is inextricably associated with manipulation and deceit, and second, that it is illegitimate to "impose" one's values on another. In an effort to vindicate the name of persuasion, these two objections will now be addressed.

First, it is true that the art of persuasion is often used to serve unscrupulous ends. The essence of persuasion is an appeal to the heart, and the persuader bent on deception will take advantage of that fact by appealing to the emotions to the exclusion of reason. This sort of persuasion is like a drug administered without the knowledge of the recipient (Adler & Van Doren, 1972), who feels himself or herself to be under the influence of an alien force. Persuasion, however, is merely a tool, and one which is used every day by persons with only good intentions in mind. To blame the tool for its misuse is to commit an error of personification (Adler, 1983).

The second objection to persuasion arises from a tendency in modern society to deny the existence of any universal human goods. This subjectivist, or "autonomic", view holds that all goods are relative to particular individuals and groups (Adler, 1985; Phenix, 1969). If there are no objectively determinable human goods, it follows that there are no objectively determinable human rights (Adler), and no person has a right to persuade another, "or, for that matter, define the good for anyone save himself (H. Simmons, personal

communication, June 1986). According to Phenix, this viewpoint fails to account for the reality of human experience because it "cut[s] the nerve of moral inquiry" (p.10). Moral judgments are reduced to mere opinions, and the conduct of human affairs is controlled by the only alternative principle: namely, might makes right (Adler).

Although it is possible to use persuasion for bad ends, it is impossible to attain the common good without persuasion. This is so because of the nature of human beings. We are value guided creatures: we see the good in a person or thing and want it because of its goodness (Simmons & Kikuchi, 1985a). As common experience shows, however, we can be mistaken about the matter of the good. We can desire what is not good and we can fail to want what really *is* good (Adler, 1970). As social beings, we depend upon one another for guidance towards the good. What is needed is a means of making the good commodious to our desire. Persuasion is that means (Simmons & Kikuchi).

A public health authority is a persuasion system because its authority is carried out by persuasion rather than force. The objective of public health is not that community members will dutifully follow the dictates of health professionals; it is that they will come to desire and seek health of their own accord. This objective cannot be achieved through force. A person's actions can be compelled through force, but not his or her desires. As Simon (1940) puts it, the proper effect of force is a physical one. It is external to the person, and once the force is withdrawn, its effect subsides. The proper effect of persuasion, by contrast, is a moral one. It is internal--part of a person's being. The pursuit of health is a moral endeavour; it is for this reason that persuasion is necessary.

Force is used little in public health work. Health inspectors, for example, may initiate the use of force by serving notice of closure of a restaurant. The use of force would have no lasting effect, however, if it were not accompanied by persuading the proprieter to use safe methods of food handling. Public health nurses have no recourse to the use of force.

Health Promotion and the Opportunity for Health

Over 2000 years ago, Aristotle pointed out that the attainment of happiness requires not only moral virtue but also good fortune (Nichomachean Ethics, Bk. I, Ch. x; Bk. VIII, Ch. xiii). In the pursuit of happiness it is clearly advantageous to maximize the potential for good fortune insofar as is possible. If potential for good fortune is roughly translated as "opportunity", then it is evident that public health has long been engaged in facilitating the pursuit of happiness through its emphasis on extending the opportunity for health of each and every individual (EBH, 1984).

The opportunity for health depends partly upon choice and partly upon chance. Choice, because as an individual grows and matures, his state of health will depend more and more upon the health-related decisions and actions he takes. This composite of health related actions is often referred to as one's "lifestyle", and lifestyle is largely within individual control (EBH, 1982b). But there are determinants of health that lie primarily outside the control of any individual. It is by chance that one is born handicapped or not, in Ethiopia or in Canada, of parents who value health or do not. This physical and social heritage rests largely in the domain of chance; it is only through the organized efforts of people that some control over the vagaries of chance can be achieved. This is the job that a just society undertakes: to chip away at the territory of chance through efforts such as genetic research, provision of universal access to health services and protection of the environment, to name a few. Public health services aim at providing all citizens with an equal opportunity to health; the assumption is that because all people are equal in their humanity, all are deserving of an equal opportunity to the constituents of happiness (EBH, 1982b).

Health promotion is a term that refers to the activities of individuals and societies undertaken in the pursuit of health; it is a systematic means of extending the opportunity for health. By definition, health promotion consists in the generation, development, protection, maintenance and restoration of resources required for the attainment and perfection of health (based on Simmons & Kikuchi, 1984). Health promotion can be direct or indirect. It is

direct when its immediate target is the body (as in immunization or therapeutic touch) or the physical environment (as in pollution control). It is indirect when its target is the knowledge, attitudes and behavior of individuals (as in education and persuasion towards a healthful lifestyle) or of societies (as in political efforts to institute healthful public policies). Health promotion, so defined, is the central activity of public health professionals.

Public Health Nursing[1]

The nature of public health nursing is best conveyed by comparing it with that of nursing in general.[2] As a special branch of nursing, public health nursing is distinguished from its parent by the difference in its object, or proximate end. While the proximate end of nursing is health as a personal good, the proximate end of public health nursing is health as a collective good. When PHNs promote individual health, they do so for the sake of the whole community.[3]

Traditionally, the unit of service in public health nursing has been not the individual, but the family. This focus is a consequence of the object of public health nursing and reflects a conviction that the family is the context in which an individual's opportunity for health emerges and is sustained and developed. The central concerns of public health nursing are the health risks and opportunities associated with *normal* life events and developmental processes (e.g. birth, death, adolescence, ageing)(EBH, 1982b). It follows that public health nursing's domain is *general* health, as opposed to specific health privations such as disease or handicap.

Almost 100 years ago, Florence Nightingale distinguished between two branches of nursing: "sick nursing" and "health nursing" (cited in Monteiro, 1985). Public health nursing is health nursing: it focuses primarily on the preservation and enhancement of health and only secondarily on restoration. As Emory (1945) puts it, the PHN's purpose is to "aid in the preservation of health through prevention, and to implement the constructive aim of

nursing through nurture; through the teaching of healthful living" (p. 69).

One of the essential distinguishing characteristics of public health nursing is its long-established practice of initiating service independent of individual client request. Emory (1945) traces this organized outreach activity back to mid-19th-century England, when the incidence of mortality from tuberculosis remained disturbingly high despite the fact that considerable knowledge was available concerning its transmission and treatment. To change this pattern, the Medical Officer of Health "enlisted the services of the nurse, calling her the public health nurse and commissioning her to go into the community and impart health knowledge [concerning the control of tuberculosis]" (p. 22). Outreach activity rests on the following presuppositions: That people may 1) have health needs of which they are unaware, 2) lack knowlege of what to do to meet their health needs, 3) be unwilling to take necessary health-promotion actions, or 4) be in a position such that they cannot act (due to lack of financial resources, for example); and 5) that all deserve an equal opportunity to health. Outreach activity is linked essentially with the promotion-prevention focus of public health: to wait until people's health privations become perceived health needs is neither humane nor economical.

The intention of public health nursing, then, is to "support people in their efforts to have a good life by planfully promoting health whereever and whenever possible" (EBH, 1984, p. 2). The challenge to the public health nurse is to be able to convey this intention to potential clients, and to make it relevant to the particular circumstances of each client.

The Form: Information Exchange and Persuasion

The Information Exchange Model

Attaining right of entry is the second of seven phases of the EBH Nursing Division (1982a) model of Information Exchange. This model is designed to enable the participants

of a conversation to arrive at mutual understanding of the topic under discussion (Simmons & Kikuchi, 1985b). In this section, the Information Exchange model will be briefly described: the following sections will be devoted to the Aristotelian model of persuasion and its application in the ROE phase of the PHN-client encounter.

The Information Exchange model emphasizes information *provision* as a means by which an interviewer validates information he or she wishes to obtain from *or* give to another person. The three essential components of the Information Exchange model are information provision, information [illegible]al and information validation. Any information exchange encounter has seven phases, starting with the planning of the exchange and going on to its actual initiation, maintenance and termination. Although each particular phase emphasizes a different component of the Information Exchange model, the essential point is that all three components must be included in each phase if mutual understanding is to be attained.

The Aristotelian Model of Persuasion

Persuasion is defined as the act of moving oneself or another to think or act in a certain way, by appealing to his or her desire and reason. Persuasion is the modern term for the ancient art of rhetoric, on which Aristotle wrote a lengthy treatise (Adler, 1983). The means, or instruments, of persuasion are referred to by the Greek terms *ethos*, *pathos*, and *logos*. The following explication of these three "tactics of persuasion" is based on the work of Mortimer J. Adler (1983).

The first act of persuasion is *ethos*, which refers to the character of a person or group. *Ethos* is the means by which the persuader establishes credibility and engenders trust. The ways of doing so can be varied to suit the particular circumstances of an encounter. Direct means include stating one's credentials and those of the agency which one represents. Indirect means include underestimating one's credentials or referring to one's association with others "whom you praise for certain qualities which you hope your listeners will also attribute

to you" (Adler, 1983, p. 33).

Pathos, the next step, is the heart of persuasion. It is the motivating factor, and consists in the arousal of the listener's emotion and the direction of this emotion to the purpose at hand. Although *pathos* can be separated analytically from *ethos*, the two are usually inseparable in practice. The task of *pathos* is twofold: to work with *ethos* in creating a favourable feeling toward oneself, and to arouse interest in the "cause" which one represents.

To establish *pathos*, persuaders should call upon the desires that move most human beings: desire for freedom, honour, justice, peace, position, knowledge, comfort, material goods. Sometimes, it is necessary to awaken desires of which people are not fully aware. This, of course, is what is done in the advertising of a new product.

Logos--the "marshalling of reasons" (Adler, 1983, p. 37) --is always the final step. *Logos* is the presentation of an argument to establish the relevance of one's product or cause to the listener's desires. Argument is used to reinforce the emotions already aroused, not to alter them. To launch into a series of arguments before the listener is emotionally receptive is to run the risk of losing him or her entirely.

In persuasion (as opposed to instruction) it is important to avoid lengthy and intricate arguments. As Adler (1983) says: "I do not have to assert that whatever contributes to a person's health is good. I need only describe my product as doing just that and doing it in full measure" (p. 43). The use of examples is an effective way of condensing arguments. An example evokes an image in the listener's mind, and images are intimately connected with feelings (Bruner, 1969; Gardner, 1975). The use of rhetorical questions (questions to which the answer is unlikely to be disputed) is another way of condensing arguments.

Application of the Aristotelian Persuasion Model to the ROE Phase of Public Health Nursing Outreach Visits

The EBH ROE framework consists of six elements, as follows:

a. Adequate identification of the PHN as an agency representative.

b. Adequate identification of the agency as credible in the eyes of the client.

c. The source of information linking the PHN to the client.

d. The valid link between the agency and the client.

e. The client's understanding of b through d.

f. Getting some "objective" indication of the client's readiness to welcome the PHN as a potential source of support.

The full framework is presented in Appendix A.

The ROE framework is designed to help the PHN get the PHN-client encounter off to the best possible start. The six elements are considered necessary and sufficient to preserve the dignity of the client as a person, and the worth of public health nursing as a means to meeting the client's need for health opportunities in the form of knowledge, attitudes and skills (H. Simmons, personal communication, June, 1986). The framework is *not* intended to serve as a recipe to be applied in identical fashion with every client. Nursing, after all, is primarily an art, or a "practical science" (Maritain, 1959); as such, it is guided by both scientific knowledge and moral virtue and must be completed by prudent judgment in the individual case (Adler, 1965). Each nurse-client encounter is unique. The ROE framework can take the PHN only part of the way; in the end, her judgment about how to apply its elements must vary with the individual circumstances of each client.

The first four elements of the framework pertain to establishing the credibility of the public health nursing agency and the PHN as its representative--*ethos*. They must be presented with *pathos*, that is, the PHN has to capture and sustain the client's interest in the "facts" of public health nursing. Some clients will be eager to listen, others reluctant. The PHN must judge how much to explain, and how to order her explanation (*logos*), keeping in

mind that people have a right to information necessary for them to decide whether they should participate in such an encounter. Confronted with a client who presents her with a pressing problem, the PHN may be tempted to forego all explanation of her purpose, in the interest of maintaining *pathos* by attending immediately to the client's desire. Reminding people of their rights in such situations can be persuasive in itself, e.g. "I want to help you with your problem, but before we talk about that, you have a right to know something about the agency I represent and what else you can expect of me. Is it okay with you if I take a few minutes to explain?"

The components of information exchange are seen in the ROE framework, in its emphasis upon providing sufficient reason for the client to engage in the exchange, and upon validating that the client understands the purpose of the encounter (Element 'e'). The final element of the ROE framework directs the PHN to seek the client's permission to move into the clinical phase of the exchange. The introductory phase is complete when the PHN is satisfied that the client understands the purpose of the exchange (*logos*), and truly welcomes her on that basis (*pathos*). To proceed into the clinical phase when faced with a reluctant or indifferent client is to run the risk of aborting the purpose of the encounter. In the final analysis, the client's will stands between the PHN and his (or her) opportunity for health. In terms of the Aristotelian conception of change, the client is the primary efficient cause (agent) of his own health; the PHN is a secondary cause, and information exchange and persuasion are simply extensions of the secondary efficient cause (H. Simmons, personal communication, June 1986). If the potential client is not inwardly willing to engage in the encounter--if, for whatever reason, he does not see the PHN as credible--he may simply "play the role" of client, giving the responses he thinks the nurse wants to hear:

> So when I go to see the nurse, they [sic] say, "Do you time your feeds?" and I say, "Yes" and they say, "How often?" and I say, "Every four hours." Then I do whatever I please (Field & Morse, 1985, p. 75).

Assumptions Underlying the Conceptual Framework

The Right of Entry framework is based upon the following assumptions:

1. Knowledge and understanding are basic human needs-needs that derive from the human capacity for conceptual thought and propositional speech (Adler, 1970).
2. Human beings possess the capacity for freedom of choice (Adler, 1970).
3. Privation of knowledge and understanding restricts human choices.
4. Knowledge and understanding are necessary, but not sufficient, conditions for systematically valuing anything (EBH, 1983).
5. Health is a universal human need.

Notes to Chapter II

1. The material in this section is based on the content of the EBH inservice education program entitled *Orientation to Extended Professional Development in Public Health Nursing: Values, Attitudes and Practice* and developed by the Nursing Division in conjunction with Dr. H. Simmons, who has continued to refine it over time.

2. This statement does *not* imply that in promoting a collective good the PHN must ignore individual rights, as Fry (1983) has suggested. The collective good contributes to, and does not detract from, the individual good. But since universal goods cannot be applied directly to particular cases without taking individual circumstances into consideration (Adler, 1970; Simon, 1962), the PHN is always required to make a prudent judgment when drawing the line between liberty and license, and between authority and tyranny, in individual cases.

Chapter III

LITERATURE REVIEW

This review of the literature focused on four categories deemed revelant to the objectives of this study: 1) Significance of the nurse-client relationship; 2) Context of the encounter between public health nurse and client; 3) The foundation of a "good" nurse-client relationship;and 4) Means of initiating the public health nurse-client encounter. Since emphasis on the importance of the nurse-client relationship began in the 1950s, this survey included theoretical works (books and texts) from 1945 to 1986 and journal literature from 1952 to 1987. Most works were from Canada, the United States and Britain. In this review, the traditional term "public health nurse" is taken as equivalent to the newer term "community health nurse". The British equivalent of the PHN is the health visitor (HV), and these terms have also been used interchangeably.

The following methods of information retrieval were used (Cooper, 1982):

1. Manual search of the *Cumulated Index of Nursing and Allied Health Literature* (1975-1987), under the following categories: public health nursing; community health nursing; professional-patient relations; communication.
2. Medline search (1970-1987) under the following code terms: public health nursing; community health nursing; consumer satisfaction; social perception; nurse-patient relations; attitude to health; attitude; public opinion.
3. The "ancestry approach"--tracking citations from one article/book to another, and
4. To a limited extent, the "invisible college" method to locate unpublished literature.

The catalogue of the J. W. Scott Health Sciences Library at the University of Alberta was used to locate texts on public health nursing.

Criteria for inclusion of works in the review were 1) Relevance to the topic of initiating PHN-client relationships and 2) Quality of research reported. Although Cooper (1982) states that the second criterion should be of primary imortance, strict adherence to this criterion would have resulted in the exclusion of most of the research reports found. Almost

all of the published studies were found in "popular" nursing journals, which often omit statistical analyses, and discussion of reliability and validity. It was decided, therefore, to present this review as representative of the "state of the art" as opposed to the "best of the art". In an effort to increase the validity of the review, a concerted attempt has been made to point out limitations to the validity of the studies reviewed.

Significance of the Nurse-Client Relationship

> There is something new in nursing. It cannot be said that the concept of interrelationships among nurses, doctors, patients and others is new, for though the emphasis has in recent years become much greater, one has sensed some awareness of the importance of this interplay even in nursing's earliest teachings. The new element consists of the approach and functioning in interrelationships (Bixler, 1951).

These words are taken from the editorial introduction to Hildegard Peplau's well-known book, *Interpersonal Relations in Nursing*. What was also new in the 1950s, as Bixler implies, was the increasing attention given to the importance of the nurse-client relationship. Since that time, countless nursing texts and articles have emphasized that the effectiveness of nursing interventions is dependent upon the quality of the nurse-client relationship.

The nurse-client relationship is not an end in itself; it is the medium through which the goals of nursing are achieved. What happens if an effective relationship is not established? The most serious consequence is that client health needs may go unmet. Conant (1966) reported that in two of 24 public health nurse-client visits that she observed, the nurse and the client never "made contact" with each other. In each case, the client wanted help and understanding from the nurse, and the nurse wanted to be helpful and understanding. Client dissatisfaction often accompanies unmet health needs. Negative experiences with the health care system may also predispose the client to reject health care

services in the future (Field, 1982). In short, the failure of the nurse-client relationship results in a waste of valuable resources: time, energy and health care dollars.

Many theorists and researchers agree that, regardless of whether the relationship is initiated by the client or the nurse, it is the nurse who bears major responsibility for its establishment and maintenance (Berengarten, 1950; Conant, 1966; Freeman, 1950 & 1970; Friedemann, 1983; Henderson & Nite, 1978; Orem, 1980; Peplau, 1951; Sundeen, Stuart, Rankin & Cohen, 1976; Warner, 1984a). It is therefore important that nurses understand what contextual factors influence the nurse-client relationship, what a good nurse-client relationship consists in and how to initiate such a relationship. These topics are the focus of the subsequent sections.

Context of the Relationship between Public Health Nurse and Client

The Societal Context

In nursing, as in other professions, the relationship between nurse and client is influenced by the prevailing social and political climate. Dingwall (1982), a British sociologist, and Beauchamp (1982), an American ethicist, hold that there is a basic tension between the collectivist ethic of public health and the dominant societal ethic of maximizing individual liberty. Fry (1983), a nurse, asserts that the primary governing ethic of public health nursing--justice--is in fundamental conflict with that of nursing as a whole, namely, individual autonomy. What does not appear to be recognized by Fry is that it is precisely the role of justice to mediate between the extremes of unrestricted liberty on the one hand, and complete egalitarianism on the other hand (Adler, 1981).

There is further evidence in the literature of the potential for negative perceptions of public health and public health nursing in relation to justice, liberty and equality. Ours is an era in which many public institutions are receiving criticism for overstepping what are

perceived to be their legitimate boundaries. Consumers of health services are increasingly concerned about violations of privacy, especially the dissemination of private information (Kaban, 1979), and may see PHN-initiated visits as interfering or policing activities (Jefferys, 1965) or as an invasion of personal freedom (Warner, 1984a). Pearson (1984) reported that some parents (n=16) saw the health visitor as a policing agent. Simms and Smith (1984) analysed the responses of 45 teenage mothers (9% of a national sample of teenage mothers in England and Wales) who were critical of health visitors. The researchers reported that one-fifth of these dissatisfied clients perceived health visitors as "bossy", "nosey" or "interfering" (p.269). In another British study, however, the few references made by clients to the "policing" role of the health visitor were ones of approbation (Foxman, Moss, Bolland & Owen, 1982). While this finding is of interest in itself, direct comparison between the two studies is not possible because of insufficient information regarding the sampling methods used. The data of the Foxman et al. study were obtained from a convenience sample of only 85 mothers as compared to a "national" sample of 533 mothers in the Simms and Smith study. It is not stated whether or not the latter sample was representative.

Public health services run the risk of being labelled as "paternalistic", a term which has sounded a pejorative note since the time of John Stuart Mill and his famous treatise "On Liberty" (1859). Indeed, public health has long been associated with Jeremy Bentham's doctrine of "the greatest good for the greatest number" (EBH, 1982) and may be accused of exhibiting that peculiar trait of modern democracies which so disquieted Mill, namely the "tyranny of the majority". No references to paternalism were found in the reviewed studies which reported on consumer perceptions of public health nursing.

Although no literature was found representing a Canadian point of view on the issue of liberty and public health, it is reasonable to assume that Canadians may well have opinions similar to those of the British and the Americans given Canada's close ties with both Britain and the United States.

The Challenge to the Public Health Nurse

Because of the outreach nature of public health, the PHN is faced with the need to "sell" herself and her services (Leahy, Cobb & Jones, 1977). She is in the unique position of being a guest in people's homes (Fowler, 1985) and cannot assume that people will either want her services or see a need for them in the absence of any felt health problems. Health promotion and ill-health prevention are rather intangible concepts, and may not be clearly understood by many members of the public ("HVs", 1979). The challenge to the PHN, therefore, is to be able to interpret for clients wherin her professional authority rests while enabling them to "maintain the feeling that they are still the master of mistress in their own house" (McIntosh, 1979, p.iv).

Even when the PHN is welcomed and gains the client's cooperation, it cannot be assumed that the client either understands or shares the nurse's goals. Cooperation may stem from the client's desire to please (Aasterud, 1965), or to fulfill a perceived obligation to a primary source of medical care (Bambino, 1969). Alternatively, clients may enjoy the PHN's visit on social grounds. Luker's (1981) study on elderly women's opinions about the benefits of health visitor visits indicated emphasis in social aspects of the visit in 30 out of 100 respondents who were asked how they had been helped by the visits (p. 55).

Client Satisfaction with Home Visits

It is noteworthy that, given the potential for negative views of public health nursing, public health nurses are invited into most of the homes they visit on an outreach basis. In 1986, PHNs made newborn infant visits to 96% of new mothers in Edmonton (EBH, 1986). Although statistics describing the ratio of nurse-initiated to client-initiated visits are not available, it is reasonable to assume that nurse-initiated visits were in the majority since postnatal home visiting in Edmonton is a program which aims at visiting 100% of new parents. The fact that some clients request a visit before the PHN receives their birth notice

does not alter the essential outreach nature of the program. This ready admittance of the PHN into people's homes was noted by Dingwall (1977) in his research on health visitors.

No data are available on the 4% of new parents who did not receive a visit, so one can only speculate about the number of refusals that PHNs received, and about the nature of these refusals. It would be interesting to know how many clients invite the PHN into their homes even when a visit is not particularly desired; it is difficult for some people to turn a well-intentioned visitor away. Johnson and Hardin, in their classic 1962 study of the content and dynamics of 956 home visits, reported that clients showed fewer examples of positive agreement with the PHN's assessments than might have been expected, and they describe this phenomenon as "passive agreement, or tacit agreement in the absence of evidence of disagreement" (p. 106). Bambino (1969) found several "contexts of acceptance" of a PHN: often, "it was the nurse's general demeanor of friendliness and interest that served to sustain a context of acceptance, even though [the visits were] not [seen as] helpful" (p. 117).

Studies of client satisfaction with public health nursing and health visiting services in Canada, Britain and the United States, while not abundant, indicate that most clients have positive views of these services, as depicted in Table 3.01. Comparisons between these studies must be made with caution, however, in light of the differences in type of study, sampling methods, and questions asked. The apparently high level of satisfaction of respondents in the Hansen and Levy (1961) study, for example, may well be due to the fact that the question put to subjects in this study was a leading one: "What would you say is the *one* most important way that a public health nurse helped your family" (p. 345). Such a question might make it difficult for many subjects to deny that they had been helped in at least one way.

Luker's (1982) study of outreach visits to seniors indicates that high levels of client satisfaction may be achieved even when visits are not seen as particularly helpful. It is evident that "satisfaction" is a multi-faceted concept and nurses who choose to do research on client satisfaction must ultimately decide which facets are legitimate and which are not if

Table 3.01. Satisfaction with Service as Expressed by Clients in Studies in Britain, Canada and the United States

Author of Study	Year	Country	Type of Study	Description of Sample	Sampling Method	Description of Response	% Giving Response
Clark.	1984	England	Longitudinal	31 mothers	Convenience	"Health Visitor (HV) was helpful"	70
Field, Draper, Kerr & Hare	1982	England	Survey	78 first-time mothers	Not stated	"Mainly positive feelings towards Health Visitors"	60
Foxman, Moss, Holland & Owen	1982	England	Longitudinal	85 first-time mothers	Convenience	"Positive without qualifications"	39
						"Positive with qualifications	10
						"Mildly positive (HV nice but not particularly helpful)"	30
Luker	1982	Scotland	Experimental	100 women age 70+	Convenience	"Enjoyed the HV Visits"	95
						"Were helped by Visits"	62
Simms & Smith	1984	England and Wales	Survey	533 teenage mothers	Not stated	"Found HV helpful"	90

Table 3.01 (continued)

Field	1982	Canada	Exploratory	35 adults	Convenience	"Expressed satisfaction with care"	83
Mills & Edwards	1982	Canada	Survey	221 mothers	Population Study (response rate 83%)	"PHN visits were helpful or very helpful"	66
						"Some help"	30
Morgan & Barden	1985	United States	Descriptive	55 perinatal clients	Convenience	"Overall satisfation with the visit"[1]	
Bambino	1969	United States	Exploratory	71 families	Population Study (Total Population = 87 families)	"Helpful"	27
						"Not helpful"	33
						Ambivalent	23
Conant	1966	United States	Exploratory	24 antepartal women	Convenience	"Satisfied with discussion of labour and delivery" (N=19)	100
						"Satisfied with discussion of diet, nutrition and weight" (N=22)	55
Hansen & Levy	1961	United States	Exploratory	169 families	Stratified Random	"No evidence of expressed or implied dissatisfaction when asked how PHN had helped"	92

[1] Includes category "were helped by visits"

[2] Mean score was 4.70 on a 5-point rating scale

satisfaction is to be used as an indicator of the success of public health nursing activities.

The Foundation of a "Good" Public Health Nurse-Client Relationship

A good nurse-client relationship is one in which nurse and client mutually agree to work together on behalf of the client's health (Cameron, 1982; Freeman, 1970; Leahy et al., 1977; Orem, 1981; Spradley, 1981; Sundeen et al., 1976). Agreement to work together presupposes that nurse and client commonly understand and accept the purpose of the PHN-client encounter, and its relevance to the client's health (Bambino, 1969; Field, 1982; Fowler, 1985; Gustafsen, 1977; Langford, 1978; Orem, 1980; Spradley, 1981; Sundeen et al., 1976; Warner, 1984a). The medical literature uses the term "concordance" to refer to this mutual understanding and acceptance of goals (Freidin, Goldman & Cecil, 1980; Hulka, Cassel, Kupper & Burdette, 1976). It is interesting to note that medical researchers have come to suspect that many of their problems of patient compliance are really problems of doctor-patient concordance (Hulka et al., 1976). Whatever the name given to it, this mutual understanding and acceptance of purpose is the foundation of the nurse-client relationship (Cameron, 1982).

It is relevant at this point to draw attention to the fact that the term "purpose", like so many words in our everyday language, is plagued by ambiguity in regard to its referents (Nettler, 1980). Purpose can be understood in two senses: 1) an object to be attained, and 2) an intention to act (Concise Oxford Dictionary, 1983). In other words, these two senses of "purpose" refer to the distinction between ends and means, between why and how. In the context of the PHN-client encounter, "understanding of purpose" refers to both senses of purpose, but primary importance is placed upon purpose as an end, because the end justifies, or prescribes, the means. In the following examples of studies relating to purpose, the importance of understanding ends is demonstrated.

Research Related to Mutual Understanding and Acceptance of Purpose

This survey of the research literature revealed six studies which dealt in some way with the concept of mutual understanding and acceptance of purpose. Of these, one (Mayers, 1973) made mutual understanding of purpose the primary object of investigation; two (Clark, 1984; Conant, 1966) focused mainly on client understanding of the nurse's purpose; and two (Field, 1982; Luker, 1982) addressed other questions, with understanding of purpose emerging as a significant variable. The sixth study (Bambino, 1969) focused on dimensions of acceptance of PHN services.

One of Mayers' research questions asked what nurse and client saw as the purpose for the public health nurse home visit. Unfortunately, only the nurses were interviewed; clients' perceptions were inferred by Mayers from her observations of public health nurse-client interaction on 37 home visits. She found that when nurses had long range abstract goals for their clients, (e.g. "to adjust to a satisfactory parental role" [p. 329]), they tended not to share these with their clients. Since about half the purposes stated by the nurses were long-range goals, Mayers concluded that "half of the purposes of the visits were completely unknown to the client" (p. 330). Although this conclusion cannot be drawn validly from the nurse data alone, Mayers' study indicates that further research is needed to determine the extent to which clients understand the purposes of the PHNs who visit them.

Clark (1984), who studied 31 mothers over the period of one year, asked mothers what they felt the health visitor was trying to do through her visits. Clark reports that the mothers found the question very difficult to answer, even though each client had received at least four visits (range=4 to 28 visits). Moreover, none of the mothers expected to receive further visits, even though continued visits were an aspect of the health visiting service that the nurses themselves had emphasized in their discussions with Clark. Content analysis of the visit transcripts revealed only one example of a health visitor explaining to a mother what the service could do for her and what she could expect.

Studies by Conant (1966) and Field (1982) give some indication of the consequences of lack of client understanding of purpose. Conant's objective was to find out how antepartal clients interpreted and reacted to PHN outreach visits. She found that clients who had had no previous experience with PHNs did not always understand why the PHN was visiting, especially when the visit was unexpected. Even after the visit was completed, four of the 24 clients were confused as to why the PHN had come. Field set out to identify sources of client satisfaction and dissatisfaction with the process of receiving public health nursing care. Her findings suggest that dissatisfaction can be a result of a client's failure to understand the PHN's purpose. Through constant comparative analysis of interview data, she found that out of a total of 35 clients, seven who were dissatisfied did not have a clearly defined goal for the visit, and did not see the nurse's activities as relevant to them. One of the hypotheses that emerged from the study was that clients who have no expectations of the care they will receive will be dissatisfied with the care given.

Luker (1982) also came up with results which suggest that PHNs may not convey their purpose adequately. Her study of elderly women's opinions about the benefits of health visitor visits showed that few respondents associated the health visit with prevention; most assumed that the health visitor's function was one of surveillance for the family doctor, and thought the health visitors should concentrate their efforts on the lonely, sick and disabled. It seems that these health visitors, like those in Clark's study, failed to explain the preventive and promotive purpose of their work. Although 90% of respondents reported that they "enjoyed" the visits, 37% of the 100 clients did not wish the visits to continue, and a further 15% were undecided. It would be important to determine whether there is a relationship between understanding the preventive focus of public health nursing and acceptance of public health nursing services as legitimate.

Bambino's (1969) exploratory study presents a discouraging picture of the extent to which clients can have misconceptions of the intent of a public health nurse visiting service. Although the majority of Bambino's 87 subjects accepted the PHN into their homes for many

visits, 33% said the PHN service was either not helpful or not needed, and 27% were ambivalent. Like Luker (1982), Bambino found that the PHN was perceived as an agent of surveillance for the doctor. The PHN service was accepted primarily on the basis of the nurse's personality and was seen as having little import for clients. Several clients reported that they did not know why the PHN was visiting. Bambino concluded that there was a need for further research examining the concepts of acceptance, participation and learning. "Participation does not mean learning, nor does it infer [sic] acceptance" (p. 140).

Obstacles to the Attainment of Mutual Understanding and Acceptance

How is it that clients can fail to understand the purpose of public health nursing visits even after several encounters with a PHN? Two possible reasons emerge from the literature: 1) PHNs do not always explain their purpose to their clients, leaving the latter to draw inferences about the purpose from observation of the PHN's actions. Possible reasons for this avoidance of explanation will be explored in the following section; 2) PHNs may themselves may be uncertain about the purpose of public health nursing and about the nature and source of their authority. Strange as this may seem, there is considerable literature, especially in Britain, to suggest that this may be the case.

In Britain, health visiting is distinguished by a history of "uncertainties about roles and responsibilities" (Clark, 1976, p. 25). There are references to the "dilemma of identity in health visiting" (Hunt, 1972a & b), the "uncertain health visitor" (Jefferys, 1965), and the "insecure profession of health visiting" (Rice, 1975). A numbers of factors are cited as contributors to this sense of uneasiness: a feeling that it is impossible to do justice to any one portion of the work when the range of health visitor responsibilities is so vast (Hunt, 1972a &b); the perceived absence of any clear demarcation between the domains of health visiting and social work (Clark, 1976; Hunt, 1972a; Jefferys); a feeling that too many visits are "routine", that is, made not to assist with problems, but to see that all is well (Jefferys); and

the question of whether other health professionals and the public see health visitors as "proper nurses" since they do not provide physical care (Hunt, 1972b). This latter concern has been echoed in the United States by one of contempoary nursing's most influential voices. In a recent interview (Shamansky, 1984), Virginia Henderson challenged the practice of separating home care of the sick and preventive public health nursing work. In Henderson's opinion, this separation is "almost baffling", and has contributed to both a lack of self-confidence among PHNs and a devaluing of public health nursing services among the American public (pp. 198,199). Chavigny and Kroske (1983) argue that the high degree of "role confusion" in public health nursing in the United States puts the specialty in real jeopardy of being lost as a separate nursing entity.

It is difficult to assess the prevalence of uncertainty about health visiting, for statistics are not always reported, and when they are, interpretation is sometimes missing. Jefferys (1965), for example, reports that of 46 health visitors interviewed in one study, 35 (76%) found their work satisfying and absorbing, yet 22 (47.8%) said they would choose a different profession if given another chance. An explanation of this apparent discrepancy is not provided. Jack (1978) categorically denies the existence of the uncertain health visitor. "We know what we are doing and why", she states (p. 463), but the evidence that would support her assertion is not documented in this brief report.

One curious finding emerging from several British studies suggests that another area of uncertainty among health visitors concerns the source of their authority. Recent studies of client perceptions of health visiting have revealed that some mothers believe that health visitors should be mothers themselves (Clark, 1984; Field, Draper, Kerr & Hare, 1982; Fox, Mossman, Bolland & Owen, 1982; Simms & Smith, 1984). What is surprising is that a substantial minority of health visitors (13 out of 40) shared this opinion, as reported in a follow-up study. As stated earlier, the authority of the PHN (or health visitor) is derived from her professional education and experience, not from her personal experience. The sensitive PHN will be alert to the fact that some mothers may *want* her to be a parent, and

she will be able to convey to them that she can be supportive without experiencing everything that her clients experience. If PHNs or health visitors are uncertain about the basis of their authority, those who are childless may find themselves in the unfortunate position of being unable to make themselves credible in the eyes of their clients, while those with children may run the risk of depending more upon their personal experience than is professionally legitimate. Bambino (1969), for example, found that when a PHN began to use her personal experience as a basis for prescription, she was no longer seen by clients as a professional resource, even when new problems arose.

