PUBLIC HEALTH NURSE PERCEPTIONS OF THEIR ROLE IN EARLY POSTPARTUM DISCHARGE

by

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Abstract

With early postpartum discharge (EPD), public health nurses (PHNs) are given the responsibility of community-based postpartum follow-up after hospital discharge, to promote the safety and well-being of new mothers and babies. Given the large number of births per year and the requirements for PHN follow-up, EPD has affected PHNs' workload. The objectives of this qualitative, descriptive study were to: a) describe PHNs' perceptions of EPD, b) document the effects of EPD on PHN practice, and c) describe the preferred role of PHNs in caring for postpartum women and newborns. The Canadian Health Nurses Association of Canada (CHNAC) standards of practice served as the conceptual framework for the study. Four sets of PHNs in the Winnipeg Regional Health Authority (WRHA) participated in this study through 1-hour focus groups.

The data were analysed using an inductive content analysis approach, in the form of constant comparative analysis. Three main themes and 10 sub-themes were identified. The three main themes were: a passion for the public health nurse role, the influence of early postpartum discharge on public health practice, and building a public health nursing future. The findings were discussed, and implications for nursing education, research, administration, practice, and policy described. The findings of this study point to the need to develop new and innovative approaches for providing EPD services to the public.

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1. CHAPTER ONE: Problem Identification and Purpose

1.1 Introduction

Mothers and their newborn babies are discharged from hospitals earlier in the postpartum period to contain health care costs, and in response to women's wishes to demedicalise their birth experiences. Shortened postpartum stays have shifted the responsibility for care and education beyond the first days post birth to health providers in the community (Goulet, D'Amour, Labadie, Pineault & Seguin, 2001). Traditionally, postpartum care in the community has been provided by nurses or midwives, most often in the form of home visits (Public Health Agency of Canada [PHAC], 2002; O'Conner, Mowat, Scott, Carr, Dorland & Tai, 2003). McCall-Jones suggests (1997) that the sustainability of hospital early postpartum discharge (EPD) practices has been due to the availability of community nursing services. Many public health agencies across Canada have mandated public health nurse (PHN) follow-up and implemented routine policies of PHN contact and home visiting, in efforts to promote the safety of mothers and babies.

In 2002, the Winnipeg Regional Health Authority (WRHA) joined many jurisdictions across Canada by implementing a program called Healthy Beginnings (HB). As part of that program, an important role that PHNs have assumed is the postpartum care of women and babies. There is evidence suggesting that PHN follow-up with postpartum families has positive effects in promoting maternal confidence and satisfaction, and may limit health problems (Gagnon, Edgar, Kramer, Papageorigiou, Waghorn & Klein, 1997; McKevver, Stevens, Miller, MacDonell, Gibbins, Guerriere et al., 2002; Goulet et al., 2001; Gozum & Kilic, 2005; O'Conner et al., 2003). To guide PHNs in maternal and newborn care, standards of practice were developed and widely adopted (Yaffe, Russillo, Hyland, Kovacs & McAlister, 2001).

1.2 Significance

Following the implementation of the HB program, EPD has triggered a series of specific events for district PHNs in the WRHA. The HB program standards stipulate that a PHN telephone every mother who has been discharged from hospital in the WRHA the day after discharge (WRHA, 2003). During that phone call, the nurse completes an initial assessment, articulates the role of the PHN and offers a home visit. The PHN "endeavours to visit" the day after discharge if the mother was discharged less than 48 hours following a vaginal birth, less than 96 hours following a caesarean section, or if problems were identified during the assessment. Otherwise, the PHN offers a home visit within 7 days of discharge (WRHA). For the fiscal year 2004/05, 6721 women gave birth in the WRHA (Manitoba Health, 2006). Because it is likely that these women were discharged to a community health area (CHA) in Winnipeg, they would have received a level of PHN care that affected PHN workload.

Given the requirements for PHN follow-up and the limited resources provided to implement the EPD program, the HB program standards have the potential to create major changes in PHNs' practice. Without empirical descriptions of the effects of the EPD program on the practice and roles of PHNs in the WRHA, preparation for PHN practice and support for PHN roles will be inadequate. It is imperative to develop a deeper understanding of PHNs' insights into the costs and benefits associated with their role in EPD. The responsibility that PHNs have assumed in EPD is only one component of their mandate (CHNAC, 2003; WRHA, n.d.). The effect that EPD has on other areas of PHN practice, such as their role in community development, is unknown. Changes in the delivery of health services could lead to PHN job dissatisfaction, stress, and decreased quality of care resulting from work overload, role conflict, and ambiguity (Reutter & Ford, 1996).

The increasing responsibility PHNs have for postpartum care is a trend that is common across Canada. Yet the most effective approach to PHN follow-up, as well as cost implications remain widely debated (Cooke & Barclay, 1999; Goulet et al., 2001; O'Conner et al., 2003; Yaffe et al., 2001). Perceptions of PHNs in the WRHA have implications for PHNs in other provinces and territories. Understanding one aspect of PHNs work in the health care system is an important contribution to supporting nursing as a profession (Canadian Nurses Association [CNA], 2000, March).

1.3 Conceptual Framework

Conceptual frameworks assist nurses in the process of organizing assessment data, planning, as well as evaluating nursing care and activities (Thorne & Perry, 2001). The community health standards of practice developed by the Community Health Nurses Association of Canada [CHNAC] (2003) served as the conceptual framework that guided my study. The standards act as guidelines for all aspects of PHN's practice activities. According to CHNAC, standards describe the scope of practice of public health nursing, identify public health as a specialty area, support growth of the profession, and encourage superior practice.

CHNAC (2003) identified five areas that represent PHN practice: promotion of health; development of individual and community capacity; development of relationships; assistance with access and equity; and demonstration of professional responsibility and accountability. PHN activities to encourage individual and community well-being contribute to the promotion and protection of health, the prevention of disease, as well as the maintenance and restoration of health. PHNs enhance capacity by assisting individuals and communities to increase control over their own health. Enhanced capacity is dependent upon effective PHN partnerships with clients and other community agencies. Building relationships is important to all aspects of

PHNs' roles. PHNs foster relationships in full participation with the client, by developing supportive environments. Supportive environments are imperative in assisting clients to increase control over their own health. To facilitate access and equity PHNs work to address the wide variety of determinants that influence health, advocating on behalf of the client when needed. Finally, PHNs demonstrate professional responsibility and accountability to clients, employers, and governments, by basing their activities on empirical evidence and by providing safe and ethical nursing care (CHNAC).

1.4 Problem Identification

Since the implementation of the HB program in the WRHA, PHNs offer routine postpartum home visits to all mothers and infants discharged from the hospital. Changes in the delivery of postpartum services have taken place in the absence of empirical research related to cost, outcomes, and overall adequacy of care for women and their families (Cooke & Barclay, 1999; Fishbein & Burggraf, 1997; Grullen & Grimes, 1997). Simultaneously, the large numbers of births and the increased role assigned to PHNs has implications for PHN practice. EPD has resulted in large-scale postpartum screening by PHNs, yet there is no documented evidence to indicate whether PHNs view current screening and postpartum follow-up activities as necessary, excessive, redundant, or inadequate. The perceptions of PHNs regarding their activities in EPD that promote health and prevent injury of mothers and newborns are important.

As experts, PHNs are able to describe the effects that EPD has on their practice, as well as to suggest the functions and responsibilities that PHNs would prefer to assume in the delivery of EPD services in the future. Although PHN follow-up is important to promote the well-being of women and their infants, there is a paucity of empirical evidence about PHNs' perceptions of their role in EPD.

1.5 Statement of Purpose

The research project had three objectives. The first objective was to describe PHNs' perceptions of EPD. The second objective was to obtain PHNs' perceptions about the effects of EPD on their practice. The third objective was to describe PHNs' preferences for providing care to postpartum women and newborns.

1.6 Research Questions

1. What are the perceptions of PHNs in the WRHA regarding early postpartum discharge?
2. What are the observations of PHNs regarding the implications of early postpartum discharge for their practice?
3. What role do PHNs prefer to assume in providing early postpartum discharge services in the future?

1.7 Operational definitions

For the purposes of this study, I used the following operational definitions:

Healthy Beginnings (HB): The HB program is one of six core public health programs in the WRHA. There are seven services offered within the HB program area: reproductive health, childbirth education, antenatal home care, postpartum follow-up and support, child health services, Baby First, and Family First (WRHA, n.d.). The objective of the HB program is the promotion of optimal growth and development, beginning in preconception and extending into early childhood. PHN activities to promote growth and development in the HB program include home visiting, telephone contact, parenting support, individual and small group education and counselling, as well as child health clinics and developmental follow-up (WRHA). Baby First and Family First are specialized programs available to families meeting predefined criteria. PHNs serve as the first point of contact for public access to these programs. PHNs screen

families to determine their eligibility, and invite the participation of those clients meeting the predefined criteria.

Public Health - The Public Health Agency of Canada (2004) defines public health as the wide range of activities that keep people healthy and prevent hospitalization. PHAC identifies some core public health activities as promotion of healthy lifestyle, provision of immunizations, and surveillance and control of communicable diseases.

Public health nurse – Public health agencies employ public health nurses to deliver services to the public. In the WRHA, PHNs work as generalists that provide health care services to individuals across the lifespan. PHNs offer care to the public under the umbrella of six main program areas: healthy beginnings, healthy school age children, healthy environments, injury prevention, communicable disease control, and life long wellness (WRHA, n.d.).

Postpartum Discharge – The timing of discharge from hospital following birth for postpartum women and newborns.

Early Postpartum Discharge – Discharge from hospital based on a length of stay that is adequate for uncomplicated pregnancies and births, but not considered adequate in complicated or high-risk situations. In the WRHA, women and infants discharged before 48 hours after a vaginal birth and 96 hours following a caesarean section are considered early postpartum discharge.

1.8 Assumptions

I made some assumptions for this research study. I assumed the amount and quality of data provided by the PHNs would be sufficient to undertake analysis that would produce meaningful results. I also assumed that participants would use the operational definitions stated above.

1.9 Chapter Summary

In chapter 1, I have explained the background and significance of the study, and provided an overview of the conceptual framework that guided my research. I outlined the problem statement and research questions, and presented operational definitions for pertinent terms. Lastly, I presented the assumptions made as I undertook the research process. In the following chapter, I will present a synthesis of the current evidence on EPD.

2. CHAPTER TWO: The Literature Review

2.1 Introduction

In this chapter, I present a review and synthesis of relevant literature to provide the context for the research study. A search of Pubmed and CINAHL for the phrase early postpartum discharge (EPD) returned 227 articles. The majority of studies have their origins in the disciplines of medicine and midwifery. Narrowing the Pubmed search to cross-reference the terms EPD and PHN returned as few as three articles. Generalising the search by using phrases such as EPD and nurse; EPD and community; or early discharge and PHN retrieved 29, 23, and 9 articles respectively. Policy documents were obtained by searching Google Scholar, Google, and professional databases. The literature review includes a definition of EPD, a description of the development of EPD, a synthesis of benefits and costs of EPD programs, a description of the role of PHNs in EPD, and different approaches to the delivery of postpartum services by PHNs.

2.2 Early Postpartum Discharge

The average length of hospital stay following the delivery of a healthy term infant has gradually declined. In the 1960s, the average postpartum stay in hospital was 5-7 days (Dalby, Williams, Hodnett & Rush, 1996). By the mid 1980s, postpartum hospitalisation stays decreased to 5.3 days (Wen, Liu, Marcoux & Fowler, 1998). The 1990s brought further declines, with the length of stay averaging 2.25 days in the beginning of the decade and dropping to 1.62 days towards the end of the decade (Lock & Ray, 1999). The current trend across Canada is a postpartum hospital stay of 48 hours or less following routine vaginal deliveries, and 96 hours following uncomplicated caesarean sections (Canadian Paediatric Society [CPS], 2004; Sword, Watt, Gafni, Soon-Lee, Krueger, Roberts et al., 2001; Walker, Watters, Nadon, Graham & Niday, 1999).

Over the last 4 decades, women have demanded the right to be more involved in their birthing experiences (CNA, 1997; McCall-Jones, 1997; Wilkerson, 1996). There has been a movement towards "demedicalisation," with childbirth recognized as a natural process not requiring routine medical intervention or prolonged hospitalisation separating families (Lock & Ray, 1999). A "family-centred" philosophy has been promoted based on the view that birth is a normal healthy life event with physical, emotional, and psychological elements that must be holistically integrated in to the plan of care (PHAC, 2002). In this type of approach, the health professional is not the expert, but rather supports and acknowledges the family's skills whilst developing mutually agreed upon goals and decisions (CNA).

Fiscal restraint has also motivated earlier discharge. To combat the rising costs associated with health care, reduced length of hospitalisation for postpartum patients was widely implemented in the 1990s (McCall-Jones, 1997). Earlier discharge of postpartum patients into the community was one method to reduce the expense of hospital care, as well as to ease problems of bed and staffing shortages (Brown, Town & York, 1996).

Current guidelines for EPD emphasize the importance of meeting predefined criteria developed to exclude mothers and newborns that exhibit potential risk factors (Grullen & Grimes, 1997). A joint statement by the CPS (2004) and the Society of Obstetricians and Gynaecologists of Canada [SOCG] provides broad policy recommendations on postpartum hospital discharge criteria and community-based follow-up (see Appendix A). The PHAC (2002) also developed guidelines, offering recommendations to assist with the planning, implementation, and evaluation of maternal and newborn services in hospital and community settings. Individual regions, facilities and agencies maintain responsibility for the implementation of local policies and procedures, to guide the delivery of services and the

practices of local health professionals. Some argue that, to promote safety, it is imperative that health care professionals and postpartum families comply with policy recommendations for discharge and community based follow-up (Frank-Hanssen, Hanson & Anderson, 1999). Walker and colleagues (1999) reported that since the implementation of postpartum follow-up guidelines the number of newborns returning to hospital emergency rooms without identified illnesses has decreased. They speculated that this was likely due to the support new parents received through EPD programs, which decreased their levels of anxiety.

EPD programs and policies are intended for mothers and babies categorised as "low-risk" (Wilkerson, 1996). A complicating factor is that definitions of risk in the postpartum period are usually based on medical assessments of physical recovery, which may not attend to social and family problems (Fishbein & Burggraf, 1997). In determining the appropriate length of postpartum hospital stay, there is a propensity to focus on the number of hours since the birth, rather than the individual needs of the mother and infant (Eaton, 2001). Evidence regarding the appropriate timing of discharge for mothers from varied socio-economic backgrounds remains unclear (Bain, Deans, Groom, Hanna, Litwak, Maracle-Ringette et al., 1998).

When surveyed Canadian and American obstetricians focused on physical indicators when deciding about postpartum discharge, while being unlikely to evaluate social risk factors. Obstetricians also defined early as discharge within 24 hours of vaginal delivery and 72 hours post-caesarean. Only 39% of obstetricians advised their patients of the need for follow-up after vaginal deliveries, with 64% of these obstetricians doing so only for mothers discharged within 24 hours, in spite of professional practice guidelines recommending 48 hours as the standard of care (Britton, 1998). Increasingly in Canada, obstetricians are providing the majority of low-risk obstetrical care, due to insufficient numbers of family physicians and midwives (British

Columbia Centre of Excellence for Women's Health [BCCEWH], n.d., Canadian Institute for Health Information, [CIHI], 2004). Given the major role that PHNs play in the delivery of postpartum follow-up services, their observations regarding the adequacy of current discharge practices are important to document.

Early discharge programs rely on a well-organized system of community-based care (Wilkerson, 1996). The integration of community health services in the postpartum period have potential to improve family satisfaction and lead to cost-savings (CNA, 2000, June; Fishbein & Burggraf, 1997; Sword et al., 2001). A coordinated interdisciplinary approach is also more likely to meet the needs of postpartum families than the provision of care by any single health professional or agency (Bains et al., 1998). In Manitoba, services such as breastfeeding support are available to new mothers 7 days per week and 24 hours per day. Breastfeeding support is accessible by telephone or in person from PHNs, other nurses, family physicians, paediatricians, lactation consults, and volunteer associations such as the La Leche League. The number of individuals and agencies providing services necessitates organization and teamwork.

2.2.1 Current Evidence about the Effects of Early Postpartum Discharge

There is a small but mounting body of research pertaining to EPD, with advantages and potential cost implications widely debated. Some elements disputed in the literature are the best time for discharge following birth and definitions of early discharge; as well as the nature of risks, benefits, and cost-savings. Specific issues include safety, hospital readmission rates, maternal satisfaction, impact on breastfeeding, adequacy of teaching and learning, and the appropriate type and quality of postpartum follow-up (Brown et al., 1996).

The fact that childbearing is somewhat unpredictable and very personal complicates EPD. Although there may be guidelines in place, in reality the length of hospital stay is dependent

upon the family's personal wishes and circumstances, and a myriad of hospital and community conditions. In situations, except for those of imminent and extreme danger to the mother or infant, mothers may consent to early discharge and for any number of reasons may be discharged from the hospital as soon as they are deemed stable, sometimes as early as 6 hours after birth. Earlier postpartum discharge is likely to persist and continue to evolve, influencing the approaches, as well as the types of services and health professionals providing care (CIHI, 2004). Below, I have outlined arguments that support and refute the benefits of EPD, as well as presented the argument that current evidence is inconclusive.

2.2.1.1 Advantages of Early Postpartum Discharge

Arguments favouring EPD document benefits for women, families, and the health system. The early postpartum period is a time of tremendous physiological and emotional adjustment (PHAC, 2002). Women regard the medical system as transforming the experience of childbirth, and hospitalisation as contributing to further alienation (Wilkerson, 1996). Early movement from hospital to the home environment is postulated to be more conducive to family cohesiveness and bonding (Fishbein & Burggraf, 1997). In addition, due to current non-smoking policies, women addicted to nicotine want shortened postpartum stays (Johnson, Jin, & Trumen, 2002; Wilkerson). Discharge from hospital eliminates risks associated with iatrogenic and nosocomial infections (Fishbein & Burggraf), and longer stays in hospital do not negate the need for medical follow-up after discharge (Eaton, 2001).

Evidence supports positive outcomes associated with the practice of EPD. Through secondary analysis of data, Grullen and Grimes (1997) examined the effect of EPD on maternal concerns and satisfaction, complications, and cost. They determined that EPD was safe for consenting mothers who had no identifiable risk factors. McCall-Jones (1997) surveyed a

convenience sample of 126 women and reported that 87.3% were satisfied or highly satisfied with the care they received following EPD, and only 1.6% of women were readmitted to hospital. Although this appears to be a low rate of adverse effects, there was no control group, so it was not possible to compare the effects of EPD.

Enhanced maternal satisfaction has been repeatedly documented because of EPD (Brown et al., 1996; Dalby et al., 1996; Gagnon et al., 1997; Lieu, Braveman, Escobar, Fischer, Jensvold, & Capra, 2000). Dalby (1996) established criteria for EPD and provided access to services that included lactation consultants, nursing home visits, a 24-hour hospital line, homemaker support, and information on community resources. The sample consisted of 319 women in the EPD group, 456 women in the control group, and 542 women in a pre-test group. The EPD program was deemed safe. Although patient satisfaction was high across all groups, the EPD group was more satisfied than the pre-test group (Dalby). Because groups reported similar levels of satisfaction, it was difficult to determine if satisfaction was an outcome of EPD or the birthing experience.

2.2.1.2 Costs of Early Postpartum Discharge

Although positive aspects of EPD have been documented, potential negative outcomes have been noted. Mothers may not be physically or emotionally ready to integrate and retain information in the short hospital stay before EPD, and teaching must focus on immediate postpartum concerns with inability to offer anticipatory guidance (Brown et al., 1996). Shortened hospital stays decrease opportunities for health care providers to observe parenting and breastfeeding, as well as neonatal transition to extra-uterine life and to screen for symptoms of underlying pathologic conditions (Yaffe et al., 2001).

Potentially harmful effects of EPD include increased risk of hospital readmission, undetected physical and/or psychological complications, and lack of health providers to assist with problems identified at home (Fishbein & Burggraf, 1997). Mothers discharged early without community-based follow-up have been shown to have high rates of morbidity (Gozum & Kilic, 2005). Infants leaving the hospital early may be at greater risk for dehydration, malnutrition, electrolyte imbalances, jaundice, and breastfeeding difficulties (Gagnon, Dougherty, Jimeniz & Leduc, 2002). In the United States, concerns about the detrimental effects of discharge under 48 hours prompted congress to enact legislation to protect mothers and infants' access to hospital services. The Newborns' and Mothers' Health Protection Act of 1996 required insurers to provide reimbursement for hospitalisation up to 2 days following vaginal deliveries and 3 days after caesarean births (Britton, 1998; Malkin, Garber, Border & Keeler, 2000).

Since the implementation of EPD practices, there have been negative infant outcomes, as well as greater utilisation of health care resources reported in the literature. Lane, Kauls, Ickovics, Naftolin, and Feinstein (1999) found that infants of mothers staying one night after an uncomplicated vaginal delivery had increased incidence of morbidity, a higher than average number of paediatrician visits, and lower rates of breastfeeding compared to those staying two nights. Frank-Hanssen et al. (1999) collected data retrospectively on a convenience sample of 199 EPD infants receiving one postpartum home visit by a nurse, and reported infants discharged before 48 hours were more frequently readmitted to hospital in the first year of life. Walker and colleagues (1999) studied EPD infants under 14 days of age. They reported that infants discharged between 24-72 hours had increased rates of readmission for feeding problems within 2-7 days, although EPD infants did not have overall higher rates of readmission in the first 2

weeks. Lastly, Mandl, Homer, Harary, and Finkelstein (2000) reported that shortened postpartum stays resulted in more primary care use, even though they did not find an increased need for urgent care.

Malkin et al. (2000) documented a statistically significant correlation between EPD and increased newborn mortality. In Washington State, they conducted a historical cohort study using administrative data, excluding low birth weight and preterm infants. Their sample consisted of 9101 newborns assigned to the EPD group, which they defined as postpartum discharge less than 30 hours; and 38,778 newborns in the late discharge group that were discharged between 30-78 hours. The mothers in the early and late discharge groups were comparable on indicators such as marital status and age; however, the early discharge infants were more likely to be born to mothers who were multiparous, healthier, and of lower socio-economic status than the late discharge group. Malkin et al. reported that infants discharged early were more likely to die of heart problems and infections within the first year of life.

At Scarborough General Hospital in Toronto from 1993 to 1997, Lock and Ray (1999) analysed rates of infant readmission within 1 month postpartum, using a retrospective before-after cohort of uncomplicated vaginal deliveries. There were 5936 infants assigned to the before cohort, and 1073 infants assigned to the EPD cohort. The EPD cohort included consistent discharge criteria, a postpartum follow-up clinic visit at 72 hours, as well as the availability of a nurse home visit within 3 hours of telephone contact. Postpartum discharge was permitted when the parents' demonstrated understanding of feeding, safety, infant care, follow-up, and maternal postpartum recovery. Based on increased rates of hospital readmission after the implementation of EPD policies, their interpretation were that EPD might produce increased morbidity for infants; they recommended research to determine if stays less than 24-36 hours were harmful.

Jaundice appeared to be the most frequent reason for newborn hospital readmission. In Alberta, the birth records of 63,972 live births were linked to administrative data from hospital abstracts over a three-year period (Johnson et al., 2002). Johnson and colleagues reported that mothers discharged at less than 27 hours post birth had higher rates of readmission for infant problems than those who stayed in hospital 48 hours or more, the most common issue being neonatal jaundice. Findings based on administrative data have potential limitations because information was collected for other purposes; however, other studies have also raised concerns about infant jaundice levels following EPD. Lock and Ray (1999) found jaundice to be the most common reason for readmission of newborns discharged early. Maisels and Kring (1998) reported a significant increase in the rates of readmission to hospital for hyperbilirubinaemia of infants discharged under 72 hours postpartum, compared to those discharged after 72 hours. Particularly concerning was that Lannon and Stark (2004) identified increased risks of kernicterus related to EPD, especially in absence of well-established breastfeeding, because serum bilirubin concentration peaks at 3-5 days postpartum.

Information pertaining to the systemic costs associated with EPD is absent. If EPD is associated with greater likelihood of hospital readmission, it may nullify original cost benefits (Johnson et al., 2002). Data are lacking regarding the effectiveness of community-based interventions such as nursing home visits in reducing overall health care costs and hospital readmission rates (Fishbein & Burggraf, 1997). A study in the United Kingdom (U.K.) reported economic cost benefits of community midwifery follow-up compared to standard hospital care (Petrou, Boulvain, Simon, Maricot, Borst, Perneger et al., 2004); however, the type of follow-up provided by midwives and the health system in the U.K. is very different from the Canadian

system. Given that PHNs work with mothers discharged early in the postpartum period, it is important to understand their perceptions of benefits, costs, and potential dangers of EPD.

Since the implementation of EPD, some studies have cited increased costs of home visits by nurses compared to other methods of delivering community based services. Lieu et al. (2000) randomly assigned 1163 medically and socially low-risk women to two groups. One group received a postpartum home visit by a nurse, which lasted approximately 70 minutes and included physical exams and preventative counselling. The second group had a 20-minute clinic visit with a paediatrician or nurse practitioner. Clinical outcomes for both groups were comparable; maternal satisfaction was higher with the home visits, although they were more costly. Escobar, Braveman, Ackerson, Odouli, Coleman-Phox, and Capra and colleagues (2001) reported similar findings of increased costs. Home visits were more expensive, while clinical outcomes were comparable to the care provided in group and ambulatory settings. In Canada, there has been no consideration of the cost-benefit ratio for community based postpartum care provided by PHNs. Considering the implications for PHN practice, it is important to understand the insights of PHNs regarding home visiting and alternate approaches to the delivery of community based postpartum services.

