HOME CARE NURSES' PERCEPTIONS OF THEIR NURSING PRACTICE IN TODAY'S HEALTH CARE DELIVERY SYSTEM

by

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We accept this thesis as conforming to the required standard

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ABSTRACT

Major health care changes have arisen recently that have affected the delivery of health care by community home care nurses. The reason for this research study was to explore and describe the experiences of home care nurses in order to gain an understanding of home care nursing practice from the perspectives of home care nurses in the current restructured health care system, and to identify the needs or concerns of these nurses with regard to their nursing practice.

Phenomenology as defined by Colaizzi (1978) was the research method that was used to obtain and determine the perspectives of the participants in this study. Phenomenology is the study of every day life as it is actually lived and experienced (Omery, 1983). Nine home care nurses who worked in a large urban health department and who were interested and could clearly and accurately articulate their perceptions and experiences of home care nursing practice participated in this research investigation.

Data collection involved two informal, minimally structured indepth interviews that were limited to one hour in length, audiotape recorded, and transcribed verbatim. Data analysis and data collection occurred concurrently so that areas for clarification and exploration were discerned, recurrent themes and theme clusters were identified, and data saturation was ascertained. A third interview took place with a focus group of six participants in order to present and to validate the research findings as being representative of the participants’ experiences and perceptions.

Major theme categories emerged from the analysis of the interviews. Three primary categories and subsequent subcategories evolved from the participants’ data. The first category identified the nature of home care practice and three subcategories, the context of home care nursing practice, the attitudes towards home care nursing practice, and the context of the client. The second category identified the prerequisites for home care nursing and two subcategories, the knowledge and skills requirements and the strategies necessary for home care nursing practice. The third category identified the organizational issues in home care nursing and two subcategories, the professional issues relevant to home care nursing practice and recommendations for home care nursing practice. These study findings had implications for home care nursing practice, administration, health policy, education, and research.
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CHAPTER 1: INTRODUCTION

Background to the Problem

Current trends in health care have shown a definite shift from institutional health care delivery to that administered in the home. A result of this shift has been the early discharge from hospital of persons with increased levels of acuity or chronicity and frequently in need of technological care (Rachlis & Kushner, 1994). 'Quicker and sicker' is a term that frequently has been applied to persons who have been discharged from hospital in the 1990's. This change in health care delivery has taken place because of advances in medical and surgical technologies, as well as fiscal restraints and limitations in resources, such as staff and hospital beds (Deber, Baker, & Mhatre, 1992; Smith, 1992; Wearing, 1991). Also, the desire to die at home in familiar surroundings where all activities are normalized has been the impetus for the terminally ill and their families to advocate for early discharge or to remain at home.

Another change in health care delivery has been the focus on health promotion and illness prevention as necessary health practices for Canadians, greater involvement of consumers in health care decisions, and more collaboration between health agencies and the local governments (Epp, 1986; Lalonde, 1974; World Health Organization, Health & Welfare Canada & Canadian Public Health Association, 1986). In British Columbia (BC), one of the recommendations of the Royal Commission on Health Care and Costs (1991) was the development of a decentralized health care system with a greater emphasis on the local management of health services with decision-making occurring at the regional and local levels. Another recommendation was the transfer of resources from acute care hospitals to community based care. The BC government's response, New Directions for a Healthy British Columbia (1993), outlined the restructuring of BC's health care system through a process of regionalization with a transfer in decision-making authority and health care funding to regional health boards. The principles of community health care, such as family centred care, health promotion and illness prevention, were expected to empower families and communities and include these groups in decisions about their health care needs.

Enhanced community funding was not meant to replace institutional care at a higher cost for care at home nor was it meant to replace community health care providers at the expense of overburdening family caregivers (RNABC, 1992). The move to community based care, that is, care in the clients' homes,
assumed that individuals were still in need of acute care nursing interventions as well as community health nursing skills (Carroll, 1995; Handy, 1989; Kenyon et al. 1990; Stewart, Blaha, Weissfeld, & Yuan, 1995). This move also assumed that individuals were willing to participate in self-care activities or take on the role of caregiving (Anderson, 1990; Brogna, 1996; Fyke, 1994; Matthis, 1992; Pilette, 1990; Wearing, 1994). With the shift in care from the institution to the community there was a need to clearly address the nursing knowledge and skills that were required to practice nursing within the community setting (Bruce, 1993; Wearing, 1994). Staff could not simply transfer between the two health care settings, as was suggested in the Royal Commission on Health Care and Costs (1991), without appropriate education and training (Bruce, 1993; RNABC, 1994). The skill levels and concepts that were required for community home care nursing were different from those required in the institutional setting and to assume otherwise was to put the community clients' health at risk and the hospital nurses' practice at risk as well (Cary, 1995; Hughes & Marcantonio, 1992; Keating & Kelman, 1988; Kenyon et al. 1990; O'Neill & Pennington, 1996; Rice, 1996). Home care nursing encompassed a broad range of physical, psychosocial, developmental, and environmental problems not encountered by hospital nurses (O'Neill & Pennington, 1996). Hospital nurses without the skills that relied on previously acquired knowledge from contextual experiences or family scenarios, could make decisions about care issues in the home that could be inappropriate and harmful to community clients (dela Cruz, 1994; O'Neill & Pennington, 1996).

Unfortunately, there was a paucity of nursing research that explicated these differences (dela Cruz, 1994; Geis, 1991; Helberg, 1993). As well, there were no nursing studies published that articulated the meaning of home care nursing practice from the perspective of the home care nurse. Also problematic to this issue was that the nursing literature was unclear as to the definition of home care nursing and the nursing profession itself was unclear about the roles, activities, and responsibilities of home care nurses (Burbach & Brown, 1988; Green & Driggers, 1989; Rothman, 1990). Because of this lack of knowledge and awareness of home care nursing practice, improper use of an important component of the health care system could result (Wearing, 1991). A description of the nursing practice by the nurses who attended to the needs of and provided the nursing care for these acutely and chronically ill individuals in the community, as described from the perspectives of home care nurses, could be useful in the identification
of the skills required of these nurses in order to meet these individuals' needs at home.

Rachlis and Kushner (1989) believed that Canada's organization of health services was in disarray. These authors maintained that alternative care arrangements, such as community home care services, could benefit individuals like the elderly, disabled, and chronically ill who were inappropriately situated in acute and chronic care settings. Although these groups of individuals had different needs than those needs of the early discharged acutely ill clients in the community (Benson & McDevitt, 1989; Mills & Wearing, 1985), the common element shared by all of them was that they required nursing interventions in the home from home care nurses who had skills and knowledge solidly based in community health principles. In applying these principles, home care nurses focused on health promotion and illness prevention, and on the environmental, psychosocial, economic, cultural, spiritual, and personal health factors that affected the behaviours of individuals, families, and communities (Humphrey & Milone-Nuzzo, 1996; Hunt, 1993; Martinsen & Widmer, 1989; Rice, 1996). The type and extent of home care services that these individuals, families, and communities needed was dependent upon their circumstances and health requisites.

Home care services played an important role in the health care continuum in Canada (Crichton, Hsu & Tsang, 1994; Mills & Wearing, 1985; Rachlis & Kushner, 1994). These services were varied, offered outside the institutional setting, and furnished by a range of government, non-profit, and for-profit organizations (Health & Welfare Canada, 1990; Richardson, 1990). Often these services appeared fragmented as organizations assisted a variety of client groups with divergent needs, and services were usually based on specific eligibility criteria, length of stay on service, and local administration policies (Richardson, 1990). BC had one of the most extensive and effective home care programs in Canada. BC also lead the country in utilizing same day surgery so that persons recovered from minor operations at home rather than in hospital, and received supports from home care nurses and ancillary services (Rachlis & Kushner, 1994).