Finally, there is some evidence on both sides of the Atlantic indicating that professionals both inside and outside of public health nursing-health visiting undervalue the work done by PHNs or health visitors. Ranson (1977), a sociologist, describes the health visitor as a generalist (which is accurate) rather than an "expert", implying that only specialists can be experts, and further derogates the knowledge of the health visitor by equating it with the "reasonably founded opinions" of a "well-informed citizen" (p. 260). In the United States, a study of interdisciplinary perceptions of the public health nurse came up with the dismal finding that PHNs were appraised negatively in terms of their competence, interpersonal skills and overall effectiveness by academic physicians, medical students, and (worst of all) nursing faculty members (Geertsma & Hastings, 1971). The samples of health professionals in this study were unrepresentative; however, other research has demonstrated that doctors may hold negative opinions of PHNs. Jefferys (1965) found that of 66 general practitioners, 30 were critical of health visitors.

Public health nurses themselves may undervalue their work, as indicated in two American studies. Conant (1966) found that PHNs underestimated the value which antepartal clients placed on their services in 21 out of 32 cases, while Keith (1976) showed that PHNs underestimated the desire of a sample of elderly subjects for their services. In Keith's study, need for services of a PHN or visiting nurse was ranked ninth out of 23 services by the elderly respondents, but only 14th by PHN respondents. It is a plausible

hypothesis that some of this "undervaluing" is due to a lack of understanding of the nature and purpose of public health nursing.

This survey of the literature suggests the hypothesis that while individual public health nurses and health visitors may have definite beliefs about the nature and purpose of public health nursing, what is lacking is an understanding of practice that is shared by everybody. A similar hypothesis was a result of Field's (1980) ethnographic study of four Canadian public health nurses. Professional statements of purpose are not lacking (e.g. American Public Health Association, 1980; Council for the Education and Training of Health Visitors, 1973; Edmonton Board of Health, 1980). What is needed is a sharing of the concepts of public health nursing (Jack, 1978; Warner, 1984a): with students, other health workers, public administrators and the public itself.

Initiating the Public Health Nurse-Client Encounter

Whatever the setting, the PHN's first order of business is to get the relationship off to a good start. The art of inititing a PHN-client encounter is central to the practice of public health nursing: it constitutes the means by which the foundation of a good public health nurse-client relationship is established. Yet, while the the literature contains many hortatory references of the importance of nurses' accepting responsibility for establishing good relationships with their clients, there is some measure of disagreement concerning the approaches that PHNs should use in the introductory phase of the PHN-client encounter.

As stated earlier, the public health nurse is faced with the challenge of demonstrating her worth to her potential clients, of making them want her services. The PHN's approach, therefore, must be a sincere appeal to both their feeling and their understanding. Most authors agree that the PHN's approach should be characterized by affective qualities such as warmth and sensitivity (Berengarten, 1950), tact and caring (Friedemann, 1983) and empathy (Elkins, 1984; Freeman, 1970; Helvie, 1981; Kalisch, 1975; Leahy et al, 1977; Sundeen et al,

1976). While such affective means are essential to the client's acceptance of the nurse as a person, they are not sufficient in themselves to ensure the acceptance of the nurse *as nurse* (Bambino, 1969); the latter requires understanding of her purpose and its relevance to the client's health.

Authors differ, however, in their prescriptions regarding the degree to which the PHN should explicate her purpose. Some advocate an approach in which the nurse's goals are kept largely implicit, while others call for a high degree of explicitness. The characteristics of these two approaches and the presuppositions on which they are based will be outlined in the next two sections; the third section will deal with right of entry; and the final section will look at the "state of the art" in terms of empirical findings regarding the two approaches.

Implicit Approaches

An implicit approach is characterized by a minimum of verbal explanation on the part of the nurse as to why PHNs make outreach visits, and what they hope to achieve through these visits. It may include a statement of *what* the PHN hopes to do, with the client's cooperation, but not *why* the action is deemed necessary or important. Thus, Gordon (1982) advises the nurse to explain her purpose, and gives the following examples of what this would entail: "'Mr. Klein, I'd like to do a nursing assessment'" (p. 122); or "'I'd like to talk to you about your health and how you are doing'" (p. 115). Implicit approaches include such variant examples as "socializing" (Berg & Helgeson, 1984) and its apparent antithesis, the "direct approach", as described by Luker (below).

One or more of four presuppositions appear to underlie the choice of an implicit approach. The first is that the client already understands the nature and purpose of the encounter and its relevance to his or her health. The second is the familiar dictum that "actions speak louder than words"; in other words, that the "why" of the encounter will be made clear through the professional activities of the nurse. These two assumptions are

reflected in the following statement by Luker (1982, p. 70):

> The findings of this study suggest that it is not necessary to build a relationship before asking direct and intimate questions. It is thought that a working relationship between a health visitor and her client already exists in the form of predetermined role expectations. It is contended that where clients have had no previous contact with the health visitor the primary or assessment visit may set the pattern for all future visits. Hence, if the first visit is used to obtain direct information about a client's health status, it is necessary to ask intimate questions which may as in the case of the study described here be answered by the client in a matter of fact way. It is suggested that the direct approach may be less confusing to the client since from the beginning she is aware that the relationship is on a professional rather than a social footing.

Although it is possible that the "predetermined role expectations" referred to by Luker may arise from widespread cultural understanding of health visiting (Dingwall, 1977), it is questionable whether Luker's findings actually support her contentions. As reported earlier, few of the elderly clients who were her subjects associated the health visit with prevention, and most assumed that its purpose was surveillance for the doctor. It is clear that research is needed to test the validity of the assumptions underlying the "direct" approach.

A third assumption underlying the preference for an implicit approach is that it may be more acceptable to clients than an explicit one. Warner (1984b) states that health visitors may choose to keep some of their goals undisclosed due to a fear that directness about health education goals may be seen as an invasion of privacy, and may therefore work against the building of a relationship. Sloan and Schommer (1975) also point out that too much explicitness, as advocated in the literature on contracting, may intimidate clients because of the legal connotations it can evoke. Finally, an implicit approach may be chosen simply because a nurse lacks the skill to carry out an explicit approach with finesse (Simmons, personal communication, January, 1986).

Explicit Approaches

In an explicit approach, the PHN explains the value of the service (Helvie, 1981), what will happen during the encounter, and why the nurse is involved (EBH, 1982a; Spradley,

1981; Sundeen et al, 1976). It is characterized by negotiation with the client, in which mutual goals and expectations are agreed upon (Langford, 1978; Sloan & Schommer, 1975; Warner, 1984a). This is the type of approach advocated in the contracting literature; it is seen as energy efficient because it prevents the PHN from pursuing goals which are not meaningful to the client (Sloan & Schommer).

The advocates of an explicit approach tend to make explicit the presuppositions on which it is based. Foremost among these are the following: that potential clients 1) do not necessarily know what they can legitimately expect from a PHN (Langford, 1978; Sloan & Schommer, 1975; EBH, 1982a) 2) may not want her services (Langford; EBH);and that 3)knowledge is a necessary condition for valuing anything (EBH, 1983).

Two observations are relevant to the issue of an implicit versus an explicit approach. First, it is not always possible to determine which approach an author favours due to lack of clarity when using the term "purpose". In initiating interactions, says Cronin-Stubbs (1984), the nurse should state his or her name, position, agency and the purpose for the meeting. Freeman (1953) has a similar list of recommendations, which she categorizes as the "usual courtesies of civilized life" (p. 58). Leahy, Cobb and Jones (1977) give equally brief treatment to the conveying of purpose. Since none of these authors gives an illustration of "explaining purpose", one can only speculate as to the degree of explicitness of the approach advocated.

Secondly, not all authors express a preference for one or other of the approaches. Warner (1984c) says that each new nurse-client encounter "requires an implicit *or* (emphasis added) explicit negotiation of professional and client-roles (p. 271). This reference to "implicit negotiation" is not entirely consistent with Warner's (1984a) previous description of negotiation as involving an explanation of one's goals, for the latter can hardly be construed as an implicit approach. The point to be noted here, however, is that Warner seems to be implying that neither approach is superior in itself. If this is indeed the case, it is important to ask what other factors must be taken into consideration in choosing an appropriate

approach in a particular situation. Possible candidates are age, sex, ethnicity, socioeconomic status, and previous exposure to PHN services. The only one of these factors referred to in the literature is the final one: Luker (1982) contends, in the passage quoted above, that even on the first encounter, the health visitor should proceed directly into the substance of the visit.

Right of Entry

The EBH ROE framework constitutes an explicit approach to initiating the PHN-client encounter. It is designed to lead to mutual understanding of the purpose of the encounter and the client's acceptance of it on that basis. The concept of right of entry is not necessarily associated with an explicit approach; indeed, the term "right of entry" is given various meanings in the nursing literature. Berg and Helgeson (1984), for example, equate right of entry with gaining entry to a client's home. Dingwall, similarly, speaks of the health visitor's problem of "obtaining warranted entry to the house" (pp. 90, 97), and he goes on to say that "obtaining a warrant involves establishing one's title to it, of demonstrating that one is a "legitimate purveyor of services that the client should reasonably require"(p. 97). Such a warrant presupposes a culture of acceptance of health visitors among clients, or, "alternatively, the health visitor may, as a condition of entry, have to demonstrate her relevance for the client" (p. 97).

Whatever the setting, the nurse seeking right of entry should, at least, include a statement of name, position, and the purpose for the meeting. These "usual courtesies of civilized life" (Freeman, 1953, p. 58) are sometimes ignored by health workers, states Oliver (1985) in a provocatively entitled article, *Nurse with No Name*. She states that a 1985 British survey revealed that 59 home visit recipients reported that they had been visited by a social worker. In fact, 42 had been visited by "another professional mistaken for a social worker" (p. 22).

Attaining right of entry is more than gaining admittance to a person's home or a patient's room. Public health nurses have traditionally not found it difficult to attain admittance to people's homes. Dingwall, in his 1977 study of health visitors, observed that "it was remarkable how many people were willing to take us on trust" (p.98). Nursing researchers, however, have found some people admit a PHN into their home without necessarily wanting her services (Bambino, 1969; Conant, 1966; Field, 1982; Luker, 1982). It may be that entry (of a PHN) into a person's home requires only a "favourable personality" (Emory, 1945) or merely the appearance of being no threat to one's physical or psychological security.

The EBH Nursing Division Right of Entry framework was the only source found that made an explicit distinction between gaining entry to a person's home and gaining entry to an individual's personal world. The latter involves the PHN's conveying that the intention of nursing is to support people in their efforts to develop, maintain and protect the health resources needed for the pursuit of happiness, and the client's "coming to understand and welcome her on those grounds" (EBH, 1984, p. 2). Attaining right of entry is thought to be necessary in whatever setting the nurse-client encounter takes place and whether it is nurse-initiated or client-initiated. The difference is that in a nurse-initiated encounter, the nurse must *earn* the right to enter, while in a client-initiated encounter, the nurse *interprets* her right to enter to the client. In either case, the PHN has to appeal to both the potential client's feeling and to his or her common sense. In other words, the nurse must be persuasive.

Research on Approaches to Initiating the Public Health Nurse-Client Encounter

It is within the domain of nursing science to pursue answers to the questions of what approaches PHNs are currently using to initiate the PHN-client encounter, and what approaches achieve the best results. So far, it seems that these questions have not captured

the attention of nurse researchers. The six studies reviewed in the section pertaining to the understanding of purpose indicate that an implicit approach has been used by some nurses, but nothing can be concluded from these studies regarding the prevalence of this approach. No studies comparing the effectiveness of the two approaches were found.

Although both intensive and extensive studies of the interaction between public health nurses and health visitors, and their clients, have been reported (Bambino, 1969; Clark, 1976 Field, 1980; Johnson & Hardin, 1962), none of these focused on the initial or "contractual phase" (Orem, 1981) of the encounter. Clark originally included the topic "relationship building", among her 51 content topics, but excluded it from her analysis on the basis that it was "not appropriate (p. 57). Morgan and Barden's (1985) finding that both PHNs and their perinatal clients agreed that the PHNs explained the purpose of their visits, raises questions about the actual content of both the explanations and the clients' perceptions. Analysis of content was not the purpose of that study however.

Johnson & Hardin (1962), in their content analysis of 956 home visits, found that the mean amount of time spent on "procedural matters" was one to three minutes where the mean length of the encounter was 30 minutes. Opening the visit was but one of the "procedural matters", along with side conversations of household members, explaining the study, answering the phone or doorbell, and closing remarks (p. 56). It is unlikely that an explicit approach could have been delivered in this short time. Johnson and Hardin noted that at the time of their study, a prevalent belief was that "attitudes conducive to a mutually rewarding relationship" were those that conveyed a lack of "domineering and autocratic means of establishing authority" and a [redacted]m of assertiveness (p. 74). These are attitudes that may be more consonant with an implicit than an explicit approach.

Finally, Dingwall (1977) reports that he did not observe student health visitors receiving any explicit instruction in modes of gaining entry to clients homes. (He acknowledges, however, that he did not attend all instruction sessions and so might have missed it). He points out that the introduction phase was "rarely elaborate", and "it was

remarkable how willing the clients were to take us on trust" (p. 98). Again, it sounds as if an implicit approach was more typical than an explicit one.

Summary

This review of both the theoretical and empirical literature relevant to the initiation of the PHN-client encounter has revealed that there is general agreement that good relationships are characterized by mutual understanding and acceptance of the purpose of a nurse-client encounter. Little attention has been given, however, to systematic explication or investigation of *how* mutual understanding and acceptance are attained.

Ignorance about the initiation of PHN-client encounters is clearly substantial. It is not known what approaches PHNs typically use, or what clients understand about the goals that public health nursing holds on their behalf. It is not even known what PHNs themselves believe about the nature and purpose of public health nursing. Finally, it is not known how clients and nurses will react to an approach that is highly explicit. These gaps in nursing knowledge await investigation by nurse researchers.

Chapter IV

METHODS

The purpose of this research was to describe approaches used by PHNs in initiating outreach visits, to compare their approaches with that represented by the EBH ROE framework, and to report PHNs' opinions about the concept of seeking and attaining *right of entry*. In this chapter, the methods of data collection and analysis will be presented, and issues of reliabilty and validity will be discussed.

Design

This study was primarily qualitative in nature; as such, it was oriented to discovering propositions about right of entry rather than to verifying them (Bailyn, 1981; Diers, 1979; Reichardt & Cook, 1979). A qualitative focus was appropriate because the research questions were exploratory (Diers; Leatt, 1986), and because the range of responses likely to be elicited from participants was not known (Tripp-Reimer, 1985). One of the strengths of qualitative research is that it allows for observation and interpretation of behavior in context (Bailyn, 1981; Cronbach, 1975; Jick, 1979; Leininger, 1985; Mishler, 1979) and so facilitates the detection of complex interactions which tightly controlled quantitative designs may suppress (Cronbach; Leatt).

Goetz and LeCompte (1981) state that most qualitative research contains quantitative aspects, and that qualitative and quantitative approaches actually lie on a continuum from the most purely qualitative (i.e. phenomenological) to the most purely quantitative (i. e. experimental). Their paradigm of the four dimensions of qualitative and quantitative research approaches was used as a framework for the design of this study. The four dimensions and the distinctions which they represent are as follows:

1. *Generative-verificative.* This dimension pertains to the position of evidence (data) in a study. In generative research, the data serve as a source for discovery of theoretical

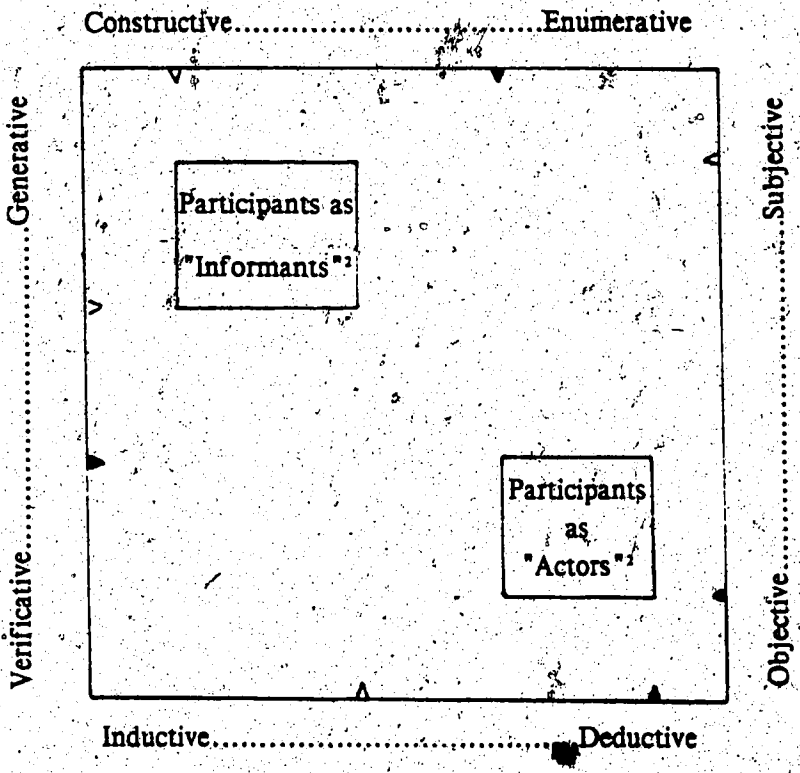
categories, propositions and hypotheses; in verificative research, the data are used to test hypotheses derived from a given theory.

2. *Inductive-deductive.* This second dimension refers to the place of theory in a study, and is closely linked with the first. Induction refers to making generalizations ("theory") from particulars; deduction refers to the application of theoretical propositions to particular cases. Examples of inductive reasoning in research are the derivation of categories from data, or the making of statistical inferences. Deductive reasoning is used when predetermined categories are matched to a body of data, or when inductively derived definitions are applied to new pieces of data. Goetz and LeCompte state that, while it is often the case that verificative research is deductive and generative research is inductive, verificative research may be atheoretical, and generative research can be informed by theory. This study conformed to the latter description.
3. *Constructive-enumerative.* This dimension indicates the ways in which a study's units of analysis are formulated. Construction is the process of deriving analytic units from the data; enumeration is the counting of previously specified units.
4. *Subjective-objective.* This dimension denotes the perspective from which the phenomena under investigation are described and interpreted. Also called the emic-etic dimension (Aamodt, 1982; Field & Morse, 1985), it refers to the distinction between viewing the subjects as "informants" versus viewing them as "actors" (Spradley, 1979).

Goetz and LeCompte indicate that since qualitative and quantitative research approaches are not mutually exclusive, "any one of the four dimensional characteristics may be found in combination with the other three" (p. 54). The advantages of using a combination of qualitative and quantitative approaches in a study are the attainment of a more comphrensive understanding of phenomena than would be gained through either approach alone (Reichardt & Cook, 1979; Tripp-Reimer, 1985), and potential enhancement of the validity of the findings through the "triangulation" of methods (Denzin, 1970; Jick, 1979; LeCompte & Goetz, 1982; Morse, 1986; Trend, 1978). The quantitative and qualitative

aspects of this study are presented pictorially in Figure 4.01, and are outlined below.

Figure 4.01. Qualitative and Quantitative Aspects of the Study[1]



[1]Based on J.P. Goetz and M. LeCompte, 1981, "Ethnographic Research and the Problem of Data Reduction", *Anthropology and Education Quarterly, 12*, p. 53.
[2]From J.P.Spradley, 1979, *The Ethnographic Interview*. New York: Holt, Rinehart & Winston.

Quantitative Aspect: Participants Viewed as Actors

In this aspect of the study, the intent was to describe and interpret PHNs' initiation of outreach visits *in terms of approaches already described in the literature*, and especially in terms of one particular approach, namely, that represented by the EBH ROE framework. Data consisted of tape-recordings of the nine postnatal outreach visits made by the PHN participants. The content of the PHNs' approaches was coded using pre-established

categories developed from the EBH ROE framework and from other approaches described in the literature. In terms of Goetz and LeCompte's (1981) continuum, the methodological focus so described may be characterized as primarily objective, deductive, verificative, and enumerative.

Qualitative Aspect: Participants Viewed as Informants

In this aspect, the intent was to describe and interpret PHNs' initiation of outreach visits *from the perspectives of the participants themselves.* Data consisted of semi-structured interviews. Both PHN and client informants were interviewed in order to obtain data for this qualitative aspect, and the interviews were analysed using constant comparative techniques (Field & Morse, 1985; Turner, 1981). The methodological focus so described may be characterized as subjective, constructive, inductive-deductive and generative-verificative.

Setting

The study was conducted in a public health agency in western Canada which served an urban community of roughly half a million people. Public health nursing services were provided through 11 regional health centres. Each district PHN was responsible for delivering a generalized program in a specified geographical area; program activities included well-baby visiting, infant and preschool clinics, prenatal classes, school health services, geriatric health assessment, and immunization. Like all of the PHNs in the agency, those in the study had been introduced to the philosophical base of public health nursing and to the concept of right of entry through a series of workshops known by the acronym *VAP.*[2] None of the PHNs were familiar with the formal ROE Framework, however, for it had not been released for general use.

[2] Orientation to Extended Professional Development in Public Health Nursing: Values, Attitudes and Practice.

Sample

Sampling Unit and Frame

Each sampling unit consisted of a PHN and a postnatal client, where the client could be either or both parents. Initial inclusion criteria for PHN participants were as follows: 1) they had held the position of district PHN for the previous 12 months, 2) they held either a bachelor's degree in nursing or a diploma in public health nursing; and 3) they had not participated in a VAP workshop for the previous three months. Nurses who held administrative or specialist positions were initially excluded, but participation was later opened to one type of specialist (Infant and Preschool Nurse) when it proved to be difficult to obtain enough participants using the sampling frame originally specified.

In choosing nurse subjects, the intention was to capture the usual practice of non-novice PHNs. According to Benner (1984), the novice nurse is equipped with principles and theory but lacks experience in applying these to clinical situations. The nurse who has made few outreach visits or who has recently been taught a new approach to making outreach visits is apt to act at the novice level. In this study, it was assumed that by the time a PHN had been with the agency for 12 months she would be past the novice stage for her job as a whole. It was furthur assumed that by three months following a VAP workshop a nurse would no longer be "trying out" new outreach approaches that might have put her temporarily back in the novice category for this aspect of the visit.

Client subjects were new parents. This group of clients was chosen because it was the target population of the agency's largest public health nursing outreach program. In order to increase the homogeneity of the client sample, parents were included as participants only if they met the following criteria: They were 1) first-time parents over 18 years of age, 2) who were married or living together, 3) whose infants were full-term singletons of 2,500 to 4,000 grams, had no abnormalities, and had had an uncomplicated vaginal or Caesarian birth, 6) who had a telephone, and 7) who spoke English fluently. Parents who phoned to request

a home visit were not eligible to participate in the study.

Sampling Methods

The PHNs were a volunteer sample. Although purposive sampling is the method of choice in qualitative research (Chenitz & Swanson, 1986; Field and Morse, 1985; Morse, 1986), ethical considerations in this study precluded the researcher's seeking out participants. Seven of the nine PHN participants said they volunteered strictly of their own accord; one was recruited by a fellow participant. (One was not asked how she decided to particiate because she left the agency before completion of the study). Although seven stated that no one personally encouraged them to participate, one of the regional supervisors reported that she had approached two PHNs whom she described as "good nurses", and had encouraged them to participate. She judged that each would be a good participant, stating that one had particuarly good "entry skills", while the other often contributed a valuable minority point of view to discussions held among the health centre staff.

Most of the PHN participants stated that they volunteered because they were interested in the research topic in particular, or in research in general. None gave spurious reasons such as external rewards; indeed, several pointed out that there were no external rewards for participating. One stated that the main reason she had participated was because "I knew you and I wanted to help you out". Two others stated that this reason was also a factor in their decision to participate.

Client participants formed a convenience sample, selected because they happened to live in the regional visiting area of a PHN who was a study informant.

Researcher Status in Relation to the PHN Informants

All the PHN participants were previously known to the researcher, through formal or informal work associations within the agency. Four had participated in VAP workshops at a time when the researcher was a co-teacher in the workshops and two were from a health

centre where the researcher had previously worked. Previous contact with two of the remaining three had been on a more short-term basis, and one was known only by virtue of working within the same agency. Like the PHNs, the researcher was a staff nurse; unlike them, she held a specialist position in staff development.

Ethical Considerations

Approval to conduct this research was received from research review committees in both the University of Alberta and the agency where the research was conducted. All subjects were given both written and oral information about the purpose and procedures of the study and were informed that they had the right to refuse to participate without fear of recrimination. Consent forms outlining the rights and expectations of subjects are presented in Appendix C; special provisions made to preserve the anonymity of PHN informants are described below.

As "actors" in the quantitative aspect of the study, PHNs were in the position of exposing their practice to the scrutiny of a researcher. It was recognized that doing so might engender anxiety in potential nurse participants, especially in view of the fact that the researcher was also a PHN employed by the same agency and known to many of the PHNs. Special provision was made, therefore, to preserve PHN informants' anonymity in relation to the researcher. A research assistant (RA) was hired to mediate communication between the researcher and the PHN participants, and to remove all identifying information from both the home visit tapes and transcripts before they were made available to the researcher. It was also planned that PHN interviews would be conducted by telephone unless a PHN herself requested a face-to-face interview. PHNs were informed that if the researcher recognized any PHN by her voice, the latter would be so informed, and would be under no obligation to remain in the study. Three of the nine PHNs initially elected to remain anonymous, but the identity of all three became known to the researcher before data collection began. One was

inadvertently identified by the RA who confused the PHN's name with her research pseudonym. The second PHN's identity became evident through voice recognition; this PHN then revealed the identity of the third "anonymous" participant. All three of these PHNs chose to remain in the study.

Entry to the Agency

Prior to review by the agency Research Review Committee, the study was discussed informally with the Director of Nursing, and the provisions to preserve the anonymity of the PHN participants were incorporated at her request. Following formal approval, the researcher attended a meeting of the Nursing Division administration staff (which included the supervisors of the 11 regional health centres), in order to explain the study and to respond to questions regarding the procedures. The researcher then attended meetings at 10 of the regional health centres to invite PHNs to participate in the study. A written description of the study was also distributed in each health centre. Interested PHNs were asked to contact the RA if they wished to remain anonymous, and the researcher if they preferred to disclose their identity.

Response to the invitation to participate was initially slow. Although the first PHN volunteered within two weeks, a second participant was not found until four more weeks had passed, and the third participant came forth four additional weeks later. At this point, a specialist in infant and preschool nursing indicated her interest in being a participant, and in view of the difficulty in obtaining participants, the inclusion criteria were expanded to include this category of specialist.

Several possible factors are postulated to account for the difficulty in obtaining PHN informants. First, the fact that PHNs were asked to volunteer of their own accord may have been a deterrent. It is speculated that it is more difficult to put oneself forward as a "suitable" participant than to respond to either a personal invitation to participate or to

random selection. Only two of the participants in this study said it would have been "easier" to respond to an invitation; most had no preference. These PHNs, however, may have been different in this respect from PHNs who did not volunteer to participate.

Second, PHNs may have been reluctant to submit their practice to observation and questioning by a researcher. In this study, one of the PHNs stated that having to tape a home visit had seemed "intimidating" at first, and one other had initially had some concerns that PHNs' remarks might be evaluated in the same manner that PHNs opinions were challenged and evaluated in the VAP workshops. PHNs who did not volunteer may have had similar concerns.

One of the most likely deterrents to participation was PHNs' perceptions of the amount of added time that participation would require. Four of the PHNs in the study stated that time was the most significant negative factor influencing their decision to participate. Several supervisors told the researcher that autumn was a "bad" time of year to initiate data collection, because the PHNs' workload was especially heavy at that time. A few PHNs themselves apologized to the researcher for not participating, citing work overload as the reason. Staff may also not have trusted that the estimated time requirement (3 to 4 hours) was accurate. One supervisor stated that her staff members were oversaturated with research, having recently acted as data collectors in a study in which the amount of time required had been underestimated. Three of the study participants indicated that other PHNs in the agency felt that they were required to participate in too much research, and that there were no rewards for doing so.

Finally, the provisions to protect the anonymity of PHN participants may themselves have been a deterrent, giving participation a "risky" as opposed to "matter-of-fact" connotation. One participant reported that the anonymity provisions had had this effect on her, and another stated that a statement in the written invitation to participate emphasizing that PHNs should not participate if they were concerned about the researcher's learning their identity had had a negative impact on many PHNs in her health centre. Having to contact a

third party may also have been unappealing. None of the PHNs whose anonymity was broken seemed disturbed by this happening, and one stated that it made procedures seem much less complicated.

Data Collection

Procedures

Data collection took place over a period of seven months; half of the data, however, were collected during the final two months. Several factors contributed to the delays in data collection: initial slowness of PHNs to volunteer as participants; a three months' measles epidemic which increased PHNs' workload and interrupted data collection; and the researcher's own work commitments.

Each of the PHNs was advised to audiotape one to two practice visits in order to familiarize herself with the data collection procedures. She then selected a client who met the study criteria from among the birth notices received for her visiting area, and gave the researcher the potential client's name and phone number. The researcher contacted the parent to explain the study and invite one or both parents to participate. A total of 16 parents were contacted. Two declined to participate, and two failed to meet the study criteria. One who consented had to be dropped from the study because an error in recording the visit yielded a blank tape. The remaining 11 parents--two couples and seven mothers--formed the client sample.

Each PHN was asked to make one home visit according to her usual procedure, recording the entire visit on audiotape. The tape recorders were battery-operated, and were to be turned on as the PHN approached the client's home, and turned off after she left. If the PHN phoned to make an appointment for the visit, she was asked to write a "script" of the conversation on a Supplementary Data Sheet provided for this purpose (see Appendix

D.02). Complete tapes and Supplementary Data Sheets were received from eight of the PHNs. The ninth PHN failed to record the opening and closing minutes of the home visit, and did not submit a Supplementary Data Sheet.

PHNs and clients were interviewed within two days to two weeks of the home visit. All PHNs were interviewed a second time. The first three PHNs were interviewed two to four months after the first interview, the long time interval between interviews being due to circumstances explained above. The remaining six PHNs were interviewed again two to four four weeks after their first interview. The setting of the interviews was arranged in accordance with the preferences of the informants. The first PHN interview of the study was conducted by telephone, and the last took place in the researcher's home. All others were conducted in an office in the health centre where the PHN worked. Clients were interviewed in their homes on all occasions excepting two. One client requested a telephone interview; the other agreed to a second interview by phone when some of the data from the original interview were lost due to a faulty tape. PHN interviews ranged from 40 to 70 minutes and client interviews from 20 to 60 minutes each. In all, 28 interviews were conducted, 18 with the PHNs, and 10 with the clients.

Instruments

The Coding Guidelines

In order to compare approaches acutally used by the PHNs with those described in the literature, a deductive coding scheme was developed. The major categories--*Implicit* and *Explicit*--were derived from descriptions in the general public health nursing literature. The four sub-categories represent different degrees of seeking entry, from the most implicit (*Does not seek entry*) to the most explicit (*Seeks entry: Elaborate*). The latter approach is that of the ROE Framework. The approach *Seeks ROE: Simple* contains the minimal criteria of an

explicit approach, as derived from explanations in the literature. The coding guidelines are presented in full in Appendix E, along with a diagram of the coding scheme.

The Interviews

PHNs were interviewed twice each, and clients once. Free-response interview guides consisting of open-ended questions (Dohrenwend & Richardson, 1963) were designed and used. This form of interview was appropriate because the structure of the topic was known but the range of responses was not (Field & Morse, 1986). Three types of questions (descriptive, structural, and contrast) were employed (Spradley, 1979). Techniques such as asking a question in more than one way, and card sorts, were used to elicit in-depth information from respondents, and to validate information already received. Demographic information was obtained from client informants at the end of the client interview.

In the second interview with each PHN, card sorts were used to clarify similarities and differences among emerging categories, and to make links between different categories. *Socializing*, for example, was found to be a means of *Breaking the ice*, which was seen as part of *getting the client comfortable*, which in turn was seen as equivalent to *Entering a client's personal world*. In the initial interviews, where the focus was on category generation, PHNs were first asked to sort the cards into as many piles as they wished (Q-sorts), and then were asked to reduce the number of piles to two or three (diadic and triadic sorts). In the final interviews, where validation of the categories and linkages was the focus, informants were asked to sort the cards under the headings of the three main categories: *Getting the client comfortable*, *Ways to get the client comfortable*, and *Not my style*.

Supplementary Data Sheet

As stated earlier, the Supplementary Data Sheet (Appendix D.02) was used to obtain information about unrecorded parts of the PHN-client interaction, and formed part of the

data for the quantitative aspect of the study. PHNs were instructed to write a script of all phone calls made before the visit, and to indicate the duration of any unrecorded parts of the home visit, along with a brief statement about why the tape was turned off, and what was discussed in the interval. Demographic information about the PHNs was also obtained by means of the Supplementary Data Sheet.

Other Data

During the interviews, brief field notes were made. Memos were written up after each interview in order to record the researcher's thoughts, feelings, and developing hypotheses. The latter were discussed with a member of the thesis committee, and were used to guide subsequent data collection.

Pilot Study

A pilot study was conducted with the first three PHN volunteers in order to test the sampling and data gathering techniques; the utility of the pre-established categorization guide; the clarity and comprehensiveness of the interview guides; and the time taken to complete the various procedures. Each PHN made one postnatal outreach visit and both PHN and client were interviewed once. A member of the investigator's thesis committee reviewed the interview transcripts to check for instances of interviewer bias. No such bias was detected, but a few minor wording changes were made in some of the interview questions. Because no major changes were necessitated as a result of the pilot study, the data from the pilot study were incorporated into the main study.

Data Reduction and Analysis

Quantitative Aspect: Research Questions, Set 1

The supplementary data sheets and transcriptions of the home visits were subjected to content analysis. PHN approaches were analysed to determine which, if any, of the EBH ROE sub-elements they contained, using the pre-established coding guide. Each approach was then given an overall designation of *Implicit* or *Explicit* with regard to explanation of the PHN's purpose. The unit of analysis was a verbalization that reflected either the content or form of a PHN approach. A unit was a word, a phrase, a statement or group of statements, or a question. One unit ended and another began when there was a change in the form or content of the approach.

A record was kept of the amount of time devoted to the non-clinical portions of the visit as a proportion of the total visit time, as done in the 1962 Johnson and Hardin study.