The variety of community based services available to new mothers has raised concerns about health care coordination and collaboration (Goulet et al., 2001). Professionals in the community usually work in different geographic locations, which can contribute to a lack of communication and fragmentation of services (Hall & Weaver, 2001). Goulet et al. reported that postpartum services in the community were duplicated by health care providers and lacked organization. PHNs' perceptions of the coordination and integration of postpartum services are important to document.

2.2.1.3 Inconclusive Evidence about the Effects of Early Postpartum Discharge

Conflicting evidence about the benefits and costs of EPD is inherent in literature evaluating EPD practices. Although there are studies indicating potential costs and adverse outcomes resulting from EPD, other studies contradict these findings. For example, Madden, Soumerai, Lieu, Mandl, Zhang and Ross-Degnan (2004) conducted interrupted time series analysis on a large sample of 20,366 mother-newborn pairs in Massachusetts, and reported no correlation between the length of stay and infant feeding problems or jaundice. Edmondon, Stoddard, and Owens (1998) also found that early discharge was not correlated to readmissions for feeding issues.

A recently published retrospective case cohort study by Oddie, Hammal, Richmond and Parker (2005) in the U.K. found EPD had no effect on infant rates of readmission. Oddie and colleagues studied 4743 infants discharged within 24 hours postpartum and assessed rates of readmission within 29 days of birth. They reported that mothers from socio-economically disadvantaged backgrounds were more likely to leave the hospital early, as were multiparous women. They found that infants discharged early were not readmitted to the hospital more often than those discharged after 24 hours postpartum. In the U.K., all women have midwife follow-up in the home, which the authors postulated might have contributed to their results.

The effect of EPD on breastfeeding outcomes is inconsistent. In a quasi-experimental retrospective study of 20,366 mothers and newborns, Madden, Soumerai, Lieu, Mandl, Zhang and Ross-Degnan (2003) reported that EPD with nursing follow-up in the home had no adverse effects on rates of breastfeeding initiation or continuation. Janson and Rydberg (1998) also reported that EPD did not affect rates of breastfeeding. Alternatively, McKevver et al. (2002) completed a trial examining breastfeeding outcomes of mothers of term and near-term (35-37

weeks gestation) infants. The experimental group consisted of mothers and infants discharged early who received in home follow-up, and the comparison group received standard hospital care and length of stay. The effect of EPD on breastfeeding was positive, because mothers in experimental group with term infants were significantly more likely to be breastfeeding than the control group. PHNs provide extensive breastfeeding support in the community, therefore, PHNs' perceptions of the effectiveness of their support for breastfeeding are important to document.

Current evidence related to the impact of EPD and postpartum depression (PPD) is mixed. In the first year post birth, approximately 10-20% of mothers experience PPD (PHAC, 2002). Identifying initial signs of PPD may be more difficult with shorter hospital stays, which tend to focus on the baby (Watt, Sword, Krueger, & Sheehan, 2002). By mail at 2 and 4 weeks postpartum, Fishbein and Burggraf (1997) surveyed 92 women discharged before 48 hours. Their sample comprised well educated women with partners; 25% of those women indicated they were depressed. At one month, 83% of respondents described themselves as sitting for most of the day while 65% reported they were not accomplishing as much as usual, and 38% sometimes did not dress for entire days. Fishbein and Burggraf postulated that mothers discharged early might be making the transition to motherhood without the level of support and education that was previously possible through an extended hospital stay. Hickey, Boyce, Ellwood and Morris-Yates (1997) also reported women discharged earlier than 72 hours were significantly more at risk for the development of PPD, compared to women staying in hospital longer. In contrast, Sword and colleagues (2001) found PPD correlated with inadequate income and lack of social and personal resources, rather than length of stay following birth. There may be a conflation between more low-income and multiparous mothers being discharged early and

thus more PPD. Since PHNs provide postpartum care and follow-up to all mothers after discharge from hospital, their perceptions regarding potential effects of EPD on PPD are relevant and important.

The Cochrane Database published a systematic review on EPD. Brown, Small, Faber, Krastev and Davis (2002) completed a thorough assessment of randomised trials to ascertain the benefits or risks of EPD based on cost, impact, satisfaction, and safety of mothers and babies. Based on review of eight clinical trials, Brown and colleagues indicated that the effects of EPD were not conclusive, although adverse outcomes were not apparent. They also reported that information about promotion of safety and acceptability of EPD with in-home follow-up , which would typically be assumed by PHNs, was unknown.

2.2.1.4 PHN Role and Approach to Postpartum Service Delivery

Although there is controversy about the costs and benefits of EPD, there is consensus about the importance of follow-up in the community by a qualified health professional (CPS, 2004; PHAC, 2002; Wilkerson, 1996). Nursing care in the home has been identified as an essential component in the optimal care of mothers and babies following EPD (McCall-Jones, 1997). The CPS states, "with many uncomplicated births, a stay of 12 to 24 hours is adequate, provided the mother and baby are well, the mother can care for her baby and there is community nursing follow-up in the home." Sword and colleagues (2001) suggested that extending the length of postpartum hospitalisation is not likely to reduce rates of hospital readmission; however, enhanced community based services are fundamental to improving outcomes for mothers and babies.

Prior to discharge, the family must have a plan for follow-up in the community. The assessment of common and predictable issues of concern after discharge can avert potential

problems and reduce hospital readmissions (Frank-Hanssen et al., 1999; Johnson et al., 2002; Walker et al., 1999). For families leaving before 48 hours, there should be contact with a health professional within 24 hours at a minimum by telephone, and a complete physical assessment performed within 48 hours (CPS, 2004). In Canada, PHNs have generally been assigned this responsibility.

The nature of PHN care varies based on the timing of discharge. The role of the PHN when mothers and newborns are discharged before 48 hours is to: assess the hydration status of infant and support feeding; evaluate jaundice and identify physical signs requiring immediate medical follow-up; complete screening tests if required; assess maternal physical and emotional recovery and adjustment; evaluate the integration of the newborn into the family; assess social issues; review future plans for health follow-up; and link the family to community resources and services (Brown et al., 2002; CPS, 2004; Johnson et al., 2002; Wilkerson, 1996). For families staying past 48 hours, a physical assessment completed by a health professional is recommended within 1-week of discharge (Walker et al., 1999). The PHN should approach each home visit with an open and inquisitive mind, and provide care based on the needs and goals of family (Hanks & Smith, 1999).

Having PHN delivery of postpartum services is a relatively recent trend, and there is insufficient evidence regarding the needs of women and the types of postpartum follow-up that are most appropriate (Cooke & Barclay, 1999). As a result, researchers have studied different methods of community based care and have evaluated various nursing interventions and outcomes. For PHNs, different approaches are important to consider because of the workload implications of EPD programs. Evidence regarding the most effective and appropriate way to

deliver post-partum services is lacking. Most significantly, the role PHNs would prefer to assume in providing postpartum services has not been explored in the literature.

Studies have compared routine postpartum hospital care to nursing services delivered in the community. Goulet et al. (2001) surveyed 1158 new mothers that gave birth in nine hospitals in Montreal by phone at 1-month postpartum. All mothers had uncomplicated deliveries and were discharged from hospital less than 60 hours following their birth. They found that telephone calls were effective in detecting problems and prioritising the need for home visits. Additionally, early nursing follow-up had a beneficial effect on newborn hospital readmissions, as well as mother's psychological adjustment.

At McGill University Hospital, Gagnon and colleagues (1997) completed the first randomised controlled trial to study the impact of EPD with nursing follow-up at home on maternal competence. Their program included women and babies discharged 6-36 hours postpartum. Community nursing services included three 1-hour home visits, completed in the prenatal period and at 3 and 5 days postpartum. Telephone contact was initiated within 48 hours, and at 10 days postpartum. The control group stayed in hospital 48-72 hours, and the woman and her physician determined follow-up. Outcomes were measured at 1 month by reviewing medical records and postnatal questionnaires. Of the 360 participants, 183 women were randomly assigned to the EPD program and 177 received the usual care. The investigators excluded 85 women in the EPD group and 74 in the usual care group. Of the remaining 80 women in the EPD group, 54 received the intervention as planned, while the others decided to stay in hospital longer and forfeit the nurse home visit. Although there was potential selection bias and the sample size was very small, maternal satisfaction was significantly greater in the EPD group. In addition, extended hospitalisation did not result in benefits for maternal

competence, health care utilisation, or newborn feeding, weight gain, and jaundice. Of interest, the researchers did not exclude socially high-risk women and reported possible advantages for them. Their sample included mothers who were single, new immigrants, those with less education and of lower socio-economic status.

In a randomised trial, O'Connor et al. (2003) compared the outcomes of two different PHN interventions following the EPD of primiparous mothers: the home visit (HV) and the telephone screen. A sample of over 700 participants was drawn over 2 years from two tertiary care hospitals in Ontario and matched for extraneous variables. Outcome measures were rates of breastfeeding, maternal confidence, documented infant health problems, and use of medical services. Outcomes assessed by telephone interview at 2, 4, and 24 weeks were compared to baseline measurements. Mothers in the telephone screen group were contacted on the first working day after discharge and an assessment was completed to elicit concerns regarding feeding, the baby's health, and mother's emotional status. A HV was arranged if need was identified by the PHN or mother, otherwise there was no additional follow-up. Conversely, the HV group was contacted by telephone on the first working day after discharge to arrange an initial HV; a second routine visit took place within 10 days of discharge. The HV included thorough maternal and newborn physical assessments. In both groups, mothers were informed of community resources and services, and referrals were made based on identified needs. The HV program was more costly. There were no significant differences between the two groups on measures of breastfeeding duration, maternal confidence, or infant medical problems in the first month. Findings indicated that for low-risk first time mothers, an in-depth telephone assessment with a HV based on identifiable risk factors was more cost effective than routine home visiting.

Gagnon and colleagues (2002) completed a randomised controlled study, with an experimental group composed of 259 mothers and babies discharged under 36 hours postpartum that received 1-hour home visits by PHNs. Contact continued in the community if it was required. The control group, consisting of 254 pairs, received a telephone call at 48 hours postpartum, and then met with a hospital nurse on one occasion in a clinic setting for a maximum of 45 minutes on day 3. Referrals for ongoing care were available. Outcome measures included rates of breastfeeding, infant weight gain, maternal satisfaction, and anxiety. The authors reported that outcomes for both groups were satisfactory; suggesting that either model of follow-up is acceptable for healthy mothers and infants leaving hospital early in the postpartum period.

In association with McGill University, some investigators initiated an in-hospital interdisciplinary follow-up clinic at St. Mary's Hospital in Montreal (Yaffe et al., 2001). They claimed their approach could offer benefits over home assessments. They evaluated a wide range of newborn outcomes including jaundice, dehydration, and signs of possible cardiac, respiratory, ophthalmologic inflammatory, and musculoskeletal disorders. Maternal assessments included breastfeeding, pain, edema, anxiety, and fatigue. An identified issue was jaundice in 39/205 infants; with high photometry bilirubin readings resulting in the serum testing of 21 infants. Although no infants required readmission, a variety of other issues was identified. These included 9 infants at risk for dehydration, 3 cases of skin rashes, 2 cases where the penis appeared abnormal, 2 cases of problems with the umbilical cord, 2 cases of musculoskeletal disorders, and 5 cases of possible cardiac, gastrointestinal, respiratory, and ophthalmologic disease. Problems were identified and treated in over 47% of the mothers. There were 17.6% of mothers that had problems related to breastfeeding that included engorgement, nipple fissures, and pain. Perineal issues accounted for 14.6% of the identified issues, with worry and anxiety

affecting 18% of the mothers. Advantages of the hospital-based clinic were identified as using resources more efficiently, less travel, and more interaction with physicians. By reducing travel, the investigators anticipated they could triple the number of mothers and babies seen in comparison to nursing home visitation. In one year, the program consisting of nurses and family physicians supported 2300 newborn visits, and incorporated standards of care that included history taking, physical exam, and anticipatory guidance.

2.3 Chapter Summary

In this chapter, I have defined EPD, discussed the advantages and disadvantages, and synthesised evidence about approaches to early discharge. One criticism is that many studies on EPD lack experimental design (CPS, 2004). An extensive systematic review on postpartum care, in which only randomised controlled trials were included and studies were limited to countries with health systems similar to Canada returned only four randomised controlled studies on EPD (Levitt, Shaw, Wong, Kaczorowski, Springate & Sellors et al., 2004). An alternative argument is that women should have choices related to their postnatal care, and therefore randomisation is not appropriate, even though women currently may not have the level of choice they had in the past (Cooke & Barclay, 1999).

The evidence on EPD is flawed by extensive variability that makes it difficult to discern cause and effect. This includes changing definitions of early discharge, differing lengths of hospitalisation, inconsistent follow-up in the community, weak methodological designs, single, small and self-selected samples, inconsistent tools for data collection, and lack of control for geographic variation (Bain et al., 1998; Cooke & Barclay; Dalby et al., 1996; Frank-Hanssen et al., 1999; Tinsdale, 1999). It is impossible to control for confounding social factors such as rising breastfeeding rates and changes in medical practice, aside from the timing of discharge

(Madden et al., 2004). Lastly, many studies have cited costs focused only on hospitals, while the costs associated with community based follow-up services were not incorporated (Brown et al., 2002).

The current role PHNs play in the delivery of postpartum services has evolved based on a small amount of conflicting evidence. While the literature pertaining to EPD is inconclusive in terms of costs and benefits, a prevailing theme appears to be increased maternal satisfaction with EPD and home visiting. There continues to be debate regarding EPD best practices related to infant safety, breastfeeding, postpartum depression, systemic costs, and alternate methods to deliver community based services. The delivery of EPD services by PHNs has been implemented in the absence of strong empirical evidence or documented consultation with, and evaluation by the individuals providing this care. Given the responsibility held by PHNs for home visiting, it is important to obtain PHN perceptions regarding benefits and costs associated with all aspects of their role in providing EPD care to the public. In the next chapter, I will present the method I used to guide the study.

3. CHAPTER THREE: Methods

3.1 Introduction

In this chapter, I describe the method I used for the study. I begin with a brief description of the research design, followed by the sampling strategy and inclusion criteria. I then discuss data collection procedures and ethical considerations. Lastly, I provide an explanation of the methods used to analyse the data.

3.2 The Research Design

I used a qualitative descriptive research design. Qualitative research incorporates elements of both arts and sciences (Cutcliffe & McKenna, 2002). The use of qualitative methods enables a greater depth of understanding and access to meaning from study participants' perspectives (Berg, 2001). To capture the complexity of the human experience there are a variety of qualitative methods that can direct the collection of data (Polit & Beck, 2004; Speziale & Carpenter, 2003). Some argue that qualitative descriptive studies do not have as strong a link to traditional qualitative methods; however, a qualitative descriptive approach provides a comprehensive interpretation of events in everyday language (Polit & Beck). Sandelowski (2000) defines the method of "fundamental qualitative description" to promote distinction from other commonly known qualitative approaches such as phenomenology, ethnography, or grounded theory.

Qualitative descriptive studies are based on the theoretical orientation of naturalistic inquiry, with the goal of presenting phenomenon as naturally as possible (Sandelowski, 2000). Naturalistic studies produce information that is rich and reflective of the realities of study participants (Polit & Hungler, 1999). Qualitative descriptive designs may incorporate hues of

other qualitative approaches. For instance, the technique of constant comparative analysis imparts overtones of grounded theory, without the goal of theory generation (Sandelowski).

3.2.1 Sample/Population/Participants

In this study, I used purposive sampling methods. Purposive samples are convenient, economical, and particularly appropriate in qualitative research (Polit & Beck, 2004). Purposive techniques obtain samples of experts, based on the researcher's knowledge of the population (Polit & Hungler, 1999). According to Krueger and Casey (2000), the rationale for the research study should be the determining factor in choosing research participants. PHNs are the professionals providing community-based postpartum care and follow-up, and are the experts capable of answering my research questions. I recruited the sample of PHNs from the population of PHNs in the Winnipeg Regional Health Authority (WRHA), working in four distinct Community Health Areas (CHAs). I purposefully selected CHAs following informal consultation with WRHA PHNs, a review of the most recent census data (City of Winnipeg and Statistics Canada, 2001), and 2004 Winnipeg Community Area Profiles. The CHAs were selected because of their geographical dispersion across the city of Winnipeg and their determinants of health and health indicators. One was centrally located in the downtown core, with the other areas representing suburban developments extending to the city limits. There was one CHA located on the west side of Winnipeg, one located on the northeast side, and one CHA that extended towards the southeast corner of the city.

I compared indicators from CHA demographic profiles that would be likely to affect the Healthy Beginnings (HB) program (see Appendix B). I compared the four CHAs to averages for the city of Winnipeg using factors such as marital status, income, education, ethnicity, and employment. The CHAs located in northeast and west Winnipeg were both considered

"average" in regards to health outcomes, income, rates of unemployment, poverty, education, and marital status. The CHA located in northeast Winnipeg had the largest population of all CHAs in the WRHA. Although this CHA was close to the mean on the majority of indicators, there was one neighbourhood area with a high proportion of single parents (Community Health Assessment Report, 2004, River East). The CHA located in west Winnipeg was slightly above average on health indicators and slightly below average on health outcomes. Interestingly, this CHA had a culturally homogenous population, with some of the lowest rates of Aboriginal residents, new immigrants, and visible minorities in the WRHA (Community Health Assessment Report, 2004, St. James). For the fiscal year 2004/2005, there were 861 births from the CHA located in northeast Winnipeg, and 455 from the CHA located in west Winnipeg (Manitoba Health, 2006). I selected CHAs that were closest to the mean on health outcomes and demographic factors purposively, to gain deeper insight into the HB program from PHNs in districts with moderate risk factors based on socio-economic indicators.

Conversely, I chose the CHAs located in central and southeast Winnipeg because they were below and above the mean on health outcomes and demographic characteristics. The CHA located in central Winnipeg was the smallest geographically, yet had high proportions of children and youth. This CHA also had the highest concentrations of single parent families, poverty, and Aboriginal people in the WRHA (Community Health Assessment Report, 2004, Point Douglas). In general, Aboriginal mothers tend to be younger and significantly more likely to commit suicide or die because of violence (Health Canada, 1999). The CHA located centrally had above average rates of teen pregnancy, suicide and hospitalization for mental health issues, as well as the highest rates of pre-term and low birth weight infants in the WRHA. The childhood immunization rates were also below average (Community Health Assessment Report). For the

fiscal year 2004/2005, there were 661 births in this CHA (Manitoba Health, 2006). I selected a CHA with health outcomes below the mean purposively, to gain deeper insight into the HB program from PHNs in a district with a wide variety of identifiable risk factors.

Lastly, I chose the CHA located in southeast Winnipeg because of population characteristics and health outcomes that were above average for Winnipeg. This CHA had some of the lowest rates of single parent families and highest median incomes in Winnipeg. The CHA in southeast Winnipeg also had the highest proportion of university-educated individuals. Education correlates with higher income and better health outcomes (Community Health Assessment Report, 2004, Fort Garry). In this CHA, there were 687 births for the fiscal year 2004/2005 (Manitoba Health, 2006). I selected a CHA with health outcomes and demographics above the mean values purposively, to gain deeper insight into the HB program from PHNs working in a district considered low-risk based on socio-economic indicators.

3.2.2 Inclusion Criteria

There were a number of criteria for inclusion in the study. The term public health nurse (PHN) referred to those nurses from the WRHA within four specified CHAs. Those CHAs were located in central, northeast, west and southeast Winnipeg. Individuals in the four CHAs all worked as PHNs in a generalist practice model, in full or part-time positions, and with varying levels of nursing experience. I assumed that PHNs with diverse experience and backgrounds would bring different perceptions of the HB program that would enhance understanding. I excluded PHNs from all other CHAs, as well as any PHNs from the four specified offices that worked within centralised programs such as Sexually Transmitted Disease; Communicable Disease; Immunization and Travel Health; or the Antenatal Home Care program.

3.2.3 Data Collection

I conducted focus group interviews with PHNs from the four specified CHAs in the WRHA that were located in central, northeast, west, and southeast Winnipeg. The director of public health nursing assisted me in distributing the information to the managers of each unit, and presented the study to the senior executive. The WRHA senior nursing executive provided approval for focus groups that were one-hour in length to take place during work time. I invited participation in the research study by distributing the poster (see Appendix C) via the program assistants in each office. Both the letter of initial contact (see Appendix D) and the consent form (see Appendix E) were then sent by e-mail to PHNs in the four CHAs.

Focus groups are a useful format for data collection for descriptive qualitative studies (Sandelowski, 2000). Focus groups are defined as qualitative interviews with a small number of people that generate data based on group discussion (American Statistical Association [AMA], 1997). In a focus group, participants share their understanding and responses to questions with a group of peers with whom there is a common point of reference (Kidd & Parshall, 2000).

There are situations for which focus group methodology is particularly well suited. Focus groups are a useful tool to provide deeper insight into complicated matters (Krueger & Casey, 2000) and are ideal in situations requiring "a one-shot" approach to data collection (Berg, 2001). Focus group research has been used successfully with health care providers in the field to gain a deeper understanding of issues regarding heath care reform (Van Eyk & Baum, 2003); and with employees to learn their perceptions of workplace issues, services, and programs (Krueger & Casey). Based on this evidence, focus groups were an appropriate form of data collection to understand the perceptions of PHNs related to their role in EPD.

There are many advantages to collecting data via a focus group methodology. Topics that are structural and attitudinal in nature can be studied by eliciting information in the interviews about the strengths and weaknesses of a particular area (Berg, 2001). In addition, focus groups elicit attitudes, feelings, and beliefs in ways not possible utilising other research techniques (Gibbs, 1997). The synergy of the group interview can generate more ideas, discussion, and diversity of thoughts and opinions than would be possible through individual interviews (Berg; Gibbs). Because of social interactions among participants, the focus group is also a more natural environment than an individual interview (Krueger & Casey, 2000). Group synergy is achieved when participants feel comfortable together, the information elicited is not of a highly personal nature (Madriz, 2003), and individuals of different hierarchal status are not present within the same focus group session (AMA, 1997; Krueger & Casey). All PHNs participating in the focus groups had the same job descriptions and position in the hierarchy. Since the PHNs were colleagues and team members, the existing relationships enhanced the synergy of the group situation.

From a research perspective, focus groups are useful because they do not require complex sampling procedures (AMA, 1997). Additionally, the moderator is able to influence the pace and direction of the conversation (Berg, 2001). As a rule, the focus group interview should be about 2 hours in total, with the discussion lasting approximately 90 minutes (AMA). Focus groups are economical, with further time and cost savings if the investigator collects and analyses the data (Kidd & Parshall, 2000; Berg). Researchers using qualitative methods want to collect as much data as possible to reflect more fully the phenomena they are studying (Sandelowski, 2000). Using focus groups, there is potential for a large amount of information to

be gathered in condensed period of time, and topics not anticipated may be elicited through the group discussion that add to the richness of the data (AMA).

Focus groups also have disadvantages. Participants may not understand the goal of focus groups as a data collection tool (Joseph, Griffin, & Sullivan, 2000). In this case, there is potential for participant behaviour and group dynamics to interfere with the research process. Some participants may dominate the discussion, precluding full participation of all group members (Joseph et al.). Participants in a group may also not respond to questions in the same manner that they would individually (Kidd & Parshall, 2000).

There may be issues with the data obtained in focus group interviews. The quality of the data is highly dependent upon the skill of the moderators, and the emotional investment of participants (AMA, 1997; Joseph et al., 2000; Kidd & Parshall, 2000). Focus groups produce less data than a series of individual interviews and therefore information may be less precise (Berg, 2001). Results are also less homogenous (Kidd & Parshall). There is a potential trade-off between the observations that could emerge in the natural setting versus the concentrated interactions gathered in focus groups, depending on the topic under investigation (Berg).

The best size for a focus group has been suggested as 6 -12 participants (AMA, 1997); however, Krueger and Casey (2000) suggested that 6-8 participants is more advantageous to allow for the emergence of greater insight and depth. If numbers are too large, groups tend to be less focused and more prone to side conversations; while with too few participants, there is potential for one or two members to dominate the discussion (AMA). In my study, there were two groups of six PHNs at the CHAs located in central and northeast Winnipeg, a group with five individuals at the CHA located in southeast Winnipeg, and seven participating PHNs at the CHA in west Winnipeg.

3.2.4 Moderator's Guide

Berg (2001) suggested that novice researchers benefit from the preparation of a moderator's guide to systematically outline focus group questions, procedures, and eliminate unknown factors. The importance of planning and preparation in contributing to focus group success is documented in the literature (Greenbaum, 1998; Krueger & Casey, 2000; Market Navigation, n.d.; McNamara, 1999). The moderator's guide should include an introduction, basic guidelines for the interview, short answer discussion questions, and guidance for the management of difficult issues (Berg). Throughout the process of planning and implementing the focus group interviews, I adhered to a moderator's guide that I developed.

The ideal focus group interview consists of a moderating team, composed of the group facilitator or moderator, and a second person to assist (Berg, 2001; Kidd & Parshall, 2000; Krueger & Casey, 2000). In a focus group multiple methods of data collection are recommended, such as note taking in conjunction with audio or video recording (AMA, 1997; Krueger & Casey). The moderator's main purpose is to encourage the flow of dialogue among the participants and take note of key points (Krueger & Casey). The role of the assistant moderator is to take thorough notes, to manage the recording device and physical environment, and deal with unexpected interruptions (Krueger & Casey). The assistant moderator debriefs with the moderator following the session (Krueger, 1998). I assumed the role of moderator in this study and Dr. Lynn Scruby acted as the second person.