Home care in Canada had many meanings. In western Canada and Ontario, home care services generally meant professional health services provided in the home, such as nursing and rehabilitation therapy, and offered ancillary and maintenance support such as homemakers (Crichton et al. 1994;
In BC, home care services reflected professional nursing with rehabilitation therapy available in some health districts throughout the province (Jodouin & Brown, 1990). In the lower mainland area of Vancouver, home care services included professional nursing and rehabilitation therapy with home care nurses providing nursing care in the home to a wide array of individuals with increasingly complex health needs, both acute and chronic in nature (Jodouin & Brown, 1990; Wearing, 1991).

The context in which care was provided in the home by home care nurses affected their nursing practice. An aging population and other demographic changes, such as family structure changes, new patient/client populations (AIDS, pediatric, and technologically assisted persons), and changes in diseases and disabilities influenced the nursing care that was required in the home (Balinsky, 1994). Also, new technological and scientific inventions, escalating health care costs, and new interventions to control these costs were increasing the type of health issues and the numbers of eligible people who sought home care services (Balinsky, 1994). A problem that home care nurses encountered recently was that the allocation of resources to the community had not kept pace with the rapid growth and demand for home care nursing services (Crichton et al. 1995; Jodouin & Brown, 1990; Rachlis & Kushner, 1994; Richardson, 1990; Wearing, 1991). Individuals who were discharged 'quicker and sicker' from hospitals without adequate discharge planning or supports in place were now aware as informed consumers that family members were "rapidly becoming unpaid givers of complex care" (Jackson, 1994, p. 497). These caregivers needed more information in order for them to capably and confidently participate in the care of their family members at home and to have their voices heard and questions answered (Gilliss & Belza, 1992).

Health care policy has been a mechanism by which these persons could be heard. The emphasis of shifting health care to the home has stimulated the health care system to move to a primary health care model where essential health care has been more available and affordable, individual and community participation in health care decisions have been more common, and interdisciplinary and multi-agency collaboration have been more frequent (RNABC, 1994; WHO, 1978). Included in this model were the key elements of self-care and self-determination of individuals, groups, and communities (Epp, 1986; RNABC, 1994). Self-care involved the decisions or actions of individuals that specifically preserve and enhance health or a state of wellness (Epp, 1986; Orem, 1985). Self-determination referred to the successful
management of health care needs, based on appropriate and sufficient knowledge and control of personal situations, that resulted in optimal health (Epp, 1986; Rice, 1996; RNABC, 1994). In order to facilitate self-care and self-determination, the integration and coordination of health services must be in place and the knowledge and skills of caregivers should be appropriately utilized (Epp, 1986; Rachlis & Kushner, 1994; RNABC, 1994). With the implementation of regionalization in BC, decisions about the health care needs of individuals, groups, and communities have been made by community health councils and regional health boards. Regional health plans have been formalized and approved by the Ministry of Health as outlined by the New Directions for a Healthy British Columbia document (1993). However, there had been mounting concern from health and social agencies, health care consumers, and different levels of government that the restructuring of BC's health care system had not been collaborative. Another concern was that monies for direct client care had been "diminished and wasted on duplication of services and increased layers of bureaucracy at the community and regional levels" (MacPhail, 1996). Consequently, then Health Minister MacPhail temporarily suspended the regionalization process in order to assess "regionalization's strengths and weaknesses" (MacPhail, 1996). Following this suspension, a review of governance and accountability in the regionalization of health services occurred. This review by the auditor-general of BC concluded that the regionalization process was complex and would take a long time to implement fully (Morfitt, 1998). Morfitt (1998) identified several key components of the governance and accountability mechanisms that were necessary for the health ministry to determine if the objectives of regionalization had been achieved. Among these components were the ministry's need to clearly communicate its vision and strategic direction for the health care system, to clarify the roles and responsibilities of all parties, to ensure health services across and between communities were coordinated and achieved efficiencies, to name a few.

From the perspective of this writer, this suspension was a welcome one. In the region where this author practiced nursing, the proposed health plan did not support the current integrated and well-established home care nursing programs that shared common client groups with rehabilitation therapy and long term care services. These programs and services likely would be fragmented with this region's approach to health care. There appeared to be very little understanding on the part of this region's health
board members that duplication of services would result if hospital nurses followed their patients into the community and provided nursing care when an efficient and effective home care nursing service was already in place. As well, health board members did not understand that nursing skills and knowledge were not readily transferable from one practice setting to another. This dilemma could be corrected if there was effective collaboration among health team members. In order for this collaboration to occur, it was necessary that professionals and health planners were informed about and respected the expertise of all the team members (Beddome, Clarke, & Whyte, 1993). The home care nurses' perspectives have not been explored and, therefore, not understood. If health care reform was to be meaningful in all areas of health care delivery, the perceptions of home care nurses around their lived experiences in the provision of nursing care in clients' homes needed to be discovered.

The Problem Statement

Major health care changes have occurred recently that have influenced the delivery of health care in the community by home care nurses. No nursing studies were discovered that clearly articulated the lived experiences of home care nurses in the provision of nursing care in people's homes nor what their nursing practice meant to them. Consequently, there was a lack of knowledge about the scope of practice of home care nurses within the nursing profession, as well as within the current restructured health care system.

The Purpose of the Study

The purpose of this study was to explore and describe the experiences of home care nurses concerning the scope of their practice in the current restructured health care delivery system. The primary objectives were to gain an understanding of the experiences of home care nurses in the current restructured health care system and to identify the needs or concerns of these nurses with regard to their nursing practice. It was anticipated that the understanding gained from the articulated experiences of these nurses would provide information on the knowledge and skills needed by these nurses to practice in the home.

The Research Question

The research question under consideration in this study was -- what was the experience of home care
nursing practice from the perspective of the home care nurse working in an urban community in the current health care system?

**Introduction to the Method**

This study utilized the phenomenological method to address the research question. A phenomenological methodology was an important and useful approach to uncover, interpret, and share understanding of the lived experiences of individuals through attention to the perceived world of the participants (Oiler Boyd, 1993). The participants' perceptions of their experiences were attained through indepth interviews and analyses of these interviews in order to ascertain meaning and themes that described these perceptions (Colaizzi, 1978). The phenomenon under investigation in this study was home care nursing practice and its meaning to home care nurses working in an urban community.

Phenomenology was selected as a pertinent method for this research study because the goal was to understand a phenomenon from the perspective of those individuals experiencing it. The purpose of this study was to explore and describe home care nursing practice from the perspectives and experiences of home care nurses. As their perceptions and experiences were uncovered and interpreted, descriptions were evolved that explained and portrayed the home care nursing experience. The interactions that occurred between the researcher and the participants were shared and meaningful as the researcher strived to truly comprehend the total meaning that the experiences have had for the participants (Omery, 1983). Without any known research done in this area to date, this methodology appeared to be appropriate in initiating the investigation of this phenomenon.

**Significance of the Study**

The significance of this study was that it could contribute to an understanding of the scope of practice of home care nurses in a restructured health care system. It could also articulate the knowledge and skills needed by nurses practicing in the home. This study could also influence health care policy as to resource allocation requirements with a description of the complexity of home care nursing practice.

**Definition of Terms**

**Home Care Nursing** -- a unique field of nursing practice that required a synthesis of community health principles with the theory and practice of medical/surgical, maternal/child, oncological, and mental health
nursing (Humphrey & Milone-Nuzzo, 1996; Rice, 1996). It was community based nursing practice as it embodied the professional nursing services to people of all ages throughout their health-illness continuum in their communities which included home, work or school (Canadian Public Health Association, 1978; Jodouin & Brown, 1990). Its focus was health assessment, health teaching, health promotive, protective, restorative, curative, and supportive care, as well as disease/illness prevention with the intent to improve and optimize the health of acute, chronic, rehabilitative or palliative individuals, families, or groups (Ministry of Health, 1992). Home care nursing encouraged and supported clients to participate in and take responsibility for their health decisions and health care.