Qualitative Aspect: Research Questions, Sets 2 and 3

Analysis of the PHN and client interviews was conducted according to the constant comparative method, which was developed by Glaser and Strauss in the 1960s as a means of generating theory grounded in the empirical world (Turner, 1979). This analytic strategy is a constructive, iterative technique in which inductive coding is coupled with ongoing comparison across all categories of observed phenomena (Goetz & LeCompte, 1981). While the starting point is the subjective constructs of the participants, the aim is to develop objective definitions, propositions, and hypotheses (Goetz & LeCompte). In the final steps of the analysis, emerging theoretical statements are compared with existing theory. The method was particularly appropriate for use in this study, in that it provided a formal means of comparing propositions emerging from the PHN and client interviews with the presuppositions ("theory") upon which the EBH ROE framework is based.

The analysis was guided by Turner's (1981) explication of the practical aspects of the constant comparative method, as well as that of Field and Morse (1985). A summary of the stages of analysis is presented in Appendix E.02. A description of their application in the present study follows:

1. The content of the interviews was first divided into broad categories based on the research questions (e.g. description of approaches; opinions about different approaches; PHNs' objectives for the visit). Sub-categories were then inductively developed from the data. Categories from the first two PHN and client interviews were entered on to cards.
2. The cards were used in the second round of PHN interviews as the basis of Q-sorts. Through this process, further instances of some of the categories accumulated until they became "saturated". Other categories (e.g. *letting the client ramble on*) were found to be insignificant, and were eliminated. When categories were found to be similar, they were collapsed into a single category (e.g. *information about public health* and *talking about public health* became *explaining about public health*).
3. Tentative definitions were formulated for the emerging categories and these definitions were used to guide subsequent interviews.
4. Categories were "exploited" by comparing them to to other related categories. Informants were asked, for example, how *explaining about public health* was related to *getting the client comfortable* and to *selling public health*.
5. From the informants' explanations, links between the categories were proposed, as well as conditions under which the proposed links held true. Examples of two (seemingly contradictory) propositions were: *Most PHNs have preferred approaches* and *A PHN's approach depends upon the client*. These two propositions were linked by means of the following conditional proposition: *If the client does not present with a strong approach of his or her own, the PHN will use her preferred approach.* These propositions were "tested" in subsequent interviews.
6. Propositions about PHN approaches emerging from the analysis were compared with

existing "theory", that is, the approach represented by the ROE framework.

7. Propositions were tested by considering their applicability in other situations. For example, the researcher asked of both herself and the final PHN informant: "Would the process of *getting the client comfortable* in a postnatal outreach visit apply in seeking entry in a research interview?"

Reliability and Validity

Means of establishing reliability and validity vary according to the sampling methods used, the data gathering techniques, and the data analysis methods (Field & Morse, 1985). The principal threats to the reliability and validity of the above aspects of this study, and the measures that were taken to diminish them, are outlined below.

Sampling Methods

Using the twin criteria of *adequacy* and *appropriateness* advocated by Morse (1986), the sample used in this research may be evaluated as "satisfactory", in that the data were adequate (i.e. saturation of the approach categories was attained) even though the preferred sampling method ("theoretical") was not employed. Morse states that the use of volunteer and convenience samples may be a threat to the validity of the data if informants volunteer for reasons "other than specialized knowledge and receptivity" (p. 184). All the PHN informants, however, were very receptive to being interviewed. All were also knowledgeable about the reseach topic: eight by virtue of their day-to-day involvement in outreach visiting, and the ninth through her involvement in orienting new PHNs to postnatal outreach visiting. Eight of the 11 client informants were very receptive to being interviewed; two were moderately receptive (they tended to give fairly short responses to the interview questions); and one did not respond to many of the questions, probably because she was by disposition

less talkative than her husband. The richness of the data obtained from the first eight clients, however, more than compensated for the relative "thinness" of the data obtained from the latter three.

Data Collection and Analysis Methods

Quantitative Aspect

At issue in the quantitative aspect of the study was the reliability and validity of pre-established coding scheme for categorizing approaches used by the PHNs in their home visits. Content validity was established by having the coding guidelines (Appendix E.01) reviewed by the primary developer of the ROE framework. Revisions were made in the definitions and examples of the categories until 100% agreement was reached on all but one of the sub-elements. Resolving the difference of opinion between the researcher and the developer of the framework was considered beyond the scope of this study, and interviews were coded to the researchers interpretation.

Interrater reliability (reproducibility) was estimated by having the same individual independently code all the home visits. Units of analysis were demarcated by the researcher, and the independent coder was asked to categorize them according to the procedures outlined in Appendix E.01. Intrarater reliability was calculated using Rubin and Erickson's (1978) formula $r = 1 - \frac{x - y}{x + y}$ where x and y represent the coding frequencies for the researcher and the independent observer respectively. This means of calculating reliability was considered adequate for this exploratory study. It is recognized that the reliability estimates are high, however, as Rubin and Erickson's formula does not correct for chance.

Interrater reliability ranged from .5 to 1 for the six main categories of the ROE Framework, and from 0 to 1 for the 18 possible sub-categories. Rubin and Erickson (1978) state that low agreement (60-65%) usually means that the rules of definition are not

complete. This was the case for the very low agreement achieved on the three d sub-elements, which reflected disagreement between the researcher and coder on the meaning of the definitions. It is likely that the distinctions between these three sub-categories were too fine. Reliability for the d *main* category, on the other hand, was .94. Rubin and Erickson state that such high agreement indicates that the rules of definition may not be rigorous enough. It appears that element d may need to be re-examined (perhaps dividing it into two rather than three sub-elements) if the ROE Framework is to be a useful learning or evaluation tool. High agreement may simply mean, however, that the rules of definition are clear and exact. Near perfect agreement would be expected, for example, in categories such as *PHN states her name and role (i.e. public health nurse)* and *PHN refers to the source of referral (i.e. the notice of birth).*

Intrarater reliability (stability) was estimated by having the researcher re-code three randomly selected home visit transcripts two weeks after the initial coding. Reliability ranged from .92 to 1 for the main categories. Except for one sub-category where the agreement was zero, reliability estimates for the sub-categories ranged from .75 to 1.

Qualitative Aspect

LeCompte and Goetz (1982) state that in establishing reliability in qualitative research, "agreement is sought on the *description or composition* of events rather than the frequency" (p. 41, emphasis added). This is partially achieved through careful description of the social, physical and interpersonal contexts in which the data are gathered (LeCompte & Goetz) and of the strategies used in sampling, data collection and data analysis (Field & Morse, 1986; LeCompte and Goetz). These measures were employed in this study, as was the use of "low inference descriptors" (LeCompte & Goetz) in the presentation of the findings, which enhances reliability by providing substantiation of the categories (Cusick, 1973; LeCompte & Goetz, 1982; Mehan, 1979). Reliability of the raw data itself was enhanced by the use of mechanical means of data collection (tape recordings) (LeCompte &

Goetz, 1982). Finally, the estimation of interrater and intrarater reliability thorough the use of frequency counts was employed for one of the major sets of categories: the PHN approach components. Instances of all the approach components as well as sub-categories of the approach component *Explaining about public health* were selected from all the interviews. Units of analysis were demarcated by the researcher, and the coding was done by an experienced independent coder, using the definitions of the categories provided in Appendix F. Interrater reliability estimates, using Rubin & Erickson's (1978) formula, ranged from .91 to 1 for the three main categories and from .75 to .92 for the four sub-categories.

As stated earlier, the design of this study was developed with the intent of reducing threats to validity through the use of different methods of data collection and analysis. The fact that there was convergence among the findings from the three sets of data increases their validity (Denzin, 1970; Jick, 1979; LeCompte & Goetz, 1982; Trend, 1978). The constant comparative method used to analyse the interview data is thought to have high validity in itself, because emerging propositions are checked with the informants as the analysis progresses (LeCompte & Goetz, 1982; Turner, 1981). Care was taken throughout the interviews to ensure that the informants' views were accurately interpreted by the researcher by asking them to verify her interpretations. Emerging findings and interpretations were also checked with a member of the researcher's thesis committee at regular intervals. This committee member also checked the interviews during the pilot phase for instances of interviewer bias, which was a potential threat to validity by virtue of the fact that the researcher was an advocate of one of the approaches (*Explicit*). As reported earlier, no such bias was detected.

A final threat to validity was the potential for social desirability bias among PHN informants, who might have associated the researcher with an *Explicit* approach because of the latter's position as co-teacher in the VAP workshops. In order to reduce this threat to validity, PHNs were informed that while the researcher believed that the explicit approach advocated in the VAP workshops was theoretically sound, it had not yet been empirically

validated) and that one of the aims of the study was to let practising PHNs speak for themselves on the issue of what approaches are "best". In fact, there was no indication that PHN informants were trying to "please" the researcher; proponents of both implicit and explicit approaches were willing to disclose and defend their preferences.

Limitations

The following are limitations to this research:

1. The research findings are not generalizable beyond the subjects studied.
2. The findings must be interpreted in light of the limitation to the content validity of the pre-established guide.

Chapter V

PRESENTATION OF THE FINDINGS

Background information about the study participants and the context in which the study took place is reported at the outset of this chapter. The findings are then presented in three parts, corresponding to the three sets of data collected. In Part A, the findings from the study home visits are presented; in Part B, the findings from the interviews with the PHNs; and in the Part C, the findings from the interviews with the parents.

The Participants and the Context

The PHNs

The nine PHNs worked out of five of the 11 regional health centres of the public health agency. All had either a baccalaureate degree in nursing or a diploma in public health nursing. Together, they represented 102 years of public health nursing experience, ranging from 2.5 to 23 years individually. Their years of experience and their age range are presented in Table 5.01.

Table 5.01: Characteristics of the PHNs

Age Range		Years of Experience in Public Health Nursing	
Age in Years	No. of PHNs	Years of Experience	No. of PHNs
25-35	4	< 5	4
35-45	2	6 - 10	1
45-55	2	10 - 15	1
> 55	1	15 - 20	1
		> 20	2

Eight of the PHNs were employed as district nurses at the time of the study. The ninth held a specialist position in infant and preschool nursing and did not have a visiting district as part of her regular job assignment, although she had past experience as a district PHN.

The Clients

Eleven clients participated in the study, seven mothers and two couples. All were first-time parents; their ages ranged from 26 to 31 years. None were single parents. All had completed high school, four had post-secondary education, and five had one or more university degrees. The mothers were employed in, or prepared for, a wide variety of occupations: production analyst, hairdresser, nurse, engineering technologist, dental receptionist, archeologist, commercial copywriter and teacher. One father was an accountant, the other a physician. Five of the mothers were on maternity leave and had definite plans to return to full or part-time employment. Two others said they would probably return to work.

Seven of the eleven individuals had always lived in Canada; the others had come to Canada as adults from Germany, the United States, and the Phillipines, one father as recently as 11 months previously. All lived in areas of the city that could be appropriately described as "middle class". Of the nine residences, six were houses and three were apartments. Two of the residences were located in a relatively new area of the city (10-15 years old); the remainder were in long-established communities (25-60 years old).

The Context: Postnatal Home Visiting

PHNs in the agency where the study was conducted were expected to make outreach home visits to all new parents. Notices of birth were sent from hospitals to the public health agency, and agency policy stated that the PHNs were to make contact with the parent(s)

within three calendar days of their receipt. The decision to phone ahead or to drop in on the client was left to the discretion of the individual PHN. The norm was one home visit per client, with further visits arranged according to the PHN's judgment regarding the need for follow-up. In most cases, therefore, the PHN had to establish the nurse-client relationship within a relatively short time. As one PHN stated: "You go into a strange situation, and you have to make it work". What was involved in "making it work" was the focus of this research.

A. FINDINGS FROM THE STUDY HOME VISITS

In this part, the following findings will be presented: a description of the structure and content of the home visits; and a categorization of the PHNs' approaches in initiating the visits according to the pre-established coding guide based on the Edmonton Board of Health (EBH) Right of Entry (ROE) framework.

Structure and Content of the Home Visits

In this study, the nine PHN participants each made one postnatal home visit. The home visits were analysed to determine a) the duration and relative proportions of clinical and non-clinical conversation; b) the sequencing of clinical and non-clinical segments; and c) the different types of non-clinical conversation and the relative proportions of each.

Clinical and Non-clinical Segments: Duration and Sequence

The nine home visits ranged in length from 35 to 78 minutes. As shown in Table 5.02, 83% to 93% of this time was devoted to clinical conversation. Non-clinical conversation ranged from three to 12 minutes, or from 7% to 15% of the total visit time.

Table 5.02. Home Visits: Clinical and Non-clinical Time

Visit	Non-Clinical Time (min.)				Clinical Time	Total Time	No Interaction
	Intro.	Intervening	Closing	Total			
1	1.0 (2%)**	3.0 (6%)**	2.0 (4%)**	6.0 (12%)	43.0 (88%)*	49	
2	3.0 (9%)	2.0 (6%)	1.0 (2%)	6.0 (17%)	29 (83%)	35	
3	1.0 (1%)	3.5 (5%)	1.0 (1%)	5.5 (7%)	65 (87%)	75	4.5 (6%)
4	2.75 (4%)	5.25 (7%)	4.0 (5%)	12.0 (16%)	66 (84%)	78	
5	?		?	?	41	41+	
6	2.0 (5%)		1.0 (3%)	3.0 (8%)	35 (92%)	38	
7	3.5 (8%)	2.0 (4%)	2.0 (4%)	7.5 (16%)	33.0 (71%)	47	6.5 (13%)*
8	3.5 (5%)	1.0 (1%)	4.5 (7%)	9.0 (13%)	61 (87%)	70	
9	1.5 (3%)	2.5 (6%)	2.0 (5%)	6.0 (14%)	38 (86%)	44	
Range	1-3.5	1-5.25	1-4.5	3-12 (7-17%)	29-67 (71-92%)*	35-78	
Mode		2	1;2	6		44-49	

* Percent of total visit time (all bracketed figures in this column)
** Percent of non-clinical visit time (all bracketed figures in this column)

In the design stage of the research project, the home visits had been conceptualized as having two non-clinical segments: an introductory segment and a closing segment. The home visit would therefore display a pattern consisting of three segments, as follows: **introductory-*clinical*-closing.** In fact, designation of the introductory phase was not as straightforward as that. In six of the nine home visits, one to three segments of non-clinical conversation occurred somewhere in the middle of the visit, each between two segments of clinical conversation. These intervening segments (one or more) of non-clinical conversation resulted in a pattern containing five, seven or nine segments. A five-segment pattern would be as follows: **Introductory-*clinical*-intervening-*clinical*-closing.** The sequencing of the non-clinical and clinical segments of each visit is depicted graphically in Figure 5.01.

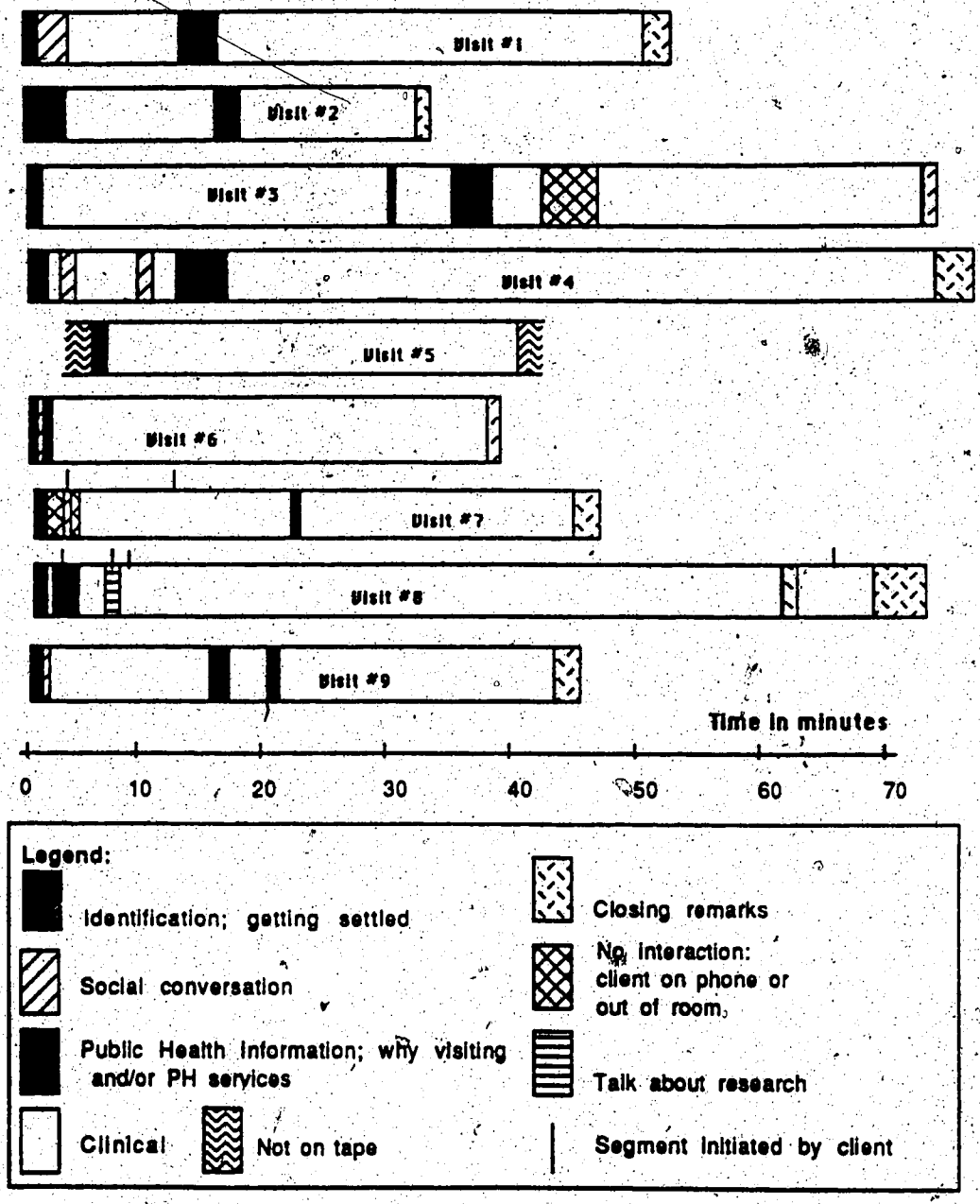
In two of the visits, there were periods of non-interaction. (In Visit #6, the conversation was interrupted by two telephone calls; in visit #8, the client left the room to tend to the baby.) The occurence, duration and relative percentages of each of the non-clinical segments are also shown in Table 5.02.

Content of the Non-clinical Conversation

The content of the non-clinical conversation fell into five categories: initial greetings and identifying information (ID); social conversation; conversation about public health; conversation about the research project; and summarizing and terminating remarks. In regard to the relationship between the types of conversation and the three non-clinical visit segments, Figure 5.01 makes evident the following findings:

1. With the exception of two visits (#2 and #6), the introductory segment consisted of either identifying information alone, or a combination of ID and social conversation. Social conversation occurred in four of the home visits for which complete tape recordings are available, and was also reported by the PHN whose tape recording was incomplete.

Figure 5.01
Structure and Content of the Home Visits



2. Social conversation constituted a rather small proportion of the non-clinical conversation, ranging from less than half a minute to a maximum of 2.5 minutes of the total visit time. In three of the eight visits for which full recorded data are available, there was no social conversation at all. Except in Visit #4, social conversation was limited to the introductory segment.
3. Talk about public health was found in the introductory segment of only two home visits (#2 and #6); it constituted less than a minute's time of this opening segment.
4. In all visits but two (Visits #4 and #8), conversation in the intervening segment or segments was conversation about public health. Visit #4 contained a *social* intervening segment as well as a *public*
5. Conversation about the research occurred as an intervening segment in one home visit (#8), and lasted only

These findings are summarized in Table 5.03. In the following sections, portions of dialogue from the visits will be quoted in order to portray the actual content of the ID and the social conversation that occurred in the visits. Excerpts of the content of the public health conversation will be presented in a later section to illustrate the PHNs' use of the elements of the ROE framework.

Greetings and Identification

In four of the home visits, the opening dialogue consisted of a simple exchange of greetings and introductions (e.g. "Hi, are you Mrs. Baker? I'm Roberta Wells, the public health nurse"). In three of the visits, however, the exchange took place under conditions of "something unexpected". In two instances, the "unexpected" was the PHN's getting lost; in the other, the client had slept past the appointed time for the visit. Excerpts from two of these opening segments are presented in order to convey the "flavour" of a visit that begins in an unexpected way:

Table 5.03. Types of Non-clinical Conversation in the Introductory and Intervening Segments: Duration and Percent of Total Visit Time

Visit	Total Length (min.)	Duration of Non-clinical Conversation (min.)			
		ID/ Greetings	Socializing	Talk about Public Health	Talk about Research
#1	49	0.75 (2%)	0.25 (5%)	3.0 (6%)	–
#2	35	2.0 (6%)	0	3.0 (9%)	–
#3	75	1.0 (1%)	0	3.5 (5%)	–
#4	78	1.5 (1%)	2.5 (3%)	4.0 (5%)	–
#5	41+		Data Incomplete		
#6	38	0.5 (1%)	0.75 (2%)	0.75 (2%)	–
#7	47	1.5 (3%)	2.0 (4%)	2.0 (4%)	–
#8	70	1.5 (2%)	0	2.0 (3%)	1.0 (1%)
#9	44	1.0 (2%)	0.5 (1%)	2.5 (6%)	–
Range	35–78	.75 – 2.0	0 – 2.5	0.75 – 4.0	
Median	%	2%	.75%	5%	

Visit #7

CLT: Hell-ooo. (Voice sounds far away)

PHN: Right!...Oh, I was so mad--I've gone everywhere! I couldn't find [the house].(Sounds out of breath)

CLT: Yeah, it's hard to find.

PHN: It sure is hard to find... Oh, talk about feeling stupid! And here it's late and I thought, "Well, here I have to phone them and cancel it". (laughs)

CLT: Have a seat in the kitchen--if you feel more comfortable here.

PHN: Oh, it doesn't matter. This looks good!...Oh, Oh, for heaven's sake! (Takes a deep breath) Well, anyway, I finally got here! I feel like...(sighs, addresses baby) Boy, what a sweetie!

Visit #8

PHN: Hi. Gloria?

CLT: Hi-i. (Sounds surprised)

PHN: I'm Katy Walters, the public health nurse.

CLT: I know, yeah.

PHN: Shall I come in?

CLT: I expected you, actually--later.... At 1:30 or something.

PHN: Yeah, it's that time!....You were sleeping, were you?

CLT: Yeah. Actually, I set an alarm.

PHN: It's about a quarter to two (Client laughs) Well, you had a good sleep! (Both laugh)

Socializing

Social conversation occurred in six of the nine visits. In four of the visits, socializing took the form of admiring or talking to the baby. Two examples follow:

Visit #9

PHN: (to baby) Oh, what a sweetheart!

CLT: Oh, you must see a *million* babies!

PHN: And they're all very, very special.... What did you name the baby?

CLT: His name's Theodore.

PHN: Theodore. Is he ever sweet. And all that hair!

CLT: Oh, he's got loads of hair.

PHN: Just like mom.

CLT: Not like dad!

Visit #4

PHN: (To baby)Who's th-is? (Sing-song voice) What's this little one's name?

CLT: Stephen.

PHN: (still talking to baby)Ste-phen...How old is he now?

CLT: Three weeks two days.

PHN: Time going fast enough for you?

CLT: Ohhh! Well, some days seem to be slow; other days just fly.

PHN: It's exciting, eh?

Of the other two instances of social conversation, one involved a comment about the client's

home: "What a beautiful home! You done a lot of renovations". The other was a comment about the neighbourhood: "This is a really nice street along here....But you've got your house up for sale. Where are you moving?"

In all the visits, the socializing was initiated by the PHN. All of the clients but one responded in kind. The latter had questions on her mind, and turned the conversation to these.

Categorization of the PHNs' Approaches

The PHNs' approaches were categorized according to the pre-established coding guide which was developed to represent the elements of the EBH ROE Framework (Appendix E.02). There were two main categories of approaches: *Implicit* and *Explicit*, each of which was divided into two sub-categories. An approach was categorized as *Implicit* if the PHN made no attempt to seek right of entry, or if she made only a partial attempt at doing so. *Explicit* approaches contained the essential elements of seeking right of entry. An approach was designated as "Simple ROE" if it contained the four ROE elements that constituted the "bare essentials" of seeking entry, and as "Elaborate ROE" if it met all the criteria laid out in the ROE framework. Approaches were also categorized according to the amount of social conversation they contained in the introductory segment, a designation of "Social" being given if at least half of the dialogue therein was devoted to social conversation.

Separate categorizations were made for the phone call, and for the introductory and intervening segments of the home visit. An overall categorization was then given for the entire exchange (phone call and home visit). The categorizations for each PHN are presented in Table 5.04. The following are the major findings:

1. All but one of the PHNs made an overall attempt to seek right of entry, but only one met the criteria of an *Explicit* approach.
2. Only one PHN made a partial attempt to seek entry on the telephone.

Table 5.04. Partial and Overall Categorizations of Each PHN's Approach

	Approach			
	Phone call	Home Visit		Overall
		Introductory Segment	Intervention Segment	
PHN				
#1	No ROE	No ROE	Partial ROE	Partial ROE
#2	Partial ROE	No ROE	Partial ROE	Partial ROE
#3	No ROE	No ROE	Partial ROE	Partial ROE
#4	No ROE	No ROE (S)•	Simple ROE	Simple ROE (S)
#5 Wife	?	Partial ROE		Partial ROE
#5 Husband	?	Partial ROE (S)		Partial ROE (S)
#6	No ROE	Partial ROE (S)		Partial ROE (S)
#7	No ROE	No ROE (S)		No ROE (S)
#8	No ROE	Partial ROE +		Partial ROE
#9	No ROE	No ROE	Partial ROE	Partial ROE

• (S) Refers to Socializing
•• Data incomplete
+ In response to client's asking re purpose of visit

3. Three of the PHNs partially sought entry in the introductory segment of the visit.
4. Four PHNs did not attempt to seek entry until the intervening segment; one of these PHNs did so in response to the client's request.
5. None of the approaches met all the criteria of the ROE framework.
6. Four of the approaches were categorized as "Social".

These findings are summarized in Table 5.05.

Table 5.05. Number of PHNs Using Each ROE Approach

	Number of PHNs			
	No ROE	Partial ROE	Simple ROE	Elaborate ROE
Phone Call	7	1		
Introductory Segment	6	3	0	0
Intervening Segment	0	4	1	0
Overall	1	7	1	0

In the following sections, excerpts from the actual home visits will be presented in order to illustrate the difference between the "Simple ROE" and "Partial ROE" approaches, and to convey the range of ROE elements used by the PHNs whose approaches were designated as "Seeks ROE: Partial".

Seeks ROE: Simple

In order for an approach to be categorized as "Seeks ROE: Simple", it had to contain all the following ROE sub-elements:

1. Adequate identification (ID) of the PHN: name; role (i.e. PHN); and agency or health centre (ROE element a).
2. A statement of the general public health *goal* or *focus* (ROE element b2).
3. A statement of the general *mandate* or the *need* for particular services. (ROE element b3).
4. A statement of the PHN's intent for the *par*[illegible]*sit* (ROE element d1).

As stated above, only one PHN's overall approach contained all of these elements. Her use of them is illustrated in the following examples. The first excerpt follows the parents' negative response to the PHN's question as to whether they "knew much" about public health. She identified the agency that she worked for, and told them about the general focus and the mandate of public health. Each ROE element is identified by number *following* the phrase which contains that element:

> PHN #4: Our goal--I work for [agency] **(a)**--and our goal is to help people be as healthy as they can: to promote healthy lifestyles and to help people maintain their health **(b2)**. Years ago, public health got started when there wasn't any water treatment and no immunization; and the people cried out to the government to do something about this **(b3)**, so that's how public health first got started.

She continued by re-stating the need in relation to postnatal home visits, and conveying the intent of the visit:

> We try to visit all new moms, because we see it as a time when you...might be a little unsure at times what to do **(b3)**, so we come promoting your health and your baby's health **(b2)**. We give you a chance to ask any questions *you* have and I've got some valuable information I can give you as well **(d1)**.

Seeks ROE: Partial

A partial ROE approach contained the ID element, as in the "ROE: Simple" approach, as well as *at least one* of the other three elements of that approach. The elements included by each of the seven PHNs who were in this category are presented in Table 5.06. Six of the PHNs included only one element in addition to the ID element: either a statement of the overall public health focus, or a declaration of the intent for the particular visit. Only one PHN included both these elements. None of the PHNs included a statement of the general mandate or need for the particular service.

One PHN's "Partial ROE" approach consisted solely of one essential element: a statement of the intent of the visit. Her statement follows:

> PHN #4: When we do these baby visits, it's mainly to see how *you're* doing, as well as the baby **(d1)**. Particularly now with your first baby, you probably have a lot of questions to ask **(d1)**. How are you feeling? (short pause) Did you have an episiotomy?

In most of the Partial ROE approaches, however, the content of the PHNs' entry seeking was not limited to these one or two elements. Although their conversation about public health lacked one or more *essential* ROE elements, it usually included other elements found in the full framework. The number of different ROE elements used by each PHN is portrayed in Table 5.07. As Table 5.07 shows, the ROE element (other than element **a**) used most frequently was **d2**. This element was often used in concert with **d1**, but was sometimes used instead of **d1**. In fact, all but one PHN used either **d1** or **d2** elements in their explanations; that is, all but one made at least one reference to the purpose of the specific visit. The difference between these two elements was that **d1** made specific reference to what the PHN hoped to accomplish on the visit, whereas **d2** was simply a general reference to the focus of the visit. This difference is illustrated in the following excerpt:

> PHN #6: Did they [sic] explain to you that we're with the Board of Health? *(Yes)* And that we do try to visit all the moms and new babies in our areas? **(d2)** And what we're doing is--we come out because we want to check with you and see how things are going, and offer assistance if we can **(d1)**.

Table 5.06. Partial ROE Approaches: PHNs' Inclusion of Simple ROE Elements

	Elements				
Visit	a Adequate ID	b_2 Overall focus/goal	b_3 Need (mandate) for service	d_1 Goal of particular visit	Totals
#1	•	•			2
#2	•				2
#3	•	•			2
#5	•			•	2
#6	•			•	2
#8	•	•			2
#9	•	•		•	3
Totals	7	4	0	4	

[1] By PHN's report

Table 5.07. ROE Framework Elements Included in the PHNs' Approaches

Visit	Elements[1,2]														
	a	**b_1**	**b_2**	**b_3**	**b_4**	**c**	**d_1**	**d_2**	**d_3**	**e_1**	**e_2**	**e_3**	**f_1**	**f_2**	**f_3**
#1	•		•		•	•		•							
#2	•				•	•	•	•							
#3	•		•		•			•						•	
#4	•		•	•	•	•	•	•							
#5	•						•							•	
#6	•						•	•							
#7	•														
#8	•		•			•		•	•						
#10	•		•		•		•	•							

[1] Elements: a = ID
b = General public health focus, goal and services
c = Source of referral
d = Focus/goal of particular visit
e = Check for client's understanding of b, c and d
f = Obtaining some "objective" indication of client's readiness to welcome PHN as a source of support

[2] Elements in bold print are essential elements of the approach "Seeks ROE: Simple".

The following excerpt from a phone call provides another illustration of a **d1-d2** explanation. The excerpt also includes reference to the source of referral (element **c**), and a request to visit (element **f3**):

> PHN #2: We received a notice that you have a new baby **(c)**, and we try to contact all new families and see if you would like a home visit **(d2)**. During the visit we tell you about the public health services available to your family and answer any questions you might be having about your baby **(d1)**. Would you like a visit, and if so, what time is good for you? **(f3)**

As reported earlier, the above PHN was the only one who included an essential entry-seeking element on the phone call. Two other PHNs each included one **d2** statement on the phone call, but most of the PHNs made no reference to the visit focus. Five, however, did refer to the research project: knowing that the client had already consented to participate in the study may have altered their usual approach on the phone call.

The other "non-essential" ROE element used frequently was **b4**, which consisted of *examples* of activities through which public health goals were accomplished. In the following excerpt, the PHN provides two service examples to illustrate the public health focus:

> PHN #1
> We are focused on health promotion and disease prevention **(b2)**, and we spend a lot of time in the schools doing teaching...about various health-related things; and our priority there is immunization **(b4)**. We also home visit, besides yourself, seniors who require help or linkages to Meals-on-Wheels--that kind of thing **(b4)**....So that just gives you an idea of where our focus is.

The following PHN selected service examples that were directly relevant to new parents:

> PHN #9
> In public health, what we are all about is protecting health, preventing diseases, and health promotion **(b2)**. And one activity of health promotion is just talking to the new moms in the hospitals **(b4)**, as well as the postnatal visit-- which I'm doing now **(b4)**. And then we'll invite you to come to our clinic if you want to have Theodore weighed and measured **(b4)**. Just drop in.

One striking fact about the PHNs' use of the ROE elements is the total absence of element e and almost total absence of element f from their explanations. The PHNs did *not* check to see whether clients understood their explanations, as called for by element **e**. And although two PHNs did "assert their intention to be helpful" (element **f2**), none explicitly

acknowledged the client's potential for self-help (f1), and none directly asked if the client was willing "to work with the PHN around the focus of the contact"(f3).

As stated earlier, most of the explanations were found in the intervening segment of the visit. In only one case (Visit #6) did a PHN *initiate* an explanation in the introductory segment (and in this visit there was no intervening segment). In Visit #8, the PHN's seeking entry was not initiated by her, but was given in response to the client's request. (This PHN stated that this mother had told her on the phone call that she "knew all about postnatal visits". The PHN was therefore somewhat surprised when the client later stated that she really didn't know what the visit was all about).

Does Not Seek ROE

One PHN's approach fell into the category "Does not seek entry". Her intention for the visit was implied, rather than stated outright:

> **PHN #7:** (After asking the client's permission to visit and receiving an affirmative response) Do you have any questions that you would like to ask about? **(implied d1)**

Summary

The approaches used by nine PHNs in initiating a postnatal outreach home visit were analysed, using a pre-established coding guide, in order to determine whether the PHN's approach was implicit or explicit in regard to seeking right of entry. The majority of the PHNs made a partial attempt to seek entry, but only one met the minimal criteria of an explicit approach. None met the full criteria of the EBH ROE Framework. The amount of time spent by PHNs in talking about public health with their clients ranged from 0.75 to 4 minutes, or a median of 5% of total visit time. Other types of non-clinical conversation (excluding closing remarks) were identification/greetings, and socializing, which comprised a

median of 2% and 0.75% of total visit time respectively. The content of each of these types of conversation was described.

B. PRESENTATION OF FINDINGS FROM THE PHN INTERVIEWS

The nine PHNs in this study described how they usually initiated postnatal outreach visits. Three sets of findings are presented: first, PHNs' overall objectives on postnatal outreach visits and in the introductory phase; second, PHNs' categorizations and descriptions of their approaches; and finally, their ideas about the concept of right of entry and its significance.

The PHNs' Objectives on Postnatal Outreach Visits

Overall Objectives

The PHNs were asked what they personally hoped to accomplish on postnatal visits, whether they thought their clients were usually aware of their objectives, and how they thought clients became aware of them. The responses of the eight PHNs for whom data are available are summarized in Table 5.08. As shown in Table 5.08, the PHNs' objectives fell into three categories, which differed according to the predominant focus of the PHN. Four PHNs focused mainly on what the *experience of parenting* was like for new parents; three focused on *increasing parents' confidence*, and one focused on *assessment* of the parents' ability to manage on their own.