3.2.4.1 Role of Moderator

The moderator or facilitator of the group is an observer and listener, and eventually will be the analyst to develop meaning from the discussion (Krueger & Casey, 2000). Therefore, they must direct their attention to all aspects of the session including carefully worded questions,

the roles of the research team, and room set up (Joseph et al., 2000). The room should comfortable, promote interaction, and have adequate lighting and sound quality (Krueger, 1998). Through the program assistants or PHNs, I arranged the focus groups in rooms that were comfortable and convenient for the nurses. All of the settings were adequate. Unfortunately, in the interview with the PHNs from the CHA located in southeast Winnipeg there was unexpected noise from an overhead fan, that did not interfere with the dynamics of the group, but made it difficult to transcribe aspects of the interview.

It is the moderator's job to create an intentional conversation to gather information about the topic under investigation, by establishing rapport and being viewed positively by participants (Berg, 2001; Sword, 1999). Berg suggested that listening to participants and guiding the discussion were paramount, with participant discussion accounting for approximately 90% of the data. Participant interaction tends to be more spontaneous with an experienced moderator, generally producing a higher percentage of lines of transcript (Kidd & Parshall, 2000). Sword recommended positioning yourself foremost as a graduate student and learner, and highlighting the expert knowledge that participants bring on the subject matter, although some personal disclosure may augment the authenticity of the findings and contribute to deeper insights. I followed these suggestions during the interviews. As a former PHN and in my current position, I have had experience facilitating groups, which contributed to my ability to successfully moderate the focus groups. Additionally, Dr. Scruby contributed a great deal of skill and knowledge in the implementation of the focus groups.

The moderator must consider their interactions throughout the focus group session. Gestures or responses that indicate agreement or disagreement must be avoided (Krueger, 1998). The moderators must reflect an attitude of intent interest, while maintaining neutrality and not

imposing personal views (Silverman, n.d.; Sword, 1999). For instance, a non-verbal behaviour such as crossed-arms can denote a negative connotation, while unconscious responses such as head nodding or statements such as "good" may indicate agreement (Krueger, 1998; Silverman).

Other important techniques in the collection of data are pausing, probing and listening. The 5-second pause provides participants time to reflect on questions and other's responses (Krueger 1998). Probes are a key technique used in focus groups to encourage further explanation. Krueger suggested using probes early in the session to elicit precise answers, and then utilising them less frequently as the session progressed. Another important role of the moderator is to listen and decide when enough has been said about a question (Krueger). Determining factors include the importance of the question, whether participants have more to say or if redundancy is becoming evident, as well as the time left in the session (Krueger). If several participants repeat the same idea, the moderator can ask the group if anyone has a differing point of view (Krueger). I kept these points in mind throughout the focus group interviews and used the suggested techniques when appropriate.

3.2.4.2 Sensitive Issues

The moderator must focus on data collection and the ultimate purpose of the study, while being sensitive to the individual needs of the participants (Joseph et al., 2000). Participants need to feel safe in the focus group, so that they can freely contribute divergent views and opinions (Silverman, n.d.). Focus group participants comment on the views presented by other members, with agreement and disagreement being fundamental to the process (Kidd & Parshall, 2000).

Group dynamics are inevitable and success of the focus group is dependent upon the moderator's skills in facilitating group interaction (Joseph et al., 2000). The moderator must be aware of the phenomena of groupthink and implement strategies to overcome it (Speziale &

Carpenter, 2003). For instance participants can be reminded of the value in differing points of view, that there are no "right" answers, or the moderator could directly ask the group if there are differing opinions or anything more to add (Krueger, 1998). Monopolisation is another common issue. A nonverbal behaviour, such as lack of eye contact with dominant talkers, is one strategy that can be attempted (Krueger). Joseph and colleagues also recommended that the facilitator not remain silent, but encourage other members of the group to respond using statements such as "That is a really interesting point; can someone else give us your take on that question?" If interrupting is required, Krueger suggested interjecting as the participant is inhaling and then moving the discussion forward. If the moderator must interject because the discussion is off topic or one individual is dominating, it is important not to interrupt in the middle of a story, or if the topic is emotionally charged (Krueger). The implementation of the focus groups went smoothly, with the cohesiveness of the groups likely contributing to the positive dynamics.

3.2.4.3 The Focus Group Structure

Several techniques can facilitate the success of the focus group. Krueger (1998) suggested planning 5-10 minutes while participants are arriving, to engage in small talk. Small talk not only helps participants to feel more comfortable, but also allows the researchers to observe group members and consider seating arrangements. Joseph and colleagues (2000) advised that if there are two researchers, they should sit at the table across from one another, to allow more opportunity for "nonverbal exchanges" when warranted. Talkative participants are best located next to the moderator, while optimal eye contact can be maintained with shy participants when placed across the table from the researcher (Krueger). Dr. Scruby and I positioned ourselves at opposite ends of the table in each interview; we welcomed the individuals

and engaged in small talk while waiting for all the PHNs to arrive. The PHNs seemed comfortable and appeared to contribute openly.

I informed the participants about what to expect from the focus group through the introduction, and I used the following suggestions. I approached the introduction by including a welcome, an overview of the topic, ground rules, and an opening question as suggested by Krueger (1998). It is essential to assure confidentiality and explain that participation is voluntary (AMA, 1997). Although participants may already be familiar with the purpose of the research study, the moderator must formally introduce the project, describe the purpose, and ask the group if they understand the research and their role (Berg, 2001). It is also important to describe the process of data collection, particularly reasons for recording devices and note taking (AMA; Berg). In setting ground rules, the moderator can explain the focus group is an open environment where everyone is encouraged to participate, there are no right and wrong answers, and participants may have differing views and opinions that are all important to hear (Berg; Silverman, n.d.). Silverman recommended that if the first activity is one where participants respond sequentially around the table, the moderator make it clear that after the first question the discussion will move into group mode.

3.2.4.4 The Focus Group Time Frame

The focus groups relied on a semi-structured interview with brief questions (Berg, 2001; Krueger & Casey, 2000). Krueger and Casey suggested there should be about 12 simple questions for a 2-hour group. Questions should be conversational, use participant language, be easy, understandable, open-ended, one-dimensional, and include clear direction (Krueger & Casey, 2000). The use of "why" questions should be avoided; responses tend to be over

intellectualised and participants often become defensive (Krueger, 1998; Silverman, n.d). If the discussion is limited, probes should be used to draw out more information (Berg).

Krueger and Casey (2000) suggested the interview should include five types of questions: opening; introductory; transition; key; and ending questions. The moderator should start with easy questions and have sequenced questions that move from general to specific, are positive before negative, are open before offering cues, and make good use of time. The "opening questions" or introductory activities help individuals feel comfortable and engage all the participants; they are not generally used for analysis. According to Krueger and Casey, introductory questions encourage conversation, get participants to consider how they feel about the topic and provide the moderator clues regarding group views. "Transition questions" begin to move towards the main area of the study, while linking to the previous questions. The "key questions," are 2-5 questions that address the purpose of the study. The discussion should be paced to move into the key questions about 1/3-1/2 way into the interview. The allocation of adequate time (10-20 minutes/question) allows for full discussion, while probes and pauses elicit detailed information (Krueger & Casey). Finally, "ending questions" conclude the discussion, to allow participants time to reflect, and to elicit key information for analysis.

In the focus groups, I gathered data using an open-ended questionnaire (see Appendix F). To promote participation, respect the busy schedules of PHNs, and adhere to the time frame approved by WRHA senior management, I conducted all interviews over approximately 60 minutes. Since the PHNs were colleagues, there was less need to establish rapport within the group using introductory activities. Based on the time constrictions and group homogeneity, I reduced the suggested number of opening and summary questions, so the interview consisted of nine questions. I structured the interview so that the four key questions accounted for 45 minutes

of the time. The purpose of the remaining questions was for introductions, transitioning, and summarising. The focus groups were recorded using written field notes and audiotapes. To show appreciation for the PHNs' participation, refreshments and a light snack were provided during the interview.

3.3 Ethical Considerations

I obtained approval for this research study from the UBC Research Ethics Board, the University of Manitoba Research Ethics Board and the WRHA Research Review Committee. Approval was also obtained from the WRHA public health senior nursing executive, including the director of public health nursing, the community area directors, and the team managers.

In the introduction for each focus group, I reviewed the purpose of the study, the consent form, confidentiality, and the voluntary nature of PHN participation. All participants were fully aware of their role and involvement in the study, and gave their informed consent by signing the consent form (see Appendix E).

I have managed the data while adhering to ethical principles of research. The focus groups were recorded using written field notes, as well as audio taped and transcribed verbatim. To ensure integrity of the information, I have kept the data labelled with the date of collection, and stored in a filing cabinet in a locked room where there is no public access. All names and identifying information were removed from the transcribed interviews. As an added measure, the transcriptionist signed a pledge of confidentiality (see Appendix G). I will keep the raw data (field notes, tape recordings, and consent forms) for a total of five years, and then destroy it, as per UBC Research Ethics Board guidelines.

3.4 Method of Data Analysis

The quality of qualitative data is dependent upon the accuracy of the transcribed information (Hupcey, 2005). As mentioned earlier, to achieve optimal results I had the focus group interviews professionally transcribed verbatim. I reviewed the transcripts for accuracy and in situations where the typist was unable to determine the text, I added text based on my recollection of events. Due to the synergy of the focus group format, where several people talked at the same time, it was not possible to transcribe all statements.

Qualitative content analysis is interpretive because of efforts to understand the latent content of the information (Sandelowski, 2000). Latent content refers to meanings interpreted by the researcher, but not necessarily known to study participants (Shapiro & Markoff, 1997). Berg (2001) cautions that if latent meaning is being denoted, the researcher should provide relevant excerpts to validate interpretations. For this reason, in chapter 4, I have provided numerous excerpts of text from the interviews.

According to Sandelowski (2000), when undertaking fundamental qualitative descriptive studies, content analysis is the technique of choice. Content analysis is also appropriate for data obtained from open-ended survey questions (Weber, 1990) and focus groups (Joseph et al., 2000). To code and interpret the text, I used inductive content analysis, following the procedural methods described by Burnard (1991) (see Appendix H).

After I immersed myself in the data by reading and re-reading the interviews, I grouped words of the same or similar meaning into broad content categories. I used constant comparative analysis to compare comments made by the PHNs both within a focus group interview and between focus group interviews. Constant comparison was a procedure to develop and refine the categories being analysed (Polit & Hungler, 1999). During the process of analysis, I identified

common themes and variations by comparing and contrasting the categories with earlier data (Polit & Hungler, Speziale & Carpenter, 2003). My coding system consisted of lower level codes such as defining EPD, and complications of EPD; general codes such as EPD required a different set of skills, and knowing the client; and broader categories such as education, and communication. In the computer program Microsoft Word XP, I used the tracking function to insert codes and develop conceptual files by cutting and pasting the categories. The categories reflected all relevant aspects of the communication and retained exact phrasing as much as possible.

As I grouped the data, categories became apparent. I reduced the number of categories by grouping the broader headings together to develop a new scheme with significant themes. As an individual with several years of experience as a PHN, I felt that I understood the realities that participants discussed. In fact, I also recognised this as a potential bias, and therefore took precautions to ensure that I acknowledged my assumptions, and was not inserting them into the data.

3.4.1 Assessing Qualitative Findings

Qualitative rigor, or the extent that data are "trustworthy" and replicate "the truth," is judged by credibility; dependability; confirmability; and transferability (Polit & Beck, 2004). Credibility in qualitative research is the confidence attributed to research findings (Polit & Hungler, 1999). In focus groups, credibility or validity is enhanced by promoting consistency of group composition and by making comparisons across interviews (Speziale & Carpenter, 2003). Another technique to improve credibility is triangulation. Person triangulation consists of obtaining multiple perspectives on the phenomena under investigation, through the collection of

data from different groups (Polit & Hungler). Persistent observation involves focusing on the portion of the conversation that is relevant to the phenomena under study (Polit & Hungler).

There were a number of ways that I enhanced the credibility of the research findings. The groups were extremely homogenous because they consisted of PHNs within the same CHA, who performed the same job. However, data triangulation was undertaken by the collection of data from the four distinct CHAs. As the moderator of the focus groups, I attempted to stay neutral and directed the discussions to remain fixed on the research questionnaire. As I illustrated with examples, throughout the process of analysis I examined the text between and across the four CHA interviews to consider similarities and differences.

Dependability is conceptually similar to quantitative reliability, and refers to the "stability of data over time and conditions (Polit & Hungler, 1999, p.430)." Dependability is promoted by ease of data replication and review of the data by external researchers (Speziale & Carpenter, 2003). Internal consistency is enhanced when one researcher, who has participated in the focus group interviews (Kidd & Parshall, 2000), analyses focus group data. One person engaging in collecting and analysing data is more likely to contribute to the exactness of unit categories and completeness of the coding system (Waltz, Strickland, & Lenz, 2005). Secondly, explicit rules regarding the inductive approach to content analysis enhances data quality and objectivity, and contributes to the extent multiple individuals will reach similar conclusions (Berg, 2001; Polit & Hungler; Mayring, 2004; Waltz et al.). For this study, I moderated the focus group, and followed procedural steps for data analysis (see Appendix H). I also had two committee members read the transcripts and compare the interview data to the codes I generated.

Confirmability refers to the objectivity of the investigation and data (Steinke, 2004). Confirmability is evident by the development of an audit trail, or the systematic documentation

and organisation of materials so that an independent researcher could reach similar conclusions (Polit & Beck, 2004). I provided information about each step of data collection and analysis so that my process was transparent. Transferability is the extent the research findings have meaning in similar situations (Speziale & Carpenter, 2003). According to Polit and Beck, the role of the researcher is to provide sufficiently "thick" description, so that readers can judge their findings on their contextual similarities. I undertook this research study, to complete the requirements for the degree of Master of Science in Nursing. I have incorporated members of my thesis committee in the analysis and decisions about method, which contributed to the study's investigator triangulation, researcher credibility, dependability, and transferability (Polit & Beck).

3.5 Chapter Summary

In chapter 3, I have indicated the nature of my sampling, outlined the procedures that I used to collect the data, discussed ethical issues important to the research process, and reviewed my methods of data analysis. After receiving ethical approval, data were collected in four CHAs in the WRHA by focus group interviews using an open-ended questionnaire. The data were gathered using written fields notes and the focus group interviews were transcribed verbatim. The data were analysed using inductive content analysis and constant comparison. Strategies to ensure the quality or rigor of the data were presented. In the following chapter, I will present my findings from the research study.

4. CHAPTER FOUR: The Findings

4.1 Introduction

In this chapter, I present the findings from my study. I will begin by providing an overview of the sample used to collect the data. Then, I will describe the themes that emerged through the process of inductive qualitative analysis. The three major themes were: a passion for the public health nursing role, the influence of early postpartum discharge on public health practice, and building a public health nursing future.

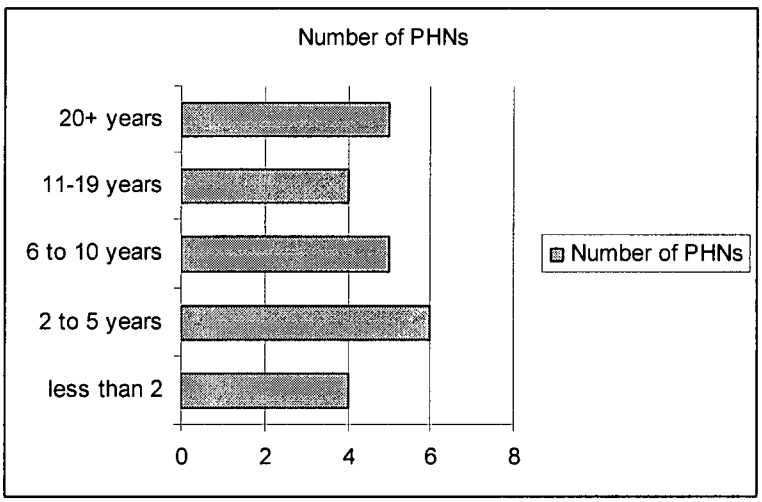
4.2 Description of the Sample

The sample consisted of 24 PHNs in generalist practice from four community health areas (CHAs) in the Winnipeg Regional Health Authority (WRHA). All participants were female. The four CHAs were purposively selected based on their socio-economic characteristics, so that I could obtain data from PHNs working with a wide range of clients. There were two groups of six PHNs, one from a CHA located in the northeast portion of Winnipeg and one from a CHA in central Winnipeg; a group with five individuals from a CHA located in southeast Winnipeg; and seven participating PHNs from a CHA located in the western portion of Winnipeg. The CHAs located in the northeast and the western areas were considered average in terms of the socio-economic status of their clients, while the CHA located in southeast Winnipeg was well above average socio-economic status, and the CHA located in central Winnipeg was far below the average socio-economic class of the city.

The PHNs ranged in work experience from a few months, to careers of more than 20 years. From the sample of 24 PHNs, there were four individuals with less than 2 years of public health experience; six with between 2-5 years of experience; five PHNs that had practiced for 6-10 years; four nurses with 11-19 years of experience; and five individuals who had worked as

PHNs for 20+ years. CHAs varied on the nature of their employees in terms of new to more experienced PHNs. The CHA located in central Winnipeg had the least experienced staff, with two PHNs having less than 2 years of experience, and the two most senior PHNs falling into the 11-19 year range. The CHA in western portion of the city had the most experienced team, with no nurses having less than 2 years of experience in public health. The average years of experience at each CHA was 7.4 years at the office located in central Winnipeg; 8.3 years at the CHA located in northeast Winnipeg; 10.8 years at the CHA located in southeast Winnipeg; and 13.0 years at the CHA located in western Winnipeg. Some of the less experienced individuals appeared to contribute less frequently than the more experienced group members.

Table 4.1
Number of PHNs by Years of Experience



4.3 The Themes

The three major themes developed from the focus group interviews were: a passion for the public health nurse role, the influence of early postpartum discharge on public health practice, and building a public health nursing future. A number of sub-themes supported each broad theme. The themes and sub-themes have been summarised in the following table:

Table 4.2 Summary of Themes:

PHN Perceptions of their Role in Early Postpartum Discharge

The Themes	Sub-themes
A passion for the public health nurse role	❖ Valuing aspects of public health nursing ❖ Building the capacity of individuals and families ❖ Developing relationships with individuals and families
The influence of early postpartum discharge on public health practice	❖ Changes in public health nursing practice ❖ Erosion of health promotion and prevention ❖ A new role for public health nurses
Building a public health nursing future	❖ Needing the proper tools to do the job ❖ Striving for a system to promote continuity of client care ❖ Expressing the desire to build relationships with community partners ❖ Requiring resources to support public health nursing programs

In the following section I will outline the themes that were developed, substantiated by direct quotations from the PHNs. For each PHN quotation, the CHAs were numbered, to allow the reader to determine the area of the city where the PHN worked. The CHA located in western Winnipeg was identified as CHA number 1, the CHA located in southeast Winnipeg was number

2, the CHA located in central Winnipeg was number 3, and the CHA located in northeast Winnipeg was number 4.

4.3.1 A Passion for the Public Health Nurse Role

The first theme that I developed was the PHNs' passion for public health nursing. This passion for the PHN role was supported by three sub-themes which illustrated the elements of the PHN role that excited participants. Participants expressed excitement, enthusiasm, and a love for nursing work in the field of public health. Being a PHN was extremely important to them. The PHNs spoke of role models and mentors that had inspired them to choose public health nursing as a career. One individual spoke of seeking further education specifically because of her desire to practice in public health. A few individuals indicated that they had always planned to be PHNs and had charted career courses that would allow them to do so. The following participant recounted her life-long dream of becoming a PHN:

> PHN (CHA 1): I always wanted to be a public health nurse from the time I was in school, since I had a public health nurse visit and I thought what a great idea to do health promotion and not have to deal with sick people but promote health. So I am living my dream.

In the first sub-theme, PHNs described the components of their practice that were central to all elements of their practice and their desire to work in public health. In the following two sub-themes, the enthusiasm that PHNs acknowledged for particular aspects of their work with individuals and families were identified. These sub-themes were: valuing aspects of public health nursing, building the capacity of individuals and families, and developing relationships with individuals and families.

4.3.1.1 Valuing Aspects of Public Health Nursing

The PHNs identified a number of characteristics that made public health a valued nursing role for them. A recurrent theme among the focus groups was the broad and diverse nature of

public health practice, and the importance of the PHN's role in promoting health. Participants believed that public health offered nursing practice that was autonomous and self-directed. The PHNs loved the opportunity to promote the continuity of care for clients that working in public health provided. In the community, clients were generally involved with only one PHN, versus the hospital setting where nursing staff changed from shift to shift. They expressed satisfaction about being in a nursing role where they had the capacity to plan their own day, to make decisions about prioritising their workloads, and to independently develop client plans of care. They thought the flexibility they had in prioritising their work and their practice was unique to the PHN role. In the following excerpt, a PHN from CHA 2 discussed the ability to organize her workload, compared to when she worked in hospital. "Not being on a strict schedule in terms of when...Because I came from a hospital, and there your day was planned for you. So I like the independence and the flexibility of planning your day and workload."

Participants linked the unique and broad scope of their practice to their desire to work in public health. PHNs believed that public health offered nursing practice that varied extensively from day to day. Elements of practice that were unpredictable included Healthy Beginnings (HB) discharges and visits, as well as communicable disease management and follow-up. The more predictable aspects of their role were child health clinics, breastfeeding clinics, acting as resources for citywide programs such as Family and Baby First, as well as school and community immunization programs. Some PHNs also spoke of additional clinics or programs that were unique to their CHAs. The PHNs loved their diverse practice areas and foci, as well as their ability to respond to local changes in their CHAs. This PHN spoke with excitement about the diversity in her practice:

> PHN (CHA 3): It is always changing. You have to be a good organiser, your work day is not going to follow your schedule. You can get thrown a CD, a

> postpartum, or be called [by a client]. You never know what your day is going to look like.

PHNs wanted to work in public health because they placed high value on promoting health, and preventing disease and/or illness/ injury. PHNs appreciated the opportunity to develop the capacity of individuals, families, and communities, by working at grass root levels to promote their health. PHNs wanted to reduce problems and keep people healthy rather than treating issues that were preventable. The following excerpts illustrated the PHNs' passion for the preventative components of public health nursing.

> PHN (CHA 4): For me it was the preventative focus. I had worked in the hospital and I was tired of dealing with the things that had come in. I thought a lot of this could have been prevented with better teaching and education, and better health practices. That is why I went into public health.

> PHN (CHA 1): I spent 4 years on the ward in a northern rural community and it was not until I went into the public health role, that I really felt part of the community. I felt a responsibility to empower people to try to make grass root changes in their lifestyle. It gave me a lot more, a better feeling actually, to be involved with the people and be living in the community and part of the community. Being able to offer them tools to make changes in their community, I liked that part.

Although PHNs had selected public health nursing because they valued diversity, they reported that the majority of their time was now devoted to EPD.

4.3.1.2 Building the Capacity of Individuals and Families

PHNs felt passionately about developing capacity and promoting the health of individuals and families. Some nurses particularly enjoyed working with families following the birth of a baby and went into public health for this reason. One nurse (CHA 3) stated, "It's just a joy to work with young families and brand new babies." Another stated:

> PHN (CHA 4): I chose it also for the preventative focus but more specifically for young parents that do not have support until something happens or they need to go into the hospital for their baby. So preventative, but with a specific focus on

> young families, to be a support for them in the community and get them what they need.

PHNs reported that families provided them with a great deal of positive feedback, and were appreciative and grateful for the support they provided in EPD.

When mothers and babies left the hospital under the auspices of EPD, PHNs assumed responsibility for some of the postpartum care that had been delivered in the hospital. In addition to the traditional PHN role of health promotion, education, and referrals to other community agencies, PHNs now also performed full physical assessments on mother and baby, including vital signs and infant weights. The result of this more clinical approach to PHN contact with families was the development of high levels of skill in their assessment abilities. As evidenced by the following excerpt, PHNs were proud of the knowledge and expertise they had acquired, and felt they were providing high quality care and building the capacity of families in the community.

> PHN (CHA 2): Public health nurses working with the early discharge program have developed a high degree of skill and we should give ourselves some kudos for that. We've talked a lot about what the issues are, but there's a lot of really good work that's been done too in terms of the medical assessment, breast feeding assessment, building capacity for families, and making referrals to the appropriate services. So it is not all bad. [There are] certainly challenges, but I think we see some really skilled practice happening out there.

PHNs valued their interactions with new families around breastfeeding support. They believed that by assisting with breastfeeding they were promoting the health of infants and mothers. Although PHNs appreciated that societal trends had also influenced breastfeeding rates, many believed their direct support had a positive impact on the number of mothers that breastfed. The following PHN from CHA 2 thought that becoming involved with families soon after discharge provided better opportunity for early intervention and facilitated breastfeeding success. "One of the benefits of the early discharge program is that we have an opportunity to

get in there very early, and have an impact on the breastfeeding rates for families in our communities."

The PHNs not only valued working with families with young children directly following their births, but also promoting the health of families more generally over their life span. The participants spoke of working in clients' home environments, which allowed them to interact with individuals and families in a more holistic and respectful manner, and improve their health status. Seeing clients in this context provided PHNs with their situational context, and allowed them to consider all of the determinants that influenced their health. In the excerpt below, the PHN described her fulfillment in assisting families to address more than their immediate medical needs.

> PHN (CHA 1): The holistic kind of scope where we see people in their homes, where they live for their lifetime and you can impact there and you hope that health promotion will be a part of their life. Because when we see them in institutions and most of us have worked in institutions, you only get this little part of their life. You do not know the whole scope of what they are living with.