**Home Care Nurses** -- registered nurses who assessed, managed, and treated the health care needs of individuals, families, and specific client groups. They worked collaboratively with the aforementioned, as well as other caregivers, health care professionals, health planners, organizations, and local governments. The home care nurses in this study worked at the staff level in an urban home care nursing setting such as Vancouver, and had a minimum of three years of experience in home care nursing. The term 'home health nurses' was used synonymously with 'home care nurses' for the purposes of this study.

**Urban Community** -- pertained to a city with a population of greater than 145,000 residents.

**Assumptions**

It was assumed that the home care nurses who participated in this study were skilled and knowledgeable in home care nursing practice and were able to clearly and accurately articulate their perceptions and experiences. It was also assumed that these home care nurses would have issues and concerns about their nursing practice and that they would proffer candid responses to the interviewer's questions.

**Limitations**

The limitation of this study was that the findings were restricted to the population studied because of the type of research design, the size of the sample, and the sampling procedure. Generalizability was not an issue with the phenomenological method as the intent of this type of study was to increase the theoretical understanding of a specific group being studied, that is, the practice of home care nursing in an urban community from the home care nurses' perspectives. However, the findings should have relevance
to other home care nurses who have practiced in a similar setting.

In summary, this chapter offered an introduction to the background to the problem, the purpose, and the research methodology utilized to address the problem of this study. Chapter two presents the views of selected literature that are relevant to this study.
CHAPTER 2: LITERATURE REVIEW

A critical review of selected literature pertinent to the topic of study has been presented to support the identified problem and demonstrate why it was timely. There were no research studies found that specifically depicted the lived experiences of home care nurses and the meaning these experiences had for home care nurses in providing nursing care, in today's rapidly and constantly changing health care delivery system. Literature from four major areas relevant to the purpose of this study has been reviewed so that the complexity of the home care nurses' practice and the issues that arose from it could be determined. These areas included a discussion on home care nursing, home care nurses, home care nursing practice, and the relationship of primary health care to the aforementioned domains.

Home Care Nursing – What is it?

Community based nursing practice has existed in Canada since 1897 when the Victorian Order of Nurses (VON) was established (Pringle & Roe, 1992). These nurses provided traditional public health nursing activities such as health promotion and illness, disease or injury prevention in schools, clinics and at home, as well as provision of care to the sick (Chalmers & Kristjanson, 1992). After World War II, a shift in VON services occurred so that the focus of nursing care became predominantly the chronically ill, the post-hospitalized medical and surgical clients, and the elderly (Pringle & Roe, 1992). During the 1950's through the 1970's, home care nursing programs emerged across Canada to replace VON services. The traditional public health nursing activities of health promotion and injury prevention became the responsibilities of public health units (Chalmers & Kristjanson, 1992). Also, during the 1970's and 1980's, the term 'community health nursing' was frequently used to refer to both home care nursing and public health nursing (Chalmers & Kristjanson, 1992; King, Harrison, & Reutter, 1995). Confusion in roles and responsibilities among nurses who worked in the community resulted because of the inconsistent use of the terms, 'community health nursing' and 'public health nursing'. This confusion has been experienced elsewhere in the nursing profession as well as within the public domain (Burbach & Brown, 1988; Green & Driggers, 1989; King et al. 1995).

Community health nursing has been used as an inclusive term to identify nurses practicing in communities outside of illness care institutions (Rodger & Gallagher, 1995; Rothman, 1990). The
Canadian Public Health Association (1978, 1990) associated community health nursing with community-based nursing practice as it embodied professional nursing services to people in their communities throughout their health-illness continuum. Community health nursing services incorporated health and illness care at home, at work or at school to individuals, families, groups and communities (Chalmers & Kristjanson, 1992). Community health nursing was considered different from public health nursing when the client and the nature of the practice were factors used to distinguish the two terms. Burbach and Brown (1988), Chalmers and Kristjanson (1992), Clarke, Beddome, and Whyte (1990), and Laffrey and Page (1989) viewed the client as a population or aggregate when public health nursing and community health nursing were deemed synonymous. When the two expressions were not seen synonymously, the client in community health nursing was referred to as an individual, family, or group (Green & Driggers, 1989; Rothman, 1990). The major distinction of public health nursing practice was its primary focus on population based health services, health promotion, illness/injury prevention and community development (Clarke et al. 1990; Laffrey & Page, 1989). When community health nursing was perceived as being dissimilar to public health nursing and home care nursing was viewed as community health nursing, the focus of home care nursing was direct primary care, and included health promotion, maintenance and restoration, health education, illness/disease prevention, and supportive care such as palliation as part of its mandate (Burbach & Brown, 1988; Kenyon et al. 1990; Rose, 1989). To avoid confusion among nurses, King and colleagues (1995) recommended that community health nursing encompassed all community based nursing practice and included home care nursing, public health nursing, occupational health nursing, and community mental health nursing as subspecialties. In this manner, each subspecialty was recognized for its area of expertise and could work collaboratively to achieve the ultimate goal of community health nursing, the optimal health of the community which included individuals, families, and aggregates (Laffrey & Craig, 1995).

A dilemma home care nursing faced then, as a subspecialty of community health nursing, was the determination of its boundaries of nursing practice. Home care nursing was not just medical/surgical or oncology nursing provided in the home rather than in an institution (Humphrey & Milone-Nuzzo, 1996; Rice, 1996). Practice was not defined solely by the setting in which it took place (Williams, 1977).
Although home care nursing was not defined by disease category or population group, there were concepts and principles specific to the community that made it a specialty area of nursing. Certain individuals and client groups seen by home care nurses had various disease conditions and needs (e.g., post-myocardial infarction, lung cancer) as well as environmental and social factors (e.g., smoking with family/friends) that impacted on their health or illness and their family’s health or illness. With a focus on disease prevention and health promotion home care nurses could apply concepts of community health nursing to these groups and could effect changes that decreased the impact or occurrence of diseases and disabilities (Humphrey, 1988). Also, home care nurses could observe the effects of environmental, social, psychological, and economic factors on these individuals at risk and could see how they interrelated with one another, and then provided them with assistance, treatment, and health teaching about their specific health conditions.

Canadian home care nursing programs have changed and expanded their practice to meet the demands of health care reform (Crichton et al. 1994; Wearing, 1991). The overall intent of these programs was to facilitate people to remain at home with their families/caregivers for as long as possible as alternatives to hospital admissions, or to avoid placement in facilities, or to expedite early discharges from hospitals (Jodouin & Brown, 1990; Wearing, 1991). In BC, home care nursing was a community based nursing practice that provided assessment, case management, health teaching, support, consultation, liaison, referral, and direct care in order to improve and optimize the acute, chronic, palliative, or rehabilitative health and independence of individuals, families and groups at home, at work, or at school (Ministry of Health, 1992, p. 1). These individuals and their caregivers were encouraged and supported by home care nurses to take greater responsibility for their health and own care. Where home care nurses previously would have ‘done for’ the clients and their families, now these persons wanted and were expected, whenever possible, to participate in the decision-making and planning of their health care and were supported in their choices by these nurses.