Of those who focused on the parents' experience, two wanted to "ease the transition into parenthood" by conveying that difficulties and frustrations are a normal part of being a new parent. They stated:

Table 5.08. PHNs' Objectives on Postnatal Home Visits, Their Estimates re Clients' Awareness of the Objectives and Their Opinions About How Clients Become Aware of the Objectives
(n = 8)

Focus of Objective	Objective	PHN	Client Aware ?	Source of Client's Awareness
	Conveying that frustrations and difficulties are normal	#2 #3	• "I hope so"	• PHN actions
Easing the transition to parenthood	Assisting with problems in coping	#8	No	
	Enabling parents to enjoy parenting	#1	Not sure	
	Adding to parents' knowledge	#5	Yes	PHN's actions
Fostering confidence	Providing reassurance re parenting skills	#9	Yes	PHN's explanations
	Emphazing the positive	#7	"I hope so"	PHN's actions
Assessment	Assessment of situation and need for follow-up	#6	Yes	PHN's explanations

• Data not available

PHN #2: I always hope when I leave that they're feeling just more comfortable with themselves and [with] some of the things they may be going through--more as a person than actual baby care....There are so many changes in your life....You know, just trying to tell them it's normal to feel like things are getting you down.

PHN #3: I would just like to make people's transition to being parents a little easier. And if I can do that--well, I try. That's my main goal, to make it easier for them; it's a difficult period in people's lives.

The theme of helping people manage better was echoed by another PHN:

PHN #8: For me, I think *my* need, when I go out there, is to make sure these moms are coping, and if they're not, then to help them. It could be on a scale of help from one to a hundred, it varies; but that's why *I* go out there.

The fourth PHN wanted to do whatever was needed to enable new mothers to enjoy parenthood:

PHN #1: What I like to accomplish *personally* is to walk out that door feeling mom is quite settled with that baby, and that I've answered her questions to the extent that she knows what to do if anything should happen....So my personal feeling is wanting to deal with whatever's going through her mind, to make it easier for her to enjoy parenting.

The three PHNs who focused on fostering parents' confidence differed in their beliefs about what increases confidence. One believed that confidence came mainly through knowledge:

What is [often] wanting is confidence, and the knowledge of baby care. And I think *mainly* that's why we go in. If they don't have the knowledge, they won't be confident.

The other two PHNs stated that confidence came from believing in one's ability to be a good parent. They said they took advantage of every opportunity to praise and encourage parents:

PHN #9: So I give them [positive] feedback, and let them know that I really feel good about that [e.g. a mother's talking to her baby], and that that is an effective way of parenting. So that's the reassurance--the support personal goal.

PHN #7: [I want] to encourage a mother that she's doing really well, to give her a pat on the back. That's my primary aim. Because I sometimes feel...that a lot of women go out there and face raising kids all on their own with everyone criticizing, and everyone giving ideas, and not enough people saying, "Hey, you're doing okay....Maybe you have to make a few changes here and there, but all in all, keep up the fine job!"

The eighth PHN differed from all the rest in that her emphasis was on assessment rather than intervention. She attributed the difference to the fact that many of her postnatal visits were to young single parents, whose parenting was much closer to barely managing than to enjoying the parenting experience:

> PHN #6: It's hard to tell how they feel about being a mother, and I don't know if *they're* really that sure either. So I don't know how easy it would be to say to a 16-year-old girl, "How do you feel about being a mother?" It's interesting, because when I talk to my own daughter, that's one of the things that's uppermost on my mind--reassuring her that she's doing a good job. Maybe it depends on the level of the person you're talking to.

Most of the PHNs mentioned other objectives that were of secondary importance to them. Some of these secondary objectives, such as adding to parents' knowledge about baby care and answering parents' questions, were means to their primary objectives. Three PHNs also wanted to convey an image of the PHN as a trustworthy health resource in the community (one called this "selling public health"), and one wanted to make the client "more health conscious".

PHNs' Estimates of Clients' Awareness of Their Objectives

Table 5.08 shows that three of the PHNs were confident that parents knew what their objectives were. Four were not so certain, and one stated she did not think her clients were aware that her goal was to help them "cope" better. Two of the three who thought their clients were aware of their objectives said they told parents what those objectives were; the other said that parents would realize through her actions of answering questions and providing information about baby care that her objective was to increase parents' knowledge. Other PHNs hoped their actions would indirectly convey their intention to encourage and support. One stated:

> PHN #3: I usually tell them that's what I hope that I can do for them--in one way or another. I don't come right out and say that...You know, I think I always tell people, "It's not easy, it's difficult being a new parent".

This PHN went on to say that while she thought her clients accurately interpreted her intentions, she wondered if clients sometimes erroneously associated the PHN's supportive function with "the personality of the nurse and not necessarily with the role of the public health nurse." She stated:

> PHN #3: I wonder if sometimes when we leave if...they don't believe that was actually a teaching or a support visit. They know that they have gotten that, but they may not have known that that was the purpose of the visit....I think in some instances they may sense it was because *you* made the visit, and nurse *x* over there wouldn't be able to do the same thing.

Since this PHN was one of the last to be interviewed, it was not possible to determine whether other PHNs held similar opinions.

The PHNs' Objectives in the Introductory Phase

Getting the Client Comfortable

In order to ascertain what PHNs' objectives were in the introductory phase of the visit, they were asked several questions. First, as they were describing their approaches, they were asked: "When you do *x*, what are you trying to achieve?" Later, they were asked specifically: "What are you trying to accomplish at the beginning of the visit?" and "What helps in achieving that?" The PHNs used a variety of terms to convey their objectives: "getting the client to relax"; "creating a positive interaction"; "establishing rapport"; "breaking the ice"; "connecting with the client"; and "hooking the client's feelings". In the second interview, card sorts were used to clarify the meaning of these terms.

The term chosen to describe the objective common to most of the PHNs was *getting the client comfortable*. This phrase was selected for two reasons: first, most of the PHNs translated the above phrases in terms of getting the client "comfortable" or "relaxed"; and second, none of the PHNs strongly objected to the term itself, whereas each of the terms

mentioned previously was rejected by at least one of the other PHNs. All but one PHN, for example, took exception to the term "hooking the client's feelings". Similarly, one PHN strongly disliked the negative connotation of "breaking the ice", and said she preferred to think of what she was doing as "connecting with the client". "Connecting", however, was rejected by two other PHNs. "It's not a human term", they stated.

In the following sections, the meaning of *getting the client comfortable* and its significance to the PHNs will be elucidated; following that, the means of *getting the client comfortable* will be outlined.

Meaning and Significance

PHN #7: You go into a totally strange situation..and you have to make it work. Well, it doesn't always.

This was one PHN's description of the challenge of initiating an outreach visit. Another elaborated:

PHN #3: What makes our visits different from a social visit [is that] we do deal with very personal things with people all the time--and very quickly. So that's why it's important to connect with them and make them comfortable.

Comfortable referred to a psychological, rather than a physical, state: being "relaxed", "not anxious", or "at ease". *Comfortable* was not a diffuse sense of ease; it implied acceptance of the PHN's being there as a public health nurse. This is made evident by two PHNs in their descriptions of the process of *getting the client comfortable*:

PHN #6: You are waiting for a sense of the client to feel relaxed, and you can see a build up of trust as you go along... and I'm watching for that and I'm wanting it to happen. If you're just getting monotone answers you know that that client is still not feeling very comfortable with who you are and why you're there.

PHN #1: I think it starts when they actually see you, and whether you have a smile on your face or not. Like--how open is this person you're going to let through the door? I have a feeling it starts right there. And then it probably solidifies once you sit down and start talking, and they get a feel for why you're actually there....It could be very short or it could be very long.

If clients felt comfortable, they would "open some doors for you--throw down some barriers"; they would share their thoughts and feelings about the new experience of parenting. If they never "opened up", never revealed their questions and concerns, it would be difficult for the PHN to assess how they were "doing" and to provide support. When that happened, said one PHN, "you feel like you haven't accomplished anything". *Getting the client comfortable* was essential, then, if the PHN was to achieve her personal goal on behalf of the client. One of the PHNs whose goal was to help new mothers with the transition to parenthood reported that if she was unable to put the client at ease, all she would be able to accomplish was retrieval of information for the infant's health record. (In the quotation that follows, the researcher's question is in italicized.)

> PHN #3: A certain percentage of people you can't draw out, and then your visit becomes question-answer. You're fulfilling your goal, but not getting at what their real needs are. *Is that the same goal you were talking about [earlier]?* No, it certainly wouldn't be my personal goal..... I suppose the filling of the *Initial Nurses Notes* is all you basically end up doing at that point. And I always feel a little sad because I haven't been the helper I'd like to be (laughs), but also because I think the client really loses out on what we have to offer.

One PHN stated explicitly that it was the PHN's responsiblity to make the client comfortable, and most of the others implied their agreement through the use of statements such as "I *put* the client at ease by...", "I want to *get* the mom relaxed", and "You have to *make* it work". Two PHNs did not agree with this point of view, attributing a good measure of responsibility to the client. One stated that all she could do was *facilitate*: "It's still up to [the client] as to whether she relaxes". In fact, none of the PHNs accepted total credit for their successes in *getting the client comfortable*. Seven stated that on many postnatal visits very little effort was needed on their part, as the client seemed comfortable with their being there right from the start of the visit. Similarly, the PHNs did not accept full responsibility for their relatively few failures. Five stated that there were some people who simply would not let an outsider into their personal lives, no matter what the PHN said or did. One of the PHNs counted herself among the number of people who generally preferred to keep their personal

lives to themselves. She stated that when her first baby had been born, she had been content with the fact that her postnatal home visit had been "more of a social visit."

One Negative Case?

One PHN did not entirely accept the idea that the initial part of the home visit was devoted to making the client comfortable. Though her objective may not be different enough from that of the other PHNs to represent a true "negative case", neither is it similar enough to be subsumed under the category *getting the client comfortable*. Her comments reveal that she thought that the whole idea of *getting the client comfortable* sounded too contrived. She stated that she did not set out to make clients comfortable, but simply to have a conversation with them:

> When we start talking, I would think of it more as *engaging in a conversation with you*, instead of *feeling comfortable with you*. It's not *feeling comfortable* and then having a conversation; I don't see it as that.

She objected even more strongly to the notion of "breaking the ice" (see below). "To me that's negative", she stated. "I don't see it like that. To me, it's all warm and comfortable to begin with. I don't see that I have to change something to make it positive". This PHN stated, however, that her objective was to "build a positive interaction", which does seem suggestive of inducing positive change. This PHN could not explain exactly what was different about her conception of initiating a home visit, and stated that her difference might simply be a matter of terminology. Analysis of her comments, however, suggests that although her difference from the other PHNs may have been one of degree only, it was more than a difference of terminology. Her dissenting position seemed to be two-pronged: 1) that the separation (even analytically) of *getting the client comfortable* from the visit as a whole was an artificial one; and 2) that the PHN's job in in conducting the visit was to *sustain* an already existing climate of ease, rather than to *create* one.

The Initial Moments: "Breaking the Ice"

Five of the PHNs stated that the initial minutes of the interaction involved a sub-process of *getting the client comfortable* called **breaking the ice**. The following comments are explanatory:

> **PHN #4**: I am fortunate in having a name that I think helps me meet people.... I think in some visits it has helped--to break the ice. You've got something to talk about when you first come in.

> **PHN #2**: I think *breaking the ice* occurs more in the initial phone call, so that when you get into their home they're waiting for you already.

One PHN described how the PHN's appearance could influence the process of *breaking the ice*:

> **PHN #1**: I consider *breaking the ice* is the initial face-to-face contact. Getting, sort of, the feel of what's happening there, whether you get vibes that--"Oh, look at her dressed up to a million dollars and here's a woman who barely has a T-shirt and jeans on!"

Two of the PHNs resisted the idea of a separate initiating phase within the larger process of *getting the client comfortable*; to them, **breaking the ice** was synonymous with *getting the client comfortable*. And, as stated earlier, one PHN had a strong aversion to the term itself. In fact, *breaking the ice* was a term preferred more by the clients than by the PHNs. The clients' views on the subject of *breaking the ice* are presented later in this chapter.

Getting the Client Comfortable: The Means

The PHNs used three main means to get the client comfortable: 1) *Focusing in on the client*, 2) *Socializing*, and 3) *Explaining about public health*. Put together in particular combinations, these means were the elements that formed the **approaches** used by the PHNs in initiating postnatal outreach visits. These approaches will be described in detail in a later section. This section will address, first, PHNs' opinions about certain prerequisites to *getting the client comfortable*, and second, their explication of the links between the means and

that end. Examples of their points of disagreement about the efficacy of certain means will also be presented.

Prerequisites

The PHNs spoke about two prerequisites to *getting the client comfortable*: being relaxed and confident, and being interested in the job. Six emphasized that in order for the PHN to put the client at ease, she had to feel comfortable herself, and confident in what she had to offer the client. One PHN explained:

> PHN #3: A lot of sensing goes on between people, and if you're uncomfortable with your position or the reason why you're there, or just uncomfortable about yourself, I think that is picked up [by clients]. It makes them a little more uncomfortable, too.

This PHN spoke from her personal as well as her professional experience: she herself had received a home visit from a "nervous" PHN, "and that made *me* nervous as well, even though it wasn't my first child." Another PHN corroborated her story by describing her own discomfort when observing home visits made by inexperienced PHNs:

> PHN #6: Going on these home visits with our new nurses, ..is hard for *me* because--Ohhhhhhhhh!--because they're nervous, and they don't know when to stop [talking]. I can see where it would turn the client off. I find it very difficult.

The other prerequisite to being able to put a client at ease was being interested in one's job. The following comment is representative of the sentiments of the PHNs: "I think [it's important] that you're interested in what you're doing and interested in people; in babies and new moms; in *helping* them with this brand new experience." Just as a PHN's feeling of discomfort would be "picked up" by clients, so would a lack of interest. Again, one of the PHNs who had been a postnatal client herself referred to her own home visit experience:

> PHN #1: [The PHN] was very nonchalant. Her eyes were more on her piece of paper--I never got the feeling she was interested in me.

The Means and Their Link with the End

1) Focusing in on the Client

All the PHNs were agreed that one of the most effective ways to help clients feel comfortable was conveying interest in and concern for them. This means will be referred to as *focusing in on the client*. One PHN described *focusing in* and spoke of its importance:

> PHN #8: [It's] being open to what they're saying...and letting them talk....And if you ignore what they're saying and go off on your own little tangent, of course they're not going to connect with you, and they will see that you're not that interested in them, I think.

Four of the PHNs believed that it was especially important that the main focus of attention be directed to the mother, as opposed to the baby. The comments of two of these PHNs follow:

> PHN #2: [I ask] how mom is....And I think that helps the mom to be comfortable, because I think most of them really appreciate somebody saying, "How are you doing?" It's not all focused on the baby....To me, that's one of the most important ways to get the mom comfortable.

> PHN #5: Mainly, I would ask the mom if she has questions about herself....They feel kind of let down if you don't, because all the attention is on the baby.

2) Socializing

Socializing was seen as especially suited to the early moments of the visit: six of the PHNs connected socializing with *breaking the ice*. Socializing could involve positive comments about any of the following : the baby, the house, the plants, the pets, the weather. Not all of the PHNs thought socializing contributed to a client's comfort. Particularly at issue were comments about clients' homes. One PHN stated that it "made things easier" if you were able to make a positive comment on something in the environment. Another thought that such comments could have the opposite effect: "I like to think we put as least pressure [sic] on parents as possible, and I don't want people to feel I'm looking around their house, because I want them to be comfortable".

One PHN thought that socializing could give clients an inappropriate sense of comfort:

> Sometimes I think social niceties get you off the track...and people tend to think the visit *is* social....*I've* found over the years that it...sometimes allows the parent to stay on a level which is more comfortable for them, but it isn't accomplishing the purpose of the visit.

3) Explaining about Public Health

As stated earlier, a client's feeling comfortable required that he or she understood who the PHN was and why she was visiting. Explaining about public health was a means by which the client could come to understand the *why* of the visit, and some of the PHNs saw this as an important means of making the client comfortable. All the PHNs agreed that it was essential to do so if the client appeared to be uncomfortable with the PHN's being there. Some, however, thought that a "routine" explanation had as much potential to make a client uncomfortable as it did to make them comfortable. One stated: "I tend to think of: 'This is who I am and this is what I'm here for' and you just go blah-blah-blah: they're not going to connect with you."

PHNs' Approaches in Initiating the Visits

The PHNs were asked how they usually initiated contact with a new parent. All reported that their preferred method was to phone the parent to arrange for a visit. Their descriptions of this process follow.

Initial Contact: The Phone Call

For most of the PHNs, the only legitimate reason for not phoning a parent prior to visiting was lack of a phone number. Only one PHN said that she felt comfortable

"dropping in" on a new parent. She did so if she happened to be in the client's neighbourhood for some extra time, but would always explain *why* she had come without phoning first. The assumption that parents would prefer to be phoned first was shared by the other PHNs: "dropping in" was seen as interfering with the client's privacy, and worse, it might convey the message that the PHN's intention was to "peek on" the client. One PHN said: "We always used to [drop in]...but I think society is changed....A lot of people are sensitive about having their privacy interrupted. It's a busy world, and people have other things on the go." For two PHNs, dropping in was a waste of time, for it resulted in too many "not found" visits.

According to the PHNs, the most important function of the phone call was that it allowed the client to be prepared for the visit and to participate in choosing a time for the visit. One PHN said that phoning ahead also allowed *her* to feel prepared for the visit: "Without a phone call, you don't know how you will be greeted at the door." Another, however, said she could not always predict the client's welcome at the home from the latter's response to the phone call. She had found that some clients who seemed to welcome the idea of the visit when she phoned were somewhat suspicious of her intent when she arrived at the home. Four other PHNs described ways in which the phone call helped to prepare them for the visit. Two stated that they could get to know the client a bit on the phone call, and this made it easier to get the visit going when they got to the client's home; two others said that phoning ahead allowed them to assess which clients needed an immediate visit, and who could wait a little longer.

Two Different Approaches

On the phone call, PHNs used two different approaches to gain entry to the client's home. Half the PHNs said they usually asked the potential client whether she would like to receive a home visit; the other half stated that they would like to visit, and asked what time would be

convenient for the parent. One PHN did not report her approach. The following examples illustrate the difference between these two approaches:

> *1st Approach.* PHN #8: I ask them...if they have heard we visit moms, and they generally say, "Yes, yes", and I say, "Well, would you like to have a visit?" And they generally say, "Yes, yes", and then we set up a time.

> *2nd Approach:* PHN #7: I say..."I understand you have a brand new baby at your house" (this is what I usually say), and then the client will say, "Yes, I do", or whatever; and then I would say, "Well, I'd like to come out to visit you when is the best time for you?"

The PHNs who chose the first approach explained that it was important for them to give clients the feeling that they were in control of the decision to visit. PHNs wanted parents to accept the visit because they *wanted* it, and not because they thought they had to agree to it. One PHN stated: "If I force myself on them, that screws up the interaction once I get there." The PHNs who chose the second approach said that it was important for them to get into the home and that they did not want to risk receiving a refusal. Two PHNs said they chose the second approach not only because there was an agency policy to visit all new parents, but also because the parents were sometimes not aware that they needed some help, and it was difficult for the PHN to assess unperceived needs on a phone call. Two had reservations that this approach was "a little high-handed" because it "puts [the client] on the spot", but they had confidence in their ability to present themselves as both useful and supportive once they met the client face-to-face, even if the latter had seemed less than enthusiastic on the phone call.

As regards getting into the home, both approaches worked well. The PHNs emphasized that it was most unusual for a parent to refuse a visit. PHNs with five or more years' experience could each cite only one or two refusals on a phone call to a first-time parent. None of the PHNs with less than five years' experience had ever been denied permission to visit a first-time mother.

Outside of the approach in gaining entry to the home, the content of the phone call varied somewhat from nurse to nurse. Five of the PHNs said they provided a brief explanation of why they wanted to visit; the most frequently given reason was "to offer information on the health services available to them through public health, and to answer any questions that they might be having with their baby." Two PHNs said they stated the purpose only if the client seemed "hesitant", and one gave an explanation only if asked, because "I assume that they know why I'm coming". If a parent said that a visit was not necessary, the PHN would then provide more specific information about what she had to offer, in order to persuade the parent to reconsider. For example, one PHN stated:

> Usually the health record, mentioning *that* will get me out there, and if I mention *that* it's, "Oh, yeah, we want a health record started, so you come." So usually that will make or break it right there.

Most PHNs then offered to answer any questions the parent had at that time, and concluded the phone call by making an appointment for the home visit.

PHNs' Descriptions and Categorizations of Their Approaches

PHNs were asked to describe the way in which they usually initiated a postnatal outreach home visit once they arrived at the client's home. They were also provided with brief descriptions of four different approaches and were asked to categorize their usual aproach according to the descriptions provided. Provision was made for the PHNs to reject all of the given approaches through the inclusion of a category named "Other". The PHNs' categorizations of their approaches are presented in Table 5.09.

The PHNs' descriptions of their approaches matched those provided in the given descriptions: no additional approaches were described. The three PHNs who selected the category "Other" all said that they did not have a "usual" approach, but that their choice of approach "depended upon the client". One of these PHNs stated: "I think I use all of these at

Table 5.09. PHNs' Categorizations of Their Approaches

Approach	Number of PHNs
1. Focusing right in on the client	1
2. Socializing and Focusing in	2
3. Explaining about-PH and Focusing in	1
4. Socializing; Explaining about PH, and Focusing in	2
5. Other: "It depends on the client"	3

different times....Where the mother is at is what I do. I don't go thinking, 'This is what I'm going to do'".

In fact, all the PHNs stated that they varied their approach according to the demands of the particular situation. The following explanation is representative of the opinions of all the PHNs:

> PHN #3: I think you assess [clients] when you meet them; it depends on what they sound like when you walk in the door, how they greet you and that. Then...you adjust what you're doing to the way you're greeted. You have to feel them out, I think.

"Feeling the client out" meant, for example, that if the client appeared obviously anxious at the outset of the visit they would address the client's concerns before doing anything else. Similarly, if the client had questions, answering the questions would be the PHN's first order of business. What can be said of the PHNs' categorization of their approaches is that, *all other things being equal*, these are the approaches they would use.

In the following sections, each of the approaches will be described from the point of view of the PHNs. The names of the approaches have been derived from the PHNs'

descriptions. In all cases, a PHN's use of the approach presupposes that the client has not stated at the outset of the visit that she or he has questions for the PHN. It was clear that none of the PHNs would ask the client to defer his or her questions until later in the visit. The PHNs' use of the approach also presupposes that the client has not displayed any obvious physical or emotional discomfort. The descriptions include the content of the conversation and the sequence of topics, and begin after the PHN and client have introduced themselves to each other at the door to the client's home.

Approach 1: Focusing Right in on the Client

Focusing Right in on the Client was the usual approach of one PHN, and was used most frequently by two others who said their approach "depended upon the client". The approach was characterized by the absence of introductory social remarks and a move into the clinical focus of the visit soon after the PHN and client had introduced themselves to each other. The PHNs described the approach as follows:

> PHN #5: I identify myself and they invite me in, and I usually stand around...until they offer me a seat. Then I talk about the mother: I ask her how she is feeling, how she's doing with the baby; if she's breast feeding, how is that going, and usually they have a lot of questions about breast feeding. Then I go to the baby.

> PHN #8: The mother would say, "Come on in.... Would you like a cup of coffee?" "No thank you." I would say, "How are things going with you and the baby?" You know, we would go from saying, "Fine" to "Oh, I'm really tired" or "The baby's been up all night"--that kind of stuff. So I would probably get right into it there, to how *they* are.

For these PHNs, *focusing in on the client* was important because it conveyed their interest in her or him; this, in turn, produced a comfortable atmosphere, or "positive interaction":

> PHN #8: Whatever I'm doing...it's always to create a positive interaction between the two of us.... And I tend to ask how *they* are, as opposed to giving too much attention to something else, I think. To the baby, or whatever.

Socializing was engaged in only if the client initiated it, and then not for long. One PHN said she was not comfortable just looking for things to remark on, and so did not make

comments about the weather, the pets or the home. The other PHN said socializing was simply not effective in helping the client to relax at the beginning of the visit. Explaining the purpose of the visit was also considered to be an ineffective means of making the client comfortable, and was not initiated by either of these PHNs unless the mother was unresponsive to the PHN's attempts to focus upon how she was feeling. Both PHNs stated that they assumed that most parents knew the purpose of the postnatal home visit, at least to the extent of understanding that the PHN was there to provide information and answer questions relating to care of mother and baby. They therefore judged that an explanation was not necessary in most cases.

Approach 2: Socializing and Focusing In

Two PHNs said that *socializing* was the approach they used most often to initiate a postnatal outreach visit. For one, use of the approach was in accord with her beliefs about which approach was best. The other sometimes used Approach 4 (*Socializing and Explaining about Public Health Nursing*) and believed that she should use it more often, but thought *socializing* was the approach she used most frequently.

One PHN stated that *socializing* consisted of making some "light" or "offhand comments", the content of which would be stimulated by the situation in which the PHN found herself. "You might stumble over the Persian cat and say something about it, or about the beautiful fireplace if it's really prominent". Socializing came easily and felt "comfortable" for this PHN, who described herself as a talkative person. She also saw starting with some social conversation as appropriate for visits between two women. "But if the [father] is home by himself...my behavior would be more formal...because a person doesn't perceive a man to be that chatty. Women more or less are."

Both PHNs believed that socializing was important in "building rapport"--in creating an environment in which both client and PHN felt comfortable. One stated:

I want [the client] to relax a little bit, and maybe I want myself to relax a little bit....

> I don't feel ready to start a visit until we've sat for a few minutes. We might talk about how the weather is here, and I will certainly admire the baby if the baby is around at the moment. I may talk about other children they've got and...if there's a pet you might notice the pet.

Social conversation that centred around other children or the baby was seen as particularly effective in making a mother comfortable, as the following examples illustrate:

> **PHN #6**: I think every mother likes to have someone admire their child....It sounds artificial, but I must admit that I really am drawn to babies... I think I'd probably talk to the baby. They're so cute--I love the babies.

> **PHN #7**: Very often I've said when I'm there for the third [baby], "I see you can teach *me* a thing or two!" I often approach it from that angle, and moms usually sit down and laugh a little bit and say, "Oh, well, it's not as hard as the first one".

As the above quotation implies, complimentary remarks about anything in the client's home had to be sincere. The potential for artificiality in such comments was recognized by all the PHNs; one who preferred not to socialize stated drily, "You don't have to butter them up!" All the PHNs who used social conversation emphasized that they made complimentary remarks only when they were genuinely felt.

When the PHNs judged that the client was reasonably comfortable, they would move into the clinical portion of the visit. They emphasized that the process of making the client comfortable was merely initiated through socializing, and was continued in the clinical phase by the PHN's focusing in on the client, as in Approach 1.

Approach 3: Explaining about Public Health and Focusing In

The PHN who described this approach said that she initiated the visit with a brief explanation about public health nursing and the purpose of the postnatal visit, and then proceeded directly into the clinical phase of the visit. She described her approach as follows:

> **PHN #9**: First of all, I would explain about public health, not in any length, but asking whether the mom has had any exposure to public health. Perhaps she had a visit from the liason nurse in the hospital, and if so, how was that for her and what information did she glean? Did she know about some of our other services? Here again, tying in our major goals of health promotion, health protection and disease prevention....Having said that, then I would ask the mom if she had any questions.

This PHN said that she had two objectives for the beginning of a visit: "building rapport" and "selling public health". Explaining about public health contributed to both objectives. Although giving the explanation "sounded a bit bookish", it was important, because "if someone was coming into *my* home, I'd want to know, Who is this person? What do they represent? Do I want to spend my next half hour with them?"

Building rapport was accomplished mainly in the *focusing in* stage, through appealing to the client's feelings. Like the PHNs who advocated Approach 1, this PHN rejected the use of social conversation as a means to building rapport, and instead looked for opportunities to give the client "positive feedback", especially about observed parenting skills and attitudes. "Then that becomes very positive and, hopefully rewarding for her, and meaningful". As in Approach 1, this PHN also appealed to the clients feelings by inviting them to voice their concerns.

Approach 4: Socializing, Explaining about Public Health, and Focusing In

Two PHNs presented Approach 4 as their typical way of beginning a postnatal outreach visit, and a third (who said her choice of approach depended upon the client) said she also used it frequently. The approach, described by one PHN as "a little chit-chat" and "some talk about public health", was essentially a combination of Approaches 2 and 3. One PHN gave a more detailed description of the approach:

> **PHN #4**: We sit down, and...if there's something that strikes me as peculiar in the house, or something I *like*, I might comment on that...and usually that's because I am interested.... And so we might spend some time chatting about that, and you know, the conversation very easily goes back to the baby and how things are for them. And *then*, before we really get into things, I ask them if they know much about public health services.

Commenting on the house, though used frequently by two of these PHNs, was rejected by the third: "That's not our purpose." Admiring the baby was accepted by all three PHNs as a natural and appropriate way of socializing on a postnatal home visit.

Like all the other PHNs, these PHNs' primary objective for the beginning of the visit was to make the client comfortable. For two PHNs who chose Approach 4, socializing was a means to that end. For the third, it was merely something to do while getting settled, but did not contribute to making the client comfortable with the visit. That was accomplished by the PHN's providing an explanation of why she was there:

> PHN #2: "...letting them know who I am and what my background and training are so that they would feel comfortable asking me their questions. And I guess letting them know there is more to us than just the baby visit, that they can come to the clinic not just for the baby but for the whole family.

The other two PHN's agreed that an explanation of why they were visiting helped the parent feel comfortable with getting into the visit proper. One wanted clients to understand how the postnatal visit was connected with the overall goal of public health nursing. She described what she told parents:

> PHN #4: I tell them that the [agency's] goal is to help everybody be as healthy as possible, and [that] we feel with a new baby at home they might have questions and concerns they never had before....So we feel we are promoting their health and their baby's health by visiting in the home. And [I say] I've got some really good information I could give her besides answering her questions.

All three PHNs also gave parents information about other public health nursing activities, because "if [clients] have a good feel or idea of what we do, then they're better able to use our services." As with the other PHNs, these PHNs stated that focusing in on the client's concerns was an important part of getting the client comfortable. Explaining about public health, therefore, was often deferred until after these concerns had been addressed.

Conditions Influencing the PHNs' Approaches

As stated earlier, the four approaches described above were the PHNs' preferred approaches only when certain conditions were absent, namely, that the client did not present with a definite approach of his or her own or display cues suggestive of concerns, at the outset of the visit. If either of these conditions prevailed, a PHN's approach would be

different. In the following sections; these two alternate conditions will be described, and the PHNs' descriptions of their approaches under these conditions will be presented.

1st Condition: Client Presents with a Definite Approach

PHNs described three approaches that clients might present with: a) clients might immediately introduce a clinical question or concern, b) they might ask a question about the purpose of the visit, or c) they might initiate socializing behaviors. PHNs' responses to each of these client approaches will be described.

a) Client introduces clinical questions or concerns

PHNs stated that clients sometimes greeted them with a remark such as, "Oh, you've come just at the right time--I've lots of questions for you!" All PHNs considered it very important to deal promptly with any questions or concerns the client had. As the following quotations indicate, PHNs regarded immediate attention to clients' concerns as both a mark of courtesy and an expedient course of action:

> **PHN #9**: I'm a guest in the mom's home, and I feel I owe it to her for her to share any concerns that she might have. And once she has done that...*I* will gain, because she'll be more ready to listen to what I have to share.

> **PHN #1**: I found when I started in public health, that if I just sort of walked in the door and got at *my* thing first, it was pretty obvious that I was just there to get my work done.... I found that as I changed my approach to dealing with mom's questions *first*, it made things more flowing, and mom felt I was there for her rather than getting the health record started, kind of thing.

> **PHN #2**: The first thing I usually try to do is to answer any questions they may have, 'cause if they're really concerned with, say, [the baby's] hiccuping, they're not going to hear anything you're going to say anyway.

Having dealt with the client's concerns, PHNs continued with the visit by one of two "routes". The four whose preferred approach included an explanation of public health

(Approaches 3 and 4), said they proceeded with that at this point. The explanation was given as a prelude to asking the client the questions the PHN needed answered in order to complete her assessment of the mother's and baby's health. The remaining five PHNs, whose preferred approaches (Approaches 1 and 2) both emphasized an early *focusing in on the client*, stated they would simply continue with the clinical conversation. "By this time, you may have got answers to most of the questions *you* wanted to ask, anyway", said one of these PHNs. These two alternate routes are diagrammed in Figure 5.02.

b) Client asks the purpose of the visit

PHNs stated that clients rarely asked them directly what the purpose of the visit was. The example of this happening on one of the study home visits was a unusual occurence, according to the PHN who made the visit. After giving the client an explanation of the purpose of the visit, all the PHNs said they proceeded into the clinical phase of the visit, as described in Approaches 1 and 2. This "route" to initiating the visit is also diagrammed in Figure 5.02.