4.3.1.3 Developing Relationships with Individuals and Families

The final sub-theme was the PHN's passion for developing relationships with individuals and families. The PHNs believed they had a professional responsibility and were accountable to build relationships during their interactions with clients. PHNs spoke of the fact that they were a voluntary service, because they required their clients' agreement to go into their home and to provide nursing care. PHNs believed that the development of a trusting relationship with the client was fundamental to their care. Because it was a privilege to be given access to clients' lives under these circumstances, the PHNs took a different approach to care than many other health professionals. They had to proceed in a manner that was respectful, and develop relationships so that they were invited to provide care and to maintain their contact with the

individual and family. They described integrating knowledge of the client's culture and beliefs into their approaches in order to provide care respectfully and responsibly.

> PHN (CHA 1): I went back to the hospital after a stint of 6 years in community. And I could not believe the approach that nurses had with clients, versus our approach. When the client came into the hospital, it was their territory and "You listen to me." Whereas, I came from the whole aspect of you are going into their home, you respect their culture, you figure out where they are coming from because that has so much impact. And that, especially having been in community for so long, really struck home for me when I went back into hospital.

As an element of their professional responsibility, PHNs indicated they developed relationships that were partnerships with clients. In this type of approach, PHNs identified the importance of meeting the client's needs by assisting them to develop and build upon their own strengths. PHNs recognised their approach as assisting families to make changes that would promote their long-term health and build their capacity.

> PHN (CHA 2): Because we are in a community capacity we see things very differently. What I find when I have oriented hospital nurses to the program, it is a different philosophy. I am going in there to facilitate and help. This is not my territory, I am going to work with the family, what they see as the strengths. Not what I identify as the issues. Because nothing will change if the family does not see them as issues. I have to work with the family.

The PHNs used communication skills to establish relationships with clients, and felt that those skills were as important as the clinical aspects of their role. PHNs spoke of their need to be flexible and adaptable in their interactions with clients. The unpredictability of clients' home environments and the many variables affecting clients' outcomes had the potential to negatively influence the client's view of the PHN. As guests invited into the home, PHNs had to be thoughtful about elements that were important to clients, even if those aspects detracted from or interfered with the PHNs' role. The PHNs in CHA 4 used examples of making accommodations for things such as toddlers, relatives, and dogs that required the PHN's or mother's attention. The PHNs described mothers who were extremely anxious at home with their new babies and

indicated they had to balance their professional accountability and responsibility for conducting assessments, with potentially increasing mothers' anxiety about their babies' distress and outcomes. The PHNs recalled mothers who became distressed about their babies' crying over being undressed and placed on the PHN's scale. In the discussion below, these PHNs recounted some of the factors they take into consideration going into the home, that were unique to their role in the community.

> PHN: That is the thing. You are a guest. And hospitals do not have any appreciation of that.
> PHN: Unless you move in a warming incubator and a sterile drape, to say, "OK, now this is my sterile field. No, I'm setting up a hospital area, let me do my job." You do not do that.
> PHN: A hospital nurse walks in the room, "Hi, I'm so and so. I need to take your blood pressure now. Can I check this, can I check that." But she is saying that as she is doing it. You walk into somebody's home, you are not just going to say "OK, give me your arm, I'm going to do your blood pressure." You are introducing yourself; you are getting to know the family. There is other family nearby. There are kids; there are dogs, there is everything. So it is really hard. You are just not going to walk into somebody's home and start directing them.
> PHN: Yea. It is a different style of nursing to work in the home versus hospital. And like you say, you are their guest. They could tell you to leave if they found things offensive and you would have to respect that.

PHNs weighed their professional responsibility to establish trusting relationships so that they could offer their skills and knowledge to the families, and potential risks where they believed clients needed care, but where clients refused PHN contact. In cases where clients refused their care, PHNs felt a tremendous sense of accountability, but were left without recourse. A PHN in CHA 4 stated, "That's important to being a voluntary service. It's so medicalised but if the family refuses something, you go back to the office sick knowing that something could be wrong there, but you have to respect that."

To promote the health and well-being of individuals and families, PHNs spoke passionately about the importance of establishing relationships. The PHNs believed that

relationships were mutual exchanges based upon a foundation of trust. PHNs developed relationships using their communication skills and knowledge of public health nursing.

4.3.2 The Influence of Early Postpartum Discharge on Public Health Practice

The second theme was labelled the effects of EPD on PHN practice. The PHNs' description of their emphasis on ongoing family health promotion, was usurped by EPD services that resulted in a greater focus on early family life. The PHNs in all CHAs used the phrase EPD "drives our practice" to describe the effect that follow-up of postpartum clients had on other aspects of their nursing role. Three sub-themes supported this theme. The PHNs discussed changes in public health practice that resulted from the introduction of EPD programs. They gave illustrations of the erosion of prevention and health promotion because the acuity of the EPD experience took precedence over other activities. Lastly, they described EPD as a new role for public health nurses.

4.3.2.1 Changes in Public Health Nursing Practice

The participants discussed the many changes that had taken place in their nursing practice since the implementation of EPD. PHNs acknowledged the benefits of EPD, particularly for the health system and clients. They believed that community based follow-up was more cost effective than extended hospital stays, mothers slept better at home, early discharge was more normalizing and beneficial for the family unit, and there was less risk of infection. The participants saw both benefits and costs accruing for PHNs from EPD. They emphasized that contacting the family in the early postpartum period offered a chance to establish a relationship with the family that might not be as easy later in the postpartum period. When the PHNs saw families early and regularly in the postpartum period, some believed, it offered an opportunity to establish rapport with clients at a point when they were adapting to their newborns and felt they

needed help. That entry point had the potential to be beneficial to the long-term health and well being of the family. The PHN below shared her idea of the role of EPD in facilitating the nurse-client relationship.

> PHN (CHA 2): Because public health nurses hold a wider community view, by getting in to see the families very early when they are at a more vulnerable stage and really want your services, we can build a relationship with families that can carry you through months and even years. That would not necessarily happen as easily if you were seeing that family at 1 week or 2 weeks, but if you are there on day 2 or 3, I think they identify you as a helping person. Somebody that is a resource to them.

Many of the longer-term PHNs spoke of their role in postpartum care prior to EPD. Previously, PHNs emphasized education and support because they were seeing clients after the acute phase of the postpartum experience, but they were still able to establish strong relationships. They did not support the notion that PHNs had to initiate early contact with families to establish a lasting relationship. The PHN below described her practice before the introduction of EPD.

> PHN (CHA 1): The thought was, if I remember the comments, "If we don't get in right after they are home, we will lose them forever." And I thought, that did not happen to me. I worked in public health and my role was more immunizing, educating, providing support.

Although PHNs acknowledged positive effects of EPD, the majority reported that it also had detrimental effects on their practice. Lack of adequate increases in staffing required PHNs to make decisions about what elements of their role took precedence. PHNs described a number of factors that together with EPD responsibilities, led to the changes in their practice. The development of standards for EPD follow-up removed the opportunity for nursing discretion, in terms of decisions around which clients were seen and how frequently. The increased complexity of the EPD visits changed the emphasis from education and health promotion, to assessment and diagnosis of variations from normal. The introduction of additional public health

programs that were centrally identified and planned, for instance immunization, competed with other aspects of the PHNs' roles. The majority of nurses commented that EPD was pivotal in changing their practice; some felt that while EPD was a factor, changes such as the addition of these other new programs and more responsibilities played an equal role. All PHNs believed that the changes cost communities in terms of attention to grass roots problems and initiatives; communities and families no longer had input into the programs PHNs provided.

> PHN (CHA 4): I find how public health has changed in the times that I have been doing it. It has not changed for the better. It really has not. We really have become pushed by the demands of the hospital and the politics and the money. It is not the community anymore. And it is not the families.

The majority of PHNs agreed that one of the biggest changes in their practice was the increased proportion of their time devoted to EPD. In two of the CHAs, the PHNs reported that more than 80% of their time was dedicated to the follow-up of mothers and babies in the community. For some PHNs, the current practice model where they focused on maternal and newborn care was the only one they had known in their careers. The PHNs defined EPD as less than 48 hours for a vaginal delivery and 96 hours for a caesarean, based on their Healthy Beginnings standards. However, the practice of providing EPD care in the community had been a component of PHN practice for years before standards identified EPD by these parameters.

> PHN (CHA 3): Early discharge as opposed to what? Because I think they started using that term before I came into public health so I do not know what it is supposed to [mean]. It has always been this way. Early for today's standard is less than 48 hours for a vaginal delivery, less than 96 hours for a caesarean. But really it has always been like that since I have been here. It is supposed to be a relative term but really it is not.

With families leaving the hospital earlier, PHN accountability and responsibility required intensive PHN home visiting, sometimes daily, depending on what problems were identified. According to PHNs, the need to see new mothers and babies in a timely manner as well as other

practice activities that were unpredictable such as communicable diseases, came at the expense of PHN activities that did not have the same sense of urgency such as health promotion and disease prevention.

4.3.2.2 The Erosion of Health Promotion and Prevention

Part of the influence that EPD had on PHN practice was decreased attention to health promotion and disease prevention. Some of the tension that PHNs experienced related to the loss of those valued activities. One nurse in CHA 4 stated "I'd like to be able to do more health prevention and education rather than dealing with the acute care issues that we're seeing in the community." Mandated or core programs that were emphasized by administration, such as EPD and communicable diseases, resulted in lack of time to address health promotion in PHN practice. Lack of time and lack of predictability around service demands made it impossible to plan health promotion and community development activities with agencies such as daycares and schools. Those activities were considered low priorities. Communicable diseases had to be tracked and treated, and EPD clients had visits mandated. The following excerpts articulated the consequences EPD had on the health promotion aspects of PHN practice.

> PHN (CHA 4): They [EPD] drive our practice. That is the bottom line. Instead of before, we used to be doing things like developing groups, getting needs, assessing needs, community development. And you would assess a need in the community and you would put something together to try and meet that need. That is gone. It is gone. We do not have the time to do that.

> PHN (CHA 3): The thing is, the postpartum drives our practice because you never know what you are going to get on a daily basis that has to be responded to right away. So it is very difficult to plan to do other things like community development and deal with daycares. We make sure they know that there is someone available, but we do not necessarily go in there with specific things that we do.

Previously PHNs had engaged in community development activities where they spent more time in their schools and daycares. As evidenced by the excerpts below, PHNs expressed

dissatisfaction because their presence in the community was limited, and they did not have the time to participate in activities they believed were important, such as community development. The mandated core services were given priority. Some of the flexibility, independence and self-directedness associated with their practice was lost.

> PHN (CHA 3): I can see myself in the past, 10, 15 years ago. We had schools, we put a lot more time into the school system. [You would] have a parenting group at school, that kind of thing. I miss that part. [Now] we have to make sure that the core services are being provided before we can go to the daycare, "Hi, public health nurses would like to provide you [with] more services." We would not have time to do that. The impact on our practice, I would say that in terms of the impact to provide other services, is not that good. Not possible, if we have to meet the other standards of early discharge or post partum, our core services. But in the past we could do a little bit more.

> PHN (CHA 2): We drop the community development because we cannot get anything else done. CDs [communicable diseases] take a priority. Immunization takes priority. And this clinical stuff takes a priority. And you only have so many man hours. But is community development very important? Yes it is. That is the crux, and health promotion is the crux of what community actually is. But that part sometimes gets dropped off to meet the workload.

PHNs expressed sadness because of the sense of loss associated with their changing relationships in the community. They indicated that a regular presence in the schools had allowed them to develop relationships with staff, students, and families. By being visible in the community at schools and daycares, in conjunction with their role in postpartum follow-up, PHNs developed long-term relationships with clients that were maintained over their life span. By being present, PHNs felt that clients regarded them as making a contribution and as integral to their communities. Some PHNs, such as the one below, identified that link to the school system as critical in maintaining lasting relationships that could promote the health of families.

> PHN (CHA 1): Historically, probably if you look back with the early discharge program becoming part of public health, that was probably the start of cutting back what we did in the schools and changing that. Because when I worked for the City of Winnipeg, you were assigned a school and it was in the core area. People that had worked for many, many years...the families in the community all

> knew the nurse and the nurse even knew sometimes more than one generation. They had children that had grown up and were now having kids. And so there was a very close relationship in the school. [The school] really used the nurse. And I think that has all changed with the early discharge program, perhaps because so much more time is taken up with that.

PHNs associated their relationships with their value to the community and the use of their expertise. Previously, they were consulted on health issues, and participated in a variety of health education activities in the schools. As evidenced below, PHNs felt that the decrease in their presence reduced their sense of connection to the schools, and the ability of the community to regard them as able to contribute knowledge and resources:

> PHN (CHA 2): We were part of the school. We had an office. The teachers knew you. The students knew you. The parents knew you. So there was that really strong link to the community. I think we have lost that now, because you do not have that association with the school other than just going in there and doing an immunization. You are just someone coming in for a day. Whereas in the past we were actually part of the school and provided plenty of resources in terms of teaching, we did a lot of the family life programs. Any communicable diseases we were consulted on. So that certainly has changed. And it really is sad.

The PHNs' functions in the school system shifted from health promotion and disease prevention to providing scheduled immunizations. One PHN in CHA 1 described the administration-generated mandate given to staff that initiated this change: "And then we were actually asked to pull back and be more of a resource because we didn't have the staffing." Historically, many PHNs had maintained regularly scheduled hours in the schools, where they initiated groups and provided a great deal of education on topics such as sexuality and birth control.

> PHN (CHA 2): I remember years ago, traditionally nurses would be very involved in their schools. We did presentations, facilitated groups, and spent time in schools. Our job at least in our area here has evolved so that most of what we are doing in the schools is the immunization program, and not a lot of other things.

PHNs felt that their roles had been limited to acting as consultants to the schools, connecting them to other services as appropriate, and responding to the occasional request for information. Many PHNs believed that a consultative role did not give them a presence in the schools and important relationships were being eroded. They felt that the community no longer recognised them as a resource, and was resentful of their absence from the school scene, which created additional tension for PHNs. The following PHNs in CHA 1 spoke of the anger expressed by employees at the schools because they had lost the PHN's role.

> PHN: I sat on a committee that discussed what we were we doing in schools, and nobody knew because we were not in there. So we decided to do a little survey. We went to the schools and asked them: "Where do you see the role of the public health nurse?" They were angry. They said, "We used to have a nurse, we knew who she was and she would come in and do stuff for us. And now it is call us when you need something." They were [saying], "Oh right, you wanted to help us but you are not actually going to do anything."
> PHN: Well they wanted time and commitment.
> PHN: Yea.

PHNs believed that because members of the school system no longer recognised the value of their contributions in promoting the health of the school-aged population, they marginalised their contributions. For example, the schools contacted the PHNs for outbreaks they considered urgent such as head lice; otherwise, they did not identify a role for PHNs. Being marginalised by the schools was part of a vicious circle, because the PHNs had the view that their skills were limited and their anger about that contributed to further marginalisation.

> PHN (CHA 2): And going back to the schools and daycares. I have had a shorter experience with public health than anybody else, but what I have seen since I have started is dealing with them on an urgent basis. They will phone if there is a terrible case of lice, or scabies, or what have you. They want help then. But really we are not seen to be able to do much else. From my experience, they do not really try to connect with me unless there is a big problem. There is not any of the health promotion or prevention, that we are supposed to be focused on. Yea, that has unfortunately been my experience, and I think that has to do with the new standards and early discharge.

The PHNs expressed concern that the continued erosion of health promotion and prevention would result in gaps and reductions to the already limited health services available to children and youth. They indicated that the early years were critical to children's development and a lack of contact with health professionals could leave children without opportunities to maximise their potential. PHNs discussed the importance of targeting services to this population, to prevent health issues in the long-term; however, PHNs were no longer able to provide their former services or to develop new ones, because adequate staff was not available.

> PHN (CHA 4): A presentation if the school would like about how to use an epi-pen, but otherwise our involvement in the school is none. So we are seeing these infants, and then what about the piece from infancy to preschool, and then school age health?
>
> PHN (CHA 2): I think that the school population, if we look at the determinants of health and we are looking at education and socioeconomic status, when we see things happening later in life those are what we can bring back to [childhood]. If we had more of a presence with the health promotion aspects in the high school or junior high or elementary, perhaps that may offset things in the future. But we just cannot, because we do not have enough people. They are putting new programs on the public health nurses, but not increasing the number of nurses that we have, so at this point it is just not feasible.

PHNs spoke of their own lack of clarity about their role in health promotion and disease prevention within the community. If PHNs were unable to articulate their own roles, they wondered how it would be possible for others to have a clear perception.

> PHN (CHA 4): Well if we are losing sight of what our role is, then how can we define that, how can we [tell] the community what our role is. If schools call us, it is like, "Well I can do this but can't do that, but yeah I'll get back to you on that."

The PHNs discussed why they believed their role in health promotion had been eroded. Some PHNs felt that their standards for EPD were set too high, and meeting those standards came at the expense of their health promotion and prevention work with the community. Others PHNs talked about the disproportionately low funding allocated to public health, which they felt

represented the health care system's lack of value for health promotion activities. In addition to limited funding, new programs were added without the consideration of staffing levels, which further eroded health promotion and prevention aspects of the PHN role.

> PHN (CHA 2): We just do not have the staffing to maintain that type of association with schools at this time because of the fact of early discharge. I think that is probably the number one reason. There is a bit more of an emphasis on getting out and seeing moms in those early days. And we have had a lot of other programs that have come into place like the Family First program, which also has a big time component, so we had to leave [other work]. Definitely, schools and daycares are not a priority at this time. They are not, we just cannot meet those needs any more. The time does not allow it. We have to prioritise for those new moms, often times with the acute care issues that they have.

PHNs acknowledged that their health promotion activities were difficult to link to health outcomes. In the excerpt below, the PHNs in CHA 4 described struggling with the loss of work that they felt was valuable, but acknowledging that they did not have evidence of its worth.

> PHN: But how do you measure prevention? Injury prevention, illness prevention, is that measurable? And can the organisation measure how much we prevented or how much we have not prevented now, as opposed to when you were in the practice following families for years? There was a huge amount of prevention component there and it is not measurable. Right?
> PHN: Right?
> PHN: Yes.
> PHN: So we are losing that and there is nothing we can say to prove it, because how do you measure prevention.

The PHN's felt that because many of their health promotion and prevention activities were not supported by evidence, they were given less priority than those activities deemed to provide evidence that they were changing outcomes. PHNs believed that important aspects of their work, such as their role in the schools and daycares, had been lost for these reasons. The cascading effect had been that PHNs described a diminishing and less well understood role within the community.

4.3.2.3 A New Role for Public Health Nurses

EPD had not only altered the health promotion activities that PHNs assumed in the community, but also the activities that PHNs had undertaken with families in the postpartum period. The main reason for the change had to do with the timing of referrals and the increased acuity. Many experienced nurses contrasted postpartum referrals arriving by mail and longer hospital stays with the introduction of fax machines, 24-hour time lines, and referrals requiring immediate attention. Previously, PHNs had visited the families 1 to 2 weeks after their births. Those parents had had more time to adjust to the newborn and to recover from birth, so the PHN visit focused on health promotion and prevention. With EPD, the care shifted to dealing with acute medical conditions and immediate breastfeeding problems.

> PHN (CHA 2): And often you may be visiting families at 2 weeks, and the breastfeeding, we did not have to work with families at all regarding breastfeeding. They were either doing OK because their problems were resolved by then and we did not have to change to bottle. Now that is a major part of the work that we do, supporting breastfeeding. Our role has changed a lot since early discharge.

The most significant aspect of EPD for PHNs was the increased potential of medical complications for their mothers and babies. Following the introduction of EPD, PHNs questioned how their roles and responsibilities had changed from encouraging client self-care and providing resources, to assuming responsibility for the clients' medical conditions and postpartum recovery.

> PHN (CHA 1): My sense, when I started public health, was definitely you are there promoting independence. That was imprinted in my brain. It was not the expectation that I was responsible for the community in (place). That was my area. But I did not feel like it was my responsibility. We were there to teach. We were there to provide people with tools. But that was before early discharge. It was before the expectation of clinical skills.

Increased perceptions of responsibility were due to the shift in emphasis from health promotion and education, to assessing and getting treatment for acute medical problems such as maternal hypertension and infection; or infant problems such as heart murmurs, jaundice, and weight loss. The focus on acute care overwhelmed experienced PHN's who had not developed those skills because they had been working in public health for many years. Although there had been some in-service education to support the change in roles, PHNs in CHA 1 reported that they did not feel adequately prepared.

> PHN: Some nurses are probably more comfortable with those clinical decisions than others. And that is one of my frustrations. I know whenever there is talk about training, I feel like I need an ICU [intensive care unit] course just to be OK. "Am I really hearing the right thing or am I doing that [right]?"

> PHN: Hate to say it, but sometimes I feel like I am a little over my head, and not knowing what [to do]. Like all the examples that you gave in terms of physical signs and "Is this good, is this bad?" I find that I do not really have a background.

In the excerpt below, a PHN discussed the effects of managing specific medical problems such as infant weight loss, on the health promotion aspects of their postpartum practice. Previously when conducting home visits, PHNs had provided holistic education that focused on promoting the health of the family; however, with the client's health at risk, and the family focused on immediate medical concerns, the PHNs did not feel the timing was appropriate to address health promotion.

> PHN (CHA 4): You see a baby who is still losing weight and you have to keep seeing that baby until it starts gaining weight or it gets more towards the birth weight. It means more visits, and initially that family is asking very medical questions and learning from what you are telling them. Then after your [medical] visits, it can be more focused on the family. So [at first your] focus is really an acute visit, and then later when the baby is gaining weight, you are starting to go into more what public health used to be.

The increased urgency of problems in early postpartum period often resulted in the need for PHNs to visit families more frequently, sometimes daily, until the medical problems were resolved.

> PHN (CHA 2): I think the drawback for us and this is not a benefit, would be that we may have more intensive work involved with clients because they are coming home earlier. We may have to support them a little bit more. Maybe go in a few days in a row or whatever the case.

Because of the increased frequency of visiting to respond to acute problems, the nurses in one unit spoke of being viewed as an "extension of the hospital" or "postpartum home care," rather than health care providers and clients appreciating the broader scope of knowledge that they possessed. The PHNs believed that the acute care system had a different approach and philosophy than public health. PHNs in CHA 4 felt that providing hospital-like services in the community was in direct opposition to the principles of public health that they valued, which were to promote health and empower individuals and families to care for themselves.

> PHN: As a public health nurse, you want to create a population, individuals to be independent and resourceful within themselves and the community. But if you come from an acute focus, you have now created a dependency on you. So you are losing sight. Do you want them to become dependent on you for medical needs? Or do you want them to try to find the resources within themselves and in the community?
> PHN: To empower them.

Participants spoke of the medicalisation of their roles around facilitating a normal transition to parenthood because of the standards that supported EPD. The PHNs viewed the standards as a continuation of the hospital based medical model, which focused on the medical aspects of the postpartum recovery, rather than considering birth a normal and healthy process. They described being less able to focus on psychological well-being. A PHN in CHA 4 stated "You get what exemplifies a very natural stage of life, which it should be. But it has become so medicalised, because of these standards that have to be met. "

The PHNs felt that the focus on potential medical problems detracted from the context of the family unit, and resulted in family members holding a narrowed view of the PHN role. The families became reliant on PHNs to provide medical care and treatment, and when that phase had passed, many families believed that treatment was the extent of their involvement with the PHN. The result was that families associated PHNs with their episodic medical needs, and did not see PHNs as health care providers with whom there might be a long-term relationship around health promotion and prevention. This negative perception was discussed by the PHN's in CHA 4:

> PHN: They [the client] see you as just hospital replacement, so once the problem is solved they do not need you any more. So good-bye, it is over.
> PHN: It is a barrier. When you are asking questions about their financial situation, they are like, "Why do you want to know that?"
> PHN: "Why are you asking?"
> PHN: "They don't ask me that in the hospital. My doctor doesn't ask me that."
> PHN: Yea.
> PHN: Some families I notice really shut down. It is almost too personal for them.
> PHN: So we are sending really strong mixed signals.

The PHNs believed that the role they had assumed in EPD was sending mixed signals to clients. The focus on immediate medical needs in the postpartum period established the client's belief that was the sole purpose of the PHN's visits. When PHNs went beyond the medical needs, to address the holistic context of the families' issues, some families reacted as though they felt PHNs were overstepping their boundaries. Families did not understand why the PHN would inquire beyond their medical needs, when other health professionals had not. They did not understand the PHNs' broader focus.

4.3.3 Building a Public Health Nursing Future

The final theme identified from the PHNs' comments was building their future. They desired a system that provided optimal care for the individual, family, and community. In terms of EPD, PHNs wanted tools that would allow them to do their job well, which included having

their skills and expertise appreciated when collaborative care was delivered to clients. PHNs also wanted to extend their practice beyond a focus on early postpartum care, to include prevention and health promotion. PHNs defined client broadly, which encompassed the individual, family unit, and the community. With their current role focused primarily on EPD and communicable disease (CDC), they felt they did not have adequate time to devote to the community as client. In trying to determine how to provide all services with finite resources and time, some PHNs suggested different approaches to service delivery. The sub-themes were: needing the proper tools to do the job, striving for a system to promote continuity of client care, expressing the desire to build relationships with community partners, and requiring resources to support public health nursing programs.

4.3.3.1 Needing the Proper Tools to do the Job

While the types of postpartum clients PHNs were seeing had changed tremendously, the changes in the nature of their care had taken place in the absence of adequate equipment, systemic supports, and education. PHNs believed that they required a number of tools to facilitate their delivery of EPD services to the public. The majority of PHNs indicated that they did not feel adequately prepared for the medical problems they encountered around EPD. PHNs viewed upgrading their skills and education as the responsibility of the employer, and expressed immense dissatisfaction because they felt their education needs were not being adequately met. A PHN in CHA 1 stated "I think the frustration is the expectations of our standards are not supported by education from the employer and in-servicing. They expect you to do this [EPD] but they won't train you to do it." Not feeling adequately prepared caused the PHNs to be fearful of making errors in their assessments.