Recently, with the continued emphasis on the need and demand to maintain people in their homes and for hospitals to efficiently and effectively utilize acute and chronic beds, home care nursing programs were often pressured into accepting more clients with greater health needs as they were discharged early.
Additional nursing hours were required to support and provide care to these clients and their caregivers so that they became self-reliant and independent (Fyke, 1994; Jodouin & Brown, 1990; Wearing, 1994). There were specific client groups, too, that preferred to be at home if their care needs could be met there. These groups included the elderly, the dying, the technologically dependent and disabled adults, persons with AIDS, and children with special needs. Clients seen by home care nurses in this province had more complex needs than ever before and the acuity and chronicity levels of these persons had increased as well. Thus, home care nurses needed certain qualities and required specific nursing skills and knowledge to professionally care for these clients in the community (Jodouin & Brown, 1990; Wearing, 1991).

**Home Care Nurses -- Who are they? What are their Roles?**

Nurses in home care nursing needed to have a philosophy that was holistic, family centred, health focused, collaborative, non-judgemental, and accepting of others and their beliefs and values (Cherryholmes, 1986; Mills & Wearing, 1985; Rice, 1996). The home care nursing ethic contended that clients and their families came first, around which all else revolved. The home care nurses had to be able to be comfortable in nonstructured situations and to have the ability to relate to people in varied circumstances and environments. These nurses had to be nonjudgemental of their clients' lifestyles and behaviours and aware that they could not change the habits of a lifetime (Anderson, Blue, Holbrook, & Ng, 1993; Cherryholmes, 1986). Anderson et al. (1993) believed that home care nurses must have knowledge of ethnic cultures' ways and mores and know that certain client behaviours and actions that were acceptable with one culture were unacceptable with another. It was beneficial if nurses could speak another language and could be available for interpretation if needed, especially in communities that had large populations of different nationalities. Other qualities were sensitivity, flexibility, adaptability, and empathy (Belair, 1986; Mignor, 1995; Stulginsky, 1993). Mignor (1995) stated that as the home was a much less controlled environment, these nurses had to understand the clients' point of view, be flexible and adaptable to the environment, and be highly organized as the clients' situations changed frequently. Belair (1986) and Stulginsky (1993) remarked that home care nurses worked autonomously and were largely self-directed but at the same time had to enlist the support, gain the cooperation, and have constant communication with the clients and their families, as well as other health care professionals.
Fundamental to the home care nurses' practice were the health promotion activities that fostered the clients' well-being and were aimed at the prevention of recurrent illnesses or other health related problems (Cherryholmes, 1986; Rice, 1996).

The enduring aspect of home care nursing, which was often developed over time and with experience, was not the performance of technical skills but the ability to know and care for people in their own homes (Tansey & Lentz, 1988). Expert home care nurses had a rich knowledge base as well as an understanding of how the context of the clients' home situations and environments may have drastically altered the approach taken by these nurses (dela Cruz, 1994; Hanner, 1994; Kenyon et al. 1990; Rice, 1996)). Kenyon et al. (1990) asserted that experienced home care nurses knew to look for meaning in the clients' and their families' behaviours and then redefined their nursing roles in the context of the clients' lives and circumstances. Tansey and Lentz (1988) claimed that the concept of clients as active participants in their care became meaningful outside the more coercive environment of hospitals or clinics. Hanner (1994) and Rice (1996) believed that home care nurses understood that they had to negotiate their nursing roles in relationships with clients and their families rather than expect client acquiescence to the demands and requirements of the health care system. It was also clear to home care nurses that all the clients' needs could not be explained or resolved by just imparting information or applying therapeutics. By using their nursing knowledge selectively and creatively, home care nurses expressed caring or nurturing through support, understanding, and sharing which often made a difference in client outcomes (Rice, 1996; Tansey & Lentz, 1989). These clients and families as health care consumers were demanding the right to actively participate in informed decision-making regarding the health and nursing care that they would receive. This nursing care should be client centred and outcome oriented (Magilvy, Brown, & Dydyn, 1988). Client satisfaction could serve as an outcome indicator of the quality of nursing care received, yet there was a paucity of literature and research describing client satisfaction within the home care nursing domain. A survey by Laferriere (1993) explored the area of client satisfaction with home care nursing and validated a high level of satisfaction with the nursing care received. Clients across the age spectrum found home care nurses efficient, effective caregivers and teachers, and supporters of the clients as active participants in their health and nursing care decision-making (Laferriere, 1993).
Magilvy et al. (1988) found in their ethnographic study of frail older adults that home care nurses were viewed as reassuring and supportive as they provided nursing interventions that promoted self-care, independence, and knowledge about specific disease processes and lifestyle activities of these older adults.

Enabling clients and families to participate in health care and health related decisions so that they took responsibility for and control of their health was a necessary skill for home care nursing practice (Kenyon et al. 1990; O'Neill & Pennington, 1996). Professional expertise and skills were used in new ways such that greater power equity in interpersonal and social relations resulted between home care nurses and clients and their families (RNABC, 1992). This empowerment strategy respected the autonomy of individuals and families and took the form of creative teaching or was an awareness and understanding of the cultural, educational and socioeconomic factors of these persons so that they could develop the capacity to act upon their health concerns (Anderson, 1990; O'Neill & Pennington, 1996; RNABC, 1992). Control belonged to the clients and as a result the home care nurses' power base required adjustment. Davies (1992), in a qualitative study, outlined empowering as a dimension of the supportive role of the nurse providing ongoing palliative care in the home. Empowering was described as not being task oriented but as strength giving and energizing and was directed toward assisting clients and their families in achieving whatever goals that they wanted to achieve, and was aimed at the preservation of the clients' and families' integrity (Davies, 1992). Both the nurse and the client experienced empowerment when there was a mutual exchange of energies and a true connection made with each other. This exchange was essential to the maintenance of the nurse's sense of personal integrity as well as the client's because what gave the nurse the strength to support the dying client and to assist the client achieve a sense of quality for the remainder of life was the empowerment that she received from the client (Davies, 1992).

Nurses in home care nursing had multiple roles and wore many hats (Green & Driggers, 1989; Stulginsky, 1993). Green and Driggers (1989) found, in a qualitative study, that home care nurses functioned in diverse roles, such as roles that focused on the clients and/or their immediate families--direct care provider, educator, preventer, relationship structurer, and assessor. Other roles required a more comprehensive knowledge of nursing and the health care system and the perception of the needs of
clients and their families that extended beyond medical diagnoses. These roles included referrer, coordinator, case finder, case manager, counsellor, and adaptor (Green & Driggers, 1989). These researchers also identified roles which implied that the scope of practice of home care nurses extended well beyond the clients and their current illnesses, and encompassed health promoter, advocate, primary care provider, and community health facilitator. Green and Driggers (1989) believed that this examination of nursing roles and their relative frequency could lead to an understanding of the nature of home care nursing practice and the specific skills and knowledge unique to this nursing practice arena.