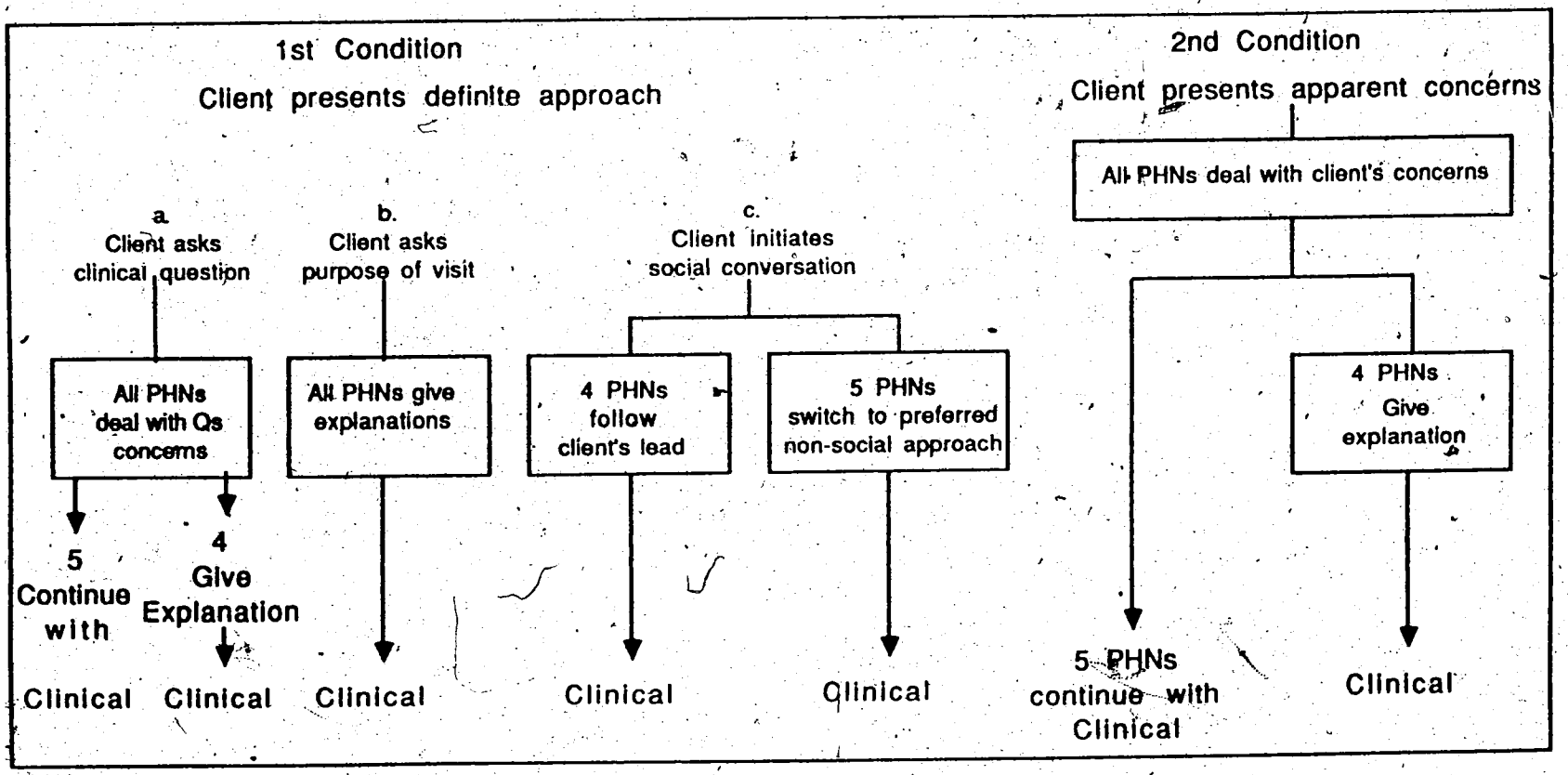
c) Client initiates socializing behaviors

PHNs stated that some clients seemed to want to spend some time socializing at the beginning of the visit. A client's social overtures might be limited to social conversation, or they might extend to offering the PHN coffee, or even to preparing coffee without asking her whether she would like some. PHNs reported responses to each of these social approaches will be presented.

Responses to Social Conversation

The four PHNs who themselves liked to socialize at the beginning of a visit said they would follow the client's lead. Those who preferred not to socialize said they would respond to the client's social overtures, but would switch the visit focus as soon as possible (see Figure 5.02). One stated:

Figure 5.02
Client Conditions Influencing PHN's Approach



> If [the client] went on to talk about the weather, of course you would not ignore it. I'd say something like, "Yes, it's really nice" or "Yes, it's really cold", and then I'd go on. I wouldn't talk about it for very long.

One PHN, who said she did not like to waste time socializing, said she dealt with social comments by "tying them in to the purpose of the visit". If the client was talking about the family dog, for example, "then I would tie that in, you know: 'How nice, the child will have a pet...'" In essence, if the socializing took the form of conversation, PHNs tended to respond by moving to their preferred approaches.

Responses to Being Offered Coffee

Not all PHNs who liked to socialize liked to accept coffee; in fact only two PHNs in the study said they almost always accepted coffee when it was offered. Six PHNs said they usually declined a client's offer of coffee, and one said her decision depended upon how she felt at the time. Of the non-acceptors, two stated they preferred not to drink anything for reasons of hygiene; three said that manipulating a cup of coffee interfered with their ability to give full attention to the visit; and three said that having coffee put too much emphasis on "the social". "It's going a bit beyond the professional", said one. If a client just left the room to make coffee, most PHNs felt there was little they could do but wait for the client to return. One, however, said that "if I have the feeling she is just doing it to be polite and doesn't really want coffee herself", she would stop her.

All the PHNs said that, if they perceived that a refusal would either offend the client or make her uncomfortable, they would accept the offer of coffee. The following comment is representative of their opinions:

> **PHN #7**: If I feel that the mother has really looked forward to the visit, and has put [coffee] on and wants to share it, then I think for me to refuse would be kind of like a slam in the face.... And some ethnic groups really *want* to treat you; I know that's the way I grew up myself. An outsider that has a profession is someone special.

Making the client comfortable was seen as the main function of accepting coffee by all the PHNs but one. "In a way, it is a bit of a primitive social thing for people to share food and

drink", said a PHN who usually accepted coffee. Both of the coffee acceptors also believed that serving coffee gave clients a desirable measure of control over an event that was taking place in their home.

2nd Condition: Client Presents with Apparent Concerns

PHNs stated that some clients who had concerns did not draw the PHN's attention to them at the beginning of a visit. As soon as they entered a client's home, therefore, each PHN would look for cues to see whether the client had concerns that needed to be addressed immediately. The following quotations are exemplary:

> **PHN #4**: They might come to the door with their baby in their arms, and as soon as you come in the door you can tell that's what they want to address, so I just let them talk and get a feel for where they're coming from, and what their concern is, and try not to interrupt until they're finished.

> **PHN #8**: Well, we're in the door and: "Hi, how are you?" And I would observe, maybe, that mom looks a bit tired, and maybe I'll comment about that, and that sometimes opens things up.

Having dealt with the parent's concerns, the PHN would proceed with the visit, by either of the two routes described under Condition 1a: This second condition is also determined in Figure 5.02.

Observing for The Client's Response

Whatever approach the PHNs initiated, all observed closely to see how the client was responding, by watching for both verbal and non-verbal cues:

> **PHN #1**: I check to see...if the mom's leaning forward (you know how you automatically lean forward when you're interested in a conversation) or if she's leaning back... if she smiles a lot or just kind of eyes me down.... Is her tone really harsh and abrupt, or does she seem quite content?

If the client's response to the PHN's initial approach was negative, the PHN would try

gauge what was making her or him uncomfortable, and would try a different approach. The PHN who preferred Approach 3 (*Explaining about public health and focusing in*), for example, said she might switch to Approach 2 (*Socializing*) if her attempts to focus in by "appealing to the client's feelings" were unsuccessful:

> **PHN #9**: If a person is giving you some cues that say "Hey, don't zero in on me very quickly, I need some time", then you back up and you might do a few social niceties.

Similarly, the PHN who said her most common approach was *Focusing in* described how she might change her approach to *Explaining about public health*:

> **PHN #5**: If I try all my little ways to make her feel comfortable and they fall flat--you know, even ask questions about herself and the baby, and I get no answers--then I'll go right in to: "Do you know why I am here?"

The Public Health Explanation

In their descriptions of their postnatal home visits, all the PHNs made reference to "talking about public health", to "giving the client information about public health", or to "explaining about public health". As already stated, for four of the PHNs, explaining about public health was an important part of their approach in initiating the visit. Other PHNs said their explanation about public health was part of their approach only on occasion, such as when the client asked about or appeared uncertain about the purpose of the visit. Some said that their explanation about public health was not given until the end of the visit. Analysis revealed that what constituted an "explanation" for one PHN, was not necessarily so for other PHNs: there were differences in both the **focus** of the explanation, and the **aspect** from which it was given. The focus could be on *why* the PHN was visiting, or on *what* public health resources were available to the client, or both. Further, the *why* and the *what* could each be explained from the aspect of the particular visit situation (i.e. postnatal) or from the aspect of public health nursing in general, or both. In the following sections, these two **focus** and two **aspect** components of the PHNs' explanations will be outlined, and the

PHNs' descriptions of the relationship of the components to their approaches in initiating the visits will be presented.

Focus on 'Why': Particular and General Aspects

PHNs who gave clients an explanation of *why* they were visiting could do so from one or both of two aspects: particular and general. As one PHN succinctly explained, the difference between these two aspects was the difference between "the real narrowing down of why you're actually at *that* visit, and [explaining] the very general public health focus." This difference is illustrated in the following PHN's description of her preference for keeping the focus on the particular:

> PHN #7: I don't go into a whole spiel about disease prevention, or that kind of line. I don't discuss that. I try to keep it only to the aspect in their home; if it's a baby, then I might just offer the things that we do for babies, rather than the whole gamut of what we do...I would say that I'm there to talk about how she's getting along with the baby: Does she have enough information? Is she comfortable dealing with the baby?

As illustrated in the following quotation, common reasons given to postnatal clients were "to offer assistance and answer questions", "to see how you and the baby are doing", and "to start a health record for the baby":

> PHN #6: I usually say the two reasons why I'm out there: first of all, we like to know how they are doing and we like to offer assistance, so that they know we are available to help them; and, secondly, we try to start a record on the baby that will stay in the clinic with the baby and will [later] go to school with the child and will stay with him right through school.

An explanation from the aspect of the general, on the other hand, was couched in terms of the broad goals and focus of public health. The following example is illustrative:

> PHN #2: [You would explain that] if they've got a healthy baby, you're trying to keep him healthy; you're working to keep the whole family healthy. And I think it's important for them to know that we don't deal only with babies (which is what I think we're best known for); we're there to support parents as well, and by supporting the parents that's helping everybody, the whole general community.

One PHN stated that she sometimes included some historical background in her explanation of the public health mandate:

> PHN #4: I may or may not talk about how I think public health got started years ago, with the public outcry to the government to do something about diseases and sanitation and that....I talk about how we as a service go out to *them*...so it's a type of service with the focus of health promotion, health maintenance, and disease prevention.

Focus on 'What': Particular and General Aspects

PHNs also included in their explanations information about *what* public health services were available to clients; as in their *why* explanations, they could emphasize the particular, the general, or both. PHNs who talked about public health services from a particular aspect referred to resources of immediate interest to the postnatal client, such as infant physical health assessment and immunization, and parenting groups. Those who included the general aspect gave clients information about resources not necessarily needed by the particular family at that particular time, but which might be relevant in the future, such as services available to seniors, or preschool dental services.

The two focus and two aspect components of the PHNs' explanations are summarized in Table 5.10.

The PHNs' Use of the Components

Theoretically, PHNs could choose to include any of the components of the "public health explanation" or none at all. Their usual choices are presented in Table 5.11, which makes apparent the following findings:

1. The provision of information about postnatal services (particular services component) was the only component that all the PHNs routinely included in a postnatal home visit.
2. Almost half of the PHNs included all four components.

Table 5.10. Components of the PHNs' Explanations about Public Health

Focus Components	Aspect Components: Particular	Aspect Components: General
Why: Reasons	• to start health record • to answer questions • to give info re PH services • to be a resource for future concerns of parents • to assess how parents are "doing"	• focus on health of whole community • generalist role • focus on health promotion and disease prevention • reach out to all • mandate from public
What: Services	• services pertinent to the immediate needs of the particular client, e.g., parenting groups; immunization	• PH services not necessarily needed by family at that time, e.g., services for seniors; dental services

Table 5.11. PHNs' Use of Components of the PH Explanation

Focus Components	Aspect Components: Particular	Aspect Components: General
Reasons	Usually: PHNs #1, #2, #4, #9 Only if client seems hesitant: PHNs #3, #5, #6, #7, #8 Or if client is new to Alberta: PHNs #7, #8	Usually: PHNs #1, #2, #4, #9 Only if client seems interested: PHN #7 Never: PHNs #3, #5, #6, #8
Services	Usually: All PHNs	Usually: PHNs #1, #2, #4, #9 Only if client seems interested: PHN #7 Never: PHNs #3, #6 (No data: PHNs #5, #8)

3. Over half the PHNs gave the client a particular statement or explanation of purpose (**particular reasons** component) only if the client appeared "hesitant" about the home visit.
4. With one exception, all the PHNs who included the **particular reasons** component *only if the client seemed hesitant,* never included the **general aspect** components.

From these findings, three patterns of public health explanation emerge:

1. An explanation that included reasons for public health nursing activities in general and postnatal home visiting in particular, as well as public health services generally available and needed by the particular family (**all four components**).
2. An explanation including reasons for postnatal visits as well as services available to new parents and other services immediately needed by the client (**particular reasons and services** components).
3. An explanation limited to services available to new parents and other services immediately needed by the client (**particular services** component only).

PHNs were divided by their preferences for a specific pattern into two groups: those who preferred Pattern 1, and those who chose either Pattern 2 or Pattern 3 depending on the client's apparent need at the time of the visit. This division reflected different beliefs about 1) parents' routine need or desire for an explanation of the reason for postnatal visits in particular, and 2) parents' interest in and probable receptivity to an explanation that included the general aspect components. These differing sets of beliefs will be presented in the following section.

Beliefs about Clients' Need for an Explanation of the Reasons for Postnatal Home Visits

PHNs who believed that it was important to tell parents why they were visiting based their conviction upon the following beliefs: that clients did not know much about the *why* of the visit, that they wanted to know, and that they needed to know. Two stated that they themselves would not want someone to visit without explaining why, implying that others

would feel the same way. Two stated that their experience in making postnatal visits had shown them that parents' knowledge of why PHNs visited was superficial. Two stated that clients seemed to "relax" when told the *why* of the visit, and saw doing so as part of *getting the client comfortable*. One said an explanation was the basis for informed consent; another, even though she said she herself did not routinely explain why she was visiting, believed that it was more professional to do so. She stated:

> **PHN #6**: It sort of gives [clients] a basis for understanding who you are and why you might want information [from them]. A lot of my clients are *so* accepting of whatever I do that there is a tendency to even forget to explain yourself.

Except for the PHN just referred to and one other, the PHNs who chose Pattern 2 or Pattern 3 believed that clients already knew why postnatal visits were made and that an explanation would therefore be redundant. One PHN stated that though this belief might be considered "presumptuous", she trusted its validity beccause she had found that few clients were hesitant about postnatal visits. Three others pointed out that many clients greeted them with questions, and "I haven't found that their questions are irrelevant, so I assume they know the purpose of our visits", said one. Two stated that new mothers' knowledge about postnatal home visits and their purpose had become more widespread in recent years as a result of the visits of hospital liason PHNs to almost all new mothers within the first few days after a baby's birth. One said she believed that clients learned more from the PHN's actions than from what they were told in advance of those actions.

In summary, PHNs who believed that postnatal clients knew why they were visiting based this belief upon their professional experience. They emphasized that this assumption applied to postnatal home visits only, and stated that when the reason for public health nursing visits was not well known, as, for example, in bereavement visiting, they always told prospective clients why they wished to visit.

Beliefs about Including General Aspects

The strongest division of opinion among the PHNs was on the issue of whether general information about public health reasons and services should be included. Those who did include it did so because they believed that clients' knowledge of public health nursing was superficial: "most know a little, but few know a lot". They stated that, in their experience, most clients were receptive to such information, and that many were surprised at the scope of the job: two stated that clients often responded with "widening eyes" or "raised eyebrows". One of these PHNs referred to this general explanation of public health as "the public health 'promo'"; the other called it "selling public health". Although the other two PHNs disliked these terms, all four of these PHNs believed that if clients had a broader grasp of public health nursing and its services, they would be more likely to use those services. One elaborated on the importance of a general explanation:

> PHN #1: It's important to the extent where if they have a good feel or idea of what we do then they're better able to use our services. So [I tell them] that the postnatal home visit isn't our whole world.... I tell them a bit about schools and what's involved there, because they may have a second child and they'll think, "Oh, well, she could be the person I call if such and such happened". And I tell about the seniors' program and then maybe they'll think, "Oh, yeah, I have a mom who could probably use this service."

In contrast, PHNs who never included such general information, believed that not only was it not needed by parents, but also that it might "turn them off". They were definite in their beliefs, as the following statements indicate:

> PHN #6: I don't think people hear that sort of thing. All they are *really* interested in, in public health, is how it relates to their baby and them; to say more than that you might as well save your breath. They don't want to hear about the health inspectors.

> PHN #7: I'm sure at that point [the mother] doesn't care a whole lot if we visit people with shigella. She might want to know a little bit about immunization, but she wouldn't think in the broad terms of preventing disease, or communicable disease control.

One of these PHNs took special exception to the idea of "selling public health", saying that this was definitely the PHN's, and not the client's, "agenda":

PHN #8: [It] is stuff we feel we have to get across whether they want to hear it or not. It is our philosophy, so we always talk about it. But where I'm at is to do anything that would have *their* needs met, and to me, this is more meeting my needs than their needs.

Another PHN was simply not convinced that the "product" merited a major advertising effort:

PHN #7: I don't make a big push about all the great things that we do, because I, personally, don't believe we do make such a terrific, huge, big difference. If I really believed that public health makes such a big difference, I would certainly yell it from the roof tops. I think the difference we make is subtle...Maybe that's our problem with public health, we don't sell ourselves enough.

None of four the PHNs who were opposed to giving clients a general explanation reported having tried it. One PHN, however, said she *sometimes* gave clients a general explanation. She stated that although she had once believed it was important to do so for all clients, experience had shown her that many simply weren't interested. She explained:

PHN #3: I have tried to go in and say, "Do you understand what public health is and what our philosophy is?" and tried to put it in terms I thought were quite understandable. 'Cause it turns me on, and I figure if something turns you on, you should be able to get it across to somebody else. And I'd get blank stares...

She stated that, although she still advised new PHNs to give clients a general explanation, she herself now gave a general explanation only when she "sensed" that the client would be interested, for she believed firmly in the importance of adapting her approach to the client.

Relationship of the PHNs' Explanation Patterns to Their Approaches in Initiating the Visits

As stated at the outset of this section, when PHNs included components of the public health explanation in their postnatal visits, these were sometimes part of the initial approach, but often were not provided until the middle or even the end of a visit. The placement of the explanation (inside or outside the initial approach) depended upon what the PHN hoped to achieve through the explanation.

As described earlier, the four approaches were:

1. Focusing in on the client
2. Socializing and focusing in
3. Explaining about public health and focusing in
4. Socializing, explaining about public health and focusing in;

and the three patterns of public health explanation were:

1. An explanation that included reasons for public health nursing activities in general and postnatal home visiting in particular, as well as public health services generally available and needed by the particular family.
2. An explanation including reasons for postnatal visits as well as services available to new parents and other services immediately needed by the client.
3. An explanation limited to services available to new parents and other services immediately needed by the client.

The four PHNs who preferred Approaches 3 and 4 usually used the Pattern 1 explanation. These PHNs, however, said they sometimes did not provide the Pattern 1 explanation as part of their initial approach, but deferred it until the middle of the visit. As explained earlier, this would be the case when a client had concerns at the outset of the visit. PHNs would first address the client's concerns; having done so, they would insert the Pattern 1 explanation (excepting the particular services component) before proceeding with the health assessment phase of the visit.

PHNs who preferred Approaches 1 and 2 used either a Pattern 2 or Pattern 3 explanation. Pattern 2, in essence, represented a deviation from the usual approaches of the four PHNs who preferred Approaches 1 and 2. These PHNs gave clients an explanation about the purpose of a postnatal visit only when the client seemed hesitant about the visit. Pattern 3 was never part of a PHN's initial approach, but was always left to the end of the visit.

Even when Patterns 1 and 2 were used, the particular services component was usually reserved for the end of the visit. It might be included as part of the initial approach when Patterns 1 or 2 were used, however, as when a PHN referred to particular public health services as a means of stimulating a prospective client's interest in the visit. For example, PHNs who told clients that one of the reasons for the home visit was to tell clients about services available to them said they might describe some of these services at that point.

Other Factors Influencing the PHNs' Approaches

The conditions discussed in the previous sections emerged from analysis of the PHNS' descriptions of their approaches; together with a PHN's own beliefs and preferences, they constituted the major factors influencing her choice of approach. In this section, factors of lesser influence, pertaining to both clients and PHNs, will be reported.

Other Client Factors

All of the PHNs were asked whether there were any other client factors that influenced their choice of approach. No PHN referred spontaneously to fixed attributes, such as age, sex and ethnic origin, with one exception. That exception was the influence of culture on their acceptance of coffee. All PHNs were asked, however, what influence, if any, the above factors had. Their responses follow.

Age

Six of the PHNs stated that age had little of no bearing on their approach. Two, however, said that visits with very young mothers were "more difficult", and three said that their approach varied slightly with mothers under 18 years of age. One said that, in her experience, young, and especially young single, mothers were often less comfortable with

postnatal visits than older mothers were, and needed more reassurance that the PHN's intention was supportive. A second PHN said that in her approach on the phone call, she would give a young single mother less option to refuse the visit. "I might say, 'Is there a time I can visit you?', rather than making it so much of a question of whether or not they want me to come."

Sex

PHNs reported that few postnatal visits were made with a father alone, and that most were made with mothers only. Most said that the sex of the client made no difference in their approach. Two said that they had to do "more explaining" with men, since fathers were usually not as well-informed as mothers about the existence and purpose of postnatal visits. As reported earlier, one PHN who liked to socialize with new mothers altered her approach when the visit was with a father only, because she believed that men were not as interested in socializing as women. "[With a man], I just stick to business more or less--strictly baby things and why you're there."

Ethnic Origin

Two PHNs stated that many of their clients from other countries were more accepting of postnatal visits than were clients in general. One exclaimed: "It kind of gives you goose pimples, because I [sic] may drop in without phoning and they accept you so readily; and I think, 'What if I wasn't a nurse?!'". The other PHN said that the result of a client's ready acceptance was "a tendency to forget to explain yourself". In contrast, when a client was from out of the province, but not necessarily of another culture, there was a *greater* tendency to explain one's purpose, according to two other PHNs.

Another PHN Factor

Three PHNs reported that mood was another condition that affected their approach. Mood affected not only the initial approach; it pervaded the whole visit. Enthusiasm and

energy were the main casualities of of a "bad" mood, as the following quotations reveal:

> Like everyone else, I have bad days. For example...one day last week I was tired and didn't feel like smiling, and I don't know how often I told [clients] that day how well they were doing.

> If you're feeling really on top of the world, then you might have more energy to share... [but] if you start off with an empty bowl, or almost empty, it's pretty hard.

PHNs' Conceptions of and Opinions about Right of Entry

One of the objectives of this research was to ascertain whether PHNs thought about initiating outreach home visits in terms of "seeking and attaining entry into a client's personal world" (EBH, 1984). They were therefore asked whether they were familiar with the term *right of entry* (or *gaining entry*), and, if so, what they conceived its meaning to be. If they did not make a distinction between entry to a client's home and entry to a client's "personal world", they were informed about these two senses of the term *right of entry*, and were asked how *they* talked about entry to a client's "personal world". Since data from one of the PHNs were lost due to an error in audiotaping, the following findings represent the views of the eight remaining PHNs.

The term *right of entry* was not part of the everyday lexicon of most of the PHNs. Although all but one were familiar with the term, only one used it spontaneously. For four, the term evoked a *déja entendu* response, e.g. "Well, I've heard the term, but I don't know much about it", or "You might have to explain it to me, but I've certainly heard the term." Of the seven PHNs who were familiar with the term, five associated it solely with seeking permission to enter a client's home (two thought it had a legal connotation), and one was uncertain about its meaning. Only one PHN was familiar with the extended meaning of "entering into a client's personal world". Stating that she herself used the term only to refer to entry to a client's home, she gave the following definition of its extended meaning:

> I think it is a term to describe the fact that you are entering the client's personal

> domain--their *lives*--and that you really have to have their permission to disturb their world.

Though the *right of entry* terminology was foreign to most of the PHNs, the concept of two senses of *entry* was not. All could point to differences required to gain entry to a client's home as opposed to his or her "personal world". They stated that entry to the home required, minimally, that the PHN establish her identity as a public health nurse. One PHN stated:

> **PHN #7**: [To gain entry to the home], I say that I am a public health nurse from the *x* Clinic. So I hope it's understood by them that I'm not the Avon lady; I'm a nurse representing an agency.

Entry to a "personal world" was not so straightforward. One PHN stated"

> **PHN #3**: I figure that once you get people talking, then you know you're okay, but you're not always able to do that. You may physically be able to get into a home, and have their permission to get *in* there, but you may never break the ice--you may never get into their minds.

As the above quotation indicates, entry to a client's personal world" was equivalent to *breaking the ice* or *getting into a person's mind*. Another term used by some of the the PHNs to describe this sense of gaining entry was *connecting with the client*. If entry in this sense was attained, the client would "open some doors--throw down some barriers". *Seeking* entry involved making the client comfortable enough to open the doors to her or his personal thoughts and feelings. As reported earlier, this was precisely the objective of the PHNs in the initial phase of their visits with new parents, and the means that they used in *getting the client comfortable* were their preferred approaches. The question of whether the PHNs' conception of *right of entry* and the approaches they used to seek and attain it differed from the end and means laid out in the EBH ROE framework, will be addressed in the following chapter.

Summary

The nine PHNs in this study were asked to describe how they usually initiated a postnatal outreach home visit, what they hoped to accomplish in the initial phase of the visit, and what they saw as the significance of "right of entry". Their objective in the initial part of the visit was to get the client comfortable with the visit, which they equated with the EBH ROE objective of "seeking and attaining entry to a client's personal world". They described three approach components designed to achieve this end: *Focusing in on the client; Socializing*; and *Explaining about public health*. Most PHNs had preferred approaches consisting of these components in various combinations, but their first consideration in initiating a visit was to adapt their approach to the needs of the particular client as manifested at the time of the home visit. PHNs had three sets of personal goals for the visit as a whole, which they tended to convey to their clients implicitly rather than explicitly.

C. FINDINGS FROM THE CLIENT INTERVIEWS

The eleven clients described their responses to a postnatal outreach home visit, and to the approach used by the PHN in initiating the visit. Their responses cover the following topics: their anticipatory thoughts and feelings; their descriptions of the PHNs' approaches; their opinions about other approaches; their beliefs about the purpose of the visit; and their evaluations of the visit as a whole.

Anticipating the Visit

The clients were interviewed after the visit had occurred. They were asked to recall how they had felt about having a PHN come to visit, what they had expected would happen on the visit, and what they had hoped would happen. Their responses fell into the following categories: anticipated value of the visit; anticipated feelings about the visit; and expectations

about what would take place on the visit. These categories are explicated in the following sections.

Anticipated Value of the Visit

Visit as Valuable

Most clients reported that they had welcomed the visit in advance, and had thought it would be helpful to them in various ways. The most commonly anticipated benefit was the acquisition of new information. Seven parents had expected and hoped that some information would come in response to their questions; three had expected and hoped that other needed information would be provided gratuitously by the PHN. Two clients made explicit reference to the PHN as a legitimate authority on matters to do with caring for a new baby. As one stated:

> CLT #7: Sometimes...you don't know what you're doing, if you're doing it right, and everybody's telling you, "No, you're supposed to be doing it like this", and then your mom tells you, "No, you gotta do it like this"....I thought she should *know* 'cause this is her job and she should know.

The opportunity to acquire new information was especially valued by two parents (one a father, the other a mother) who felt they "didn't know anything", but was also seen as valuable by a parent who considered herself well-informed, for "there's always more to learn".

The other frequently-anticipated benefit was support in the face of a new and sometimes frightening experience. Four mothers reported that they had felt reassured by the thought that a PHN would be coming to visit them. "I think it's caring", stated one, "because I think it's very scary to be a new mother". In addition to wanting information and support, one mother had also welcomed the visit on social grounds, "I was kind of looking forward to her coming-it was company, you know."

Value Questioned

One couple thought that the idea of PHN outreach visits was a good one, but had questioned the value of the visit for themselves. The father stated:

> CLT #4b: I remember when she first phoned--we were both in a quandry. [*Name*] is a nurse and I am a doctor, so we sort of thought, "I wonder what she will tell us that we don't already know." I was kind of unsure whether it was of any value for her to come or not. 'Cause we'd been doing all sorts of reading on our own, you know, about how kids were-raised and what to do with them and stuff.

Anticipatory Feelings

Positive or Neutral Feelings

Four of the clients stated that they had been glad that the PHN was coming; they associated their positive reaction with their expectation that the visit would be of value to them. Four other parents, including the couple who were unsure of their need for the visit, revealed that their feelings toward the visit had been essentially neutral. When asked if they had considered refusing the visit, the father replied, "You know, the thought of saying she shouldn't come never even entered my head!" Another parent also described an attitude of neutral expectation: "I was just waiting to see what the visit would bring."

Mixed Feelings

Two mothers reported that although they had been glad the PHN was coming, and had wanted to ask her plenty of questions, they had had some feelings of apprehension about the visit. These were the two mothers who had felt the greatest need for emotional support from the PHN, and they had been worried that they might not get it. One recalled:

> CLT #8: I had a bad thought, like I thought, "Maybe she's really--well--bitchy".... I thought, "She's going to interfere", because another friend of mine told me *her* health nurse interfered with everything. She didn't like the bed and she didn't like the feeding and the house and the clothes, so I thought, "Oh, boy, if I would have a health nurse like that..."

The second mother had similar apprehensions, and had asked her sister to be present at the

visit, just for support. She stated:

> CLT #7: At first when she phoned, I kept saying..."Oh, no! She's probably going to check to make sure my house is clean and stuff!" I was a little nervous, 'cause I didn't know what they were *really* coming for... I guess they visit *every* newborn, don't they?

The above quotations illustrate two types of unsupportive behaviors that parents thought PHNs might display: "checking you out" and "lecturing". *Checking you out* implied an examination of one's fitness as a parent. One mother worried that PHNs might hold this as an ulterior motive, even though they had stated in the agency prenatal classes that their purpose in visiting new parents was to offer support.

Lecturing referred to having errors pointed out in a critical manner. Both of the above parents emphasized that if they were doing something wrong, they would want the PHN to tell them, but they would like the telling to be done "in a nice way". As one stated: "There are some people [who say]: 'Well you better be doing it this was and that way', and if I wasn't, I'd probably feel like a loser, failing as a mom, or some darned thing!"

One mother whose anticipatory reaction was neutral had also considered the possibility that the PHN might "lecture". She stated that this did not bother her, however, for she intended to take whatever the PHN had to say as "opinion only", unless it made sense to her.

Expectations About The Visit

Parents' expectations about the visit fell into two categories: expectations of the PHN and expectations of themselves. The first category was by far the larger; only one mother reported that she had expectations about what the PHN expected of [her]: "I thought I should have questions...I didn't have any questions, so I thought, well, does she need to come?"

Parents had three sets of expectations about the PHN: what she would talk about, what she would do, and how she would "be".

Expectations about Talk

The most frequently reported expectations were expectations about the content of the conversation between the parent and the PHN. The PHN was seen primarily as the purveyor of information: parents thought she would be able to answer their questions and provide gratuitous information about parenting and baby care, as well as information about public health services and other resources useful to them as new parents. Even five parents who initially stated that they had "no idea" or were "not sure" what to expect from the visit later indicated that they expected the PHN would not only deal with their questions but would also provide information that they were not aware they lacked. Two clients expected that the PHN would also be an information gatherer: that she would assess how the mother was coping and determine whether the baby was being properly cared for.

Expectations about Action: Physical Assessment

Eight of the 11 parents expected that there would be an action component to the PHN's visit. The most frequently expected (and desired) form of action was physical assessment of the baby. Two parents also expected the PHN to check the environment, including the crib, the electrical outlets, and the plants. One couple thought that the PHN would check the mother's episiotomy, since she was still experiencing considerable perineal discomfort. Two parents expected that the baby would be weighed, but the others said they did not expect this, even though they would have liked it to be part of the visit routine.

Expectations about the PHN's Attitude

Only three parents expressed expectations about the PHN's attitude. As described in the section entitled *Mixed Feelings*, these expectations were expressed as possibilities, negative attitudes that parents thought the PHN might convey. Undesirable, but possible, attitudes would be manifested if the PHN's manner was imposing, perfunctory, officious, or unfriendly.

Comparison: Expectations and Desires

In most cases, parents' stated expectations about what the PHN would talk about and do corresponded with what they they hoped she would say and do. As reported in the previous sections, there were only a few instances where what parents expected was not also what they desired. A comparison between what parents expected and what they saw as valuable is presented in Table 5.12

Clients' Descriptions and Evaluations of the PHNs' Approaches

All clients were able to provide a general description of how the PHN got the visit going. Four stated they had difficulty remembering specific content and its sequence, but nonetheless gave fairly detailed descriptions. Some descriptions were couched primarily in evaluative terms: even when parents could not remember exactly what the PHN had said and done, they could recall how they had felt about her approach.

In all cases but one the most detailed descriptions were provided by the parents who had the strongest praise for the PHN's approach. The criterion of a "good" approach was that it had made the parent feel "comfortable", or that the beginning of the visit had been "easy". Two mothers who reported an easy beginning described approaches that were accompanied by humour:

> CLT #8: It was easy,...Something funny happened; we laughed, and it started really easy. We started, actually with a bit of a joke; [then] I think she just asked if there's something special I would like to talk about. She actually let *me* make the beginning.

> CLT #7: I really got a kick out of her, you know. She just bubbled in and, "I'm here! Better late than never!" She was real easy to get along with.

For two couples, "comfortable" meant knowing the reason for the visit. One of the fathers described how the PHN's approach had put him at ease:

> CLT #4b: I don't recall exactly how she started. I just recall thinking that I wanted to know *why* she is here, and somehow, in the first few minutes, she'd sort of told me that. And I felt more comfortable after the first few minutes, 'cause up

Table 5.12. Parents' Expectations and Desires

	Expected	Desired		
		Yes	No	Neutral
Expectations about Talk				
Questions answered	8	8	–	–
Gratuitous information re:				
Baby care/parenting	4	2	–	2
Health Centre services	4	4	–	–
Outside resources	3	3	–	–
"Lecturing"	3**	–	3	–
Assessment re:				
How mother coping	3	3	–	–
Baby properly cared for	4	2	2*	–
Expectations about Action				
Physical Assessment:				
Baby	4	6	–	–
– baby's weight	2	2	–	–
Mother	2	2	–	–
Home environment	3	2	1*	–

** Seen as a strong possibilty
* Interpreted by parents as "checking you out"

until that time I wasn't really sure what she was going to *do*.

The second couple stated they would have felt more comfortable if the PHN had explained why she was visiting. Addressing the researcher, the husband stated:

> CLT #5b: Basically, Julie [the PHN] did not tell us why she was here. (*Wife:* "*Yeah*") She just went around and did whatever she had to do....Like, we know exactly why *you're* here...but we still don't know *exactly* why Julie was here....So, it would put our minds at ease to find out why she was here.

In spite of this, however, he was pleased with how the PHN had opened the visit, saying that "couldn't have asked for a better start". He described the PHN's approach as "personal and casual":

> It was a personal thing, like, "How are you?" I talked: "Are you a mother yourself?" "Yes, I have my own baby--he's 33 years old!" Sort of to create a mood where the atmosphere would be personal and...[not] like, "I've come here to visit you and check you out." It was very casual, in other words.

A "casual" approach was also appreciated by two mothers. One stated:

> CLT #3: I prefer the more casual, the more down-home sort of approach, so...what she did was perfect for me. She just kind of blended in like a neighbour showing up to welcome you to the neighbourhood.