> PHN (CHA 4): There is a lot of worry and fear, because now it is the standard that you are meeting. The standards were set so high that a lot of nurses felt if I am

> doing the complete infant assessment which is what they do in hospitals and I am supposed to pick up a heart murmur...there is no orientation on how to check for S1- S4 gallops, you are [not] given a cardiac stethoscope. I mean, we do not have the equipment, let alone the...
> Researcher: The knowledge, education.
> PHN: Yea.

Many PHNs identified ongoing education as the most important thing in performing their role adequately and maintaining their competence in postpartum care. PHNs debated whether the amount of education provided now, was more or less when compared to the past. However, there was agreement that more education was needed due to the wide variety of new programs that had been incorporated into their practice, including EPD, and the follow-up of sexually transmitted infections and other communicable diseases. One PHN in CHA 1 stated, "They just keep putting more on, more on, more on. And again without the proper background education." PHNs' days were taken up with delivering services to the public. They felt that they did not have the time available at work to educate themselves. As indicated in the following excerpt from a PHN in CHA 4, PHNs viewed supports as fundamental to their ability to deliver public health services competently. "We do not have that link currently and yet we are going to start a breastfeeding support group. Who is going to be supporting us in doing so? Otherwise, it will be ineffective."

PHN believed that adequate ongoing education was necessary, especially when introducing new roles. PHNs also stressed the importance of individual differences that might result in varying needs for education or support. They came with different experiences and from different backgrounds, and wanted education that was tailored to manage their diversity. As evidenced by the excerpts below, some experienced nurses felt that the education provided for EPD was not adequate to prepare them for the new roles and responsibilities they were expected to assume.

> PHN (CHA 1): When they rolled out those standards, they did have a film to watch.
> PHN: A video.
> PHN: Did have a few meetings.
> PHN: A video that went over, listen to the heart sounds here, here, here.
> PHN: But you cannot fit all that.
> PHN: That was not enough for me. Maybe I am a slow learner but I have been doing this a long time.

> PHN (CHA 2): I did not really think about it, but being with the system for a while, the clinical aspect was not that great of a focus and it certainly has become more of a focus. So I think we need to recognize that. And continue to provide upgrading and education, and recognition that we do need to keep working on our skills. It has changed tremendously in the last 10 years, at least for me.

> PHN (CHA 1): And now that they are discharged early you are put into a lot more of these situations where you need that background, that clinical background.
> PHN: Uh, huh.
> PHN: And if we do not come from a hospital. I have always been in public health, I have always operated this way, and I do not have that background. And where am I going to get it?

Some of the PHNs discussed the extensive preparation for EPD that was part of the orientation for new nurses, compared to the orientation that had been offered to nurses in the past. The new orientation provided detailed information on the PHN role in EPD, but little information was provided about other aspects of the PHN role.

> PHN (CHA 4): It is interesting going through the orientation process that they have established in the last few years. I went through it about 2 years ago. You got probably five, maybe 6, 7 days of solid orientation on how to do telephone triage, how to go out and do home visits, from a medical point of view, breastfeeding. And I think we got maybe an hour and a half on community development. So, even in terms of orientating staff, the push is towards that medical public health nurse versus health promotion.

One of the recently hired PHNs spoke of her need for education in areas other than EPD. As evidenced below, that particular PHN in CHA 4 identified her learning needs to be more related to prenatal than EPD. "Even prenatal I find that we do not get enough. Just being a

recent public health nurse, I feel very undereducated and having a huge knowledge gap in terms of prenatal."

The PHNs spoke of the need for the proper tools and equipment to do their job in EPD. One tool the nurses in CHA 3 identified was a comprehensive computer system. There was no centralised database in which information was kept. Without a way of cross-referencing information, there was potential for overlap and inefficiencies in service delivery. For instance, if one nurse knew the family, she would be the appropriate one to do a communicable disease follow-up; however, there was no effective way to determine who was involved with specific families. Computerisation would also make it easier to prevent inefficiencies such as two different PHNs visiting in the same building at the same time. These PHNs also spoke of the value of an electronic medical record that extended beyond their own agency, so everyone was aware of other agencies with which families were involved. Some families had the involvement of numerous agencies and health providers, yet these providers were often unaware of each other's involvement.

> PHN: Computerisation then. Because we do not always cross-reference. Someone will go out and do a CD [communicable disease] and realize that another nurse in the office had that family. So if we were on a database, that would do it.
> PHN: Yea. Because I agree with what you are saying, but a lot of times it does not work that way and we find out after the fact. Or even addresses. We will find out that one nurse is in one suite and another nurse is in the other suite practically at the same time. And the two were sisters. We do not have a really good way to cross reference.
> PHN: Even in regards to working with other services though. For example, you said EIA [employment income assistance].

The PHNs also spoke about their need for tools to assist them in their clinical practice. For example, PHNs were so concerned about their ability to assess jaundice that they flagged it with management. PHNs did not feel they had the capacity or experience to make such

assessments. The assessment of jaundice was complicated by factors such as the culture and age of the baby. As the PHN below described, she feared making an error in her clinical assessment that might have negative repercussions on her relationship with the family.

> PHN (CHA 1): Because your only tools are pressing on the baby's skin and seeing whether it's in the body, the legs, the arms and then making a decision. If you get some children that are Asian or Aboriginal descent, they already are dark skinned, and it is hard to tell just that way. I think we are all scared of making a mistake, and that has been my experience too. Where parents are angry that you scared them, upset them and nothing is wrong, so they do not want to see that nurse again.

When PHNs followed medical problems such as jaundice in the community, it raised other concerns about their lack of confidence and/or competence in making clinical decisions in the home, which were exacerbated by a perception of limited support. The PHN below described her frustration in determining the path to follow when additional consultation was required. Often PHNs did not know who to call, or how to access them. Sometimes when they reached the primary care provider, the information provided and the PHN's role in providing it was not valued.

> PHN (CHA 4): With early discharge, we need to consult more and more with doctors, obstetricians. The one who just delivered this baby 18 hours ago. So how do we contact that doctor and what does he know of us out there in the community? There is a real gap there because we need to contact these doctors and it is not as easy as for a hospital nurse. It is easier for a hospital nurse to go and get that doctor. They have their accurate pager numbers with everything right there and the doctor is probably on site. With us, how do we get that doctor who is over in the hospital doing whatever?

When PHNs identified concerns based on their physical assessment, they were limited in what they could do. They generally had to direct families back to the emergency room, resulting in lack of continuity of care for the client. Professional consultations were not available in the community, whereas, in the hospital there would be professional consultations, adequate equipment, and additional supports such as labs to draw blood when needed. Working with

inadequate resources often put PHNs in uncomfortable situations with clients and other health providers. As the excerpts below described, PHNs assumed they were responsible for and accountable to the client in these situations.

> PHN (CHA 2): We are seeing the families when they are at a very vulnerable state and it is one thing if you are in the hospital and the baby is day 3 and looks a little yellow. We will send for a blood test and the lab tech comes. And it is a totally different ball of wax if you are saying, "I'm not sure and this may [cause problems]." Inevitably they will ask you what the implications of jaundice may be and it may be permanent brain damage so we will send this baby back to the emergency room. Those implications are just huge, so like [name] said, if we had an objective measure. And that ties into early discharge because we are seeing those babies day 2, day 3, day 4, day 5, as jaundice is increasing, so to be able to do our jobs better for the clients we need the right equipment.

> PHN (CHA 1): Well I have had a physician get really upset because he goes "What's the blood pressure if you can't do a protein urine dip. Why aren't you doing that? That is more significant than the blood pressure." So there are some tools that we do not have in the community. Including we have asked for a bilirubin screening tool so that we can screen the babies.

Some PHNs spoke of the importance of support from colleagues regarding the clinical component of their practice. They wanted to debrief about difficult clinical situations, and learn from others' experiences through interactions with other PHNs. For this reason, some of the PHNs expressed concern about another change in their work environments; the trend towards multidisciplinary teams. Although PHNs were in favour of multidisciplinary care, they were concerned that the teams would further separate PHNs from the nursing colleagues they needed to support their professional practice and clinical skills.

> PHN (CHA 1): In this office we have a team, but we are split. Some of the nurses are upstairs, some are down. We always feel that that is such a crucial part of public health, that we are in the same room so you hear, you learn from each other as you are on the phone. Discussing, assessing, that sort of thing. You need that other colleague because you work so independently you need someone else to say, "Does that sound normal?"

The PHNs identified lack of understanding of their role in the community as one potential barrier affecting their ability to do their job. Some PHNs acknowledged that there was not always appreciation for PHNs' total responsibilities, which contributed to misconceptions about what they did. Some PHNs believed that the hospital personnel saw them as an extension of the tertiary care system, as opposed to recognising their community expertise and the prevention and promotion aspects of their roles. A PHN in CHA 4 stated "I think hospital nurses do not really know that we are generalists and the general nature of our program. They think that all we do is early discharge. And that is not it at all."

PHNs speculated that their EPD standards reinforced the view that they would immediately pick up medical assessments and treatments when care in the hospital was over. Because of this perception, PHNs believed that the clients were discharged from hospital by physicians who had the expectation that PHNs would see them without delay. PHNs did not feel that other health care professionals adequately understood their limitations regarding their access to homes.

> PHN (CHA 4): They [physicians] do not know really what a public health nurse does and does not do. We do not take prep; we do not take directions from hospital doctors. That is not our role. But they're directing us like we're hospital nurses.
> PHN: But the care mapping standards are now portraying our role that way. Public health now has the standards and that is encouraging them to say, "Oh public health's going to see you tomorrow," so we will let them take off.

In the excerpt below, the PHN believed the physician did not have an understanding of her role, because he wanted her to monitor a mother's blood pressure continuously.

> PHN (CHA 4): I have found high blood pressure with an early discharge. I called the doctor back, and he asked me to stay and take the blood pressure again in 20 minutes, then again in the evening, and then again the next day. So he doesn't understand that we are not a hospital nurse that can follow up with these [clients] every shift.

Some of the PHNs spoke of their frustration with a system that was poorly coordinated. In situations where clients required additional care, there were no mechanisms or links to facilitate it. The PHNs did not have access to transport for clients to return to hospital, and did not always have adequate discussions with other care providers about their decisions. In the conversation below, PHNs in CHA 1 spoke of their role in giving clients information to promote their own health, as opposed to being there to monitor their health similarly to nurses in hospitals. In times where the client may have left the hospital too early this did not always seem adequate, however, the PHNs had limited options.

> PHN: My frustration is someone with issues and being able to link them back. I feel I can only be there for 1 hour. I can't be there for a 7 to 8 hour shift to do the observation. That frustrates me, because I think, OK, I can give them the tools, I can say "Watch for this, watch for that." But...
> PHN: The onus is on them.
> PHN: ...the onus is on them to make some choices too.

When physicians did not provide assistance, it often left the PHNs in uncomfortable situations, which required them to make a decision about whether or not to send the new mom and baby back to the emergency department. Such decisions had major consequences because sending family members to the emergency department was disruptive and an additional stressor for the new family that had only recently returned home from the hospital.

> PHN (CHA 1): I think that is where the frustration comes in. Sometimes you are not really sure. You do not want to overreact and say, "Go to the hospital." And then they get there and they say, "Oh, you did not need to come." And I think that is what people are saying. We are not sure sometimes of the decision. And if you can't get somebody on the phone to consult with, then it comes back to you. Do I say "Rush off back to the hospital," or do I watch or wait? And that's when you wake up in the night and wonder about these people, if you gave them the right advice or not. Because it may not be something that you commonly see and you are not really sure [if] it is really bad.

PHNs were confined by the limitations of the system, but they were accountable for ensuring clients' health outcomes were adequate. The PHN's expressed frustration in trying to meet their

professional responsibilities to provide care for clients, while simultaneously meeting the needs of client and working in a system where they believed they did not have adequate tools, education, or supports.

4.3.3.2 Striving for a System to Promote Continuity of Client Care

PHNs desired a system that provided continuity of care for clients. The term 'seamless' was used by one PHN in CHA 3 to describe her vision of the health care system. However many PHNs reported barriers to continuity, which included their inability to access clients or clients refusing visits. When PHNs defined public health nursing as a voluntary service, it limited their ability to be accountable. The PHNs believed these issues were compounded by lack of communication between hospital personnel and PHNs, lack of understanding by other health care professionals regarding PHN access to clients, and differences in the nature of PHN relationships with families compared to other health care professionals.

In many cases, PHNs believed that clients were discharged because there was an expectation that the PHN would be in the home the next morning to assess the client's medical condition. In some cases, physicians had written orders that the PHN must visit. One of the nurses in CHA 4 stated, "I've had doctors write on referrals, must see PHN tomorrow. And that was their criteria for discharging." As indicated below, those expectations contrasted with a reality that PHNs might not be able to access clients, or clients may not want a visit.

> PHN (CHA 3): I guess, and this is more between the hospital and community, maybe them not understanding our role. But a lot of times we will say things like "We are voluntary, so people do not have to let us in." So when we see on a referral priority contact, doctor wants BP done, or weight needs to be done, or they are being sent home because the client said they would let the public health nurse in. When we can not get in, it's like, "Oh my lord." We call the doctor and tell them but, you know, even to have that sense that we might not get in. Not to rely that we are going to get in within those 24 hours.

Because public health nursing was regarded as a voluntary service without the regulated authority to intervene, PHNs were placed in difficult positions when families declined visits. In the discussion below, the PHNs in CHA 4 spoke of situations where the clients were discharged before they were ready, due to the belief there would be nursing follow-up in the home the next day.

> PHN (CHA 4): Unfortunate too because I think the hospital sends them home knowing public health will call them the next day. So it's OK to send them home doing the finger feeding or supplementing, because public health will be in there the next day. Where sometimes the family might even decline a visit. They might be home supplementing and if they decline us to go into the house for whatever reason, then they are just, they are on their own.
> PHN: I think that is a misperception on the hospital's part sometimes, because I have gotten referrals with stars, "Please see next day." Whereas the client may not want a visit the next day.
> PHN: They assume that we will be in there calling them, even first thing the next morning.
> PHN: And some, they do not want to be seen. But you almost feel bad that you haven't pursued it more with them. It is not their needs, it is your need.
> PHN: Yea. Our needs to meet our standards rather than what the family's needs are.
> PHN: So then you are left going, "Oh I should have seen them because of our standards, but they would not let me and how could I."

The ability to balance client wishes with the need for medical follow-up was especially difficult when there were specific areas of concern. The PHN below described the tension that developed between the family and the PHN, when the PHN became more forceful due to her concerns about infant weight loss and inadequate breastfeeding.

> PHN (CHA 3): According to our standards, if it is under 48 hours for a vaginal delivery, and under 96 for C-section [caesarean], we have to contact them within 24 hours of discharge and offer a visit. And sometimes when they decline, but the information that you receive on the referral states that breast feeding needs to be assessed, baby has a weight loss between 8 and 10 percent or greater than 10 percent, then you are kind of insisting, and sometimes that can create a tension between you and the family. And when you start insisting, they may say, "It's my life, I don't want you." They will not use those words, but that is a feeling that you get when you have to insist that you come and see them.

The PHNs indicated that despite expectations they would visit the next day, they felt that all of the relevant information was not available on the chart due to concerns about patient confidentiality. Without clear client histories, PHNs believed it was difficult to provide continuity of care and to connect clients with the appropriate resources. A PHN in CHA 3 stated "There is no continuity. There is no knowledge of their history. And it makes it really difficult because I think that that is a big part of our job, connecting people with resources." The PHNs spoke about the importance of communicating all aspects of medical history to maintain the plan of care and ensure appropriate follow-up in the community.

> PHN (CHA 1): And yet we need good information if we are going to provide good care. And we are all Winnipeg Region now. We all have FIA [Freedom of Information Act]. This is all confidential; if they give us information, it is not going to go anywhere. So, we need to understand the systems better and work better together.

4.3.3.3 Expressing the Desire to Build Relationships with Community Partners

PHNs identified their need to work collaboratively with other professionals and agencies in the development of public health practice that would provide optimal client care. In particular, they wanted to work more collaboratively with physicians regarding medical issues in EPD. One of the PHNs described her anxiety when the situation was one that required medical attention:

> PHN (CHA 3): Just the well being of this new family that comes home, mom and baby. For me, its important when I go to bed at night, I know her blood pressure was 160/100. And I called the physician, and the physician was able to see her and prescribe proper medication, and that mom didn't die of stroke and leave this baby an orphan.

PHNs reported varying experiences when they contacted physicians with medical problems. Some physicians acknowledged the PHNs skills and acted immediately. One PHN spoke of the positive interactions that she has had:

> PHN (CHA 1): With the contact to physicians, I have always been quite impressed. I don't think we call terribly often, when we do, I think they know there is a concern. So I usually find that they are right on it and they will say, "OK, I will make room today. Would you feel better if I see them?" And that has been so helpful for me, that it compensates for the few grumpy ones.

Other PHNs reported extremely negative and stressful experiences with physicians. In some cases, the physicians did not treat PHNs in a professional manner, acknowledge their role in providing care to clients, or respect their clinical skill and knowledge. In the following excerpt a PHN in CHA 3 described her belief of physician's perceptions of PHNs. "You are calling because you are concerned about mom's blood pressure. And they're like, well why are you calling me. You are wasting my time." A negative experience and view of another PHN is described below.

> PHN (CHA 3): I remember a paediatrician who said no wonder I pay so much tax. I was so upset, I hung up on him. You see that in the older ones. Younger ones, they have more knowledge, more education about these are our colleagues, these are medical staff partners. But the older ones seem to have more problems.

PHNs spoke of potentially negative repercussions when physicians diminished or did not support their professional judgement. Some discussed the impact of the physicians' actions on the PHNs' relationships with clients. PHNs believed that physicians' lack of support in their interactions with clients could result in PHNs losing credibility with the family. Sometimes they felt it completely sabotaged the relationship PHNs had developed. One particular area where this was an issue pertained to breastfeeding. PHNs believed they were very skilled and knowledgeable in facilitating breastfeeding. In the excerpts below, PHNs discussed when physicians ruined their work with families in developing breastfeeding plans. PHNs in CHA 3 expressed frustration that physicians did not seem to understand their job, or consider the PHN role during their interactions with patients.

PHN: In an ideal world I think we would see a lot more support from the paediatricians and the gynaecologists.
PHN: Oh yea.
PHN: Yea, especially when it comes to the complications of breastfeeding.
PHN: Yea.
PHN: Paediatricians are one of the big obstacles to provide the most appropriate care and support that that family needs at that specific time.
Researcher: What kind of obstacles?
PHN: You could have this whole feeding plan and mom agrees, and she calls to make the appointment and for some reason she gets hold of the doctor and the doctor says one thing. Your feeding plan is gone.
PHN: It is over.

When a PHN's assessment was in conflict with a physician's assessment, the physician's interactions with the family could negatively influence the family's perception of the PHN and her contribution. PHNs reported that these types of situations sometimes ended their relationships with clients.

PHN (CHA 1): I had one mom [where] this baby had a high respiration rate in the hospital, but was sent home. I went out and found the same thing and told the doctor. He said, "Take her back in right away." So she went back in. [Then] he said, "No it's fine. And when I wanted to do a follow-up, the mother said, "I don't want a public health nurse involved any more."

PHN (CHA 1): I had that happen just over doing a Denver Developmental on a baby that was early. I was showing her and suggesting some things that the baby could be doing so that the baby would start to lift themselves up. Well she went to the doctor and the doctor told her that all was fine. But she took it in a different way and it carried on for a long time. Like when she had her next baby, "I do not want to see that public health nurse." [She] made it quite clear. And I was blown away because I didn't know what I had said or done.

4.3.3.4 Requiring resources to Support Public Health Nursing Programs

A sub-theme that was requisite for building a public health future was having appropriate resources to support public health nursing programs. In the current system, reorganisation of service delivery had taken place with the addition of minimal staffing and resources. Study participants raised the assignment of other programs to unit PHNs as potential concerns. The PHNs spoke of services that included the follow-up of communicable diseases such as

tuberculosis (TB) and sexually transmitted infections (STIs); immunization programs in the schools; and prenatal classes that were previously delivered through centralised programs. As well, some participants talked of citywide programs implemented by the WRHA such as breastfeeding clinics that required unit PHN attendance. The excerpt below indicated the turmoil felt by PHNs in CHA 1 around meeting the expectations of multiple programs, especially when their prioritising was complex due to the urgent nature of many of the issues.

> PHN: The frustration for me is that I might have to be immunizing. I might have a meeting with Family First and yet have a postpartum, so the prioritising can be frustrating when there are too many things going on.
> PHN: STDs [sexually transmitted diseases] and CDs [communicable diseases] and TB [tuberculosis] and prenatal classes.
> PHN: And we are not just pre, you know, baby,
> PHN: That's right. Like the antenatal program, for example, focuses on everything antenatal. And that is it.
> PHN: But our job is much more.
> PHN: Whereas we have it coming from all kinds of angles.

PHNs expressed frustration with the number of program responsibilities that were added to their jobs, and the effects of those responsibilities on other aspects of their roles. PHNs believed it was the expectation that they would continue to maintain their previous practice responsibilities, while managing the workload associated with the new programs. PHNs felt that the effect of more programs was an inability to provide any of the services at appropriate levels. PHNs in all of the CHAs used the phrase "jack of all trades, master of none" to describe how they felt. In the discussion below, the PHNs in CHA 4 expressed their frustration with the number of programs they were managing, and around their view that management expected them to undertake additional activities like community development.

> PHN: I think that they have all these other programs floating around. "Give it to public health." So it stretches you so thin so that each program is not getting the full benefit of the public health nurse. It is just meeting the basics and moving on.
> PHN: It is skimming the surface.
> PHN: Yea, exactly.

> PHN: And it is very frustrating as a public health nurse.
> PHN: And now they are going to be adding the STD [sexually transmitted diseases], STI [sexually transmitted infections] and TB [tuberculosis].
> PHN: And TB [tuberculosis].
> PHN: follow-up to our place in the community.
> PHN: The other thing is there is a theoretical piece that is floating up there. Our higher-ups say "You will do community development, you will do this, you will do this, you will do that, and you will do this." But when you narrow it down to what we are actually doing, it's like they have pie in the sky. There is no reality check in terms of you have finite resources. We can only do so much and you have mandated us to do this, this, this and this. But yet if you talk to people in higher-up positions, it is, "Well, we are doing community development, we are doing this, we are doing that." But the reality of the program is that we are not doing that. We are not doing all pieces of public health like we used to anymore because this [EPD] is just driving our practice. It is taking up so much of our time.

PHNs did not want to sacrifice the health promotion aspects of their practice to provide EPD and other mandated services, however, because of the workload implications, PHNs required management approval prior to their involvement in the community. PHNs believed, because they could not spontaneously offer their services, communities questioned their commitment to community projects.

> PHN (CHA 4): The direction has probably come so that they [management] could assess to make sure that we have enough staff available for all of the mandated services. But then, it is the communities, when they ask for your input or involvement, you are kind of like, "Well, I don't know if I can." Then you are being seen as not wanting to participate, although you would like to.

PHNs expressed concern there were not opportunities to work with communities and develop programs based on individual needs. As the following PHN described, the community development work that PHNs previously undertook no longer existed.

> PHN (CHA 2): One of the most frustrating things is because public health has a wider array than just the clinical skills. But because we do not have the staffing, our community development that we did many, many moons ago, has really fallen by the wayside.

PHNs believed the administrators in the organisation had taken a centralised approach to community development. PHNs spoke of programs that were implemented on a citywide basis

from the top-town. Although the citywide programs were well staffed with inter-professional teams, the PHNs questioned whether this could be considered community development. Many PHNs agreed that these were valuable programs, but the programs did not originate from the needs of individual communities. The nurses in CHA 1 discussed this new approach:

> PHN: I would not call it necessarily grass roots types of community development activities. They are more government driven, like the Healthy Child Manitoba programs, Great Expectations. You know we are very committed to those programs. I guess in a way it is community development. But it is more professionally driven than actually grass roots involvement in the community. The neighbourhood resource networks and the child and youth groups, we try and encourage community memberships, but primarily it is professionally driven. So. I would use the term community development rather loosely in terms of describing what we do.

PHNs questioned whether the needs of the community were being addressed adequately, and whether the community valued the centrally controlled programs in the same way they valued programs that they had initiated. Below, the PHNs in CHA 1 described their belief that communities did not have the same enthusiasm for these programs, compared to those initiated by PHNs in collaboration with the community.

> PHN: I look at the program Great Expectations and you guys have…
> PHN: Things are taken care of.
> PHN: …a nutritionist, a nurse, childcare, you have it all figured out. But I don't get this, I don't know, the heart isn't the same when you do something.
> PHN: No, not. No.

The PHNs believed that inadequate staffing and resources undermined their ability to deliver community development services. The PHNs wanted adequate staffing, as well as funding to support service delivery. The PHNs described conflicting directives from management, and lack of PHN involvement in decision-making. The PHNs in CHA 4 expressed frustration in prioritising their workload, when there were finite resources and many competing demands.

> PHN: We have people saying, "Postpartum should be your focus." We have other people saying, "CD [communicable disease] is your focus." When you have both of them on your plate, then which one do you get to? They cannot even decide higher-up which is a priority. They are just saying "You will do both." Well we have finite resources, we can only do so much at a certain time. And then it is frustrating because you are either not meeting one standard for CDs or you are not meeting the other standard for early discharges.
> PHN: Or Family First, which is an ongoing one.
> PHN: Exactly, which is another one. Yea.
> PHN: And you can not even get to that.
> PHN: Highly funded.