**Complexity of Home Care Nursing Practice**

Home care nurses were not merely acute care or hospital based nurses who 'just ran into the home to do a procedure' (Humphrey & Milone-Nuzzo, 1996; Rice, 1996; Wearing, 1994). Like other specialty areas of practice, nursing care in the home setting did require special preparation and knowledge (dela Cruz, 1994; Kenyon et al. 1990; Rice, 1996). Burbach, Conrad, Schumacher, and Lindsay (1991), Pender, Barauskas, Hayman, Rice, and Anderson (1992), and Thobaben and Bohanan (1990) suggested that nurses working in home care nursing should be educated at the baccalaureate level. Baccalaureate nursing education provided the framework for professional nursing practice in the community setting as public health theory and community health nursing principles were incorporated into the curriculum which prepared home care nurses for community practice (Greenwood Schaal, 1989). This background also provided a basis for home care nursing practice that involved management skills, family and community concepts, expanded clinical experiences in community health settings, and exposure to the nursing process that emphasized critical thinking, independent decision-making, and assessment of clients at all points on the wellness-illness continuum (Pender et al. 1992; Rice, 1996). In addition, home care nurses required specific and expert skills and knowledge in judgement and evaluation, effective communication and health teaching, case management and creative problem solving, technological competence, and organization and documentation when providing care in the homes of clients (Carroll, 1995; Cloonan & Shuster, 1990; Cormier-Daigle, Baker, Arseneault, and MacDonald, 1995; dela Cruz, 1994; Handy, 1989; O'Neill & Pennington, 1996; Wearing, 1994). Previously acquired knowledge, assessment and clinical judgement of each individual situation, and collaboration with the clients about health care plans formed
the basis of decisions made in home care nursing (dela Cruz, 1994; Kenyon et al. 1990; O'Neil & Pennington, 1996). Many nurses that entered home care nursing assumed that they would employ the same sets of skills and knowledge base as in their acute care hospital based practice (Kenyon et al. 1990; O'Neil & Pennington, 1996). The actuality was that increased skill levels were required and supplemental abilities and concepts were needed to practice effectively in the community; in home care nursing (Kenyon et al. 1990; O'Neil & Pennington, 1996; Stulginsky, 1993). Many home care nurses had learned the required home care nursing practice skills through hands-on work experience and orientation programs (Burbach et al. 1991; Green, 1994; Long, 1995; Twardon, Gartner, & Cherry, 1993). These authors claimed that proficiency in case management, required documentation, and specialty community nursing skills often were acquired through on-the-job orientation and courses that were offered in staff development or continuing education programs. O'Neil and Pennington (1996) stated that acute care nurses had difficulties in adjusting to home care nursing practice because they had to revert to novice decision-making in new practice settings instead of the proficient decision-making they had used in their previous and more familiar settings. Stulginsky (1993) asserted that while home care nursing did embody acute and chronic care nursing skills, the home care nursing experience was different, and the home visit required nurses to practice in ways that they had seldom, if ever, done before.

In a concept analysis of home visiting, Byrd (1995) defined home visiting as a nursing intervention and a process with specific phases that encompassed a client-nurse encounter. Zerwekh's (1992) findings of a phenomenological study discovered that expert community health nurses spoke of "getting through the door" (p.18) but also of needing to gain entrance to the family system. Home care nurses were invited into homes as guests. Entrance was granted, not assumed, as in the case of hospitals and to gain entrance, home care nurses needed to establish trust and rapport quickly (Stulginsky, 1993; Zerwekh, 1992). Technically, home care nurses were in homes to deliver care to clients but in actuality, the entire family became the recipients of care (dela Cruz, 1994; Mignor, 1995). Family issues became more visible in homes than in hospitals. Behaviours were more natural and offered a clearer picture of individual and family dynamics, ways of coping, and lifestyle choices. Home care nurses had to be realistic about what they could 'fix' and had to adjust their roles and priorities accordingly (dela Cruz, 1994; Stulginsky, 1993).
The trend of shorter hospital stays has led to the 'quicker and sicker' discharges of individuals to home care nursing services and often has placed these clients' health and well-being at risk (Haddard, 1992; Simon, Showers, Blumenfield, Holden, and Wu, 1995). Consequently, home care nursing services became more diverse as the field of practice grew and became more complex (Lieder & Liebig, 1988; Kenyon et al. 1990; Stulginsky, 1993). The higher acuity and chronicity mix of clients in the home required technologically advanced nursing skills as well as the continued focus and use of the principles of community health practice, such as family and community centred care, holistic nursing care, personal and family responsibility and control of health and health related decisions, and a combination of wellness care and illness care (Benson & McDevitt, 1989; Wearing, 1991). These community health principles and clinical skills needed to be applied consistently and knowledgeably by home care nurses as clients and their families/caregivers were more fragile, in need of more nursing care and support so that they could remain at home safely, with confidence in their abilities to manage their own care. Also, home care nurses should know how to utilize other community resources and clinical skills so that all care provided was in their clients' best interests. A concern home care nursing confronted today with advances in technology was the ability to meet the demand for home care nursing services, as seen by the increasing availability of technological aids in the homes, incidences of chronic illnesses, elderly population, and government interest in cost containment strategies (Deber et al. 1992; Handy, 1988; Wearing, 1994).

Who will provide this care? It was assumed in BC by some health care reformers that acute care hospital nurses could easily shift their nursing skills from the hospital arena to the community (Royal Commission on Health Care & Costs, 1991; Ministry of Health, 1993). This recommendation was based on the assumption that home care nursing was only treatment and task oriented, illness and curative focused, and short term or episodic in nature (Burbach & Brown, 1988; Green & Driggers, 1989). Despite a lack of research on home care nurses and their clinical practice patterns and capabilities, there was both a debate and tension in the literature over the definition of home care nursing and what its practice entailed (Burbach & Brown, 1988; Green & Driggers, 1989; Rothman, 1990). In the USA, this debate occurred because of the way home health nursing was currently organized and reimbursed by Medicare and Medicaid (Kent & Hanley, 1990; Olson, 1986; Rose, 1989). Reimbursement criteria impacted the scope of
home health nursing practice by compressing its scope rather than expanding it (Kent & Hanley, 1990; Rose, 1989). Prior to the advent of reimbursement legislation in the USA, home health nurses had a broad scope of practice, and following legislation their scope of practice narrowed (Olson, 1986). This practice changed from a health promotive, maintenance, and preventive scope to that of client specific tasks and procedures with treatments directed by physicians and, primarily, reimbursement schedules (Kent & Hanley, 1990). Thus, health assessment, health teaching, family counselling and supportive care, and other appropriate professional community nursing responsibilities were not considered reimbursable activities, and were no longer consistently practiced by home health nurses (Kent & Hanley, 1990; Rose, 1989).

With the literature reflecting the episodic, illness focused, task oriented home care nursing practice in the USA, it was no wonder that nurses and other health care professionals believed that acute care nurses could shift their hospital nursing care to the community. However, Rose (1989) reported that in a survey of 35 home care nursing agencies (Siefer, 1987), 83% of the agencies stated that with the rapid and continued increase in client acuity and instability, home care nurses had to quickly become efficient in high technological tasks, which they did without difficulty. At the same time, hospital nurses were recruited into home care nursing because of their skills in 'high tech' care. Yet, Rose (1989) stated that these acute care hospital nurses were not familiar with the other activities of home care nursing, the family focused care, health promotive and preventive teaching and counselling, and referral to other resources and created problems for the agencies' managers. This study was important in that it pointed out that home care nurses could learn task oriented procedures quickly but it took longer to learn community health principles and put them into practice, which appeared to be the case with the recruitment of hospital nurses into the community.

A quantitative study done by Hughes and Marcantonio (1992) on the clinical practice patterns of home health nurses, hospital nurses and public health nurses indicated that there were differences evident between the three areas of nursing. These researchers reported that home health nurses spent more time than hospital nurses and public health nurses in the following areas: client and family care planning and teaching which included illness management, health maintenance, health promotion, and disease
prevention; teaching, consulting, and supervising students and other colleagues; and evaluating clinical outcomes. Hospital nurses spent more time in direct care than either home health nurses or public health nurses and very little time in any of the aforementioned activities (Hughes & Marcantonio, 1992). These researchers noted that home health nurses believed that their jobs provided more opportunities to use their clinical skills than their hospital and public health counterparts. Although there were clear differences between the three nursing areas and the scope of practice in each area, the study found that there were similarities between home health nurses and public health nurses in the time spent in the domains of direct care, administration, supervision and consultation. Hughes and Marcantonio (1992) asserted that their findings suggested that home health nursing practice contained critical aspects of both hospital and public health nursing practice. This research was important in that it signified that hospital nurses could not expect to provide, at the entry level to home care nursing and without preparation in community health principles, the same kind of nursing care that home care nurses provided as suggested by health care reform government officials. Furthermore, in a quantitative study by Cloonan and Shuster (1990), client care coordination was depicted as an activity central to home care nursing practice. Home care nurses believed that this component of care contributed in a meaningful way to the clients' well-being and facilitated their abilities to manage independently at home. Cloonan and Shuster (1990) reported that care coordination by home care nurses was comprised of indirect care activities that required expert assessment and organizational skills, knowledge of community resources, interdisciplinary and multi-agency collaboration, client advocacy, and supervision and preceptoring of students and colleagues. Hughes and Marcantonio's (1992) findings supported Cloonan and Shuster's (1990) study in that home care nurses spent more time on indirect care activities than direct care activities, and therefore practice was less focused on task oriented care. As the clients' needs increased so did the time required to meet their coordination needs (Cloonan & Shuster, 1990). A similar study by Hectcke, MacQueen, and Carr (1992) reported that home care nurses used a considerable amount of time on activities not directly related to client care, like documentation and travelling time, which home care nurses believed detracted from the quality of care. However, Rice (1996) posited that the development of care plans and precise documentation provided nurses with systematic and scientific methods in the delivery of client care.
Documentation should be relevant to the specific client care plans, treatments, and situations. Additionally, the nursing process offered integrity and direction to professional nursing practice in the home, and coordinated and evaluated multidisciplinary care (Rice, 1996).