In all, 10 clients reported that the opening of the visit was comfortable or easy. The one client who had felt "a bit uncomfortable" did not attribute her discomfort to the lack of explanation, but to the fact that she had been feeling unwell on the day of the visit. Her husband also remarked that she was "very shy", implying that she was usually somewhat uncomfortable when meeting new people. Six parents spoke of the ease with which the visit began in terms of personal characteristics of the PHNs, who were described as being "personable", "non-threatening", "down-to-earth", "open" and "flexible". Even in one instance where the PHN had held a microphone and the client had found this rather obtrusive, the latter reported that the PHN herself was "very easy-going and relaxed. I was glad".

Overall, the parents' evaluations of the PHNs' approaches varied in degree from enthusiastic approval, as exemplified in the most of above quotations, to matter-of-fact

acceptance. The three parents in the latter category spoke of the PHN's approach as follows:

> CLT #1: How the lady did it was just fine...just sort of average, you know.
>
> CLT #6: The visit was basically non-threatening, and she was just pleasant by her mannerism.
>
> CLT #2: Well, she never made me feel uncomfortable at *all*. She had a good rapport, but, um, nothing striking, you know.

The parents' overall categorizations and evaluations of the PHNs' approaches are summarized in Table 5.13.

Breaking the Ice.

In describing what happened at the beginning of the home visit, eight parents said that the first order of business was "breaking the ice". Seven of these parents used the term spontaneously, three in reference to their own visit from the PHN and four when giving their opinions on different PHN approaches. Breaking the ice was seen as a humanizing or equalizing process whose effect was that the client began to feel comfortable with the PHN. Most parents said that breaking the ice occured during the initial face-to-face contact between the PHN and the client; one said it took place for her when the PHN phoned to say she was lost. None of the clients spoke of breaking the ice in reference to the phone call during which the visit was scheduled.

Breaking the ice could take place all at once, or gradually. When an unexpected event put the PHN in a vulnerable position, breaking the ice could occur all at once. This happened on two of the home visits. In both instances, the PHN arrived late at the client's home, having lost her way. The clients described how breaking the ice occured for them:

> CLT #3: [The PHN] said, "Hi, I'm sorry I'm late"....That sort of broke the ice

Table 5.13. Clients' Categorizations of and Reaction to the PHNs' Approaches

Client	Client's Categorization of PHN's Approach*	Client's Reaction to PHN's Approach
#1	Focusing in - explanation	"Good rapport"
#2	Focusing in	Manner pleasant
#3	Focusing in	Comfortable
#4 (a and b)	Social - focusing in -explanation	Comfortable after explanation
#5 (a)	Did not state purpose	"A bit uncomfortable"
(b)	Social - focusing in	Socializing very comfortable; wanted explanation
#6	Social - explanation - focusing in	Comfortable
#7	Social - focusing in	Very comfortable
#8	Focusing - explanation	Very comfortable
#9	Focusing in	"Fine - average"

* Based on clients' descriptions of the PHNs' approaches

> right there...It just sort of lended [sic] a little bit more *human* touch to it instead of, you know, health professional and little old me down here.

> CLT #7: She phoned down at the pay phone, and maybe that broke the ice, type of thing. You know: "Well, I'm down here and I'm--I'm lost! Can you help me?" She felt *so* bad.

Humour could also break the ice rapidly. On another visit, the PHN's knock at the door awoke the client, who had set her alarm for the wrong time. The PHN laughed and made a light-hearted comment, and "the ice was broken".

More frequently, breaking the ice was described as a gradual process of "coaxing the client" into feeling relaxed. The most frequently mentioned means for gradually breaking the ice was socializing at the beginning of the visit. The social approach personalized the interaction, putting PHN and client on common and familiar ground. Only one client connected breaking the ice with a different approach; for her, asking if the client had questions was the best way for the PHN to break the ice.

All the clients talked about breaking the ice in connection with what the *PHN* said or did. It may be inferred, therefore, that clients saw breaking the ice as primarily the responsibility of the PHN. One client was explicit about this:

> CLT #7: They do [home visiting] for a living; like, you think maybe they should know how to break the ice. If I had to go to somebody's place...well, I'd be a nervous *wreck!*....I like it when they take a little bit of control.

Three clients acknowledged that if the client was easy to talk to it would be easier for the PHN to break the ice. Another way for clients to share in breaking the ice was offering coffee. Four clients said that sharing coffee helped to create a relaxed atmosphere, and one stated outright that offering coffee was "my way of breaking the ice".

Clients' Opinions about Different Approaches

Clients were asked how they would advise a new PHN to get a postnatal home visit off to a good start, and what their opinions were about different approaches used by PHNs. The opinions of the 10 client informants who responded to these questions are presented in the following sections.

The Importance of Social Conversation

Seven parents thought it was important that the PHN open the visit with some social conversation. Social conversation could consist simply of a few remarks while the parent was inviting the PHN to be seated, or it might continue for several minutes "before getting down to the nitty-gritty".

> CLT #7: Some little thing that would make me feel like, "Oh, she's not going to start harping at me already", you know. Just down-to-earth talk for even just five minutes. That makes you feel as if they're not just here because they *have* to be, [as if] you're in a lineup and you feel just rushed through, just like a bunch of cattle or something.

One father found the PHN's admiring the baby particularly appealing:

> CLT #4b: I think the chit-chat at the beginning is okay, it's *comfortable*, you know. Especially when they start talking about the most important person in our *lives*, and she [sic] starts gooing and gaaing about our kid. You know, that's pretty good - she can win my heart doing that!

Socializing was seen as an appropriate way to begin a visit in the home setting: it was "comfortable", "relaxing", personal and "human". As one mother stated, starting the visit without some "chit-chat" would be "a pretty businesslike affair". Social conversation also served to diminish the role distance between client and PHN:

> CLT #5b: [The PHN] is a professional and there is an air of distance between her and me, so when you talk of other things beside the purpose of the visit initially, it sort of breaks the ice.

> CLT #3: [Then] it's not like, you know, health professional and little old me down here.

Only one client thought that the inclusion of social conversation would not add anything positive to the visit: "It's okay, but that's not the purpose".

Two parents were indifferent to the inclusion of social remarks at the beginning of the visit. Their sense of comfort with the opening of the visit was linked with the quality of the PHN's attitude towards them, and was independent of the content of her opening remarks.

Explaining the Purpose of the Visit

Seven of the parents thought it was necessary, and one thought it was "a good idea", for the PHN to give clients an explanation of the reason for postnatal outreach visits and what PHNs hoped to accomplish through these visits. Five of these parents thought the explanation should be provided near the beginning of the visit, "I like to know where I am going with a conversation," said one father, "particularly if someone has initiated it themselves." His wife added that an early explanation would prevent the client from spending the whole interview trying to "second-guess [the PHN] to find out where she is going, rather than absorbing what she is actually telling you." The father who did not receive an explanation said that a statement of purpose would have validated what he and his wife believed the purpose to be:

> CLT #5b: We do have answers to those questions [about why the PHN was here], but it's the answers we've constructed as a result of the visit, not out of what she said. But it would have been quite helpful if she had laid it out straight from her own mouth.

For these five parents, the most opportune timing for the explanation was following some introductory social conversation. Giving the explanation right at the beginning was seen as too formal, too businesslike an approach. "We *wanted* to know why she was here", said one father, "but not at the start. Maybe, you know, some time after the personal touch had been established." "A few social pleasantries to break the ice, and then on to the purpose of the visit would be ideal", said a mother.

Among the three other parents who wanted an explanation of purpose one preferred that the explanation be deferred until after the PHN had inquired about her concerns, one had no preference, and one was undecided. The latter mother acknowledged that starting with the purpose of the visit conveyed respect for the client's humanness:

> CLT #8: I think you can expect that somebody explains to you what they are doing and not just, "Hi, well come on in", and say, "Oh, your apartment looks nice; so what questions do you have?". It's nice if somebody explains what they are doing and why---that's really good. They give you sort of--it's a feeling of caring, and that they think about people, because people wonder why.

On the other hand, she thought that giving an explanation at the beginning might not be as appealing to clients as focusing directly on the client's concerns:

> If she comes and explains first, you sort of sit there and, "Hmmm, okay." But if you talk about a few problems first, or if she asks you, "What would you like to know? or "Can I help you with something?" I think it's very personal and it's a nice way to start it.

This mother decided that she would advise a new PHN that either of the two approaches was acceptable, but stated that she personally preferred the latter.

Two mothers thought that explaining the purpose was not really necessary. They stated that doing so might make the client less, rather than more comfortable, particularly if the explanation included a broad overview of what PHNs hoped to accomplish through outreach visiting. One stated:

> CLT #9: That way maybe would have lost me, because it really doesn't matter to me what [public health nursing] is all about. Like, it matters, and it's probably an important thing in the community, but I would want to get to what I wanted out of it more than to hear what it was all about, 'cause I assumed nurses were nurses.

The second mother seemed to associate an explanation with an attitude of officiousness on the part of the PHN:

> CLT #7: I think if I had [a PHN] that was a little--"Well, I'm here for this reason and this reason and that reason"....she'd kind of put me on edge. Like, that would probably bother me; I'd kind of hope her interview would be over right away!

Both of these parents advised that, if the PHN were to provide an explanation, it should be

brief and given in a "friendly sort of and not a clinical way".

Two of the parents who thought an explanation of the PHN's purpose would be beneficial also stressed that it be brief. "I prefer to get *into* the visit to see what it will bring, rather than go through a lot of preliminary stuff about what it will bring", explained one. "I wouldn't want a very general, broad view of public health, but...a small, small introduction would have been fine." A prescription for an adequate statement of purpose was provided by a father. Playing the role of the PHN, he stated:

> **CLT #5b**: The reason why I'm here is to make you aware of my presence-the public health nurse--a person that you can come to in case you have problems on this and that....I'm also here to make you aware of the service we offer. I'm not here to assess how good or bad a mother you are; I'm just a person that could be of help to you.

Getting Right into the Visit

Getting right into the visit was the approach of choice for two parents, and was also recommended by three others. Except for the one parent referred to earlier, who thought socializing served no purpose, these five parents preferred a bit of social conversation first. There were two ways that the PHN could make the transition from socializing to "diving right in". The first was inviting the client to raise any questions or concerns. This could be done through a very general question such as, "How are you doing?" or "How are you feeling?" This approach was seen as appealing because it put the focus on the client:

> **CLT #8**: [It] gives you sort of the feeling, "Well, she's interested in me, 'cause she wants to know what is my problem...It's important to let people talk when you work with people.

The second way to initiate the clinical portion of the visit was to ask specific clinical questions of the client. This was particularly helpful if the client did not have any questions, did not know what questions to ask, or had questions she or he was too embarassed to ask at the outset.

> "Isn't she going to *ask* me something?" You know, I wouldn't know what to come out and say. Like, I wouldn't sit there right off the bat and start talking about my [sore] bottom or something. You know--a complete stranger!

These clients used the beginning of the clinical portion of the visit as a means of getting comfortable with the PHN. One client said she needed to assess whether the PHN's intention in visiting was truly supportive, as parents had been told in the agency prenatal classes. It was important, therefore, that the PHN ease into the clinical phase of the visit with content that was not too personal. Two clients gave the following advice:

> CLT #9: You're not used to sitting there and whipping your shirt up and showing somebody how you do it [i.e.breast-feed], you know. I don't know, maybe getting into something that's not personal, but kind of is in a way.

> CLT #7: Like, I'd start with, maybe, going to the baby and saying, "How much did it weigh?" and this and that;. "How is he or she [doing]? And gradually talking about, "Is everything okay?"

The Importance of the PHN's Attitude

One parent considered the PHN's attitude to be the most important factor in her approach. This mother, who described herself as easy to talk with, and said that it did not matter to her whether the PHN chose to socialize, to explain her purpose, or to get right into the visit. It was essential, however, that the PHN be confident and not too formal:

> CLT #3: I would say just try to be as friendly and open as possible, and God, don't be nervous! I think if there'd been a lack of confidence on the part of the nurse that would have been a turn-off to me. 'Cause you're supposed to be a professional-you're supposed to know what you're doing, and if she'd been very sheepish about approaching me that would have been-"Oh, golly, what right do you have here if you're that hesitant--you're not going to be that much help to me"....A real laid-back sort of approach would be the best bet.

Three other parents also referred to the importance of the nurse's attitude. She should be friendly, relaxed, caring, and not officious. One parent said that she "knew when she opened the door" that she could trust the PHN. She did not even recall that she herself had interrupted the PHN (who had opened the visit by asking her if she had any questions), to

fact that the PHN did not immediately state her purpose was insignificant compared to the fact that the PHN was "caring" and conveyed genuine interest in her.

The Most Important Aspect of the PHN's Approach

Because clients stressed that what was happening in the initial part of the home visit was coming to feel comfortable with the PHN it was possible to infer what they saw as the most important aspect of her approach from their comments about what did, or would, make them most comfortable in the early part of the visit. Parents varied considerably in their opinions about what was important, with no more than two agreeing on the preeminence of any particular aspect. Their preferences are presented in Table 5.14.

Comparison of Tables 5.14 and 5.13 shows that there was a good match between the PHN's approach (as perceived by the client) and what the client thought was important; most of the clients reported that they had felt comfortable with the way in which the visit had begun.

Dropping In: Clients' Perspectives

In light of the strong opinions voiced by the PHNs about the importance of phoning the client to set up the visit, the last five client informants were asked what their reaction would have been if the PHN had visited without phoning first. Their responses, given without hesitation, were emphatically negative:

> CLT #6: Oh, well, there just would have been [no way]. It's rude. I don't like surprises like that!
>
> CLT #2: That wouldn't have been acceptable at all as far as I'm concerned.
>
> CLT #3: I don't like it when my friends drop in unexpectedly, never mind a total stranger!
>
> CLT #7: Oh, I don't like [that]...like, if I had a, my laundry all over the front room floor and I hadn't folded it yet and someone shows up at your door and your

Table 5.14. The Most Important Aspect of the PHN's Approach

Client	Sex	Opinion: Most Important Aspect
1	F	Prompt focus on client's concerns
2	F	Minimal introduction; time valuable
3	F	Attitude of confidence; informal manner; adjust approach to client
4a	F	Explanation of purpose
4b	M	Explanation of purpose
5b	M	Socializing followed by explanation of purpose
6	F	Socializing followed by explanation of purpose
7	F	Spending time socializing: "Breaking the Ice"
8	F	Attitude of caring; non-officious manner
9	F	Getting into visit, but beginning with impersonal questions

> CLT #9: Oh, no...'Cause I would have felt more like I was being checked up on, and because, kinda, I'm not prepared.

These parents' statements verified the PHNs' belief that the phone call is important because it allows parents to prepare both physically and psychologically for the visit, and prevents them from being disturbed at an inconvenient time or in an embarassing situation.

Clients' Conceptions of the PHNs' Objectives

All the clients were asked what they thought the PHN had been trying to accomplish through her visit with them. Seven of the 11 clients thought that the PHN's primary objective was to introduce them to public health services and to the PHN as a community resource. Five also stated that the PHN was there to see what their needs were and to assist them with their concerns. The following responses, by a father and two mothers respectively, illustrate these two perceived objectives:

> CLT 5b: It's awareness [illegible] existence of the public health nurse as an individual who could be of some help to people like us. That's what we thought the whole purpose was: to, ensure, you know, that you're giving the best of yourself, as a mother, to this newly born life.

> CLT #4a: To me, she was trying to introduce me to the public health system and its availability to me.

> CLT #3: Oh, I suppose to help you with your concerns and see what your needs are. To explain about their services, about the clinic--you know, where they are located and stuff. What their purpose is, like why they are there: for your information. If you ever have any trouble, just phone them, that's what they're there for.

Not all clients were accurate in their conception of the kind of help the PHN was prepared to provide. One mother stated, with considerable assurance, that PHNs were available "when you need help right away and can't reach your main physician. I think that was basically her purpose, and she covered it quite well".

Two mothers thought that the PHN's main objective was to provide reassurance and bolster the confidence of new parents. They stated:

> CLT #1: To offer reassurance. To make sure that I felt comfortable with the baby. To me, it was more care for the *mom*, more of a concern for--to make sure that I was feeling okay being at home with the new bundle.

> CLT #8: I really would say she was trying to make me feel better, to help me, to give me more security. Boy, how can I say? To tell me that what I am doing is right. Actually, I really think the reason is that they try to give you the feeling that you're a really good mother, or a normal mother, or that whatever you go through is normal, and you do all right.

One client, a father, thought that one of the PHN's objectives was to assess the mother's abilities to care for the baby: "to ensure that mothers are functioning as they should be." This client was one of four who had anticipated this "checking up" component before the visit. (The father and one mother saw this assessment objective as a favourable objective, that is, for the parents' benefit. The other two mothers saw it more as "policing".)

Two of the study clients made reference to broader public health goals that they thought were part of what the PHN was trying to accomplish. One, a father and a physician, was the only client who made reference to the prevention-promotion focus of public health:

> CLT #4b: She is promoting proper approaches to health, right from the start. It's a lot of preventive stuff, like, "Watch out for this; if this happens, this is what you can do; these are the resources we have available to you". She warned us about sleeping properly, and all that stuff.

The other, a mother and a teacher, was the only client who referred to the community focus of the PHN's job, saying that by visiting all new parents, the PHN would get "an idea of what was going on in the community". She attributed her knowledge of the community focus to her association with PHNs in the schools.

Finally, one client expressed disappointment with what she conceived the PHN's objective to be:

> CLT #9: Well, it seemed to me she was trying to accomplish just about his

> immunization [sic], and my immunization and my husband's immunization, that's about all. And she just answered some questions, and that was her purpose, I think....I just thought it was to start off the forms for his immunization.

This mother was one of two clients who stated that their conception of the PHN's objective was markedly different after the visit than it had been before the visit. The client cited above had assumed that the purpose of a visit in the home was to check to see that the environment was safe for the baby. "I just assumed that was the purpose of the visit, maybe because it was the Board of Health". The second mother, who saw the visit afterward as being primarily "reassurance for the mom", had initially assumed that the objective was to assess the health of the baby. The fact that the visit did not include a physical assessment of the baby was disappointing to her. As stated above, two other mothers also saw the PHN's objectives differently after the visit. No disappointment accompanied the difference in their case, however, for what was different was the apparent absence of a "checking you out" objective that had, in fact, been unwanted.

Clients' conceptions of the purpose of the visit are summarized in Table 5.15, which also provides a comparison of that conception with the PHNs' stated purpose and her personal goal. The table reveals that clients' conceptions of purpose were sometimes congruent with the PHN's personal goal, sometimes with her statement of purpose, and sometimes with both.

Clients' Conceptions of the Reasons for Outreach Visits

Clients were asked why they thought PHNs invited themselves to visit new parents, as opposed to waiting for parents to request a visit. Their responses are presented in Table 5.16.

One client said she didn't know the reason for outreach visiting. All the others answered the question in terms of what would happen if PHNs did *not* offer a visit: "People wouldn't ask" for one. Parents would be missed, therefore, if they were unaware of the service, did not perceive a need for help, did not wish a visit, or were reluctant to ask for a visit. Two

Table 5.15: Comparison: PHNs' Personal Goals; PHNs' Stated Objectives; and Clients' Conceptions of Purpose

Visit	PHN: Personal goal	PHN: Objective as stated on home visit	Client: Conception of purpose
#1	Enabling parents to enjoy parenting - focus on health promotion		- reassurance for mother
#2	Providing reassurance	- answer questions/info re services	- introduction to PH services
#3	Providing reassurance	- assessment/assistance - focus on prevention	- introduction to PHN as a resource when doctor not available
#4	*	- promoting healthy lifestyles - provide info/answer questions - disease prevention	- promoting health lifestyles - assistance with questions - introduction to PH services
#5	Adding to parents' knowledge	- "to see how you and the baby are doing"	- assessment/assistance introduction to PH services
#6	Assessment of situation/need for followup	- "to see how things are doing" and offer assistance prn	- assessment/assistance - introduction to PH services - allows PHN to assess community
#7	Fostering confidence by emphasizing the positive	**	- assessment/assistance - introduction to PH services
#8	Assisting with problems in coping	- info re PH services and parenting - preventing problems	- reassurance - fostering confidence
#9	Providing reassurance	- answer questions; start record - focus on health promotion	- starting the health record

*data not available
** not stated

Table 5.16. Clients' Conceptions of Why PHNs Make Outreach Visits

Conceived Reason	Number of Clients
1. People would not ask for a visit:	10
Unaware of service	4
Too shy or scared	5
Unaware of need for help	1
No desired for help	1
2. Surveillance for doctors	1
3. "It's their job"	1
4. "I don't know"	1

mothers thought that parents would be "too shy" to call, even if they wanted help.

> CLT #7: I think that a lot of people probably just wouldn't [ask], not for the right reasons. You know, just because they're shy, or figure, "Well, no. I'll struggle through somehow" or, "I have my husband's mother's grandmother to ask questions to", or whatever.

> CLT #3: I don't think too many parents would call and invite them in. I would never have thought to call anyone....Yeah, it's easier, I think if someone reaches out to you rather than trying to stick your toe in there and ask for help.

Two mothers stated that they thought that some clients would be "too scared" to call. Each had worried herself about the kind of "help" her request might yield. They stated:

> CLT #7: Me, I probably wouldn't have phoned. I probably would just have thought, "Oh, if I phone *them*, they're probably going to say, 'Well, you better be doing it this way and that way', and if I wasn't, I'd feel like such a loser, or some darned thing!"

> CLT #8: I mean the really biggest point is I think that they come out because they *have* to, it's an organization. Well, that's if you see it really cold, and if you see business, that's the normal reason. But if you have luck, and you get a nurse who really cares, you can have the feeling she does it because she wants to do it, she loves to do it, and she just wants to see you.

The latter client was one of two mothers who referred to the fact that PHNs "had to" make postnatal outreach visits: "it's their job". Her comment, and the one that follows, suggest that one of the reasons that parents may be reluctant to call is the association of PHNs with an impersonal organization:

> CLT #1: Well, I would imagine it's their job to provide this type of service, but I don't think I would have called. If I had concerns, I just would have called the doctor. I wouldn't have called the health unit.

Parents' Evaluations of the Visit as a Whole

Parents' overall evaluations of their visits with the PHN ranged from "very helpful" to "not really helpful". This range of responses is presented in Table 5.17, which also compares parents' evaluations of the actual visit with the value anticipated prior to the visit, and portrays the "fit" between expected and actual outcomes.

Table 5.17. Actual and Anticipated Value of the Visit as Reported by Clients

Actual Value	Client	Fit between Expected and Actual Outcomes	Anticipated Value
Very helpful	#7	Positive expectations met;	Potential for support
	#8	Negative expectations not actualized	recognized but negative outcome seen possible
Helpful	#4a&b	Expectations exceeded	Value questioned
	#2	Expectations met	"Wait and see"
	#3	Expectations met	
Somewhat helpful	#1	Some expectations met,	Expected as valuable
	#5a&b	some not	
No, not helpful	#9	Expectations not met	Expected as valuable
	#6	Few expectations met	Expected as valuable

The above table indicates that the parents' evaluations of the visit were influenced by their expectations and desires about the visit. Generally speaking, if parents' desires and positive expectations were met and if negative expectations were not actualized, the visit was judged as helpful or very helpful. The following examples suggest that the distinction between "helpful" and "very helpful" had to do with the strength of the felt need prior to the visit. A greater need, fulfilled, resulted in a higher evaluation than a more moderate need fulfilled. Needs for information were felt as moderate in most cases, and the visit was judged as helpful when the desired information was received:

> CLT #3: I think it was quite helpful, 'cause...she gave me a few extra brochures....It's always helpful to have...a little more information. There were things I didn't know about, or didn't know as much about as I probably should have...so it was helpful.

> CLT #4a: What I found...really helpful is that she was able to give me [information about] a lot of resources that were available, not only in the public health unit but in the community.

A verdict of "helpful" was also given when the information given exceeded the client's expectations. The father who was a physician had not anticipated that the PHN would have information valuable to him and his wife; the actual result was information that he saw as valuable both personally and professionally:

> CLT 4b: When she phoned...we sort of thought: "I wonder what she will tell us that we don't already know". We were sort of wondering if it was a waste of her time to come.... [But] she told us things we didn't know...and it was valuable....For somebody that didn't have a medical background, that would be *invaluable*. Even as a physician, I find that my awareness of the public health system is fairly limited...I don't, or I *didn't* know a lot about the resources...that I could get my patients involved in.

When the need for help was felt more strongly, and the support given by the PHN eased a new parent's anxieties, the visit was evaluated as "very helpful". In the following examples, two mothers describe how the PHN met their needs:

> CLT #7: She [the PHN] was almost like a *mom*; she was *very* understanding.... Like, I'm just new at this; I didn't know anything about anything! So she helped me....She told me all about what I was wondering about. I was worried about [the

baby's] needles; I was worried about her belly button; about bathing her right; am I feeding her right?... Oh, I was glad she was there, 'cause it makes you think, "Oh, maybe I *am* doing something right!"

CLT #8: I was very depressed and I was very scared, and I thought, "Okay, if here comes the health nurse, maybe after that I'm more secure and more sure of myself.... Afterwards, I was more sure; I didn't have too much fear anymore....I sort of had the feeling she listens and tries to understand and that was really good....When I told her about [my postpartum depression], she didn't just say, "Okay, that's normal". She said that too, but she also tried to figure out why, and how to help me, and that was nice.

In instances where significant desires and positive expectations were *not* met, clients' judgment was qualified as only "a bit" helpful, or "not really" helpful. The evaluations of the four clients who had expected that the visit would include a physical examination component fell into the above categories. The theme "*It was just a visit*" ran through their comments:

CLT #6: It wasn't really that helpful, you know, for me. I found it was just a getting-to-know-yourself *visit* rather than...checking the baby to make sure she was all right....I would have appreciated that a lot more.

CLTs #4a & 4b: **Wife**: We were expecting something like, she's going to see my episiotomy...not like just the interview...I would have preferred that.
Husband: We got the feeling it was just a *visit*, nothing else, you know....We were hoping it would be an examination.

CLT #1: The baby never got checked; instead, we just *talked*. ....We talked about *my* care; it was good. It was *talk*. It was just conversation, which was--comforting. The only thing I would have suggested was maybe insisting to see the baby, to make sure everything was okay.

One client had several unfulfilled expectations. She was explicit about the relationship between her expectations and her evaluation of the visit:

CLT #9: Once you have your mind made up on something, like: "This is how it's going to be", it was sort of a shock that it wasn't....I don't know where I got the idea from, but it wasn't anything like I expected.

The following are some of these unfulfilled expectations:

Well, she helped me with the nursing, so that was helpful...but I expected she was going to do more. I just assumed she would check the premises...just sort of like: "That plant there is poisonous"; but I realized that she was just here to ask questions and stuff like that....I wanted her to show me the bottle, and she kind of shied away from that. I thought she'd look at the baby or check his room....I thought it would be more for the baby, not just for his immunization.

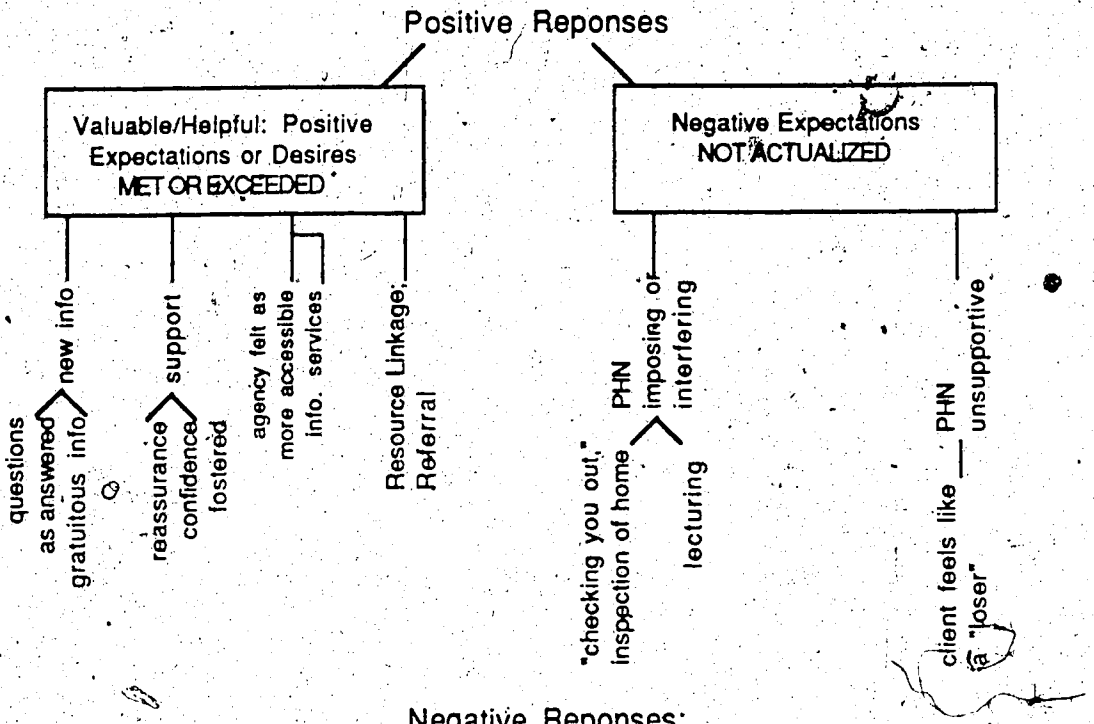
As reported earlier, in all cases, the PHN herself was judged to be friendly, personable and pleasant. No instances of comission of undesirable actions were reported, only instances of omission of desired ones.

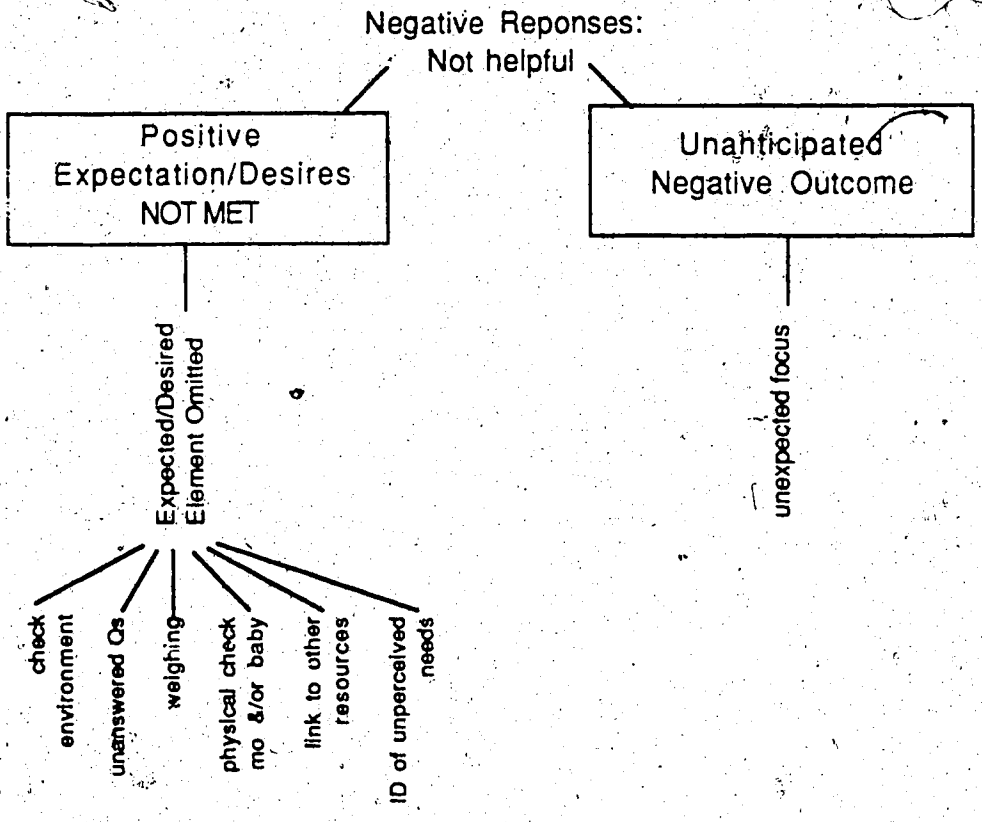
The specific content of all the parents' evaluations is depicted graphically in Figure 5.03.

Summary

The 11 clients described their responses to a postnatal outreach home visit and to the approaches used by the PHNs in initiating the visits. Most clients anticipated that the visit would be valuable in terms of information and support. They described three different PHN approaches: *Getting right into the visit; Socializing and "getting in"*; and *Socializing and explaining the purpose of the visit.* Clients wanted the PHN to phone before visiting. All stated that the PHN's approach had been "comfortable". Although clients did not demonstrate awareness of the broad preventive focus of public health nursing, their perceptions of the specific purpose of the visit were reasonably accurate. Their evaluations of the visit as a whole were influenced by the degree to which their expectations and desires were met, and by the degree to which the PHN was able to make them feel comfortable.

Figure 5.03
Clients: Actual Value of Visit





Chapter VI

DISCUSSION OF THE FINDINGS

In the preceding chapter, PHN approaches in initiating postnatal outreach home visits were described from three perspectives: 1) that represented by the EBH Right of Entry framework, 2) that of the PHNs, and 3) that of a sample of clients that they visited. In this chapter, these three sets of descriptions are compared and are interpreted in light of a) the concept of *seeking and attaining right of entry*, as embodied in the ROE framework, and b) the nursing literature on initiating the PHN-client encounter. Conclusions are presented and implications for future nursing research and scholarly activites, as well as for nursing practice, are considered.

The Object of the Initial Phase of a Postnatal Outreach Visit

Both the PHNs and their clients stated that the object of the initial part of a home visit was to make the client feel comfortable. PHNs stressed that *comfortable* referred to a feeling of ease based upon clients' knowing who the PHN was and why she was visiting them. *Getting the client comfortable* was the essential means to a client's "opening up", (that is, revealing personal thoughts and feelings related to the experience of being a new parent). If clients did not open up, it would be difficult to assess their needs and subsequently to be of assistance to them.

Clients tended to describe *comfortable* in terms of the absence of discomfort. It meant *feeling* that the PHN was a human being just as they were, and *knowing* that she was visiting in order to be supportive to them as new parents. Clients did not use the term *opening up*, but implied that they would do so if the PHN was seen as being personally trustworthy and as having something to offer them professionally.

The object embodied in the ROE Framework was *the attainment of entry into a client's "personal world"* on the basis of the client's understanding that the intention of public

health nursing was "to support people in their efforts to have a good life by planfully promoting health" (EBH 1984). This object was very similar to the reported objectives of both the PHNs and the clients. The PHNs themselves explicitly equated this objective with their own objective of *getting the client comfortable*. The PHNs and the clients' conceptions were also congruent with accounts in the nursing literature of what initiating a sound nurse-client relationship required, namely, acceptance of the encounter based upon mutual understanding of its purpose (Field, 1982; Fowler, 1985; Gustafsen, 1977; Langford, 1978; Orem, 1980; Sloan & Schommer, 1975; Spradley, 1981; Sundeen, Stuart, Rankin and Cohen, 1976; Warner, 1984).