PHNs expressed concern that they were losing sight of the needs of the community, because the programs were implemented from a management perspective. Additionally, the PHNs did not have time to undertake community assessments, establish relationships, or to advocate on behalf of the community regarding their needs. As a result, PHNs feared that the needs of the communities were ignored because their time was devoted to EPD.

> PHN (CHA 4): We are losing sight of what the needs of our community are, because a lot of it is driven from management as to what supports they feel we should be providing. But every community has different needs and we are not able to express those things or take time to find that out - systematic assessments of the community. Because we are doing more such an acute focus in public health, which loses the whole perspective of what public health is.

The PHNs spoke of wanting to engage in social marketing to increase community knowledge regarding the role of the PHN, but not having time to do so. The PHN below discussed the lack of adequate funding and staffing for public health programs and health promotion. The result was that PHNs were challenged to engage in any activities that would promote the health of communities, or increase the community's awareness of the PHN role.

> PHN (CHA 2): I would like to see public health nurses having a higher profile in the community. There are many people in a community that do not know what we do. But I think that is directly tied to staffing and resources and it is part of a much bigger problem in terms of health care, where money is funnelled into acute care and tertiary care. Not to take away that, that is obviously very important, but the leftovers always go to the well population, the health promotion and disease prevention, which are the pillars of public health. And we do not see that money

> and resources coming to us, so it is always a bit of a struggle to let people know what we are doing out in the community. By having more resources available to us, we could reach out to other organisations and then increase that profile in the community.

The PHNs talked about the issue of CHA staffing, with some of the units having vacant PHN positions for extended lengths of time. Additionally as one participant indicated, PHNs in regular staff rotations were not replaced when they were away because of illness or vacation, as nurses in the hospital would be. This created additional workload pressures and contributed to PHN stress within the units.

> PHN (CHA 2): Unfortunately, right now, we are a position down because of an injury and we do not get replaced. There is no sick time replacement as in hospital, you would have somebody come in. We do not. You have to figure where you can take your holiday times and the remainder of the staff basically has to cover you. There is no illness replacement. We have been short a position since September when the nurse was injured and she probably will not be back for another month. And then a nurse left. We have been short, [name] is now in that position. So we feel the impact. And then, again, that also erodes what we can offer. And it stresses staff out. With the amount of senior staff we have, a full year is probably holidays.

PHNs provided EPD services 7 days per week, along with other services that extended into the evening hours. When working the weekends or evenings, PHNs had to take back their time during the regular workweek. PHNs linked the impact of this type of staffing at unit level to further limitations in the daily services they could provide.

> PHN (CHA 2): It pulls away from what we can provide Monday to Friday. And that is really important when you are talking about the weekends. The prenatal classes are something new as well. Public health nurses will be providing that education to families in the evening. So as a result, there will be time taken back during the week, so it further erodes the manpower during the week.

The PHNs in the CHAs identified as low and high-risk indicated there were needs that were unique to their areas, and those needs affected their resources and service delivery. In a CHA with the highest proportion of teen moms, the PHNs talked about young moms having

limited ability to advocate for themselves. As a result, the PHNs often spent more time visiting, or advocating on behalf of such clients with other health professionals and community agencies. A PHN described a situation in which a client left the hospital with an infection, because she was unable to discuss this with staff in the hospital.

> PHN (CHA 3): Very shy. Even though they may have symptoms, they may not talk to the nurse. And then if they don't talk to the nurse, nurses in hospital do not realise that this mother should stay for 1 or 2 more days for observation. By the time they come home, all the fever and everything. In a suburb area, they may not have this problem. Because once they [the client] do not feel well, "I am not feeling well. I am not going home, no matter what you tell me." So that is the difference. Most of our mothers they do not talk, tell the nurse.

Due to the high-risk nature of their clients, PHNs in CHA 3 spoke of their families often being involved with a wider range of agencies in the community. They reported that these types of issues increased the amount of work for the PHNs by necessitating more follow-up, more time for the establishment of relationships with families, and more time connecting with other community agencies.

> PHN (CHA 3): In this area compared to other areas, there are more social issues. So we are spending a lot of time with Families First, more risky families, Child and Family Services, which the other areas do not as much. So our time is taken there quite a bit.

The PHNs in the CHA with the highest income spoke of the misperception that their clients did not have the same needs for community nursing services as other areas. With EPD, the acuity of the clients was high in all areas. PHNs reported that they often had to follow clients because of complicated medical issues, or assist them with resources and referrals. The increased intensity of EPD challenged their ability to provide services within the resources available.

> PHN (CHA 2): Some of the things that we are seeing is the degree of complexity of some of the cases, where moms and babies are being discharged with quite complex medical issues. That is a challenge for us to be able to provide service to

> those families in the community. It involves a lot of coordination of services and referrals. And that can be a real challenge, especially if your resources are such that it is difficult to find time and the resources.

The PHN below offered her opinion that, although her clients may have advantages with their socio-economic status, services in the postpartum period were not available to purchase. Additionally individuals of higher socio-economic status may still have the same physical and emotional health needs requiring PHN follow-up and support.

> PHN (CHA 2): What is frustrating is that the staffing level is not what it should be, because the philosophy is parents who are higher socioeconomic status do not need the services that target groups do. Those areas do not get serviced, nurse-wise, in the same manner. But that clientele still does need that support system. They need the services and we have to go more on demand for service. We have a wider range of clients. However, with this type of clientele, they can find services elsewhere. There are not those services to purchase. There are not those services to get. For us, where it is frustrating, is these clients do need the support. They do need us in there. Yet we are not given staff accordingly, so sometimes it can be a little overwhelming.

The PHNs wished for more balance in their workloads. They believed that PHNs would provide the best service and be more satisfied with their jobs if there were the resources and staffing to support all aspects of public health programs. The PHNs also indicated that programs must be continually reassessed, to determine their effectiveness and impact on PHN workload.

> PHN (CHA 2): I think the bottom line is ensuring that there is enough staffing so that we have a balanced workload. So everybody feels satisfied and we can provide the best service possible. We have to make sure that the balance of staffing to workload is always being reassessed and it is as balanced as possible. I think that is the bottom line. Because I do not think we are going back to longer hospital stays.

In discussing the ability to continue to provide their current services and maintain the quality of their practice, a few of the PHNs spoke of models of service delivery. In the WRHA, the model has been that of a generalist practice where all PHNs provided EPD, worked with the schools and daycares, and engaged in communicable disease follow-up. Although, the majority

of nurses seemed to favour the generalist model, they believed that staffing was not at the level to permit generalist practice. A PHN in CHA 4 stated, "Its competing priorities. And we're not doing a good job of almost everything." The response of a PHN follows, which was agreed upon by other PHNs. "I think that is a bit of an issue with the generalist program." In the excerpt below, the PHNs expressed their frustration that services were organised in this manner, however, the PHNs were unable to practice in a generalist fashion because of the workload implications associated with EPD.

> PHN (CHA 4): We will hear in January if we get any staffing based on that, yet another component, because they feel it is better for us to be following up with families in the community. Well that is great, but we do not know what family practice looks like any more. We are just doing medical follow-up with postpartums.

Some PHNs discussed the concept of focus nursing as an alternative to the generalist model of practice. One nurse indicated there were advantages to having PHNs focus on specific areas of practice. She spoke of a group of nurses who might follow all the communicable diseases, and would therefore become very knowledgeable about that process, whereas another group of PHNs might have a family focus and primarily focus on EPD.

> PHN (CHA 1): There is something about being considered expert in a particular field, whether it is family health, whether it is communicable disease. When you can really become very knowledgeable and feel confident. Because, I might get a Hepatitis B once a year to follow-up and then it takes a day to do it, but you need to.

The nurses in CHA 1 made the inference that a program specific focus might be less stressful in terms of managing their workload when there were numerous competing priorities.

> PHN: Well we do not know what is coming down the pipe exactly in January, bit of an in-service as to which STDs we will follow and how much. But if you were an STD nurse, you would get on it right away. Doesn't matter what it is. But with our early discharge program, with TB. They have been going out and doing Mantouxs. Had a 14-year-old at the school that is pregnant that has no services. What is most important? They are all important.

> PHN: Or the high-risk families that are in crises and are suicidal. You feel like you are juggling a lot.

Because of staffing and time constraints, the PHNs spoke of competing priorities that challenged them to manage and prioritise their workloads based on the complexity and acuity of their community issues. These competing priorities created stress, tension, and frustration for PHNs, who wanted to offer the best care possible in all situations.

4.4 Chapter Summary

In this chapter, the findings were presented. Four focus group interviews with 24 PHNs, working in four community health areas in Winnipeg, yielded rich and meaningful data. From this data, three major themes were developed, each with several sub-themes. The first theme was a passion for the public health nurse role. The sub-themes were valuing aspects of public health nursing, building the capacity of individuals and families, and developing relationships with individuals and families. The second theme was the influence of EPD on public health practice. The sub-themes were changes in public health nursing practice, the erosion of health promotion and prevention, and a new role for PHNs. The third theme was building a public health nursing future. The sub-themes included needing the proper tools to do the job, striving for a system to promote continuity of client care, expressing the desire to build relationships with community partners, and requiring resources to support public health nursing programs. In the next chapter, I will discuss these findings in the context of available literature, as well as suggest recommendations for nursing practice; education; administration; policy and research.

5. CHAPTER FIVE:

Summary, Discussion of Findings, Nursing Implications and Conclusions

This chapter includes a summary of the research and discussion of the findings in the context of existing literature. Based on the discussion of the findings, the implications for nursing education, practice, administration, policy, and research will be presented. The chapter will end with the conclusions drawn from the study.

5.1 Introduction

The sample consisted of 24 PHNs working in generalist practice from four Community Health Areas (CHAs) in the WRHA. The four CHAs sampled were located in west, northeast, southeast, and central Winnipeg. I purposively selected the CHAs based on their socio-economic characteristics and mortality and morbidity profiles to obtain PHNs working with a wide range of clientele. The PHNs ranged in their skill levels from those with a few months of experience, to several individuals who had been employed as PHNs for more than 20 years.

I used focus groups to collect the data, with a semi-structured interview guide consisting of nine questions. The tape-recorded interviews were transcribed verbatim, and written field notes were kept. The PHNs appeared to speak openly, and vigorously discussed the questions posed. The groups were homogeneous because they consisted of PHNs with the same job description, and I made comparisons across groups through a process of constant comparative analysis. An audit trail and research credibility were developed through the input of my thesis committee and the process of writing the thesis.

To code and interpret the text obtained, I used an inductive content analytic approach, following the procedural methods described by Burnard (1991). After immersion in the data by reading and re-reading the interviews, I coded each line in the transcripts, compared, and

contrasted the codes across interviews. I freely grouped codes of the same or similar meaning into broad content categories. I reduced the categories by grouping the broader headings together to develop a categorical scheme, with 3 main themes and 10 sub-themes. The three main themes were: a passion for the public health nurse role, the influence of early postpartum discharge on public health practice, and building a public health nursing future.

5.2 Discussion of Findings

5.2.1 The Context of the WRHA

A complete restructuring has recently taken place in the WRHA. For 85 years prior to 1998, services in Winnipeg were delivered by two separate jurisdictions, the Province of Manitoba and the City of Winnipeg (WRHA public health consultation, 2000). These two jurisdictions organised their geographic services differently, provided services using different practitioners, and covered their staff under different collective agreements. In 1998, following the introduction of regionalisation in Manitoba, these districts were amalgamated into the WRHA. The merger of these two regions resulted in many changes to public health practice for both jurisdictions.

Since that time, the WRHA has redefined its public health programs to create a common philosophy, model of practice, and strategic direction (WRHA public health consultation, 2000). The mission can be summarised as pubic health practice that is based upon best evidence, evaluation, partnerships, and promotes healthy and self-reliant communities (Tjaden, 2005). The ways of working include a generalist PHN practice model, with specialty teams in geographic orientations where appropriate, and multi-disciplinary teams of service providers (WRHA public health consultation). The activities of PHNs include assessment of the individual, family, and community; as well as education, counselling, referrals, and community development (Tjaden).

Through centralised support and leadership with regionalised coordination, services are provided in six key areas: healthy beginnings; healthy school age children; healthy environments; communicable disease control; injury prevention; and lifelong wellness (WRHA, n.d.).

5.2.2 Conceptual Framework

The conceptual framework that I used for the study was the Community Health Nurses' Association of Canadian (CHNAC) Standards of Practice. I choose this framework because CHNAC set out principles that reflected the practice of PHNs. CHNAC (2003) identified five areas that represented PHN practice: the promotion of health; development of individual and community capacity; development of relationships; assistance with access and equity; and demonstration of professional responsibility and accountability. I will explore the applicability of the CHNAC standards of practice to my research findings.

5.2.3 Comparisons of Findings to the Literature and the Conceptual Framework

I will now discuss the findings of my study in relation to the literature and the standards of practice outlined by CHNAC (2003). The major themes in my findings were: a passion for the public health nurse role, the influence of early postpartum discharge on public health practice, and building a public health nursing future. Although the role that PHNs have assumed in providing care to mothers and babies following EPD has become accepted and routine, there is surprisingly little evidence to support this practice. Because of this shift in the emphasis of their work, the PHNs in my study commented that the EPD component of their practice was undermining other elements of their role that were equally important to them.

I could locate no studies that specifically asked PHNs about their role in EPD, therefore, I have referred to literature specific to the PHN role in maternal child-care or overall practice. Two Canadian studies have focused on PHNs' perceptions of their practice. Recently in Nova

Scotia, Meagher-Stewart and Aston (n.d.) collected data through individual interviews with 43 PHNs that were randomly selected; as well, they interviewed 32 PHNs in focus groups. Reutter and Ford (1996) conducted the other study, using individual and focus group interviews with 28 PHNs in Alberta.

5.2.3.1 A Passion for the Public Health Nurse Role

The nurses in my study described a love of their job and valuing their public health roles tremendously. The PHNs perceived that their practice was unique, and different from other areas within nursing. Specific aspects important to them were autonomy, the diverse nature of their practice, as well as the opportunity to promote health and work with a healthy clientele across their life span. PHNs loved the flexibility and excitement of a practice that was always changing. They believed that they promoted the health and capacity of their clients. Reutter and Ford (1996) reported that PHNs in their study also believed they were unique from other health professionals, because they viewed clients holistically and took into account their circumstances based on their broad knowledge of theory and community resources. They enjoyed working with clients across the life span in diverse settings, their autonomy, independent decision-making, and using the generalist practice model. PHNs valued their role in health promotion, the capacity to be innovative, and feared a practice that was "task-oriented." Meagher-Stewart and Aston (n.d.) recently interviewed PHNs in Nova Scotia with comparable results. Based on their interviews with nurses they identified the theme of professional autonomy, which described the independence, flexibility, and self-directed nature of PHN practice.

According to CHNAC (2003), PHNs promote health by collaborating with clients and assisting them to assume responsibility for their well-being. They assist clients to assume responsibility for their health through a comprehensive range of strategies that address the

determinants of health, incorporating client strengths and research evidence. PHNs prevent and protect health by assisting clients to recognize potential risks and make informed decisions about protective and preventative health strategies that include immunization, breastfeeding, and birth control (CHNAC).

Although CHNAC indicated that PHNs should maintain clients' health through the provision of clinical nursing care, by providing education, and by linking clients with other resources and supports (CHNAC); the PHNs in my study indicated that the voluntary nature of EDP could preclude their access to clients. PHNs are given guidelines to enhance capacity by empowering individuals and communities to increase control over their own health. The PHNs in my study indicated that they had minimal involvement at the community level due the demands of EPD and that their presence in the schools, one of the key areas identified by CHNAC, was attenuated. Enhanced capacity is dependent upon effective PHN partnerships with clients and other community agencies (CHNAC). The PHNs in my study indicated that their partnerships with other health care providers were limited and characterised by misunderstanding about roles, and that they could not always maintain partnerships with clients who viewed their role as specific to the early discharge experience.

Specifically in terms of meeting clients' immediate needs in the postpartum period, the PHNs in my study spoke of their role in EPD in improving the level of health and well-being of their clients. The PHNs believed they were able to support EPD families in their homes, build their capacity to care for their infant, connect them to resources, as well as promote health and prevent injuries or illnesses. The literature supports their claim that assessment of common and predictable issues of concern following EPD can avert potential problems and reduce hospital readmissions (Frank-Hanssen et al., 1999; Johnson et al., 2002; Walker et al., 1999). For these

reasons, the CPS (2004) recommends that families leaving before 48 hours after birth should have contact with a health professional within 24 hours at a minimum by telephone, and a complete physical assessment performed within 48 hours (CPS, 2004). This approach is reflected in the WRHA standards for PHN follow-up of EPD clients. Interestingly, there is no discussion in the WRHA standards about PHN accountability in the event that the PHN is unable to contact the client, or the client refuses a visit.

A review of current research indicated that PHN home visiting could address an array of health and social problems for maternal-child clients (McNaughton, 2004). PHNs utilised their knowledge of theory and community resources, in addition to nursing interventions such as education, to build capacity and improve the health of families with unfavourable birth outcomes, social problems, and breast-feeding issues. Unfavourable birth outcomes included low birth weight or prematurity; social problems included adolescent and single parenthood, unemployment and abuse; while breastfeeding consisted of promotion and maternal bonding. The social support provided to mothers by PHNs has also been positively associated with mothers' self-confidence, and their ability to cope and care for their newborn (Tarkka, Paunonen, & Laippala, 1999).

PHNs in the WRHA spoke repeatedly about being guests in the clients' home, and the associated implications in establishing relationships that would allow them to promote their client's health. Many PHNs believed that EPD facilitated this role. PHNs undertook a variety of approaches to ensure their relationships with clients would be positive, and the families would be interested in continuing PHN involvement. The PHNs discussed the need to be respectful of the clients' home environment, including guests, and to allow them to maintain control. PHNs used strategies that included creating a safe and respectful atmosphere, focusing on client strengths,

building the individual's capacity, and providing care based on current evidence. According to CHNAC (2003), PHNs foster relationships with the client by developing these types of supportive environments. McNaughton (2000) completed a review of 14 qualitative studies on home visiting from the perspective of PHNs, and reported that PHN-client interactions were vital in establishing ongoing relationships that facilitated the client's receptiveness to nursing interventions.

One of the most significant differences in my study from those that discuss the PHN role in maternal and child health, was the concerns that PHNs described around building trusting relationships with their EPD clients. With the expectation that PHNs would visit within 24 hours, and the potential for postpartum clients to be at greater risk for illness or injury stemming from their early discharge from the hospital, PHNs believed that it was imperative for them to establish a relationship that would allow them access to the client's home. They indicated that their service was voluntary and they had no recourse in situations where clients refused a visit. McNaughton's (2000) work supported the significance of trust in building PHNs' relationships with clients; she indicated that they worked to establish rapport that would not cause premature termination, but would foster collaboration and allow the relationship to continue. The PHNs in her study stressed the importance of respecting the client's need for control. Similar to the PHNs in my study, those PHNs reported relationships were strengthened by being sensitive to the client's way of doing things, which promoted communication and established the foundation for promoting their health (McNaughton). Meagher-Stewart and Aston (n.d.) also reported that PHNs believed relationships were foundational to their practice, and described the theme of "building relationships of trust."

The majority of PHNs in my study expressed concerns about the level of information that they had to collect from clients to meet the WRHA standards for EPD. They believed the standards drove the visit using the PHNs' agenda rather than the client's needs, which could threaten their fragile relationship with the client. The literature supports the perspectives from the PHNs in my study, because mothers have described seeking mutuality when establishing relationships with PHNs (Jack, DiCenso & Lohfeld, 2005). They viewed mutuality as a comfort with the PHN that was promoted through engaging in social conversations, sharing information, allowing the mother time to speak, and positive reinforcement by the PHN (Jack et al.). Mothers reported diminished mutuality and less desire to maintain the relationship when the PHN came with her own agenda, and appeared to collect family assessment data automatically, without first establishing a level of comfort with the mother (Jack et al.). Those findings fit with PHNs' concerns in this study about service driven agendas.

The generalist model of practice was highly valued by most of the PHNs in the WRHA. This view was more apparent in the experienced PHNs, because they had been exposed to practice before many of the changes elicited by EPD. PHNs believed that, although nurses required increased knowledge to practice in a generalist capacity, it promoted greater diversity and satisfaction. The generalist model also allowed nurses to know their communities and to develop lasting relationships within communities. Reutter and Ford (1996) supported the perceptions of the PHNs in my study because they reported PHNs found the generalist model stimulating and satisfying. On the other hand, in Nova Scotia, because of a lack of funding and resources, the PHNs in Meagher-Stewart and Aston's (n.d.) study described moving from a generalist to a focused model. While some of those PHNs identified this as a positive change, the majority believed that generalist practice allowed a unique opportunity to develop ongoing

relationships with communities that promoted their health. Their nurses indicated that although focused nursing allowed PHNs to be more confident in particular areas, it contributed to a lack of visibility and the loss of connections within the community (Meagher-Stewart & Aston).

5.2.3.2 The Influence of Early Postpartum Discharge on Public Health Practice

The majority of PHNs in the WRHA indicated that EPD had negatively influenced their public health practice. The WRHA standards for EPD recommended that PHNs should visit clients discharged under 48 hours for a vaginal delivery, 96 hours for a caesarean, or those with identifiable concerns within 24 hours. All other clients were to be visited within 7 days (WRHA, 2003). There is consensus in the literature about the importance of follow-up in the community by a qualified health professional following EPD (CPS; PHAC, 2002; Wilkerson, 1996). For families leaving hospital before 48 hours, there should be contact with a health professional within 24 hours at a minimum by telephone, and a complete physical assessment performed within 48 hours (Brown et al., 2002; CPS; Johnson et al., 2002; Wilkerson). For families staying past 48 hours, a physical assessment completed by a health professional is recommended within 1-week of discharge (Walker et al.). The difficulty with the literature is that most references do not distinguish the contact by type of health care professional. This lack of clarity has the potential to lead to duplication of practice when a number of different health care professionals are seeing women and infants within the first week of hospital discharge.

According to CHNAC (2003), PHNs demonstrate professional responsibility and accountability to clients, employers, and governments, by basing their activities on empirical evidence, and by providing safe and ethical nursing care. However, the PHNs in my study indicated the practice of early home visiting had become the routine, regardless of whether the client met the EPD definition. Their comments called into question the claim that their activities

were based on empirical evidence. It is possible that individuals not meeting early discharge criteria had medical or breastfeeding concerns that necessitated PHN contact. Alternatively as indicated by the PHNs in this study, the PHN role may have been considered an extension of the care provided in hospital, without any awareness of the other activities included in their job.

Based on the WRHA standards, PHNs were required to complete full physical assessments on all mothers and babies. Since the introduction of EPD with mandated PHN follow-up, the PHNs in my study reported increased complexity and acuity of clients in the community. The mothers and babies often had a variety of complex medical needs, which changed the focus of the home visit from education and health promotion, to assessment and diagnosis of variations from the norm. The increased level of complexity and acuity of EPD clients has been substantiated in the literature. Gagnon et al. (2002) reported that infants leaving the hospital early were at greater risk for dehydration, malnutrition, electrolyte imbalances, jaundice, and breastfeeding difficulties. Jaundice was the most frequent reason for infants discharged early to be readmitted to the hospital (Lock & Ray, 1999; Maisels & Kring, 1998). Increased risk of kernicterus has also been linked to EPD (Lannon and Stark, 2004).

PHNs in my study reported an increased workload required by daily visits, and that the increased focus on medical issues reduced the receptiveness of clients to the health promotion activities in which they could engage. Clients viewed PHNs as extensions of the hospital system or "postpartum home care," and associated them with their episodic medical needs. The PHNs questioned whether this approach was fostering client dependence, rather than building their capacity. Alternatively, once the family's medical needs were addressed, they often no longer identified a reason for PHN involvement. PHNs believed this acute care focus detracted from the holistic view of the family, and caused a narrowed view of the PHN's role. Moreover, the

PHNs in this study suggested that EDP had the potential to undermine their efforts to build ongoing relationships with families focused on determinants of health and health promotion.

Another primary component of PHN's work in the context of EDP in the WRHA was breastfeeding support. The PHNs spoke of the value of their role in promoting breastfeeding, and believed that they improved breastfeeding rates in their communities. According to Statistics Canada, breastfeeding rates have increased in Manitoba. In 1994/95-1996/97, 17.1% of recently born children were breastfeeding, with 31.9% of those continuing to breastfeed until at least 3 months (Statistics Canada, 2001). In 2003, 88.6% of newborns initiated breastfeeding, with 51.7% breastfeeding for at least four months (Statistics Canada, 2005). Although societal trends play a role, this evidence suggests that PHNs in the WRHA could be influencing breastfeeding rates. Janson and Rydberg (1998) reported that mothers are breastfeeding longer, and the support of health care providers plays an important role.

Limited research has evaluated the role of the PHN in providing breastfeeding support. Madden and colleagues (2003) concluded that breastfeeding support provided through community based nursing follow-up after EPD had no adverse effect on rates of breastfeeding initiation or duration. McKevver and colleagues (2002) found that breastfeeding support in the home facilitated incidence and frequency of exclusive breastfeeding for mothers of term and near-term (35-37 weeks gestation) infants. Similar to my study, Reutter and Ford (1996) reported that PHNs believed they were better able to facilitate breastfeeding success through home visiting and addressing concerns in the client's environment where they were in control. These PHNs also believed that clients appreciated the breastfeeding support and services they provided.