dela Cruz (1994), in a qualitative study, examined the clinical decision-making activities of home health nurses because it was believed that with the earlier discharges of sicker clients from the hospital to home, the continuity and quality of care was contingent upon the expertise of the home health nurses' clinical decision-making abilities. This study revealed that experienced nurses demonstrated three different styles of decision-making strategies in the management of client care: skimming; surveying; and sleuthing (dela Cruz, 1994). Skimming was used to expedite and deliver pre-determined and well-defined tasks in follow-up visits; surveying was used logically and consistently to identify and plan for specific and distinct client problems; and sleuthing was used to manage ambiguous, uncertain, complex, ill-defined, and unstructured client problems (dela Cruz, 1994). dela Cruz (1994) noted that the choice of styles used by these nurses was dependent upon: the clients' clinical status; the social, environmental and psychological conditions; the decision-making situations that the nurses encountered with clients and families in the home; and the nurses' knowledge and experience. Thus, experienced home health nurses switched from one style to another in order to meet the clients' and/or families' needs. This research showed that hospital nurses could not be expected to make the same type of decisions as experienced home care nurses because the decision-making activities were not transferable when interacting with clients and families in the home environment and the process of decision-making depended on specific client/family situations. As stated earlier, until they became comfortable and knowledgeable in the community, hospital nurses proficient in one area of nursing practice reverted to novice decision-making activities when encountered with a similar set of circumstances but in a different setting (O'Neill & Pennington, 1996).

Home care nursing has been described traditionally as 'hands-on' physical care and more recently as 'high tech' care. However, Geis (1991) believed that home care nursing was not a new and emerging field that some would claim, as it had ancient roots in visiting nurses associations and community health practices. For these reasons, this researcher asserted that home care nursing should be considered as a subspecialty of community based nursing practice. In Geis's (1991) study, home care nursing was
distinguished from other community health nursing subspecialties, public health, occupational health, and school health nursing areas by differences in technology. Geis (1991) conceptualized technology as units of uncertainty, instability, and variability and explored it from the cognitive dimension of practice rather than 'hands-on, high tech' care. Home care nursing ranked highest in all three dimensions of technology which reflected, according to Geis (1991), increased acuity of home care clients and the necessity of a more holistic approach to care in the home care setting. Geis's (1991) work further reinforced and supported the view that, with earlier hospital discharges, home care nurses provided nursing care to individuals with more complex, multiple, unstable and varied conditions, resulting in greater physical and psychological needs. Geis (1991) asserted that home care nursing practice was as complex as was the complexity of the individuals' and their families' health needs and situations.

High technology home care was used to treat or sustain clients who would have required the expertise and equipment of an institutional setting. These technologies included a range of monitoring devices and therapeutic machines that could deliver highly sophisticated treatment in familiar home settings to a degree that was previously possible only in the intensive care unit (Mehlman & Younger, 1991; Rothkopf & Younger, 1992). Home intravenous (IV) infusion therapies which included IV antibiotics, hydration, pain management, chemotherapy, and total parenteral nutrition (TPN) were becoming increasingly common in the community as alternatives to hospitalization (Handy, 1989; Mehlman & Younger, 1991; Sheldon & Bender, 1994). As well, persons who required ventilatory support and special pulmonary care or renal dialysis were being discharged from the highly structured hospital context to a more informal arrangement between the client, family and a diverse group of community health care professionals (Rothkopf & Younger, 1992). Whenever such a shift in care setting was effected, it should be made clear that this 'high tech' home care was in the best interests of the clients and their families (Aday & Wegener, 1988; Lieder & Liebig, 1988). Treatments at home often allowed the clients and their families to become active participants in the recovery process with less disruption in their lifestyles. However, the rationale for IV therapy at home must be made known to the clients and their families, and to the home care nurses who would provide the ongoing teaching and supportive care in the home (Rice, 1996; Sheldon & Bender, 1994). Home infusion therapy was nursing intensive because coordination of services and staffing, client
and family/caregiver education, and the clinical expertise needed to execute IV therapy services by the
home care nurses was vital to the safe administration of these therapies outside of the acute care setting
(Rice, 1996; Sheldon & Bender, 1994). In order to ensure effective participation and the safe and
successful implementation of the clients' treatment plans, the clients were carefully screened and met
specific admission criteria prior to the initiation of home infusion therapy (Sheldon & Bender, 1994;
Wearing, 1994). Home care liaison nurses who worked in the hospital were an important link between the
hospital and the community in the discharge planning process of these clients with complex needs. Client
assessments conducted by the discharge planning team needed to include measures of caregiver
capacity to deal with 'high tech' home care and to determine what necessary initial and follow-up training
should be provided in the home by the home care nurses (Lieder & Liebig, 1988). Also, home care liaison
nurses were in a position to interpret for the hospital from a community perspective what was required to
maintain these individuals at home, such as mothers who left the work force to care for ventilator assisted
children which resulted in loss of income, freedom and personal growth (Aday & Wegener, 1988;
Anderson, 1990). Another example was the need, prior to discharge, to assess and support the
appropriateness of this type of care at home by the older clients as they could be the caregivers of
cognitively impaired family members at home (Dellasega & Cutezo, 1994). Wearing (1994) suggested
that targeting individuals and their families who could learn to self-administer IV antibiotic therapy at home
was more cost effective than nursing those individuals who could not learn this task. Because a service
was available in the community did not mean everyone should use it, especially if safety and quality of
care were an issue (Lieder & Liebig, 1988; Rice, 1996; Sheldon & Bender, 1994; Wearing, 1994).

Lieder and Liebig (1988) asserted that little was known about the specific effects on caregivers of
extended periods of responsibility for technologically dependent persons and whether caregivers
welcomed this heavy responsibility for care or felt competent to assume the skilled nursing and on-site
case management tasks demanded of them. Aday and Wegener (1988) reported in a national study of
home care programs for ventilator assisted children that most families wanted to have their children at
home and found it rewarding to be together again. However, such decisions had great psychological and
financial costs that outweighed these families' capacities to accept the responsibilities for care at home.
Thus, 'high tech' home care could add to the family caregiver burden rather than diminish it. Home care nurses who provided the nursing care, education and support for the clients and their families in the caregiving tasks at home also needed to continue to act as advocates for these persons to ensure that this high technology health care was not simply the delivery of high technology care in a different setting.

Primary Health Care – Where does it fit in?