Only one author was found who disagreed with this objective. Based upon her research on health visitor visits to elderly women, Luker (1982) concluded that "it is not necessary to *build* a relationship before asking direct and intimate questions...because it is thought that a working relationship between a health visitor and her client *already exists* in the form of predetermined role expectations" (p. 24, emphasis added). One of the PHNs in the present study held a view similar to that reported by Luker. Her opinion that the PHN-client relationship was, in most cases, "warm and comfortable to begin with" represented a "negative case" among the findings. Like Luker, this PHN believed that the majority of new mothers were familiar with both the existence of and the reason for postnatal visits, and saw them as desirable.

The Approach Components

The PHNs' approaches represented their means to getting the client comfortable. Their descriptions of the different types of approaches (actual and possible) were very similar, and were in accord with approaches described in the literature. The PHNs specified three approach components: *Focusing in on the client; Socializing; and Explaining about public health.* Put together in different combinations, these resulted in four approach types:

1. Focusing Right In On the Client,
2. Socializing and Focusing In.
3. Explaining about Public Health and Focusing In, and
4. Socializing, Explaining about Public Health, and Focusing In.

Clients described the same approach components, which they called, respectively, *Diving right in* or *Getting right into it; Some casual conversation (or "chit-chat")* ; and *Explaining why the PHN is there.* They described the PHNs as using, among them, all of the approach types except *Explaining and Focusing In*, and agreed that the latter was a possible (though not a desirable) approach.

The PHNs' and clients' descriptions of each of the approach components will now be contrasted with descriptions found in the literature and with the approach represented by the ROE Framework.

Focusing Right In On the Client

As an approach type, *Focusing right in on the client*, as described by the PHNs, comprised two aspects: 1) focusing in on the clinical aspect of the visit, and 2) doing so in a relatively short time (i.e. with no "preliminaries" other than mutual identification of the PHN and client). The fact that the approach has been labelled *Focusing in on the client* rather than *Focusing in on the clinical* indicates the PHNs' emphasis upon the importance of "starting where the client is at". Specifically, this meant beginning with questions designed to elicit the client's felt needs as opposed to questions designed to retrieve information needed to complete an objective assessment of the client's health status. Clients' descriptions of the approach included the same two aspects but whereas the PHNs emphasized the *focusing in* aspect, clients tended to emphasize the *timing* aspect, as indicated by their use of language such as "diving right in", "getting right in", and "getting down to the nitty-gritty".

A similar approach has been described in the nursing literature by Luker (1982). Calling it "the direct approach", Luker stated that it was distinguished by an early move into "asking direct and intimate questions...to obtain information about a client's health status" (p.62). Despite obvious similarities, however, *Focusing in* and the *Direct approach* differ from each other in a significant respect: while seemingly identical as means, they serve two essentially different ends. The *Direct approach* is a means of directly assessing the client's health; it was *not* intended as a means to building a nurse-client relationship, for, as reported earlier, that was assumed to exist already. *Focusing in*, however, was seen by both PHNs and clients as designed to do precisely that.

In terms of the ROE Framework, *Focusing in* would be designated as "Does not seek entry". This would be congruent with the intent of the approach as Luker describes it, but appears to conflict with the PHNs' assertion that they were indeed seeking entry into a client's "personal world". The ROE Framework categories do not refer to a PHN's intent, however, but only to her actual use of certain elements deemed necessary to the attainment of entry. A coding of "Does not seek entry" really means "Does not *explicitly* seek entry." The PHNs who used the *Focusing in* approach agreed that their entry seeking was wholly implicit. Indeed, most of the PHNs who chose this approach did so because they believed that intentions are more effectively projected through actions than through statements of intent, or, as one PHN expressed it, "through fancy words and theories". This philosophical issue, at the heart of the difference between competing opinions regarding the relative value of *Focusing right in* versus *Explaining about public health*, will be more fully explored when the latter approach is discussed. First, the *Social* approach and its functions, as decribed by the subjects, will be interpreted and compared with views of nursing scholars and researchers.

Socializing

Socializing was recognized as an approach component by both the PHNs and the clients, and has been advocated in the literature as being very important in establishing rapport (Berg & Helgeson, 1984; Leahy, Cobb & Jones, 1982). *Socializing* was not seen by any of the study participants as sufficient in itself to make a client feel comfortable (nor has it been so advocated in the literature). Rather, it was seen as a prelude to either *Focusing in* or *Explaining about public health*, or both.

Although there was general ageement that *socializing* constituted conversation "about things other than the purpose of the visit", as one of the clients stated, the dividing line between social conversation and clinical conversation was blurred when the topic of conversation was the baby. One PHN stated that: for her, admiring the baby was clinical conversation, implying a conception of social conversation as "things" *irrelevant to* the focus of the visit. Indeed, PHNs and clients who attributed a negative value to socializing did so precisely because of its irrelevance to the purpose of the visit.

The clients more than the PHNs attributed a positive value to the part played by socializing in getting clients comfortable, and they were more articulate than the PHNs about how socializing did that, referring not only to *what* it accomplished (e.g. "it is relaxing"), but also to *how* the relaxing effect was achieved. Thus, the "equalizing" or "humanizing" effect of socializing was mentioned only by the clients. The link between socializing and *Breaking the ice* was also explicated primarily by the clients.

In this study, roughly half of the PHNs and a third of the clients attributed either a neutral or a negative value to socializing. The findings indicate that social conversation can be used by PHNs in two ways: as a "filler" while the PHN and client get physically settled, or as a "delaying tactic". When used as a filler, it seems that social conversation is either positive or neutral. When used as a delaying tactic, it is positive if the client sees an immediate jump into the clinical focus as precipitous. Socializing has the potential to be negative, however, as when a client is *eager* to get into the visit proper, and the PHN wants

to socialize, or when the PHN judges that a client's desire to socialize stems from a reluctance to get into the clinical content. Clearly, a PHN needs to be sensitive to a client's readiness to turn to the clinical aspect of the visit, and to choose other means to promote this readiness when socializing is inadequate. She also has to judge how much socializing is enough. In the home visits in this study, a median of less than 1% of total visit time was devoted to social conversation, and all clients stated that this was an appropriate amount. In contrast, the 15 student nurses in Berg and Helgeson's (1984) study reported a median of 25% of time spent socializing. Even when allowance is made for the fact that PHNs in this study initiated the visits knowing that one visit only was the norm, while Berg and Helgeson's subjects were making the first of several visits, the amount of time the student nurses spent socializing seems exhorbitant, and the investigators' conclusion that socializing is an essential component of a first home visit would appear to be untenable in light of the findings of the present study.

From the point of view represented by the ROE Framework, socializing plays no part in attaining entry to a client's personal world. The assumption underlying the framework is that *valid* entry is based only upon the client's understanding the purpose of the visit. Since socializing contributes nothing to that understanding, it is irrelevant to seeking and attaining right of entry. The findings of this study do not contradict this contention. No clients or PHNs claimed that socializing made clients feel comfortable with the visit *as a public health nursing postnatal visit.* It did make many clients feel comfortable with the PHN as a *person.* One would have to conclude that this is the most that social conversation can achieve in the context of a public health nursing postnatal home visit.

Explaining about Public Health

Most of the PHNs and clients thought a PHN's approach should routinely include a

in the literature by virtually all authors; acceptance of the importance of doing so is matter-of-fact, almost as if to *not* state one's purpose would be unthinkable. Yet, no models for an ideal explanation were found. The PHNs and clients in this study did describe different models of explanation of purpose. Two models, or patterns, emerged:

1. An explanation which focused on the purpose of the specific visit, and
2. An explanation which also included reference to the general focus and goals of public health.

Both the PHNs and the clients were divided in their opinions about whether an explanation should be routinely be provided, and which "model" was preferable. Interestingly, providing an explanation was seen by some clients and PHNs as having a greater potential to make the client *uncomfortable* than to make the client comfortable. Unless the client had no understanding or expectation of the visit, starting off with an explanation of purpose was seen by these informants as being too formal, too businesslike, or too authoritarian. This opinion is acknowledged as valid by Sloan and Schommer (1978) who state that an explanation of purpose can give the encounter an unacceptable legal connotation. An explanation was also expected to have a negative impact if it took too long or was too broadly focused, as in Pattern #2. These opinions reflect the following assumptions held by both PHNs and clients in the study and also reported in the literature: that public health nursing outreach visits are part of the accepted local health "culture" (Luker, 1982; Dingwall, 1977); and that clients can infer the purpose of the visit from observation of the PHN's actions (Luker, 1982).

Informants who believed that PHNs should routinely explain their purpose assumed, in contrast, that most clients do not have an adequate understanding of why outreach visits are made, an opinion also expressed in the literature (Langford, 1978; Sloan & Schommer, 1975; EBH, 1982). An explanation, therefore, would contribute to the client's comfort, but, as some PHNs indicated, it would also serve another end, namely, the client's right to

seen as necessary.

A comparison between the ROE Framework approach and the explanation patterns used by the PHNs will be presented below. First, the discussion will address the relative contributions of the three approach components just described to getting the client comfortable.

Getting the Client Comfortable: Relative Contributions of Each of the Approach Components

Of the three approach components, *Focusing in on the client* was seen by informants as contributing most to getting the client comfortable. It did so because it put the focus on the client as opposed to the PHN; it involved the PHN's demonstrating interest in the health concerns of the client as a new parent. It also provided the only means by which the client could judge whether or not the PHN's interest and desire to be helpful, if previously conveyed in words, was genuine in fact.

Whereas *Focusing in*, put the focus of attention on the client, *Socializing* distributed the focus equally between the PHN and the client. By its nature, social conversation demands relatively equal participation by the persons involved, qualitatively and quantitatively. It thus contributed to getting the client comfortable because it highlighted the similarity rather than the differences between the PHN and the client. Because this equality was irrelevant to the visit focus, however, socializing played a lesser role in getting the client comfortable than did focusing in, and could have a negative effect in some instances.

Explaining about public health was the only approach component that focused primarily upon the PHN rather than the client. It was essential to getting the client comfortable if the latter was uncertain about the purpose of the visit. If the PHN was already seen as credible, however, (even if the client's judgment had been made on insufficient information) an explanation might have more potential to make the client

intended to serve other ends as well (informed consent; "selling public health") it is probably better postponed until after the client has been made to feel comfortable by other means, as was the predominant pattern in the home visits made in this study.

Application of the Approach Components in Other Outreach Situations

It is instructive to ask whether *getting the client comfortable* applies to situations other than public health nursing postnatal home visits, and, if so, whether the same approach components are used. Bereavement visiting is an obvious example: still a clinical situation focused on a life event, albeit a sorrowful rather than generally a happy one. What was quite different about bereavement visiting was that it was a much newer outreach activity in the agency than was postnatal visiting, and consequently, public awareness of its existence was assumed to be low. The PHNs in this study agreed that this made bereavement visits much more difficult to initiate than postnatal visits. An explanation of their purpose -more detailed, usually, than that provided on postnatal home visits- was mandatory at the outset, and could not be deferred until the middle of the visit. The fact that the focus at the outset was on the PHN rather than the client made the opening of the encounter less personal than on postnatal visits; because of this, some PHNs chose to initiate the visit by dropping in rather than phoning first. As in postnatal home visits, *focusing in* played an important part in *getting the client comfortable*, although socializing was not seen as appropriate by most of the PHNs.

A second contrast is provided by a non-clinical outreach situation: that of a researcher inviting a potential subject to participate in a research project. One of the PHN informants in this study spontaneously drew a parallel between the two situations, indicating that a bit of socializing before the interview had made her feel comfortable, but that the researcher's explanation of the purpose of the interview had contributed more to her comfort

participate. It is postulated that *Focusing in* is also applicable to initiating a research interview, being the initial establishing of comfort by asking "easier" (i.e. more general and less personal) questions first.

The above examples suggest that *Explaining one's purpose, Socializing* and *Focusing in* are generic approach components, applicable in any outreach situation. Further, the relative importance of *Explaining* versus *Focusing in* as means by which the initiator makes the invited participant feel comfortable is dependent upon the latter's prior understanding of the purpose of the encounter. In situations where this antecedent knowledge is low, the best approach is likely to be one that, in its form, approximates that of the ROE Framework.

Comparison between the ROE Framework Approach and the Approaches Described by the Informants

The ROE Framework embodies a highly explicit approach designed to "establish the character of public health and the [public health] nurse as its agent" (EBH, 1982). The essence of the approach is an appeal to the client's understanding, and the criterion of successful entry is that the client welcomes the PHN *on the basis of that understanding*. The ROE framework calls for the PHN to *check* the client's understanding of her explanation, and to correct any misinterpretations. In this study, only one PHN came close to meeting the full requirements of the ROE framework; one of the elements that she did *not* include was checking for the client's understanding. Her clients, however, stated that they "felt comfortable" with the visit after the PHN's explanation, and the husband's explanation to the researcher of the purpose of the visit was very similar to what the PHN had actually told him. It would seem, therefore, that the PHN *was* sucessful in attaining entry on this visit, based on the above criterion.

therefore, that their *intention* was to make some appeal to the client's understanding, even if that appeal was implicit. The PHNs confirmed this conclusion, stating that their objective of making the client comfortable with the visit was equivalent to seeking and attaining entry to the client's personal world. Their criterion of successful entry was that the client "opened up", that is, indicated her or his acceptance of the PHN by sharing personal health-related thoughts and feelings with her, and they judged themselves as being generally very successful in attaining entry on postnatal outreach visits.

Despite the PHNs' assertion that their objective was the same as that of the ROE framework approach, only one of the approach components that they described bore any resemblance to the ROE Framework approach. Moreover, this approach component (the #2 "model" of explaining about public health) was not seen as necessary by all the informants, and was even seen as undesirable by some. Although in some instances the explanation given in the study visits was minimal, all clients except one husband and wife stated that the PHN gave an adequate explanation of purpose .

The biggest difference between the ROE Framework approach and the approaches preferred by the PHNs is that the former depends upon an appeal to the *understanding* while the latter depend primarily upon an appeal to the *feelings*. The ROE approach does not contain any feeling oriented elements; it *assumes* that PHNs will include them in her approach. Because this assumption is not made explicit in the explanation accompanying the framework, it is possible that the framework may be taken to represent a necessary and sufficient means to seeking right of entry rather than just a necessary one. This would fit with the convictions of both the PHN and client informants who stated that an explanation *alone* is never sufficient to attain entry to a client's personal world.

In terms of the three componments of the Aristotelian framework of persuasion--*ethos, pathos* and *logos*, the PHNs may be characterized as relying most heavily

the needs of their clients, and their success in the use of *pathos* is indicated by the clients' statements that the PHNs were able to make them feel comfortable, and demonstrated interest in them. The PHNs demonstrated a sound grasp of the principles of persuasion by taking advantage of the fact that the *ethos* of public health nursing in regard to postnatal home visiting was already publicly established to some extent; by deferring their explanations about public health (*logos*) until after they had made the client feel comfortable by other means; and by avoiding lengthy and intricate arguments to "sell" public health. In contrast, the ROE framework puts the most emphasis upon *ethos* and *logos*. Its first four elements are directed to establishing the credibility of the PHN (*ethos*) by what Adler (1983) calls "direct means", that is, making explicit the credentials of public health and the PHN as its agent. It is assumed, but not explicitly stated, that the PHN will provide this explanation only when *pathos* has been established.

Granting Entry: The Client's Perspective

The findings of this study suggest that there were two grounds upon which the clients granted entry to the PHNs: 1) their expectation that a PHN had something of value to offer them; and 2) their experience of the PHN herself as being non-threatening and able to make them feel comfortable. Further, it appears that the extent to which they admitted the PHN into their "personal world" was commensurate with their perceived need for the "goods purveyed" by the PHN, to use Dingwall's (1977) terminology. Client's who wanted information only were perceived by the PHNs as being less "open" than clients who wanted emotional support. In fact, although two of the PHNs in the study judged that they had not really gained entry to their client's personal world, their clients were quite satisfied with the visits. Like the PHNs in Conant's (1966) research, these PHNs had wanted to be more

whether the clients in this study understood fully what the PHN intended to accomplish on their behalf. Although all of the PHNs had personal goals for their postnatal visits, only two reported that they usually made these goals explicit to clients, and fewer than half were confident that their clients were aware of them.

Generally speaking, however, the clients in this study demostrated a better grasp of the purpose of the visit than did clients reported in previous research on outreach visiting (Bambino, 1969; Clark, 1982; Conant, 1966; Field, 1982). In the study home visits, none of the PHNs specified their personal goals, but their statements of their general objectives were congruent with those goals. The clients' conceptions of the PHNs' objectives revealed that all but one were aware of either the PHN's personal goal or her stated objective, or both. Likewise, most parents appeared to be aware that postnatal outreach visits were made because parents might need information or support but be unaware of that need or reluctant to request a visit.

These findings appear to contradict Mayer's (1973) conclusion that if a PHN's purpose is abstract and she does not state it, that clients will not be aware of it. It *is* possible for clients to "figure out" the PHN's purpose from what she does during the visit: one client in this study admitted that he had done so. In Mayer's study, as in Clark's, however, PHNs continued visiting on a long-term basis without stating their purpose. It may be less likely that clients will understand the purpose of the PHN visits under these circumstances.

Clients in this study were less well-informed about the general goal and focus of public health nursing visits than they were about the purpose of postnatal visits in particular. Most, for example, were seemingly no more aware of the preventive focus of public health than those in Luker's (1982) research on outreach visits to elderly women. Only one client referred to the PHN's role in promoting healthy lifestyles, although five of the PHNs had

prevention", even though she stated that the PHN had spent a considerable amount of time discussing immunization.

Focusing In Versus Explaining about Public Health: A Philosophical Issue

The approaches reported by the PHNs in the study fell on a continuum of explicitness that ranged from completely implicit (as in *Focusing in)* to very explicit (as in the Pattern #2 explanation). This study also shows that some clients were able to correctly infer the PHN's purpose from what she did. One client preferred to do so; another was disappointed that the PHN had not provided an explanation to validate his understanding of the purpose. Still another client wanted a previous explanation validated by the actual visit. On the other hand, one client was misinformed about the PHN's role even though the PHN had provided an explanation.

In view of the variety of client preferences, it would seem difficult for the PHN to decide what to do. Ultimately, such a decision cannot be based simply upon what clients want, but must take into consideration what is needed by any client. As one PHN stated, it is a matter of obtaining the client's informed consent.

The RØE framework represents an extremely explicit aproach to obtaining a client's informed consent. Based on the findings of this study, it is reasonable to conclude that the ROE approach is rarely found in practice. This research also suggests that one reason for the absence of this approach in practice may be that as a PHN's explicitness increases, so does the potential for making a client uncomfortable. This tension between between "knowing why " and "feeling comfortable" was expressed by one of the clients, who said:

> I think you can expect that [the PHN] explains to you what she is doing...because people wonder why...[but] if she comes and explains first, you sort of sit there and , "Hmmm, okay". [It's not] very personal.

The issue remaining, then, is whether or not the omission of an explanation such as that called for in the ROE framework can be justified on the grounds that (in some instances at least) it mitigates against the objective of getting the client comfortable. This issue can be resolved only through philosophic inquiry. Two questions (at least) must be addressed. The first is an ethical one: Is is right for a PHN to accept an invitiation to enter a client's personal world if a) she does not know what that invitation is based on, or b) if she knows that the invitation is based upon the client's feeling rather than upon his or her intellectual understanding? The second question is an epistemological one: How do people come to know? There is a growing body of literature in nursing that argues that knowledge acquired through "intuition" is at least as important as that acquired through exercise of the intellect (e.g. Benner, 1984; Schraeder & Fischer, 1986). Defining intuition is itself no mean task; perhaps it is better to ask what sort of knowledge is referred to when PHNs state (as some did in this study) that they provide an explanation only when they "sense" that the client does not understand the purpose of the visit.

Conclusions

The following are the conclusions of this qualitative study, in which PHNs and their clients described PHNs' approches in initiating postnatal outreach home visits and explained what the approaches were designed to achieve.

1. PHNs' objective in the initial part of an outreach visit is to get the client comfortable with the visit, and their approaches are designed to attain this end.
2. Clients more than PHNs conceptualize the first step in getting the client comfortable as comprising a tension-reducing process called *breaking the ice*.
3. PHNs equate their objective of *getting the client comfortable* with the ROE Framework

understanding, whereas the approaches used by PHNs appeal essentially to a client's feelings.

4. Most PHNs have preferred approaches, but their first consideration in choosing an approach is to meet the immediate needs of the particular client as expressed (explicitly or implicitly) at the outset of the visit.

5. If a client does not present with a strong approach of his or her own, or appear to be physically or psychologically uncomfortable at the outset of the visit, the PHN will use her preferred approach.

6. There are three possible components to a PHN's approach: 1) Focusing in on the client, 2) Socializing, and 3) Explaining about public health. These components are combined in different ways to produce four approach types: 1) Focusing right in on the client; 2) Socializing and focusing in; 3) Explaining about public health and focusing in; and 4) Socializing, explaining about public health and focusing in.

7. *Focusing in on the client* comprises the transition from the non-clinical to the clinical aspect of the visit. It is an important aspect of getting the client comfortable, for it involves an appeal to the client's feelings in which the PHN demonstrates her interest in the client *as a person with a particular health concern.*

8. Clients more than PHNs emphasize the importance of *socializing* in breaking the ice, attributing to it a "humanizing" (or "equalizing") effect whereby the client comes to feel comfortable with the PHN *as a person.* Its potential negative effect lies in its irrelevance to the health focus of the visit.

9. *Explaining about public health* is an appeal to the client's understanding about the purpose of the visit whereby the client comes to feel comfortable with *the idea of the visit.* It also serves other ends: the client's right to be informed, and "selling" public health. The potential negative effect of *Explaining about public health* in regard to

10. Both clients and PHNs consider that the PHN's attitude is an important aspect of her approach. Desirable attitudes are genuine interest in the client, self-confidence and a relaxed manner.
11. Most clients are aware of the purpose of a postnatal outreach visits whether or not the PHN explains the purpose, but do not demonstrate a grasp of the broad preventive and community-oriented focus of public health.
12. Clients grant entry to a PHN on the following grounds: 1) their expectations that a PHN has something of value to offer them, and 2) the PHN's ability to make them feel comfortable at the outset of the visit.
13. Clients' overall evaluations of a postnatal outreach visit are influenced by the degree to which their expectations and desires about the visit are met and by the PHN's ability to make them feel comfortable with the visit.
14. Clients who have no expectations about the visit will judge the visit as helpful if the PHN demonstrates that she has something valuable to offer them, and if she makes them feel comfortable.

Implications for Nursing

This study comprised a beginning description of PHN approaches in initiating home visits, an area of public health nursing practice that has as yet received little attention from nurse researchers. The findings point to several possibilites for future research. First, the validity of the approach components would be enhanced through replication of the study with a larger sample, and through a comparative approach, using PHNs from different agencies and in different outreach situations, such as bereavement visiting. Observing individual

Second, the findings could be used to develop a valid and reliable instrument suitable for large-scale measurement of PHNs' and clients' perceptions about right of entry and of the relative frequency of PHNs' use of the different approaches. This implies a need to refine the coding guide and to extend it to include the *focusing in* component described by the study informants.

Third, the question of whether use of the ROE approach (in full) would make clients *uncomfortable* could be answered by replicating the present study with PHNs trained to (expertly) apply it.

Fourth, the study findings point to the need for philosophic research (inquiry) to address the question of what a "good" approach consists of; i.e. Is the ROE Framework ideal? Are some approaches ethically better than others?

Finally, the study findings also have implications for public health nursing practice. They can be of "cognitive use" (Weiss, 1981) to individual PHNs in examining their own practice in initiating outreach visits, especially those assumptions upon which their approaches are based. They also point to the need for nurse educators in both academic and practice setings to examine what nurses are taught about seeking right of entry, especially in relation to the need to appeal to both the understanding and the feelings of potential clients.

REFERENCES

Aamodt, A.M. (1982). Examining ethnography for nurse researchers. *Western Journal of Nursing Research, 4*(2), 209-221.

Aasterud, M. (1965). Explanation to the patient. In J.K. Skipper Jr. & R.C. Leonard (Eds.), *Social interaction and patient care* (pp. 82-87). Philadelphia: J. B. Lippincott.

Adler, M.J. (1965). *Poetry and politics.* Pittsburgh: Duquesne University Press.

Adler, M.J. (1970). *The time of our lives; The e[illegible] sense.* New York: Holt Rinehart & Winston.

Adler, M.J. (1971). *The common sense of po[illegible] York:* Holt, Rinehart & Winston.

Adler, M.J. (1981). *Six great ideas.* New York: Macmillan.

Adler, M.J. (1983). *How to speak, how to listen.* New York: Macmillan.

Adler, M.J. (1985). *Ten philosophical mistakes.* New York: Macmillan.

Adler, M.J. & Van Doren, C. (1972). *How to read a book.* New York: Simon & Schuster.

American Public Health Association. (1980). *The definition and role of the public health nurse in the delivery of health care: A statement of the Public Health Nursing Section.* Author.

Aristotle. (1976). *The ethics of Aristotle: Nichomachean ethics.* (H. Tredennick, Rev. trans. Original translation by J.A.K. Thompson, 1953). Harmondsworth, England: Penguin Books.

Bailyn, L. (1981). Research as a cognitive process: Implications for data analysis. *Quality and Quantity: European and American Journal of Methodology, 112,* 97-117.

Bambino, C.F. (1969). *Dimensions of acceptance: Client perceptions of public health nurse home visits.* Ann Arbor, MI: University Microfilms Inc., # 69-18,879.

Berengarten, S. (1950). When nurses interview patients. *American Journal of Nursing, 50,* 13-15.

Berg, C.L., & Helgeson, D. (1984). That first home visit. *Journal of Community Health Nursing, 1,* 207-215.

Bixler, G. (1951). Editorial introduction. In H.E. Peplau, *Interpersonal relations in nursing* (pp. vii-viii). New York: G. Putman's Sons.

Belmont, CA: Wadsworth.

Benner, P. (1984). *From novice to expert*. Menlo Park, CA: Addison-Wesley.

Bruner, J. (1969). *Toward a theory of instruction*. Cambridge, MA: Belknap Press of Harvard University.

Cameron, J. E. (1982). Giant leap forward begins with the nursing interview. *Australian Nurses Journal, 12*(2), 47-48.

Castell, A. (1964). Position papers in the philosophy of education. *Curriculum Bulletin: School of Education, University of Oregon, 20*(241), 1-27.

Chavigny, K.H. & Kroske, M. (1983). Public health nursing in crisis. *Nursing Outlook, 31*, 312-316.

Chenitz, W.C. & Swanson, J.M. (1986). *From practice to grounded theory*. Menlo Park, CA: Addison-Wesley.

Clark, J. (1976). *A family visitor*. London: Royal College of Nursing and National Council of Nurses of the United Kingdom.

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

Conant, L.H. (1966). What patients say about antepartal home visits. In *Exploring progress in public health nursing practice: Papers presented at the 1965 Regional Clinical Conferences sponsored by the American Nurses Association*. New York: American Nurses Association.

Concise Oxford Dictionary. (1983). (7th ed.). London: Oxford University Press.

Cooper, H.M. (1982). Scientific guidelines for conducting integrative research reviews. *Review of Educational Research, 52*, 291-302.

Council for the Education and Training of Health Visitors. (1973). *The health visitor: Functions and implications for training*. London: Author.

Cronbach, L.J. (1975). Beyond the two disciplines of scientific psychology. *American Psychologist, 30*, 116-127.

Cronin-Stubbs, D. (1984). Interpersonal relationships in community health nursing practice. In W. Burgess & E.C. Ragland, *Community helath nursing*, (pp. 393-418). Norwalk: CT: Appleton-Century-Crofts.

Cusick, P.A. (1973). *Inside high school*. New York: Holt, Rinehart & Winston.

Denzin, N. K. (1970). *The research act: A theoretical introduction to sociological methods*. Chicago: Aldine.

Diers, D. (1979). *Research in nursing practice*. Philadelphia: J.B. Lippincott.

Dingwall, R. (1977). *The social organization of health visitor training*. London: Croom Helm.

Dingwall, R. (1982). Community nursing and civil liberty. *Journal of Advanced Nursing, 1*, 337-346.

Dohrenwend, B.S., & Richardson, S.A. (1963). Directiveness and non-directiveness in research interviewing: A reformulation of the problem. *Psychological Bulletin, 60*, 475-485.

Edmonton Board of Health. (1980). *Manual of philosophy, goals and objectives.* Unpublished manuscript. Edmonton, Alberta.

Edmonton Board of Health. (1986). *Report of the Edmonton Board of Health.* Author. Unpublished manuscript.

Edmonton Board of Health Nursing Division. (1982a). Information exchange. *Orientation to extended professional development in public health nursing: Values, attitudes and practice.* Unpublished manuscript. Edmonton, Alberta.

Edmonton Board of Health Nursing Division. (1982b). Public health: Defining characteristics, underlying presuppositions, and implications for practice. *Orientation to extended professional development in public health nursing: Values, attitudes and practice.* Unpublished manuscript. Edmonton, Alberta.

Edmonton Board of Health Nursing Division. (1983). Teaching and learning. *Orientation to extended professional development in public health nursing: Values, attitudes and practice.* Unpublished manuscript. Edmonton, Alberta.

Edmonton Board of Health Nursing Division. (1984). *Guide to support counselling tool.* Unpublished manuscript. Edmonton, Alberta.

Elkins, C.P. (1984). *Community health nursing: Skills and strategies.* Bowie, MD: Prentice-Hall.

Emory, F. (1945). *Public health nursing in Canada.* Toronto: Macmillan.

Field, P.A. (1980). *An ethnography: Four nurses' perspectives.* Doctoral dissertation. University of Alberta, Edmonton.

Field, P.A. (1982). Client care-seeking behaviors in a community setting and their sources of satisfaction with nursing care. *Nursing Papers, 14*, 15-28.

Field, P.A. & Morse, J.M. (1985). *Nursing research: The application of qualitative methods.* Rockville, MD: Aspen.

Field, S., Draper, M., Kerr, M., & Hare, M. (1982). A consumer view of the health visiting service. *Health Visitor, 55*, 299-301.

Fowler, L. (February, 1985). Communication: A sound basis for nursing. *Community Outlook.*

Foxman, R., Moss, P., Bolland, G., & Owen, C. (1982). A consumer view of the health visitor at six weeks postpartum. *Health Visitor, 55*, 302-308.

Freeman, R. (1950). *Public health nursing practice.* Philadelphia: Saunders.

Freeman, R. (1970). *Community health nursing practice.* Philadelphia: Saunders.

Friedemann, M.L. (1983). *Manual for effective community health nursng practice.* Monterey, CA: Wadsworth Health Sciences Division.

Freidin, R.B., Goldman, L., & Cecil, R. (1980). Patient-physician concordance in problem identification in the primary care setting. *Annals of Internal Medicine, 93,* 490-493.

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

Gardner, J.F. (1975). *The experience of knowledge.* Garden City, NY: Waldorf Press.

Geertsma, R.H., & Hastings, G.E. (1971). Interdisciplinary perceptions of the public health nurse. *Medical Care, 9,* 152-159.

Gordon, M. (1982). *Nursing diagnosis: Process and application.* New York: McGraw Hill.

Goetz, J. P., & LeCompte, M. D. (1981). Ethnographic research and the problem of data reduction. *Anthropology and Education Quarterly, 12,* pp. 51-70.

Gustafsen, M.B. (1977). "Let's broaden our horizons about the use of contracts. *International Nursing Review, 24*(1), 18-19, 24.

Hansen, A.C. & Levy, J.M. (1961). Families speak for themselves. *Nursing Outlook, 9,* 344-349.

Helvie, C.O. (1981). *Community health nursing.* Philadelphia: Harper & Row.

Henderson, V.E. & Nite, G. (1978). *Principles and practice of nursing.* New York: Macmillan.

Hulka, B.S., Cassel, J.C., Kupper, L.L., & Burdette, J.A. (1976). Communication, compliance and concordance between physicians and patients with prescribed medications. *American Journal of Public Health, 66,* 847-853.

Hunt, M. (1972a, Feb.3). The dilemma of identity in health visiting: 1. *Nursing Times: Occasional Papers,* 19-22.

Hunt, M. (1972b, Feb. 10). The dilemma of identity in health visiting: 2. *Nursing Times: Occasional Papers,* 23-24.

HVs: Questions or challenge? (1979, Jul. 12). *Nursing Times Community Outlook.*

Jack, S. (Dec., 1978). "An investigation into the principles of health visiting". *Health Visitor, 51,* 463.

Jefferys, M. (1965). The uncertain health visitor. *Society at Work, 6*(161), 16-18.

Jick, T.D. (1979). Mixing qualitative and quantitative methodologies: Triangulation in action. *Administrative Science Quarterly, 24,* 602-611.

Johnson, W.L., & Hardin, C.A. (1962). *Content and dynamics of home visits of public health nurses: Part I.* New York: American Nurses Foundation.

Kaban, J.D. (1979). Legal aspects of social trends in nursing. In *Political, social and educational forces in nursing: Impact of social forces*, (pp.9-16). NLN Publications #15-1774.

Kalisch, B.J. (1975). What is empathy? In B.W. Spradley (Ed). *Contemporary community nursing*, (pp. 275-283). Boston: Little, Brown.

Keith, P.M. (1976). A preliminary investigation of the role of the public health nurse in evaluation of services for the aged. *American Journal of Public Health, 66*, 379-380.

Langford, T. (1978). Establishing a nursing contract. *Nursing Outlook, 26*, 386-388.

Leahy, K.M., Cobb, M.M., [redacted] (1977). *Community health nursing.* New York: McGraw Hill.

Leatt, P. (1986). Descriptive and experimental approaches to nursing problems: Issues in design. In S.M. Stinson & J.C. Kerr (Eds.) *International issues in nursing research*, (pp. 1-27). London: Croom Helm.

LeCompte, M. & Goetz, J.P. (1982). Problems of reliability and validity in ethnographic research. *Review of Educational Research, 52*, 31-60.

Luker, K. (1982). *Evaluating health visiting practice.* London: The Royal College of Nursing of the United Kingdom.

Leininger, M. (1985). Ethnography and ethnonursing: Models of qualitative data analysis. In M. Leininger (Ed.) *Qualitative research methods in nursing*, (pp. 33-71). Orlando: Grune & Stratton.

Maritain, J. (1959). *The degrees of knowledge.* (Trans. by G.B. Phelan). New York: Charles Scribner's Sons.

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

McIntosh, J. (1979). The nurse-client relationship. *Nursing Mirror, 154*, (Suppl. Jan. 25).

Mehan, H. (1979). *Learning lessons: Social organization in the classroom.* Cambridge MA: Harvard University Press.

Mishler, E.J. (1979). Meaning in context: Is there any other kind? *Harvard Educational Review, 49*, 1-19.

Mill, J.S. (1859). *On liberty.* (Reprinted 1978). Indianapolis: Hackett.

Mills, K.M. & Edwards, A.J. (1984). *Post partum discharge: A study of client and public health nurse experience.* Unpublished report. Edmonton Board of Health.

Monteiro, L.A. (1985). Florence Nightingale on public health. *American Journal of Public Health, 75*, 181-186.