The PHNs in my study did not comment specifically about their work with mothers experiencing post-partum depression (PPD). The PHNs spoke of complex medical needs and greater acuity in the community, as well as spending extra time connecting families to resources since the implementation of EPD. In the first year post-birth, approximately 10-20% of mothers experience postpartum depression (PHAC, 2002). Concerns have been raised that because of EPD, mothers might be at increased risk for PPD since they are making the transition to motherhood without the level of support and education that was previously available through extended hospital stays (Fishbein and Burggraf, 1997; Hickey et al., 1997). In my study, all of the PHNs spoke of their increased workload resulting from the complexities of EPD. As the PHNs were not explicitly asked about PPD, it is likely that when they used broad terms and referred to increased workload, PPD was one of the problems they were referencing. Sword and colleagues (2001) found depression correlated with inadequate income and lack of social and personal resources. In my findings, the PHNs working in the CHA with the lowest socio-economic status specifically spoke of the increased amount of time they spent working with families and other agencies in the community because of EPD.

Many of the PHNs in my study spoke of EPD as comprising the majority of their workload, and eroding their other health promotion and prevention activities. PHNs no longer had the time to devote to health promotion in the community, or community development. EPD and communicable disease programs mandated by administration were prioritised at the expense of those other activities. Because those programs were offered seven days a week and unpredictable in nature, they further compromised the activities that PHNs could provide during the week. PHNs had to set priorities around which important aspects of their work should take precedence, leaving health promotion and community development at the bottom of the list.

According to CHNAC (2003), to facilitate access and equity PHNs work to address the wide variety of determinants that influence health, advocating for healthy public policy and on behalf of clients when needed. Clearly, the PHNs' descriptions indicated they were not fulfilling that mandate because of inadequate time and resources to do so. PHNs could find their roles in EPD usurped by increasing midwifery capacity because home visiting for 6 weeks falls within midwives' scope of practice. If EPD continues to erode other programs, there is potential for many important aspects of the PHN's role or the PHN entirely to be lost.

Although there is minimal research regarding the absence of the PHN role in the community, findings similar to those in this study are documented. A number of factors have contributed to the lack of visibility and public perception of the PHN role within the community. Traditional PHN activities such as health promotion and community development have been reduced because of organisational influences that have not supported these roles (Underwood, 2003). A study of PHNs in five California counties maintained the notion that the majority of PHN time was spent on activities related to individuals, with few PHNs providing interventions at the community level (Grumback, Miller, Mertz, & Finocchio, 2004). Reutter and Ford (1996) reported that the public associated PHNs with tasks such as providing immunizations, and therefore it was difficult for the public to distinguish them from home care nurses. The diversity of nursing services in the community has also contributed to confusion about the roles and responsibilities of the different types of nurses, and the agencies that they work for (Underwood).

In this study, the demands of competing programs and lack of direction from WRHA administration resulted in a lack of clarity amongst PHNs concerning their roles. The consequence was that PHNs no longer had time or the desire to take on the additional responsibilities that were part of their professional practice, but outside of their mandated

programs. These included education, establishing relationships with community partners, and community development. Although the practice of early discharge had come into effect long before the WRHA standards, the PHNs thought that their EPD standards were set at an unrealistically high level, which eroded their health promotion activities. The junior PHNs reported that the current practice was the only one that they had known. More experienced PHNs shared stories of their past roles in health promotion and community development. An element of lack of familiarity with former practice roles by new practitioners is the loss of those roles when senior nurses retire.

PHNs in the WRHA indicated that their diminished role in the community created tension and resulted in frustration when dealing with area members. Promoting health and building capacity at the community level was dependent upon the development of relationships that required time and commitment. Yet because of their decreased presence, members of the community no longer recognised or utilised the skills of the PHNs. The PHNs interviewed by Reutter and Ford (1996) also believed that time pressures did not allow for planning, developing relationships with clients, implementing programs at a community level, community development, or advocating for healthy public policy. They suggested that PHNs' work had a level of uncertainty, because of the conflict between mandated programs and other activities. This uncertainty caused PHNs to conserve their energy, to make their workloads manageable and to meet the expectations associated with their mandated programs. The PHNs interviewed by Meagher-Stewart and Aston (n.d.) also described their practice as juggling heavier caseloads, needing to do more documentation and administrative work, travelling greater distances, as well as working with high-risk clients that required more time for referrals. Similarly to the PHNs in

my study, these studies reported that PHNs wanted to participate in community development and health promotion, but did not have the time or resources to do so.

Unfortunately, these workload pressures prevented PHNs in the WRHA from meeting the standards of practice identified by CHNAC. The same principles displayed by PHNs in their work in EPD, must be applied at the community level. In addition to working with individuals and families, PHNs should also work at the community level to address the underlying socio-political issues affecting health (CHNAC, 2003). PHN's address community needs through strategies incorporating population health concepts based on the Ottawa Charter for Health Promotion (CHNAC). Strategies based on the Ottawa Charter include developing healthy public policy, creating supportive environments, strengthening community action, developing personal skills, and reorienting health services (World Health Organization [WHO], 1986).

The PHNs in my study reported negative effects on their role in school health, due to the time and energy devoted to EPD. Allocating time to schools and daycares was an important aspect of building relationships with the community. PHNs who had been working in public health for many years often described their familiarity with entire families and all of their children, many times more than one generation. PHNs were identified as a resource by families and the school system, and they promoted the health of children and youth through education, and by being readily available for consultation. They reported that their role in the school was reduced to providing immunizations at scheduled intervals throughout the year, thereby reducing their visibility within the community, and contributing to confusion about their responsibilities. PHNs believed that their skills and knowledge were no longer well utilised in the schools, contributing to a significant gap in the already limited health resources available to this target population. Reutter and Ford (1996) also reported that PHNs perceived that having a physical

presence in the school promoted their value, while their diminished presence resulted in loss of opportunities to address important health issues for children and youth.

Although the PHNs in my study discussed many negative aspects associated with EPD, they believed that early discharge was beneficial and helpful for families. They felt that mothers appreciated and were highly satisfied with the EPD services provided by PHNs in the WRHA. According to Fishbein & Burggraf (1997), EPD is more conducive to family cohesiveness and bonding. Enhanced maternal satisfaction has also been repeatedly documented in studies of EPD (Brown et al., 1996; Dalby et al., 1996; Gagnon, et al.,1997; Lieu et al., 2000).

5.2.3.3 Building a Public Health Nursing Future

The PHNs in my study spoke of a variety of elements that were necessary to build a public health nursing future. The increased acuity of EPD clients had resulted in more PHN contacts with families that were low-risk to manage their medical needs, and more time to make referrals and connect with other agencies involved in the care of high-risk families. PHNs indicated that their level of education and the availability of tools to perform their EPD physical assessments were often inadequate; as a result, they did not feel satisfactorily prepared. The most common assessment concern raised by the PHNs was the issue of hyperbilirubinaemia. The PHNs spoke of the need for resources to be able to assess levels of neonatal jaundice confidently. The literature indicates that hyperbilirubinaemia can place infants at risk following early discharge (Gagnon et al., 2002; Johnson et al., 2002 Lannon & Stark, 2004; Lock & Ray, 1999; Maisels & Kring, 1998). Moreover, the benefits of EDP programs are based on skilled and extensive physical assessments and prompt referrals for identified problems (CPS, 2004; PHAC, 2002; Wilkerson, 1996). There have been no evaluations of the rates PHNs detect, or fail to detect jaundice or other preventable issues, during their contact with EPD families.

PHNs in the WRHA were overwhelmed with the amount of work that they were doing, and with organisational restructuring and the addition of new programs, the PHNs identified the need for their employer to provide them with ongoing support and education to ensure the best care for clients. The College of Registered Nurses of Manitoba (CRNM) stipulates that although the individual has a professional obligation to meet their continuing competence needs, employers also share accountability in providing learning opportunities to enhance nursing practice (CRNM, n.d.). The literature emphasizes administrators' responsibilities to increase PHN's accessibility to continuing education that maintains their competencies (Chang, Tseng, Hsiao and Wang, 2003). According to Chang and colleagues (2003), it is reasonable for PHNs to feel they require new knowledge to meet the changing demands of their roles; more than half of their sample reported continuing education was fundamental to improving their skills and practice. The magnet hospitals in the United States that support nursing practice and professional development have found higher rates of nurse satisfaction and lower rates of job turnover (Upenieks). Most significantly empowering and increasing the professional practice of nurses is more likely to contribute to the most effective and efficient client care (Laschinger & Sullivan, 1996).

According to CHNAC (2003), PHNs demonstrate professional responsibility and accountability by initiating strategies to address the determinants of health, and advocating for changes in society that will improve the health of populations (CHNAC). Although the PHNs in my study supported this guideline, they perceived limited control in shaping their overall practice. Resource constraints created tension for the PHNs, who felt that health promotion and prevention activities were central to their role, but were not supported by administrators in practice. The PHNs often set priorities for mandated programs and limited their involvement

with the community as a result. Although the PHNs felt these programs were important and they were committed to them, they believed that the government and their employer were the originators of the programs in their communities, rather than the public. PHNs were saddened about the loss of their role and relationships with the community, but felt powerlessness to change the current system. There has been no other research evaluating the impact of EPD on the PHN role in the community. However, Laschinger and Wong (1999) found that nurses' beliefs about their access to information, supplies, and support correlated to empowerment and role effectiveness. Adequate resources and supports have also been identified as essential retention strategies (Upenieks, 2003).

The PHNs in my study did not believe that the health systems within their communities were well integrated, and identified the need for better communication among professionals. They described a lack of awareness about their roles, and health care providers' expectations regarding their length of engagement with families that were inconsistent with their work hours and access to resources in the community. PHNs felt they were often provided with incomplete information to develop appropriate plans of care. In many cases, PHNs believed that clients with problems were discharged early with the perception the PHN would visit within 24 hours to evaluate their status. However, because of the voluntary nature of the PHN's involvement they were not always able to access the client, which left them in a position where they felt accountable and responsible for the client's outcomes, without the ability to provide care. The PHNs were also very clear that clients could refuse their services at any time after they had gained entry. According to CHNAC (2003), PHNs foster relationships in full participation with the client by developing supportive environments. The standards created stress for the PHNs,

who felt that in many cases clients were discharged from the hospital on the basis that the PHN would see them the next day, but clients could refuse their care.

Of particular significance within the community were PHN's relationships with physicians. The PHNs in my study indicated that they preferred collaborative relationships; however, in general, the PHN and physician worked in parallel silos with each practitioner isolated from the other. They believed that physicians had the capacity to undermine their work with clients, particularly pertaining to infant nutrition and breastfeeding. The PHNs elaborated on the damage that could occur to their relationships with clients, if physicians were not in agreement with their plans of care or provided differing advice. The PHNs regarded themselves as highly skilled and knowledgeable about breastfeeding. They spoke of physicians sometimes interfering and/or sabotaging their client's breastfeeding success, and not feeling valued when their professional expertise was undermined. Meagher-Stewart and Aston (n.d.) reported that many of the PHNs they interviewed spoke of the need to increase collaboration, and "break down the walls" between organisations. Reutter and Ford (1996) reported similar findings to those in my study regarding PHN interactions with physicians and their potential impact on infant nutrition. They indicated that lack of understanding of the PHN role influenced collaboration, resulted in duplication of services, and affected PHN self-esteem. In the literature, a well-integrated system of community-based follow-up has been identified as a key component of EPD programs (Wilkerson, 1996).

According to CHNAC (2003), PHNs develop interdisciplinary and inter-sectoral partnerships to ensure clients receive appropriate health services. In contrast to the standards outlined by CHNAC, PHNs in my study indicated they did not have adequate time or energy to foster trusting relationships with other health professionals and agencies in the community, even

those that were involved in postpartum care. Occasions for social marketing and developing linkages in the community were lacking and were not prioritised in PHN practice. Interdisciplinary partnerships needed to be developed with physicians, the hospital system, and other health professionals that cared for new mothers and babies. There was also the need to develop inter-sectoral relationships with other agencies. For instance, the PHNs in CHA 4 spoke of the need for better communication with Child and Family Services, as well as Employment and Income Assistance. According to the literature, EPD should rely on a well-organized system of community-based care (Wilkerson, 1996). A coordinated interdisciplinary approach is more likely to meet the needs of post-partum families than the provision of care by any single health professional or agency (Bains et al., 1998). A coordinated inter-professional approach is also believed to be necessary in meeting the needs of families and reducing systemic costs (Bain et al, 1998; CNA, 2000, June; Fishbein & Burggraf, 1997; Sword et al., 2001).

PHNs in the WRHA discussed the importance of colleagues. When working in close proximity they were able to learn from one another, and colleagues were valuable in debriefing difficult situations. The PHNs regarded health care restructuring and the movement towards inter-professional teams of health care providers as important. They also indicated that inter-professional teams had the potential to undermine their support from colleagues, which they needed to sustain their professional practice. The PHNs interviewed by Meagher-Stewart and Aston (n.d.) reported that peers were their greatest source of support because they had a shared philosophy and knowledge that contributed to PHN enthusiasm and shared workloads. In Nova Scotia, restructuring occurred where the links between PHNs were lost, which PHNs reported was their greatest regret.

PHNs in the WRHA believed that their role was not well understood by the public or other health professionals, and limiting their community activities had exacerbated this situation. According to CHNAC (2003), PHNs must use social marketing strategies and advocate for community level changes to promote health. Although the PHNs felt that social marketing was important to increase their visibility in the community, they did not believe they had time to devote to this task. The PHNs speculated that part of the reason for this shift away from health promotion was the difficulty in finding evidence to support the effectiveness of PHNs' roles in health promotion and disease prevention activities. Although the literature has pointed to the diminished PHN presence in the community contributing to the invisible nature of the PHN role, (McKay, 2005, Meagher-Stewart & Aston, n.d.; Scruby, 1999, Underwood, 2003), there has been no discussion about the effects of the move to evidence-based practice on their health promotion activities.

The PHNs that I interviewed spoke of inadequate funding allocated towards prevention. When new programs were added to their workloads, it was often in the absence of adequate resources or staffing. However, PHNs also believed that new programs were being added with the assumption they could continue with their former activities. Although PHNs expressed the desire to be working at the community level and meeting the CHNAC standards of practice, this was not their current reality because of mandated programs that consumed their time. According to Laschinger and Wong (1999) the capacity of nurses to meet the standards and values of their profession, is a major determinant of job satisfaction and organisational commitment. Other PHNs across Canada have talked about the implications of inadequate funding allocated towards health promotion. They have reported inadequate time and resources as stressors that eroded their ability to participate in health promotion and prevention activities (Meagher-Stewart &

Aston, n.d.; Reutter & Ford, 1996). Increased work constraints and fragmentation of services developed from staffing cutbacks, increased numbers of mandated programs, and insufficient funding (Meagher-Stewart & Aston; Reutter & Ford).

Many of the findings from my study result from the extensive role that PHNs in the WRHA have assumed in the home visiting of postpartum clients. Although PHNs believed that community-based care was more cost-effective than hospital care, it had a detrimental impact on other aspects of their practice. Since the implementation of EPD programs, studies have cited increased costs of nursing home visiting compared to other methods of delivering community-based services, though home visits have been associated with higher degrees of maternal satisfaction (Escobar et al., 2001; Lieu et al., 2000). The PHNs in my study did not suggest alternate methods to deliver EPD services in the community. They were likely not familiar with some of the different models of service delivery examined in the literature, and they accepted standards encouraging home visits for all was evidence based. It could be that their distance from central administration where decisions were made about the implementation of programs decreased the likelihood they would question the nature of the evidence supporting the policies and standards of new programs.

Degrees of evidence of the five CHNAC (2003) standards were found in the data provided by the PHNs as it applied to the postpartum care of mothers and babies in the community. However, the narrowed approach to public health practice that PHNs in the WRHA had assumed, based on a practice that primary consisted of EPD, did not fully meet the standards outlined by CHNAC. Ironically, in attempting to meet the WRHA standards for EPD, the PHNs impeded their ability to meet the professional standards for their overall practice expected by their professional organization and employer.

5.3. Study Limitations

This study contributes to the sparse research regarding PHNs' perceptions of EPD. Although the data were rich in content and saturation was reached in the four interviews, the study had some limitations. The sample was drawn using purposive sampling techniques and consisted of 24 PHNs from four CHAs in Winnipeg. Due to time constraints, the data were collected in a relatively short period and in the weeks just prior to the December holidays. Because of the time of year, many of the PHNs in each office were away on vacation. There is the possibility that the participants who volunteered for the interviews had differing views than those individuals who did not volunteer, or who were away. Given the size of the sample and the limitations of the recruitment process, generalisability beyond study participants would be inappropriate.

The data were collected in a focus group "one-shot" format, using a semi-structured interview guide. Even though no changes would be made to the interview guide which proved to be effective, perhaps additional information of value could have been elicited through the inclusion of individual interviews, or a second interview with the same groups of PHNs to ascertain if they were in agreement with the study findings. Although group synergy was apparent in discussions, there was the potential that in this synergy the purpose of the study was overlooked, and therefore results may over-state some of the issues. Additionally, due to the synergy of the group discussion, there were multiple voices on the taped interviews and it was not always possible to distinguish individual speakers.

Discerning the individual speakers during the conversations presented an interesting dilemma that developed during the process of analysis. In segments of conversation composed of multiple PHNs, it was not possible to determine when the same PHN began to speak again.

This is a point for consideration at the onset of the research process. Possible suggestions might be to have the transcriptionist present during the interviews, and to have the PHNs introduce themselves with a pseudonym each time they speak. However, there is the risk that introducing oneself with a pseudonym might interfere with the synergy that characterised the interviews. In the analysis, each CHA was represented with a number, and although no participant could be identified, it was possible to determine the CHAs of the speaking PHNs.

5.4 Implications for practice, education, administration, and policy

Although the nurses interviewed believed they were providing high quality care to new mothers and newborns, the findings of this study have a number of implications for practice, education, administration, and policy.

5.4.1 Implications for Nursing Practice

The findings of this research study are important for PHNs and for other health professionals with whom they work. The PHNs believed that their involvement in EPD promoted the health and well-being of families in the community; however, they spoke of a lack of coordination and collaboration among providers and services in the community. More importantly, the PHNs believed that the public and other health professionals did not fully understand or appreciate their skill, knowledge, or role. For these reasons, I would recommend that increased continuity of care be promoted, as well as increased efficiency and coordination of the services offered to mothers and newborns in the postpartum period. Particular goals should be a focus on enhanced collaboration among health professionals, and EPD services delivered based on the principles of primary health care.

To deal with fragmented services and lack of coordination among health care professionals, PHNs could foster collaborative relationships with other health care professionals

and agencies, particularly physicians and hospitals. One model with positive outcomes consisted of services provided by interdisciplinary teams in community-based settings (Yaffe et al., 2001). A suggestion could be to develop partnerships with paediatricians and family physicians that would begin to build community-based teams. In Manitoba, a referral from a family physician is not needed to see a paediatrician; therefore, the majority of families see paediatricians for their baby wellness check-ups and immunizations. An innovative way to deliver services could be to develop partnerships with physicians, where PHNs provide routine immunizations and health education on certain days for doctors. In addition, after the initial postpartum visit, if problems were identified they could do joint follow-up with physicians so that they would have access to resources for testing bilirubin levels or re-admitting infants to hospital. There are many issues to work out which would require managerial support, the biggest being remuneration, as physicians are unlikely to give up work that impacts their income. Conversely, if physicians were freed from tasks that could be delivered by PHNs, it would allow them to increase public access to services. There is also the potential that physicians might increase their job satisfaction and incomes by being able to undertake more work using their full scope of practice. The overall result could be appropriate care provided by a team of health professionals, that is more comprehensive and better meets the needs of clients.

PHNs could build relationships with others in the community that facilitates continuity of client care, limits duplication of human resources, and increases health system efficiency by being the first point of contact for the first year of a child's life. Children have a minimum of four appointments with physicians for health promotion activities such as immunizations. If PHNs were to deliver those services there would be significant system cost savings, as it is more cost effective to use health providers other than physicians (Naylor, 1999).

Although utilising PHNs to deliver services for the first year is a more cost-effective approach, our system is not currently structured in this manner. An interim solution would be to utilise PHNs as the first point of contact in the first weeks following EPD for families without medical risk factors. The PHNs could see the families as needed during the period immediately following birth. Once the PHN's involvement was completed, they could fax a referral to the physician for the ongoing follow-up of the 2-month booster that documented the client's postpartum recovery. According to CIHI (2006) the total costs of care provided by PHNs in the 4 weeks following birth, which included telephone consultations and home visits, was $86 per mother/infant pair. This compared to medical costs totalling $129 for care by a physician. Mothers and infants often have their care duplicated by nurses and physicians because providers in our current system work in a parallel fashion. Current funding models facilitate the parallel practice of multiple providers, which further increases costs to the health system. An interdisciplinary approach based on salaries is an effective method of reducing health care costs, providing comprehensive services, and limiting duplication of interventions and valuable health human resources (Hall & Weaver, 2001).

Given the invisible nature of PHN work, it is imperative that nurses become more assertive and engage in social marketing. Although the PHNs have time constraints because of workload pressures, there will be no change in awareness by the public and other health care professionals, unless PHNs lobby their administrators and increase awareness of their role. As health care continues to undergo reform and alternate methods to deliver services are explored, PHNs can be actively involved in change, and have their ideas heard and taken into consideration. According to Donaldson (1995), "the challenge to nursing is that failure to participate in health care reform may allow reshaping of nursing from sources beyond the

profession." Without PHN involvement in health care changes, other agencies and tertiary care facilities may diversify to include health promotion and prevention programs, threatening the viability and unique aspects of public health nursing (Reuter & Ford, 1996).

PHNs can find ways to bring health promotion and community development to the forefront of health care agendas by advocating for and educating others about the importance of preventing chronic disease and future problems, especially as it pertains to youth and early childhood intervention. Target groups could include the public, PHN managers and senior executive, as well as governments. PHNs can become more proactive and involved in planning by suggesting solutions that might begin to address some of the issues they experience. PHNs occupy the best position to offer results that will be effective, based on their skill and knowledge of the role. In summary, I recommend that PHNs engage in social marketing to increase awareness and understanding of the PHN role and function among the public and other health professionals.

5.4.2 Implications for Nursing Education

There are implications that are important to consider for those who educate nurses. Students could be exposed to findings indicating how PHNs felt about their role, and the passion with which they spoke about a career in public health nursing. It is also important to expose students to nursing perspectives that have developed from generalist practice, where community development and relationships were vital components of PHNs' roles; otherwise, practice knowledge about those areas will be lost.

The pan-Canadian health human resource strategy regarding interprofessional education for collaborative patient-centred practice has as a goal to move towards a concept of interprofessional education, where the various health professionals are educated together, rather

than in their individual silos (Health Canada, 2004). I recommend that all providers advocate and move towards interprofessional education. The area of EPD is a complex and interesting area to consider, for health care students who plan to work in the community. It would be extremely valuable for future PHNs, family physicians, paediatricians, midwives, and lactation consultants to identify professional contributions to patient care, particularly areas of similarity, difference, and overlap. Ideally, student clinical opportunities and course work would be designed to be interprofessional in scope. Those designs create issues for curriculum development, however, starting with students in their educational programs is one way to begin to break down the barriers and limit some of the professional territorialism that currently exists. It also has the potential to sensitise health care providers to the many facets of practice that affect contributions to specific patient groups. The area of EPD is an important place to begin, based on the number of mothers and babies and the variety of health professionals in the community.

Although it is important to educate nurses from theoretical perspectives, they must be prepared to enter the field. Students not only need to understand the concepts and how to work with communities, they should be aware of the realities of PHNs' practice. Students require learning opportunities to understand the significant role that PHNs have assumed in delivering EPD services and the implications for their practice. They would also benefit from an awareness of the effects of central administrative decisions for programming on aspects of PHNs' roles. Students should have experience in the area of health policy, and understand their role in influencing policy development and shaping their practice. Perhaps by educating students about these issues, before they enter the workforce, they will be better prepared to advocate for aspects of their practice. In summary, in addition to moving towards interprofessional models of education, I recommend that nursing students be educated about EPD and the implications for

PHN practice, as well as the importance of health policy and advocating for aspects of their practice.

5.4.3 Implications for Nursing Administration

The findings of this study have a number of implications for individuals in administrative or management positions within public health programs. The PHNs expressed frustration and dissatisfaction with certain aspects of their practice. Specifically PHNs were dissatisfied with administrators' emphases on EPD, immunization, and other centrally mandated programs, and the fact that their practice had become more task-oriented with minimal focus on community health promotion. They attributed their diminished role in the community to inadequate funding and staffing levels. These comments were in direct opposition to the reasons the nurses expressed for choosing and valuing the field of public health nursing which were variety, autonomy, and the desire to promote health. These discrepancies have the potential to contribute to unhealthy work environments and ultimately high turnover if not resolved.

I recommend that nursing managers in the WRHA improve relationships with direct care staff by actively including PHNs in decision-making processes related to client care. Nurses who work in environments where their expertise is valued; and with administrators who have a decentralised, participatory, and supportive management style, are happier and more satisfied with their work (Upenieks, 2003). As the public health nurse leaders, managers can provide support and clear direction for caseloads and work priorities. PHNs described competing priorities and not meeting any of their responsibilities effectively. Managers and administrators have a responsibility to monitor the effects of adding programs to the extensive roles undertaken by PHNs, and to examine whether assumptions they hold about PHNs' ongoing activities are accurate. The PHNs spoke of the incongruence between their agency mission and vision

statements, and the reality of their practice. Management is partially accountable and responsible in cases where PHNs are not meeting the standards of practice identified by CHNAC (2003). Nursing leaders have the responsibility to support and advocate for PHNs, so that the agency mission and vision is consistent with the work that is taking place in the field. Nursing managers also have a responsibility, to the best of their abilities, to determine and provide appropriate levels of staffing and resources to support service delivery.