Health and social policies significantly affected the scope and purpose of nursing care in the homes of people throughout the country. Home care nurses struggled daily with issues such as the type, extent, cost, and quality of care that they should provide, and the people who should receive it. These issues were not new and they were not limited to home care nursing, rather they were shared by society (Pera & Gould, 1989). Home care nursing, because of its desirability and potential cost effectiveness, had a role in the policy decisions related to health care delivery and from the perspective of a primary health care model. Primary health care was a philosophy of care and a strategy for organizing and providing health care (WHO, 1978).

With primary health care as a model of health care delivery, community based services offered a range of essential health care services of which home care nursing was a part. In this province, home care nursing was easily accessible, offered nursing services at home to individuals and their families throughout their health continuum, from birth to death. These nursing services varied depending on the needs of individuals and families or groups, could be episodic or continuous, and were generally focused on illness care, disease prevention, health promotion, restorative, curative, rehabilitative or supportive care, such as palliative care (Ministry of Health, 1992). Home care nursing encouraged, promoted and supported individuals and their families to participate in decisions regarding their health and their health care needs. With 'closer to home' (Ministry of Health, 1993) initiatives in place throughout the province, target groups such as women and seniors have benefited from partnerships between agencies and health consumers in such endeavours as early discharge maternity programs and early discharge joint replacement programs (Ministry of Health, 1995). Home IV antibiotic therapy programs, another 'closer to home' collaboration, allowed individuals to receive and to self-administer a necessary treatment at home without lengthy and costly hospitalizations (Ministry of Health, 1993; Wearing, 1994). Other target
populations (Ministry of Health, 1995), people with disabilities and mental disorders relocated from institutional care to care in group homes in the community, received home care nursing services in collaboration and consultation with these consumers, their families and advocates, the appropriate government ministries, and the local health care agencies. As these nursing services indicated, the elements of primary health care were present within the parameters of home care nursing practice.

The RNABC (1990) defined primary health care as "essential health care, universally accessible to individuals and families in communities by means acceptable to them, through their full participation and at an affordable cost" (p. 2). By this definition and from a primary health care perspective, home care nursing could be considered: an essential health care service to those persons who did not require hospitalization but required nursing care in order to remain at home; accessible to all persons within their communities and as a point of entry for health care as some nursing services did not require physicians' referrals; affordable and acceptable to clients and their families as nursing services were 100% funded through the Ministry of Health (although there could be minimal costs for needed supplies); and a collaborative service as clients and families were encouraged to participate in their health care and health care decisions (Hunt, 1993; Ministry of Health, 1992; Mills & Wearing, 1985).

A challenge for home care nursing today was how to incorporate these principles of primary health care into the daily practice of home care nurses when the mandate and philosophy of home care nursing programs referenced primary health care only in general terms (Ministry of Health, 1992). The broad focus of primary health care was on community based health promotion and maintenance, rather than curative care of individuals (Stewart & Langille, 1995). Health promotion was the process of enabling individuals to increase control over their health (Epp, 1986). Wearing (1991) suggested that the mandate and philosophy of home care nursing should reflect the principles of health promotion. As well, home care nursing and public health nursing programs needed to collaborate on the determination of community needs and the explication of the two programs' common ground so that health promotion activities were relevant to both community nursing programs. Maglacas (1988) voiced a concern that there was a danger of one professional nursing group assuming the responsibility of the promotion of health to the exclusion of other professional nursing groups. All professional nursing groups should see it as their responsibility
to enable and empower individuals, families, and community groups in their endeavours to increase control over and improve their health. Professional nurses were accountable, responsible, and autonomous health care service providers and, as such, should see that enabling and empowering were activities of improving health at the individual, family or community level (Maglacas, 1988; RNABC, 1994). Home care nursing was concerned with the promotion and preservation of the health of individuals, families, and specific client groups as well as in the curative, restorative, and supportive care of these persons. Greenwood Schaal (1989) pointed out that the three objectives of comprehensive home care nursing services were health promotion and disease prevention, health restoration, and health maintenance. She further asserted that as part of the larger field of community health nursing, home care nursing was unique in that it always embodied these three objectives into the clients' care plans.

Another concern for home care nursing was the fragmentation of services experienced by individuals and their families as they moved through the health care system (RNABC, 1994; Wearing, 1991). Shifting care from the hospital to the community was not suitable without the necessary communication between service providers and the reallocation of resources to assist these persons at home (RNABC, 1994; Wearing, 1994). It was not always appropriate or cost effective to provide nursing care in the home if individuals and their caregivers were unwilling to participate or unable to acquire the skills needed to manage self-care activities at home (Lieder & Liebig, 1988; Wearing, 1994). Home care nurses and other health care providers needed to be aware that the burden on the caregivers was being transferred as well, and support services could be required for the caregivers. In addition, the caregivers' personal feelings about accepting responsibility for learning about caregiving tasks were frequently ignored by health care professionals who promoted self-care and independence in the attempt to free up hospital beds and bring health care 'closer to home' (Anderson, 1990). Although home care nursing was accessible to all individuals, home care nurses needed to maintain services that were sensitive to the needs of the underprivileged, cultural minorities, and stigmatized groups. Anderson (1990) reported, in a qualitative study, that Chinese families who were without English language skills could not access the help of health care professionals. This researcher also noted the fact that it was the socioeconomic circumstances of these immigrant families and the lack of health care services designed to help these families, and not
necessarily the families' cultural beliefs that influenced illness management. Illness was a family and community experience and home care nurses played a more central role in illness management and the promotion of health of those individuals with a chronic illness and their families. Stewart and Langille (1995) reported, in a study by Stewart, Hart, and Mann (in press), that persons with AIDS and hemophilia and their caregivers experienced prejudice, avoidance, and insensitivity from nurses, physicians, other health care professionals and friends that influenced their willingness to access the health care system.

Much of home care nursing was practiced in the clients' natural environment, that is, in their homes or sometimes at work or at school. Self-care was a key component of public participation and health promotion (Epp, 1986), and was a major focus of home care nursing practice (Ministry of Health, 1992; Wearing, 1994). The health focus of self-care was for individuals and families to maintain a state of wellness and utilize the basic activities that aided health promotion, well-being and health maintenance (Orem, 1985). Home care nurses could support clients by assisting them to acquire the knowledge and skills to problem solve, make decisions and set goals about their health, and to develop strategies for the implementation of these goals (Holzemer, 1992). Benson and McDevitt (1989) suggested that home care nursing practice provided holistic nursing care to clients and families that went beyond the treatment of an illness and that this nursing care required a broader approach that helped clients to achieve and maintain a state of wellness. That is, clients successfully performed life's tasks in the presence or absence of wellness. The practice of holistic nursing in home care nursing embraced illness care and wellness care (Benson & McDevitt, 1989) and nursing interventions were directed toward assisting clients and families to develop behaviours that focused on wellness (Pender, 1987). Therefore, the partnership of home care nurses and their clients and families to plan both health promoting and health protecting behaviours assisted these individuals and their family members in reducing or eliminating some of the major risk factors to health (Benson & McDevitt, 1989; Pender, 1987). For example, Green and Lydon (1995) described the development of a home care cardiac rehabilitation program that was designed to meet the needs of clients with new or exacerbation of heart disease, and those clients recovering from cardiac surgery. Through an understanding of cardiac risk factors and an awareness of internal reactions to physical and psychosocial stress that often affected health, these clients and their families were able to
favourably alter their behaviours and modify their lifestyle habits with support from home care nurses and other health team members (Green & Lydon, 1995). With this type of community program, home care nursing responded to the needs of this client group, improved quality of life and reduced health care costs.