Morgan, B.S. & Barden, M.E. (1985). Nurse-patient interaction in the home setting. *Public Health Nursing, 2*, 159-167.

Morse, J.M. (1986). Quantitative and qualitative research: Issues in sampling. In L. Chinn (Ed.), *Nursing research methodology.* Rockville, MD: Aspen.

Nettler, G. (1980). Sociologist as advocate. *Canadian Journal of Sociology, 5*, 31-53.

Oliver, J. (1985, June 19). Nurse with no name. *Nursing Times, 81*(25), 22.

Orem, D. E. (1980). *Nursing: Concepts of practice.* (2nd ed.). New York: McGraw Hill.

Orem, D.E. (1981). Nursing: A triad of action systems. In E. G. Lasker (Ed.) *Applied systems and cybernetics: Proceedings of the International Congress of Applied Systems Research and Cybernetics.* New York: Pergamon.

Pearson, P. (1984, Nov. 21). Images of a health visitor. *Nursing Mirror, 159*(19), 21-23.

Peplau, H. E. (1951). *Interpersonal relations in nursing.* New York: G. Putnam's Sons.

Phenix, P.H. (1969). The moral imperative in contemporary American education. *Perspectives in Education, 2*(2), 6-13.

Ranson, B.H.A. (Aug. 1977). Health visiting: The personal touch or the professional image--which is more important? *Health Visitor, 50*, 258-261.

Reichardt, G.S. & Cook, T.D. (1979). Beyond qualitative *versus* quantitative methods. In T.D. Cook & C.S. Reichardt (Eds.) *Qualitative and quantitative methods in research evaluation* (pp. 7-31). Beverly Hills: Sage.

Rice, D. (1975). As others see us. *Health Visitor, 52*, 422-425.

Ruben, R. & Erickson, F. (1978). Research in clinical nursing. *Journal of Avanced Nursing, 3*, 131-144.

Schraeder, B.D. & Fischer, D.K. (1986). Usng intuitive knowledge to make clinical decisions. *Maternal and Child Nursing, 11*, 161-162.

Shamansky, S.L. (1984). Community health nursing revisited: A conversation with Virginia Henderson. *Public Health Nursing, 1*, 193-201.

Simmons, H. & Kikuchi, J. (1984). Presuppositions about health. In *A philosophy of nursing*. Unpublished manuscript. Edmonton, Alberta.

Simmons, H. & Kikuchi, J. (1985a). *Persuasion*. Unpublished manuscript. University of Alberta, Edmonton.

Simmons, H. & Kikuchi, J. (1985b). *Information exchange*. Unpublished manuscript. University of Alberta. Edmonton.

Simms, M. & Smith, C. (1984). Teenage mothers: some views on health visitors. *Health*

Visitor, 57, 269-270.

Simon, Y.R. (1940). *Nature and functions of authority*. Milwaukee: Marquette University Press.

Simon, Y.R. (1951). *A general theory of authority*. Notre Dame, IA: University of Notre Dame.

Sloan, M.R., & Schoettmer, B. T. (1975). The process of contracting in community nursing. In B. W. Spradley (Ed.) *Contemporary community nursing*, (pp. 221-229). Boston: Little, Brown.

Spradley, B.W. (1981). *Community health nursing: Concepts and practice*. Boston: Little, Brown.

Spradley, J.P. (1979). *The ethnographic interview*. New York: Holt, Rinehart & Winston.

Sundeen, S.J., Stuart, G.W., Rankin, E.D., & Cohen, S.P. (1976). *Nurse-client interaction: Implementing the nursing process*. St. Louis: C.V. Mosby.

Trend, M.G. (1978). On the reconciliaton of qualitative and quantitative analyses: A case study. *Human Organization, 37*, 345-354.

Tripp-Reimer, T. (1985). Combining qualitative and quantitative methodologies. In M. Leininger (Ed.) *Qualitative research methods in nursing*, (pp. 179-194). Orlando: Grund & Stratton.

Turner, J.A. (1981). Some practical aspects of data analysis: One way of organizing the cognitive processes associated with the generation of grounded theory. *Quality and Quantity, 15*, 225-247.

Warner, U. (1984a, June 13). Asking the right questions. *Nursing Times Community Outlook*. 214, 216.

Warner, U. (1984b, Jul 11). Achieving goals. *Nursing Times Community Outlook*. 242.

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

Weiss, C.H. (1981). Measuring the use of evaluation. In J.A. Ciarlo (Ed.), *Utilizing evaluation: Concepts and measurement techniques* (pp. 17-33). Philadelphia: J.B. Lippincott.

Whitehead, A.N. (1933). *Adventures of ideas*. New York: The Free Press.

Appendix A

The EBH Right of Entry Framework[3]

Right of Entry

In situations initiated by the nurse:

1. Obtains "right of entry" by providing relevant information in nurse-initiated counselling situations:
   a. -Identifies self by name, role, agency, region
      -If a referral, and where not obvious, identifies by name the referring agency and/or person; focal client(s) and service category
   b. -Describes public health's interest in the health of the public, connecting it to the service being offered
      -Makes explicit public health's mandate to offer this support service to the client
   c. -Discloses the intent of this particular contact; checks for and ensures client understanding to this point
   d. States source of information that underlies focus of contact, if other than herself
   e. -Makes explicit reference to issue or *focus* of contact and checks client's awareness of it
   f. -States nurse's role relevance in relation to the focus
   g. -Asks client to paraphrase what nurse has said about the relevance of the nurse role in the situation
   h. -Asks client what his expectation is, given what has been said
   i. -Acknowledges client's potential for self-help
   j. -Asserts her (nurse's) willingness to be helpful if and where possible
   k. -Asks for commitment of client to work around the focus of the contact

[3] Reprinted from EBH Nursing Division, 1984, *Guide to Support Counselling Tool.* Unpublished manuscript. Edmonton Board of Health, Alberta.

Right of Entry: Goal and Elements

In situations initiated by the nurse

GOAL:

Attaining right of entry into the personal world of the client by the nurse's conveying that the intention of public health nursing is to support people in their efforts to have a good life by planfully promoting health whenever and wherever possible--using as the main way of doing that, appealing to the client's common sense regarding the knowledge, attitudes, skills (KAS) and technology that support individual effort toward achieving health for themselves, their families and their communities. And the client coming to understand the intention and welcoming the nurse on that basis.

ELEMENTS:

a. Adequate ID of yourself as an agency representative.
b. Adequate ID of your agency as credible in the eyes of the client as a health support system.
c. The source of information linking nurse to client.
d. The valid link between you (your agency) and the client.
e. Client's understanding of b through d.
f. And getting some "objective" indication of the client's readiness to welcome you as a potential source of support.

Note: Under b above, try to include the following:

WHO AND WHERE:

1. PH's intention to serve the entire Edmonton population across life cycle, with and without problems.
2. Intention of public health nursing is to cooperate with nature to bring about health in individuals and families.

WHY:

1. Because believe people try to make a good life for themselves and can't without help.
2. Public taxes pay for service, same as education for all.

HOW:

1. Support people's efforts to attain health KAS plus technology (e.g. immunization) (Build upon what people already know or do on behalf of their health).
2. Focus on everyday developments and problems related to health (not treatment oriented).
3. Link public to resources required outside of PHN service.
4. Work with different parts of PH system to give everyone equal opportunity to health: environment, dentistry, nutrition, health education, etc.
5. Work with other parts of health system and social services; schools.

WHAT:

1. Programs--reflecting health needs across the age spectrum when new opportunities for health and learning, and resources, are likely to be strained; keep families functional and not let small sectors of population slip through and negatively influence health status of others.

Appendix B

Descriptions of Approaches

TO: PHNs interested in participating in a study investigating how PHNs begin outreach[4] home visits.
FROM: Hasana Birk, RN, MN Candidate: Investigator

The approaches listed below have been taken in part from the literature and in part from my experience as a public health nurse. Since one of the aims of this study is to find out what variety of approaches that PHNs actually use in practice, it is not assumed that the list of approaches below is exhaustive: it merely reflects approaches that have been described or used by at least one PHN at one time. Please feel free to elaborate on whatever approach you use as yours.

APPROACH 1

In this approach, the PHN and the client move into the clinical focus of the visit immediately, with little or no preliminary conversation. Example:
PHN: Hello, Mrs. Flaherty, I am Brenda Jones, a public health nurse from the Edmonton Board of Health.
CLIENT: Oh, do come in. You've no idea how how glad I am to see you! The baby has been crying all day--I don't know what's wrong with her and I really could use some advice on what to do.
PHN: Can you tell me what you are feeding her and how often?

APPROACH 2
In this approach, social pleasantries (e.g. admiring the baby, the home, the pets; commenting on the weather, etc.) are exchanged before the conversation turns to the specific clinical focus of the visit. Such preliminary conversation is considered by some authors to be important or essential in establishing rapport between PHN and client.

APPROACH 3
In this approach, the PHN makes explicit the purpose of public health nursing postnatal outreach visits, and what usually takes place on these visits, before turning to discussion of the specific clinical content of the visit. The following is one PHN's account of her use of this sort of approach:

> "I explain what public health is about as I see it ...often I'll find out what it is she [the postnatal client] knows about public health and then just fill in the gaps".

APPROACH 4
This is a combination of Approaches 2 and 3 above. In this approach, preliminary conversation is divided more or less equally (as measured by amount of time) between the content of Approach 2 and that of Approach 3.

OTHER
If you do not think that your way of starting postnatal outreach visits "fits" any of the above descriptions, please check off "Other" and explain your approach in the space provided.

---

[4] Outreach visits: Visits initiated by the PHN as opposed to those made at the request of a particular client.

PLEASE DO NOT WRITE YOUR NAME ON THIS FORM

PHN CODE NUMBER---------- Date----------

"I would describe my usual approach to beginning POSTNATAL OUTREACH visits as":

2. APPROACH 1
3. APPROACH 2
4. APPROACH 3
5. APPROACH 4
6. OTHER (Please elaborate below)

Filling out this sheet indicates only that you are interested in being a subject in this study. It is not a consent form. Any information you provide will be treated as confidential and none will be used as data in the study unless you are selected as a subject and you give your written consent.

Appendix C.01

PHN Consent Form

Project Title: APPROACHES USED BY PUBLIC HEALTH NURSES IN INITIATING OUTREACH HOME VISITS
Investigator: Hasana Birk, RN, MN Candidate (University of Alberta)
Phone: Business: 482-1965 (Extension 274); Home: 436-0895

This is to certify that I,---------- (*Please print name*), agree to participate in a nursing research project investigating approaches used by PHNs in initiating outreach home visits. I understand the following points:

1. I will be required to make one postnatal home visit. I will record the visit on audiotape; the content of the visit will later be transcribed (typed). I will also make a written script of any conversation I have with my client before the tape recorder is turned on. I may be requested to tape a second visit if, for any reason, the data from the first tape are not usable.

2. I will also be required to participate in one to three (1 to 3) tape-recorded telephone interviews with the researcher. Each interview will be approximately one (1) hour in length and will be at a time convenient to me. The tapes of the interviews will be transcribed.

3. My anonymity will be protected by the following means:
   a. I will be known to the researcher only by code number. My written consent and the list of names and code numbers of PHN subjects will be kept in a locked file by a research assistant who is not an employee of the Edmonton Board of Health. Neither the researcher nor any other employee of the Edmonton Board of Health will have access to that information, and it will be destroyed by the research assistant at the completion of the study.
   b. My name will be removed from all tapes and transcriptions before they are reviewed by the researcher. My identity will not be revealed in any research report.
   c. Any oral communication between me and the researcher will take place by telephone.
   d. The client(s) that I visit will be requested not to reveal my name to the researcher.

4. I recognize that it is not possible for my anonymity to be completely ensured. The researcher may be able to identify me through voice recognition, or my client(s) may inadvertently reveal my name. If the researcher becomes aware of my identity, she will inform me of this fact.

5. I may waive my right to anonymity if I so desire.

6. The information obtained from me will not be used to evaluate my performance as an employee of the Edmonton Board of Health.

7. All tapes will be erased at the conclusion of the study. The transcriptions will be stored in a locked drawer in the researcher's home and will be destroyed three (3) years following the completion of the study.

8. I may decline to answer any questions put to me by the researcher.

9. I may withdraw from the study at any time with no adverse consequences to me. If I withdraw, I may grant permission to the researcher to use any information obtained from me prior to my withdrawl. It is my right, however, to insist that all information obtained from me be removed from the study.

10. I will not necessarily benefit from this research project.

11. I will be given a summary of the final report if I so desire.

Signature of PHN----------

Date----------

Appendix C.02

Client Consent Form
(Consent to be Recorded on Audiotape)

Investigator: Hasana Birk, RN, MN Candidate, University of Alberta
Phone: Business: 482-1965 (Extension 274); Home: 436-0895

This is to certify that I, ----------, agree to participate in a nursing research project studying home visits made by public health nurses to new parents.

I understand the following points:

1. A public health nurse will visit me after my baby is born. The conversation between me and the public health nurse will be tape recorded by the nurse. The tape recorder will be turned on as the nurse approaches my home, and will be turned off after she leaves. The content of the conversation between me and the public health nurse will later be transcribed (typed). My name will be erased from the tape and the transcription, and will be replaced by a code number.

2. I will also be interviewed by the researcher within one to three (1 to 3) weeks following the public health nurse's visit. This interview will be tape recorded and will last approximately one (1) hour. The interview will take place either in my home, or by telephone, according to my preference, and will be at a time convenient to me. The tape recording of the interview will be transcribed.

3. I may decline to answer any questions put to me by the researcher.

4. All information obtained from me will be confidential. The tapes will be erased at the end of the study. The transcriptions will be kept in a locked file in the researcher's home and will be destroyed three (3) years after the completion of the study.

5. My name will not be used in any report of the research findings.

6. The information obtained from the tapes and interviews will not be used to evaluate the performance of the public health nurse.

7. I may withdraw from the study at any time with no adverse consequences to me. If I withdraw, I may grant permission to the researcher to use any information obtained from me prior to my withdrawl. It is my right, however, to insist that all information obtained from me be removed from the study.

8. I will not necessarily benefit from this research project.

9. I will be sent a summary of the final report if I so desire.

Date of audiotaped consent----------

Address of Subject----------

Client Subject Code #----------

Appendix D.01

PHN Interview Guide

(Most of the questions are general in nature. Where appropriate [e.g. to clarify general statements], reference will be made to specific home visits taped by the informant. The order and wording of the questions may be varied according to the responses of the informant. The bracketed numbers in the right hand column refer to the specific research questions being addressed through the interview questions).

As you know, I am interested in how PHNs begin a public health nursing outreach visit. May I ask you some questions related to this subject?

1. [2.1]
ew PHN and I had never made an outreach visit, and I asked you, "How begin a postnatal outreach visit?" What would you tell me? Could you igh" the beginning of a typical postnatal outreach visit?

you make contact with the client? What do you usually say? How do you get to the client's house? When do you consider that the visit is over?

[2.1]
ches" sheet that I (as researcher) sent you, you named your approach as ow well would you say your approach fits the description given on the sheet? uld you ever use any of the other approaches?

Probe: Is there anything you would avoid doing in the initial phase of a postnatal outreach visit? Anything you make sure you always do?

3. [2.1, 2.2]
I'd like to move from postnatal outreach visits to outreach visits in general. Suppose, again, that I am a new PHN, and I ask you, "Does the type of outreach visit make a difference in how you approach the client?" Could you describe the difference?

Probe: E.g. bereavement visits, school visits.

4. [2.1, 2.2]
What about outreach visits as compared to client-initiated visits?
(What difference, if any, is there in your approach?)

5. [2.2]
Can you think of any other factors that might affect the way you approach a client?

Probe: What about age? Sex? Ethnic background? Eager versus reluctant client? Did participating in this research project make a difference in the way you began the visit you taped?

6. [2.3, 2.4]
In general, what would you say you are trying to accomplish in the introductory phase of an outreach visit?

Probe: When you do (did) *x*, what was it you were trying to accomplish?

How do (did) you know when you have (had) accomplished it? Does your objective change under any of the conditions we talked about earlier?

7. [2.3]

How important is it for you to have a client who really welcomes your visit? How welcomed did you feel by the client you visited for this study?
When you meet with a reluctant or indifferent client how do you proceed?

8. [2.

How important is it for you to know that your client understands the purpose of a pu health nursing outreach visit?
Probe: What, specifically, would you want her (him) to understand?

9. [2.4]

Are you familiar with the term "right of entry"?
What does it mean to you?

Probe: How would you talk about right of entry in a conversation with a new PHN?
How important is right of entry, in your opinion? (If seen as important) How do you know when you have achieved it? Would you say you achieved it in the visit you made for the study?

Appendix D.02

PHN Supplementary Data Sheet

Date of visit---------- PHN Code #---------

1. Conversation between PHN and Client before the home visit.

   If you phoned your client before visiting her (him/them), would you describe, to the best of your recall, any conversation that took place on the telephone.
   Please write your conversation in the form of a script, as opposed to a narrative. The intention is to obtain a picture of what you did on one particular occasion, NOT a description of your "usual" or "best" performance. If you cannot remember what you or your client said at any particular point, just put in brackets "Not sure what I said next", rather than "creating" a script.
   The following is an example of what a script would look like:

   (Conversation on phone)
   PHN: Hello, could I please speak with Mrs. Kowalski?
   CLIENT: Speaking.
   PHN: I am...(etc.)

2. Untaped conversation during the home visit.

   If there was any time during the visit when the tape was turned off, would you please indicate:
   a. The reason
   b. The focus of the untaped conversation, and
   c. Your estimate of the amount of time the tape was turned off.
   This description should be brief; it need not be in script format.

   Example 1: "Tape turned off at client's request; discussion re sex; about 10 minutes.
   Example 2: Tape (side 1) ended while I was checking the baby's cord--forgot to turn it over--off for about 5 min. Topic: care of cord.

3. And finally, a few questions about yourself:
   a. How many years experience do you have in public health nursing:
      At the EBH------ At another public health agency?-------

   b. How long have you been working as a district PHN at the EBH?------year(s)

   c. When did you last participate in a VAP series?----------(month and year).

   d. What is your approximate age?

      Under 25------ 45-55------
      25-35------ Over 55------
      35-45----------

Thank you very much for your participation in this research project.

Would like a summary of the final report? Yes-----No-----

Appendix D.03

Client Interview Guide

(The order and wording of the questions may be varied according to the responses of the informant. Bracketed numbers to the right refer to the research question[s] being addressed).

I am doing a study on public health nurses and their visits with new parents. I am particularly interested in talking with parents who have had a visit that was initiated by the public health nurse (as opposed to visits made at the request of the parents). "Would you be willing to talk with me about your experience?" (Bambino, 1969, p. 25).

1. [3.1, 3.2]

I'd like you to think back to the point when the public health nurse first contacted you.
How did you feel about the idea of having a public health nurse come to visit you?
When she first arrived at your home, how much did you want to participate in the upcoming visit with her?
Was there any point at which your feelings changed?
(If any change) What do you think contributed to your change in feelings?

2. [3.1, 3.2]

What did you expect would happen on the visit?
Did it turn out as you expected? If not, in what way was it different from your expectation?

3. [3.1]

Looking at the visit as a whole, what do you think was the public health nurse's purpose in visiting you; that is what do you think she was trying to accomplish? (Clark, 1984)
What did *you* hope the visit would accomplish?
Overall, how helpful (or unhelpful) would you say the visit was? What made it helpful (unhelpful)?

4. [3.1]

What is your impression of the reason that public health nurses make these visits; that is, why do you think they initiate visits, as opposed to visiting only when people call to request a visit?

5. [3.1, 3.4]

Can you recall how the public health nurse started off the visit?
If so, could you describe in your own words how it went?
Prompt: How did she make contact with you? What did she say? What did she first say/do when she arrived at your home?
If you were asked to advise a new public health nurse about the best way to start off a visit, what would you tell her?

6. [3.3]
I'd like you to imagine a visit in which the nurse started off in a different way. I will describe some approaches that other nurses say they use. Could you tell me how you think you might have responded to each of them? (Researcher to describe approaches outlined in Appendix D not already referred to by the informant).

7. [3.4]
If a neighbour asked you, "What types of services can my family expect from public health nurses in Edmonton", what would you tell her or him? How did you come to know about these services?
How did you feel about the public health nurse giving (not giving) you this sort of information on your visit together? (If applicable) At what point in the visit should the public health nurse give this information?

8. I have just a few more questions, mostly about yourself. But first, could I ask if you have ever had contact with a public health nurse before the visit last (week, Monday, etc.)? (If yes) Could you briefly describe the circumstances of that contact?

9. What is your baby's date of birth?

10. What is your age?

11. Are you employed outside the home? If so, what is your occupation?

12. What is the last grade of school that you completed?

13. Were you born in Canada? If not, what is your country of origin? How long have you lived in Canada?

Thank you very much for participating in this research project.

Would you like to receive a summary of the final report? Yes----- No-----

If yes, where should I send it?

Name:----------

Address----------Phone ----------

Appendix E.01

Coding Guidelines: PHN Home Visits and Phone Calls

Approaches are to be coded according to the categorization scheme depicted in Appendix E.02. There are two main categories of approach: Implicit and Explicit. Each of these main categories is divided into two sub-categories; each sub-category is further divided into two more sub-categories, making a total of eight possible approaches.

OVERVIEW OF CODING PROCEDURE

The following steps apply to both the pre-visit phone call(s) and to the home visit itself, except where otherwise indicated. Definitions are found below.

Step 1. Break all conversation into clinical and non-clinical segments. Identify the *introductory* and *intervening* non-clinical segments of the home visit.

Step 2. Code all elements and sub-elements of the EBH ROE framework found in the non-clinical segments.

Step 3. Code all social conversation.

Step 4. Categorize the approach according to the coding scheme depicted in Figure x (p. 6), for the following parts of the PHN-client encounter:
1. The phone call.
2. The introductory segment of the home visit.
3. The intervening segment of the home visit.

Step 5. Make an overall categorization of the whole encounter (phone call and home visit combined).

DEFINITIONS

Clinical Conversation: Conversation which pertains directly to the public health nursing focus of the particular visit; it consists of nursing assessments, interventions, and evaluations.
Example:
PHN: Hello, Mrs. Flaherty, I am Brenda Jones, a PHN from the Edmonton Board of Health. I...
CLIENT: Oh, do come in. You've no idea how glad I am to see you! The baby has been crying all night--I'm sure she's not getting enough to eat, and I really need your advice on what to do.
PHN: Can you tell me what you are feeding her and how often?

Non-Clinical Conversation: All conversation other than clinical conversation.

Introductory Segment: The initial non-clinical segment of the home visit. It extends from the beginning of the home visit to the first clinical segment.

Intervening Segment(s): Non-clinical conversation occuring between two clinical segments of the home visit. A visit may contain no, one, or more than one, *intervening segments*.

Social Conversation: Consists of statements and questions that might take place in *any*

exchange between persons. In the context of a postnatal outreach visit, although social conversation may be indirectly relevant to the health focus of the visit, it is not *about* health matters. Social conversation includes the following: statements or questions about the plants, the garden, the weather, the household furnishings, the pets, the neighbours, the news, or similar topics not obviously related to the visit focus or a health need.
Single statements or questions should be considered in the context of the rest of the conversation: e.g. the questions "How are you?", "How are things going?", or "Having a baby is a big change, isn't it?" may be either "*Social* or *Clinical* depending upon the response of the client and subsequent statements or questions of the PHN.

Implicit Approach: An approach in which the PHN does not articulate, or adequately articulate, the purpose of the PHN-client encounter or the reasons why PHNs initiate these encounters.

Explicit Approach: An approach in which the PHN articulates for the potential client the purpose of the PHN-client encounter and the reasons why PHNs initiate these encounters.

CODING OF THE APPROACHES

IMPLICIT APPROACHES (Approaches 1 and 2).

Approach 1. Does not seek ROE. The PHN's dialogue may contain Component 1, but lacks Components 2, 3, and 4, of *Approach 3: Seeks ROE--Simple* below.

Approach 2. Partially Seeks ROE. The PHN's dialogue contains Component 1 and one or two of the three remaining components of *Approach 3: Seeks ROE-- Simple*, below.

EXPLICIT APPROACHES (Approaches 3 and 4).

Approach 3. Seeks ROE: Simple. The PHN's dialogue contains the following four components:

1. Identification of the PHN by name, role (i.e. PHN) and either agency or health centre.
2. A statement of the *purpose* (goal, object, aim) or *focus* of public health nursing visits in general.
3. A statement of the PHN's intention to act: What the PHN intends to accomplish on this particular visit.
4. An explanation of the *reason why* PHNs make outreach visits; i.e. the general public health mandate or the need for particular public health nursing outreach programs, such as postnatal home visiting.

Example 1: [We make these visits in order to provide assistance and support for new parents.] Code bracketed segment as **(3)**
Example 2: ["Public health has always tried to improve the health of the whole population] **(2)**, and [we believe that if you want to reach everyone, you can't wait for people to call you."] **(4)** Code bracketed segments as indicated.

Example 3:["Public health has always believed that everyone deserves a chance to be as healthy as possible]**(4)**; [we want to prevent problems before they happen]**(2)**, and so we reach out and offer assistance [at times when attention to health is particularly important--such as when a baby is born."]**(4)**

Note: The four components of **Approach 3** are equivalent to the following sub-elements of the

EBH ROE framework (see pp. 4-5):

Component 1= ROE sub-elements a1; a2; and a3 or a4
Component 2= ROE sub-element b2
Component 3= ROE sub-element d1
Component 4= ROE sub-element b3

Approach 4: Seeks ROE: Elaborate. The PHN's dialogue contains all 6 elements of the EBH ROE Framework (see pp. 4-5).

Approaches WITHOUT Social Conversation (1A, 2A, 3A, 4A)
Less than half of the dialogue (measured in time) in the introductory segmentof the home visit consists of social conversation.

Approaches WITH Social Conversation (1B, 2B, 3B, 4B).
Half or more of the dialogue in the introductory segment of the home visit consists of social conversation.

The EBH ROE Framework

Element a. Adequate identification of self as an agency representative.
Sub-elements:
a1. Name
a2. Role (i.e. PHN)
a3. Agency
a4. Region (i.e. the particular health centre that the PHN is associated with.

Element b. Adequate identification of agency as credible in the eyes of the client as a health support system.
Subelements:
b1. States to whom public health nursing service is directed.
e.g. The EBH's intention is to serve the entire Edmonton population (people with and without problems) across the life cycle.
b2.States what the goal or focus of the service is.
e.g.1. To cooperate with nature to bring about health in individuals and families; to keep families functional and not let small sectors of the population slip through and negatively influence others.
2. Focus on prevention and promotion. 3. To support people at times of life changes, when health may be at risk.
b3. States why service is given.
e.g. Because people try to make a good life for themselves and can't without help; because there is a mandate from the public to protect the health of all and funding is provided through public taxes; because everyone deserves an equal opportunity to health.
b4. States how this is accomplished.
e.g. through programs which:
-support people's efforts to attain health knowledge, attitudes and skills plus technology (e.g. immunization); build on what people already know or do on behalf of their health
-focus on everyday developments and problems related to health (not treatment oriented)
-link public to resources required outside of public health nursing services
-work with different parts of the health system to give everyone equal opportunity to health: e.g. environmental health services, dental services, speech and language services
-work with other parts of the health system; with social services; with schools
-focus on life events and developmental processes when new opportunities for health and learning are present and when existing resources are likely to be strained, ie. in times of

change (e.g. birth, bereavement, adolescence, aging)

Element c. Identifies the source of information linking PHN to client.
In the case of postnatal visits, this is the Physician's Notice of Birth (PNOB) which is sent to the EBH by the hospital (if a hospital birth) or by the attending physician (if a home birth).

Element d. Identifies the valid link between PHN (agency) and client.
Sub-elements:
d1. Discloses the goal of *this particular visit.*
d2. Makes explicit reference to the issue or general focus of the contact.
d3. States PHN's role relevance in relation to the focus

Example: We try to visit all new parents **d2** to assess your baby's health--and yours; to help you find answers to any questions you may have; and to let you know what public health services are available to you and your family **(d1).** We are expected to have up-to-date knowledge about the care of new babies, and we have experience in what it's like to have a new baby, from visiting so many new parents **(d3).**

Element e. Checks for client's understanding of one or more of subelements **b** through **d.**
Subelements **e1, e2, and e3** refer to the client's understanding of one or more of subelements **b, c, and d** respectively.

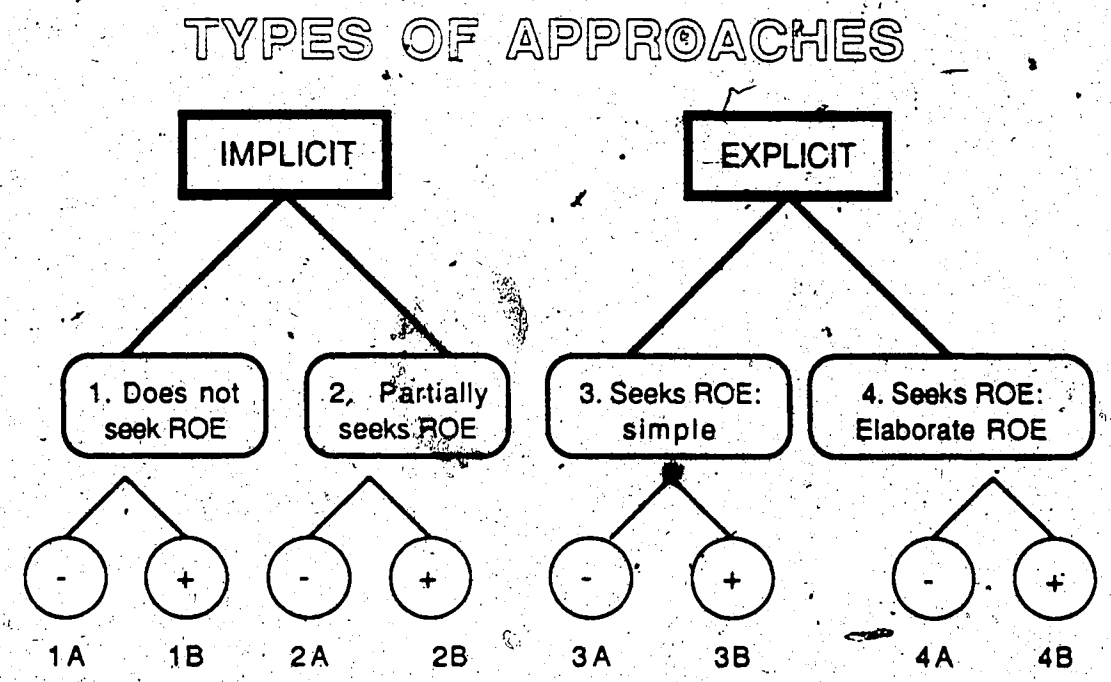
Example:
"Mrs. Cohen, I'd like to make sure that I've given you a good idea of what public health nursing is all about **(e1)** and what you can expect from me **(e3).** Do you mind if I ask you what your impression of public health nursing is and what you think you can expect from me?"

Element f. Obtains some "objective" indication of the client's readiness to welcome the PHN as a source of support.
Subelements:
f1. Acknowledges client's potential for self-help.
f2. Asserts willingness and intention to be helpful if and where possible.
f3. Asks for commitment of client to work with the nurse around the focus of the contact.

Example: "Mrs. Ewing, I'd like to talk with you about your baby's health and how things are going for the whole family. It's not that I think that you can't manage on your own **(f1)**, but if there's anything I can add to what you already know, I'd be pleased to do that **(f2).** Would you find that helpful? **(f3)**

Appendix E.02

Diagram of Approaches



Legend:

(-) = Without social conversation

(+) = With social conversation

Appendix E.03

The Constant Comparative Method: Analytic Stages

The following stages of analysis are based on the explications of Turner (1981) and Field and Morse (1985).

1. *Develop categories inductively* from the data by labelling the observed phenomena.
2. *Saturate the categories* by accumulating examples until criteria for inclusion in the category become clear.
3. *Formulate abstract definitions* by stating explicitly the inclusion criteria that are recognized implicitly in Stage 2.
4. *Use the definitions* to guide future fieldwork (interviews) and to stimulate the flow of ideas in the researcher's mind.
5. *Exploit the categories fully* by comparing them to other related categories: inverse, opposite, more specific, more general; search actively for negative instances.
6. *Develop and test links* between categories; note relations, formulate tentative hypotheses, and consider the conditions under which the linkages hold.
7. *Make connections to existing theory;* compare and contrast.
8. *Test emerging realtionships* through the use of extreme comparisons, to see if the relationships hold both within and between categories.

Appendix F

Categories Emerging from Analysis of the Informant Interviews

The Approach Components

Three approach components (categories) were identified. Definitions and examples of each follow.

1. **Focusing Right In on the Client** refers to an approach in which the PHN moves into the clinical aspect of the visit shortly after mutual identification of the PHN and client.

Examples

PHN: I identify myself and then they invite me in and...offer me a seat. Then I talk about the mother: I ask her how she is feeling; how she's doing with the baby.

PHN: The mother would say: "Come on in...Would you like a cup of coffee?" "No thank you". I would say: "How are things going with you and the baby?"...So I would probably get into it right there, to how *they* are.

CLT: She just asked if there was something special that I would like to talk about, or something. She actually let *me* make the beginning--or what's important for me.

2. **Explaining about Public Health** refers to an approach in which the PHN provides the client with information about public health nursing. This information may or may not include the purpose of the visit.

Examples

PHN: First of all I would...ask whether the mom has had any exposure to public health...Did she know about some of our other services? Here, again, tying in our major goals of health promotion, health protection and disease prevention.

PHN: I tell them that the [agency's] goal is to help everyone be as healthy as possible...that we feel we are promoting their health and their baby's health by visiting in the home.

CLT: I just recall thinking that I wanted to know *why* she was here. And somehow in the first few minutes she'd told me that.

3. **Socializing** refers to an approach in which the conversation is about matters other than the health focus of the visit: "small talk" or "chit chat".

Examples

PHN: We might talk about how the weather is here, and I will certainly admire the baby if the baby is around at the moment...If there's a pet, you might notice the pet.

CLT: The chit-chat at the beginning is...comfortable, especially when she starts gooing and gaaing about our kid...You know, that's pretty good--she can win my heart doing that!

PHN: Making a comment *to* the baby on how beautiful the baby looks, or..."Where's the pumpkin today?" or something like that.

EXPLAINING ABOUT PUBLIC HEALTH: SUB-CATEGORIES

A PHN's explanation about public health could involve one or more of four components. These components are defined below and examples are proviued in Figure x.

A. Explanation focuses upon **particular reasons**, that is, the purpose of and/or reasons for making postnatal home visits in particular.

B. Explanation focuses on **general reasons**, that is, the broad (general) focus of public health nursing and/or the need (or mandate) for public health and/or public health nursing services in general.

C. Explanation focuses on **particular services**, that is, services to new parents, and/or other services needed by the particular client at the time of the home visit.

D. Explanation focuses upon **general services**, that is, public health services available to everyone but not necessarily needed by the particular client at the time of the home visit.