Nursing leaders in the WRHA could be more innovative in the delivery of primary care services, basing PHN practice on the best available evidence and considering alternate methods of providing services. Nurse leaders could assume an approach where the majority of their role is one of coordination, integration, and facilitation (Laschinger & Wong, 1999). New models for delivering EPD programs may create more time for PHNs to participate in health promotion and community development activities, and to work at reducing the barriers among health care professionals. O'Conner et al. (2003) reported that PHN telephone triaging to determine the need for home visits was as effective as routine home visiting. Rather than offering routine home visits to all mothers, PHNs in the WRHA could complete a detailed telephone screen to determine the need for home visits. The need for home visits could then be assessed based on the individual PHN's professional judgement regarding appropriateness.

Care provided by PHNs in community-based settings has lowered systemic costs, without influencing client outcomes (Escobar et al., 2001; Lieu et al., 2000). A clinic-based team model had positive outcomes for clients, and increased nurses' available time by decreasing travel (Yaffe et al., 2001). Using the PHN in conjunction with a team of professionals, such as a physician, lactation consultant, and social worker could provide clients with a range of services that might better meet their health care needs. As the first point of contact, a team of PHNs

could provide EPD services to clients to complete assessments and determine the need for referrals. For instance, rather than having PHNs go into clients' homes, daily drop-in office hours could be offered for new mothers wishing to bring their babies in to the health units. This would provide an opportunity to empower the mother, as she would begin to assume control of her own health and that of her newborn, as well as the opportunity to develop social support networks by meeting other mothers with new babies. It would create situations where PHNs were encouraging clients to identify problems rather than starting from their view of potential problems, which can undermine long-term relationships. This also provides a natural link to the parenting groups and child health clinics provided by PHNs within the CHAs. Although this would require a shift in attitude, new mothers attend a wide variety of appointments with other health professionals outside the home. Yaffe and colleagues reported that 90.3% or 205/227 of postpartum clients attended their clinic appointments. For mothers unable to maintain clinic appointments or who report special circumstances, PHNs could continue to offer home visits. In summary, I recommend that nursing leaders consider interprofessional agency based alternatives to the current model of EPD service delivery where every new mother receives a PHN home visit.

Another recommendation is that WRHA nursing leaders support PHN practice with continuing education opportunities, which maintain their competencies as health care continues to change. To promote quality work environments, nursing leaders and administrators need to sustain nursing practice, listen to PHNs, and work together to create positive atmospheres. The PHNs spoke repeatedly about their need for education related to EPD. Although individual PHNs assume the professional responsibility for the care they provide, administrators and managers have a responsibility to maintain the competence of their practitioners in the ever-

changing heath care system, and especially following the addition of new areas of practice. Nursing leaders could strive to foster an atmosphere of life-long learning.

A committee of PHNs in the WRHA could be developed to plan in-services for staff on a regular basis to address their continuing education needs. Following a needs assessment, internal and external experts could be scheduled to begin to address the issues identified. Monthly citywide in-services on broad topics of interest could be organised, one and half to two hours in length, and at the beginning or end of the day to allow for optimal PHN attendance. An example of a topic is neonatal jaundice, which was a primary PHN concern and identified as a significant issue in the literature. As PHNs were already overwhelmed by competing work demands, this should be prioritised as an important initiative with protected PHN time devoted towards it.

A method of addressing unit specific learning needs is through the establishment of a journal club. A journal club that meets monthly for two hours to review current literature on important topics would allow the PHNs to meet their own learning needs and ensure their practise is evidence-based. If one hour was provided on work-time, the PHNs could be asked to devote another hour over their lunch. The journal club could be a forum to develop tools for practice that could be shared throughout the WRHA region. Through activities such as these, management would be assisting PHNs in gathering some of the tools they need to support their professional practice. Individuals also need to assume responsibility for their personal learning needs and styles, and as is the case with all aspects of nursing, they would assume the responsibility to review information and tools on their own time.

There are a number of functions that nursing leaders could assume because of their advanced educational preparation and nursing skills. Nursing leaders in the WRHA can be proactive in reviewing the literature and disseminating current information to staff. Although

staff assume the responsibility for their practice, the vast amount of research available creates a need for administrators or clinical nurse specialists with advanced knowledge of research methods to discern important information and make it available to staff. Two recent examples have changed PHN practice. Evidence was published regarding the need for infants to sleep on their back to reduce SIDS, and the discontinued use of alcohol on umbilical cords. Although PHNs provide more than this information in their teaching to new parents on these topics, these are two examples of vital pieces of information that can be provided to PHNs in a timely manner, so that they maintain evidence-based practice.

Lastly, nursing leaders are in the position to promote understanding of the PHN role among a wide variety of stakeholders. Nursing leaders interact with health care professionals such as physicians and nurses, with other managers, and with policy-makers. They could use those opportunities to educate others on the roles and functions of PHNs, to protect their practice and to increase their visibility within the health care system. In addition, nursing leaders are situated to advocate for adequate funding and resources. To do so, they should stay current on the issues, work collaboratively with stakeholders, and write proposals for funding. In summary, I recommend that nursing leaders advocate for adequate funding and resources, to support staffing levels and service delivery of public health programs.

5.4.4 Implications for Policy

The findings of this study have a number of policy implications. The first policies that must be considered are those of the WRHA. As a result of their EPD standards, nurses have indicated that the Healthy Beginnings program has displaced other valued aspects of the PHN role, because of the high volume of home visits and the associated workload. The standards indicate that the PHN should endeavour to visit all mothers and babies the next day if discharged

under 48 hours for a vaginal delivery, 96 hours for a caesarean, or if issues are identified. Otherwise, the PHN should visit within 1 week. Based on these criteria, PHNs are offering home visits regardless of individual circumstances or identified risk factors. The limited research available does not support a policy stating that PHNs should provide home visits to every postpartum client.

One suggestion would be to alter the policy to indicate that PHN contact be initiated within 24 hours. During this contact, the PHN could do an in-depth telephone assessment to determine the family's plan for follow-up, and the need for a home visit the following day. A telephone screen is more cost-effective and adequate in determining the need for a home visit, without compromising client outcomes (O'Conner et al., 2003; Goulet et al., 2001).

The WRHA policy is consistent with recommendations in the literature, if PHNs were the first and only point of contact with the family and there were no other health professionals involved. Because in the WRHA clients are involved with the PHN as well as other health care providers such as physicians, there are two possible policy implications. The policy could be amended to include other health professionals. Clients, who choose to see other members of the interdisciplinary team such as their doctors or lactation consultants, should not simultaneously have the PHN visiting and providing a parallel service. To reduce duplication and conserve valuable human resources it would be desirable for only one professional to be seeing the client, and for all professionals to communicate openly. Communication and sharing of information between professionals is vital, and continuity of care would be facilitated through the introduction of an electronic health record (British Columbia Reproductive Care Program, 2002). Secondly, if the policy is to remain unchanged, then PHNs should provide continuity of care, particularly in the areas of postpartum management, newborn, and breastfeeding information,

prior to the postpartum family resuming care with their physician. PHNs should also work in collaboration with family physicians to be able to refer the client to other health professionals such as a physician, lactation consultant, social worker, or pharmacist, when there are issues outside their scope of practice. It may mean that this referral will reduce the frequency of PHN visits. This latter recommendation has a number of implications throughout the health system, requiring planning at government levels where negotiations with physicians take place.

It is important to include PHNs in all policy decisions that affect their practice. As the experts providing the services to the public, the nurses are in the best position to plan for new programs and to improve their current practice. According to Scruby (1999), PHNs are often alienated from the process of health promotion policy development and implementation, and a grass roots approach would be beneficial to nurses, agencies, and government. Systems of shared governance also have the potential to empower nurses, and to create high quality nursing practice environments (Laschinger & Wong, 1999). My recommendation is to utilise a decentralised management approach in the WHRA based on participatory models of decision-making regarding service delivery.

The final policy implication is a system-wide issue. Although public health plays an important role in preserving the health of Canadians, the public health system and its workforce have been chronically under funded (Lichtveld & Cioffi, 2003). In fact, of the $130 billion spent on health care in 2004, only 6% was allocated to public health (Canadian Institute for Health Information [CIHI], 2005). The rising costs of treating diseases are forcing governments and employers to look toward health promotion and disease prevention initiatives to reduce the burden of chronic illness and injury (PHAC, 2004). Community development must be recognised and valued as a strategy to promote health (Scruby, 1999). However, lack of

adequate funding prohibits PHNs from having adequate time or appropriate resources to participate in health promotion and prevention activities (Meagher-Stewart & Aston, n.d.). Administrators and governments associated with the WHRA must be held accountable for targeting appropriate areas to use funding and providing evidence of its effectiveness.

5.5 Implications for Research

The findings of this research study have several implications for research. Further research is necessary to delineate the roles that PHNs play in delivering EPD services, in particular the effectiveness of their interventions. The available research primarily has its origins in the disciplines of midwifery and medicine. The medical research stems from the medical model, which focuses on treatment rather than prevention. The midwifery philosophy is likely more similar to that of PHNs; however there have been no evaluations undertaken to determine its applicability.

The nursing role in EPD has not been substantiated in the literature. It is unknown whether PHN physical assessments are beneficial for every new mother and infant. Are routine physical assessments picking up potential issues and health problems? Are the physical assessments done by PHNs changing the family's perception of the PHN role in a detrimental way and reinforcing the medicalisation of the birthing process? Are PHNs improving breastfeeding rates in the community? What role do PHNs play in preventing and working with mothers experiencing PPD? There must be substantiation of the aspects of EPD that are working well and those that could be changed. Evaluations could be undertaken to determine if there are short and long-term outcomes pertaining to capacity building and community resources.

A cost-benefit analysis could be undertaken regarding different approaches to the delivery of EPD. Different models of delivering services must be compared on health outcomes

and indicators, as well as client and PHN satisfaction. Additionally, in the WRHA, a cost-benefit analysis of the generalist practice model is necessary prior to implementing changes in practice. The PHNs spoke of the contradiction that they are working in a generalist model, yet EPD, which is highly specialised, has become their primary focus. This concept could be further explored with the PHNs. An environment scan, using a Delphi technique could be completed across Canada to ascertain the experience of other jurisdictions.

In this study, I explored the perceptions of PHNs in the WRHA regarding their role in EPD. It is also important to undertake this type of research with managers in the WRHA, to compare their views and perceptions, to those of PHNs. Similarly, it would broaden the scope of our knowledge to proceed with interviews in other offices in the WRHA as well as outside the city of Winnipeg. Service delivery varies considerably in rural and northern locations, and often EPD contact is not available to the same extent that is possible in the city. It would be useful to learn the extent that northern and rural locations in Manitoba are influenced by WRHA EPD policies and practices, as well as the roles of PHNs in those regions. Most importantly, are there differences in the outcomes of women and children in the WRHA compared to those areas outside of Winnipeg, because of the level of PHN follow-up provided?

There is limited literature from the perspective of the women and their families. It would be valuable to understand the type of support and interventions they would value from PHNs. It is also crucial to understand how women and their families would feel about different models of service delivery. The government and WRHA have a responsibility to deliver quality care in a form that utilises funding and resources efficiently. For these reasons, it may not be possible to meet every persons needs in the manner they would prefer; however, views of women and their families should be taken into consideration through research studies.

It is important to evaluate all aspects of the PHN role. However, there is a particular need and urgency in area of EPD, stemming from the impact it has had on PHN practice. Ways in which PHN care affects and improves the quality of client care, while being cost effective, must be measured and documented (Clarke, 2000). Extensive data is required about nurses and their roles in improving client outcomes to strengthen the argument for investments in nursing resources (Kimball, 2004; Reutter & Ford, 1996). This is true for public health nurses in particular, given the lack of clarity about the PHN role and their function within the health care system. In summary, my recommendation is that practices in the WHRA be based on current evidence, ensuring that staffing levels are appropriate to support service delivery. In situations where best practice is lacking, there should be a clear plan of evaluation incorporated. Research is needed in a wide range of settings and with all providers of EPD services to critically evaluate EPD practices and the impact on the PHN role.

5.6 Communication of the Findings

The purpose of nursing research is to expand and develop a body of knowledge that is significant to the profession of nursing (Polit & Beck, 2004). According to Berg (2001); without the dissemination of research findings, there is no benefit to the scientific community. The distribution of research can take place a number of ways. Evidence can be disseminated at conferences in the form of poster or oral presentations, through small group presentations, as well as through publication (Betz, Smith, Melnyk & Rickey, 2005). For this study, I will disseminate the findings in the WRHA, offer to present my work to the PHNs, as well as seek opportunities for publication through appropriate nursing journals.

5.7 Conclusion

Although EPD with PHN follow-up is now common practice, this change has taken place without any empirical evidence to support its effectiveness. A small but growing body of literature has evaluated the practice of EPD; however there has been no research documenting the perceptions of PHNs as it relates to EPD and their practice. This study was a first step in addressing that gap. The PHNs in my study believed that EPD was an important service for mothers and their newborns; however, the PHNs spoke of many barriers and challenges that ultimately influenced the effectiveness of care received by families, and contributed to inefficiencies within the health care system. The PHNs also described the detrimental impact that current EPD policies have had on other aspects of their practice. This study offers valuable insight into the delivery of a health care service, by the individuals providing that care.

The findings of this research study point to the need to develop new and innovative approaches for providing EPD services to the public. New methods of providing care will be most effective if developed through the collaborative efforts of PHNs, nursing administrators, and other community stakeholders. The findings also indicate the need for policy changes, and suggest many areas of consideration for future research. EPD has evolved for a variety of reasons, and it is unlikely there will be a return to longer postpartum hospital stays for new mothers and their babies. Based on the impact that EPD has on PHN practice, it is imperative that those with a knowledge and passion for public health nursing become actively involved in charting its future.

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Appendix A: Criteria for discharge less than 48 hours after birth

Maternal	Newborn
PURPOSE: To ensure postpartum mothers are safely discharged following the birth of their baby, they should meet basic criteria and have appropriate arrangements for ongoing care. Prior to discharge, the following criteria should be met.	**PURPOSE:** To ensure newborn infants are safely discharged, they should meet basic criteria and have appropriate arrangements for ongoing care. The baby should be healthy in the clinical judgment of the physician, and the mother should have demonstrated a reasonable ability to care for the child.
• Vaginal delivery • Care for the perineum will be ensured • No intrapartum or postpartum complications that require ongoing medical treatment or observation* • Mother is mobile with adequate pain control • Bladder and bowel functions are adequate • Receipt of Rh immune globulin and/or rubella vaccine, if eligible • Demonstrated ability to feed the baby properly; if breast-feeding, the baby has achieved adequate "latch" • Advice regarding contraception is provided • Physician who will provide ongoing care is identified and, where necessary, notified • Family is accessible for follow up and the mother understands necessity for, and is aware of the timing for, any health checks for baby or herself • If home environment (safety, shelter, support, communication) is not adequate, measures have been taken to provide help (e.g., homemaking help,	• Full-term infant (37-42 weeks) with size appropriate for gestational age • Normal cardiorespiratory adaptation to extrauterine life* • No evidence of sepsis† • Temperature stable in cot (axillary temperature of 36.1°C to 37°C) • No apparent feeding problems (at least two successful feedings documented) • Physical examination of the baby by physician or other qualified health professional within 12 hours prior to discharge indicates no need for additional observation and/or therapy in hospital • Baby has urinated • No bleeding at least 2 hours after the circumcision, if this procedure has been performed • Receipt of necessary medications and immunization (e.g., hepatitis B) • Metabolic screen completed (at >24 hours of age) or satisfactory arrangements made • Mother is able to provide routine infant care (e.g., of the cord) and recognizes signs of illness and other infant problems • Arrangements are made for the mother and baby to be evaluated within 48 hours of

social services) • Mother is aware of, understands, and will be able to access community and hospital support resources ————	discharge • Physician responsible for continuing care is identified with arrangements made for follow-up within 1 week of discharge ————
* Mothers should NOT be discharged until stable, if they have had: • significant postpartum hemorrhage or ongoing bleeding greater than normal; • temperature of 38C (taken on two occasions at least 1 hour apart) at any time during labour and after birth; • other complications requiring ongoing care.	†Infants requiring intubation or assisted ventilation, or infants at increased risk for sepsis should be observed in hospital for at least 24 hours

Joint statement with the Society of Obstetricians and Gynaecologists of Canada

Fetus and Newborn Committee, Canadian Paediatric Society (CPS)
Maternal Fetal Medicine Committee, Society of Obstetricians and Gynaecologists of Canada (SOGC)
Clinical Practice Obstetrics Committee, Society of Obstetricians and Gynaecologists of Canada (SOGC)

Approved by the CPS Board of Directors in 1996
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Appendix B: Healthy Beginnings Indicators by Community Health Area

Community Health Area (CHA)	Winnipeg	Central	Northeast	West	Southeast
Indicator					
Proportion of Winnipeg population	100%	6.30%	14.2%	9.00%	9.70%
% married (Age 15+)	49.10%	36.3%	51.5%	51.70%	55.50%
Common Law	6.90%	9.0%	6.7%	7.00%	6.90%
% married couples with children living at home	58.7%	60.2%	58.9%	50.80%	61.80%
Divorced	7.60%	10%	7.50%	8.20%	5.70%
Single parent Families	18.30%	32.80%	18.50%	16.50%	14%
Aboriginal	8.50%	25.90%	7.50%	5.4%	3.90%
Recent Immigrants	N/A	10.60%	10.90%	7.30%	15.50%
Visible Minority	N/A	16.90%	7.70%	4.60%	17%
Average household income	$53,752	$33,831	$52,060	$54,946	$66,202
Median household income	$43,837	$26,749	$43,576	$47,562	$56,544
Incidence of low income	20%	41%	19%	15%	14%
Incidence of low income families	15%	35%	16%	11%	10%
Education less than grade 9	7.70%	17%	8.70%	5.10%	4.10%
Unemployment rate (Age 15+)	6.00%	10%	5.00%	5.00%	5.00%
Health status and outcomes compared to Winnipeg		Below Average	Average	Average or slightly above on determinants but slightly below average health outcomes	Above Average

Source: Community Area Profiles
Population Health Profiles, CHA Report 2004

The proposed research project has three objectives. The first objective is to describe PHNs' perceptions of early postpartum discharge (EPD). The second objective is to document the effects of early postpartum discharge on PHN practice. The third objective is to describe the role PHNs would prefer to assume in the care of postpartum women and newborns.

As the professionals providing community-based postpartum services, PHNs are the experts to describe the effects that early postpartum discharge has on their current practice, as well as to identify the functions and responsibilities that PHNs would prefer to assume in EPD services in the future.

Study Procedures:
A qualitative descriptive research design will be used to gain a deeper understanding of the research problem. Data will be collected in focus group interviews using an open-ended interview guide. PHNs in four different community health areas (CHAs) in Winnipeg will be sampled: River East, St. James, Point Douglas and Fort Garry.

Dr. Lynn Scruby and Cheryl Cusack will conduct the focus groups. Ideally, there will be about 6 PHNs participating from your site, and the session will take approximately 60 – 75 minutes of your time to complete. The focus groups will be recorded using written field notes, as well as audiotapes that will be used for verbatim transcription.

Your participation in this study is voluntary. Approval for this research study has been obtained from the UBC Research Ethics Board, the University of Manitoba Research Ethics Board and the Winnipeg Regional Health Authority (WRHA) Research Review Committee. Approval for this research study has also been obtained from the WRHA public health senior nursing executive, including the director of public health nursing, the community area directors, and the team managers. If you decide to participate, you may withdraw at any time with no implications for your employment status. A summary of the study will be provided if you request it.

Confidentiality:
Although confidentiality can not be guaranteed because of the focus group format, the researchers will maintain your confidentiality outside of the interview. The researchers will encourage all participants to refrain from disclosing the contents of the discussion outside of the focus group; however, we cannot control what other participants do with the information.

During transcription of the interview data, all names and identifying information will be removed and replaced with code numbers. As an added measure, the transcriptionist will be asked to sign a pledge of confidentiality. All data will

Purpose:
You understand that the proposed research project has three objectives. The first objective is to describe Public Health Nurse (PHN) perceptions of early postpartum discharge (EPD). The second objective is to document the effects of early postpartum discharge on PHN practice. The third objective is to describe the role PHNs would prefer to assume in the care of postpartum women and newborns.

Study Procedures:
You understand that you will be participating in a descriptive research study. Data will be collected in focus group interviews using an open-ended interview guide. You will participate as a member of one of four community health areas (CHAs) in Winnipeg which will be sampled: River East, St. James, Point Douglas and Fort Garry.

You understand that Dr. Lynn Scruby and Cheryl Cusack will conduct the focus groups. Ideally, you will be part of a group of about 6 PHNs participating from your site. Your session will take approximately 60 – 75 minutes to complete. The interview will be scheduled at a time that is convenient for you and your colleagues. You understand that the focus groups will be audiotape recorded and comments will be made in written field notes. You understand that the tapes will be transcribed verbatim.

Your participation in this study is voluntary. Approval for this research study has been obtained from the University of British Columbia (UBC) Research Ethics Board, the University of Manitoba Research Ethics Board and the Winnipeg Regional Health Authority (WRHA) Research Review Committee. Approval for this research study has also been obtained from the WRHA public health senior nursing executive, including the director of public health nursing, the community area directors, and the team managers. If you decide to participate, you may withdraw at any time with no implications for your employment status. A summary of the study will be provided if you request it.

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Although confidentiality can not be guaranteed because of the focus group format, you understand that the researchers will maintain your confidentiality outside of the interview. You understand that the researchers will encourage all participants to refrain from disclosing the contents of the discussion outside of the focus group; however, we cannot control what other participants do with the information.

You understand that, during transcription of the interview data, all names and identifying information will be removed and replaced with code numbers. As an added measure, the transcriptionist will be asked to sign a pledge of

confidentiality. You understand that data will remain with the researcher, be labelled with the date of collection, and be stored in a filing cabinet in a locked room where there is no public access. The researcher will store the raw data (field notes and tape recordings) for 5 years, after which time it will be destroyed.

Compensation:
You understand that the WRHA senior nursing executive has provided approval for the focus groups (one-hour length) to take place during your work time. In appreciation of your participation, refreshments and a light snack will be provided during the interview.

Contact for Information about the study:
If you have any questions or desire further information with respect to this study, you may contact Wendy Hall (1-604-822-7447), or one of her associates at (204) 786-7324.

Contact for concerns about the rights of research subjects:
You understand that, if you have any concerns about your treatment or rights as a research subject, you may contact the Research Subject Information Line in the UBC Office of Research Services at (604) 822-8598.

You appreciate that the study has the potential to provide important information about PHNs' perceptions of their role in early discharge programs and to inform managers and planners about PHNs' views of effective practice.

Consent Form

Consent:
Your participation in this study is voluntary and you may refuse to participate or withdraw from the study at any time without jeopardy to your employment.

Your signature below indicates that you have received a copy of this consent form for your own records.

Your signature indicates that you consent to participate in this study.

Subject Signature Date

Printed Name of Subject

Appendix F: Focus Group Open-Ended Questionnaire and Planned Time

Opening Questions # 1, 2, 3 (5 minutes in total)

1. Tell us your name and how long you have been working in public health. (1 minute)

Introductory Question

2. Think back to when you first started working in public health. What attracted you to this area of nursing? (2 minutes)

Transition Question

3. When you hear the words "early postpartum discharge (EPD)" what comes to mind? (2 minutes)

Key Questions (45 minutes)

4. What are the benefits of EPD? (5 minutes)

Cues: What are the advantages of early discharge for families, women, infants, PHNs?

5. What is particularly frustrating about EPD? (10 minutes)

Cues: What are the costs associated with EPD for families, women, infants and communities?

6. What impact does EPD have on your PHN practice and role? (15 minutes)

Cues: How are other areas of your practice affected - daycares, schools, community development, health promotion?

7. In an ideal world, what role should PHNs play in delivering EPD services (15 minutes)

Cues: Do you see services organized differently? If so, how and why?

Ending Questions (10-15 minutes)

8. Of all the things that we have discussed today what is most important to you? (5 minutes)
9. Is there anything that we should have talked about, but didn't? (5-10 minutes)

Total time: Approximately 1 hour

Purpose:

This form is intended to further ensure confidentiality of data obtained during the course of the study entitled PHN Perceptions of Their Role in Early Postpartum Discharge. The transcriber for the research study will be asked to read the following statement and sign their name indicating they agree to honour this pledge of confidentiality.

I hereby promise to keep confidential any information that I may become privy to during the course of this study. I agree to discuss material directly related to this study only with the primary researcher for this study (Wendy Hall) or her associate (Cheryl Cusack). I agree to remove names and obvious identifiers of participants from all audiotaped interviews that I transcribe.

Transcriber Signature Date

Printed Name of Subject

Appendix H: Procedural Steps for Qualitative Analysis

Burnard (1991) suggests the following steps in the analysis of qualitative interviews.

a. Make notes after each interview. These notes act as memory joggers during the process of analysis.

b. Become immersed in the data, by reading transcripts and making notes on themes. Attempt to become aware of the participants 'life world.'

c. Review transcripts and develop headings to describe all aspects of the content and account for the entire interview data. Freely generate categories.

d. Reduce categories by grouping together headings into broader categories.

e. Review the new list of categories and remove similar headings.

f. Invite two colleagues to independently generate categories, then discuss and adjust the categories as necessary. This step enhances the validity of the categorizing method and protects against researcher bias.

g. Reread the transcripts in comparison to the list of categories and sub-headings, to cover all aspects of the interview data.

h. Review each transcript and computer code according to the categories and sub-headings.

i. Cut out, paste sections of the interviews, and code them into the appropriate categories and subheadings. Keep copies of original text.

j. File all sections together, and keep them available for referencing during the process of writing up findings.

k. The process of writing begins. The researcher starts to link filed data together using a commentary. Approach each section in this way, referring back to the original transcripts and tape recordings as needed.