Health programs and the use of technological innovations should be suitably adapted for the community's needs and not just as an extension of hospital care services (Cormier-Daigle et al. 1995; Rose, 1989; Wearing, 1991, 1994). Technology has already greatly affected the manner in which health care services have been organized and delivered, and clinical practice has altered in response to these technological changes as requisite nursing skills and abilities must be in place in order to work in today's 'high tech' health arena. The primary health care principle of acceptable technology was broad and referred to the appropriate use of health care resources which included funds, personnel, education and equipment, and should be used for prevention and promotion as well as for treatment purposes (Beddome et al. 1993; CNA, 1993). Home care nurses were challenged in balancing specialized treatment protocols with lower cost community based alternatives like home IV antibiotic therapy and home subcutaneous analgesia management without the use of expensive infusion pumps (Cormier-Daigle et al. 1995; Wearing, 1994). Cost effectiveness and appropriateness of the specialized functions in the home were often contingent upon the self-care capabilities of the recipients and their caregivers (Wearing, 1994). Home care nursing needed to ensure that specialized procedures were acceptable and of benefit to clients and families, were safe and legitimate for use in the home environment, and were an improvement to the clients' and families' quality of life (Cormier-Daigle et al. 1995).

Multi-agency and interdisciplinary collaboration was important in the implementation of primary health care (Stewart & Langille, 1995). It was one area in which home care nurses could influence policy formation, if they could overcome their lack of understanding and involvement in socioeconomic issues and the context in which health care decisions were made, and their distaste for politics (Anderson, 1990; Maglacas, 1988). With the health care decision-making authority decentralized and transferred from governments and professionals to include local communities, health agencies and consumers (Ministry of Health, 1993; Rachlis & Kushner, 1994), home care nurses had the opportunity to share in the decision-making and contribute to the development of local and regional health plans. For home care nurses to
actively and successfully participate in interdisciplinary and intersectoral teams their skills needed to include an understanding of the political agendas and priorities of the key policy decision-makers (Anderson, 1990; Maglacas, 1988). Home care nurses, and nurses in general, should recognize their responsibilities in enhancing the coordination and delivery of health care services by: realizing the importance of primary health care; collaborating with other health care providers, non-health care sectors, and health care consumers; and incorporating the principles of primary health care into their programs' mandate and philosophy which then could impact on the clinical practice of home care nurses.

Summarily, the literature was reviewed from several perspectives with regard to home care nursing, home care nurses, home care nursing practice, and the relationship of primary health care to these perspectives. Very little information was revealed in the literature review that was from the perspective of home care nurses. Most of the information was provided from the viewpoint of persons who had some knowledge or impressions of home care nursing practice. In the following chapter, the methodological approach utilized to acquire and ascertain the perspectives of the participants in this study is described.
CHAPTER 3: METHODOLOGY

Research Design

Changes in the health care delivery system that resulted in an increased need for home care nursing services required home care nurses to define the scope of their practice and to develop research in this area. Gaining an understanding of the experience of home care nurses from their perspective was the initial step in the process and was the purpose of this qualitative study. Phenomenology, an inductive descriptive research method, is the study of everyday life as it is actually lived and experienced (Omery, 1983). The aim of phenomenological research for nursing is understanding (Sandelowski, 1986). Because little was known about the meaning and expression of home care nursing practice from the home care nurses' point of view, a qualitative descriptive design was selected to uncover what was there, what meanings were attached to the home care nurses' practice experiences, issues and discoveries, and how the meanings could be organized into a description of the phenomenon. Phenomenology as a philosophy and as research method has been ascribed primarily to Edmund Husserl (Omery, 1983). The process of discovery, the approach to the phenomenon without preconceived frameworks or expectations, and the exploration of the meanings as the participants' experiences unfolded in the storytelling facilitated the interpretation and understanding of the phenomenon of interest (Omery, 1983). In this regard, phenomenology was an important and useful method to uncover, to interpret, and to understand the experiences of home care nurses as they worked in the current restructured health care delivery system.

In this study, understanding was acquired through repeated, indepth interviews with home care nurses. Each home care nurse was interviewed twice and six nurses participated in a focus group in an attempt to attain insight into their experiences from their perspectives.

There are several different methodologies for pursuing phenomenological research (Munhall & Oiler Boyd, 1993; Omery, 1983). In this study, the methodological approach described by Colaizzi (1978) was utilized as a means for sample selection, criteria for selection, ethical considerations, identification of the researcher's role, data collection and analysis, and the assurance of reliability and validity.
Sample Selection

A theoretical or purposive sampling method was used to select participants. Colaizzi (1978) stated that participants in a phenomenological research design must be fluent and experienced with the topic under investigation. As the researcher was interested in uncovering the meaning and understanding the phenomena of interest, participants were selected on the basis of their ability to articulate, elucidate, and provide comprehensive and relevant data about the phenomena under study (Morse, 1986; Sandelowski, Davis, & Harris, 1989). These characteristics of the participants assured the appropriateness and adequacy of the information required and collected (Morse, 1986; Sandelowski et al. 1989). In this study, the phenomena of interest were the lived experiences of home care nurses in delivering health care to clients at home, as perceived by the home care nurses. Thus, participants were selected according to their interest and ability to furnish information that illuminated and facilitated the understanding of the phenomena under study (Colaizzi, 1978; Morse, 1986; Sandelowski et al. 1989). The precise number of participants could not be decided a priori in a qualitative study. The number of participants required was determined by the purpose of the inquiry and the quality, amount and completeness of information proffered by the participants (Sandelowski et al. 1989). Lincoln and Guba (1985) stated that the purpose of purposive sampling in phenomenology was "to maximize information, not facilitate generalizations" (p. 202). Final sample size was achieved when saturation of the data had occurred, that is, no new patterns or themes evolved from the data, information appeared complete and logical, and had been confirmed (Morse, 1986; Sandelowski et al. 1989). Sample size was usually small in qualitative studies due to the length and detail of the data gathering interviews (Omery, 1983). In this study, a sample size of nine interested participants was achieved from a convenience sample. The sample was acquired from a large urban health department, such as the Vancouver component of the Vancouver/Richmond Health Board. After the sixth and seventh interviews, the researcher began to experience data saturation, as the rich and comprehensive data generated from the participants illuminated their perceptions of their practice. The eighth and ninth participants that were interviewed were language designated home care nurses, and it was important to include these different perspectives in this study so that four of the five health units were represented.
Selection Criteria and Participant Characteristics

In purposive sampling, participant selection was founded on criteria established by the researcher and on what was required to be known or verified (Morse, 1986). The researcher anticipated that participants would describe their home care nursing practice in detail and any professional issues that affected their practice. Participants in this study were selected based on the following criteria:

1. Participants were nurses currently practicing in permanent full time or part time positions in home care nursing with a minimum of three years of home care nursing experience.
2. Participants were articulate and experienced in their home care nursing practice.
3. Participants were interested in being interviewed and lived within the greater Vancouver area.

All nine participants were employed full time by the Vancouver/Richmond Health Board and worked at the staff level in four different health units in Vancouver. However, during the course of this study, one participant was temporarily assigned to the position vacated by the clinical nurse specialist responsible for the Home Intravenous Program. Another participant reverted temporarily to part time status during this study, due to an exacerbation of a chronic illness. Five participants had baccalaureate degrees in nursing and three of these nurses were enrolled in a master of science in nursing program. Four participants had diplomas in nursing and one of these nurses was enrolled in a baccalaureate degree nursing program. All participants had hospital nursing experience prior to their home care nursing experience that ranged from three years to 21 years, and occurred in other countries and settings like England and Australia, and rural and urban Canada. The majority of participants in this study had more than 10 years of hospital nursing experience. These nursing experiences were diverse and included such areas as medical/surgical, oncology, pediatrics, maternity, psychiatry, gerontology, intensive care, neurology, and mental health nursing. The average number of years in home care nursing for participants was nine years and ranged from six years to 14 years. All participants had more than five years of home care nursing experience and three nurses had more than 10 years of home care nursing experience. All participants were women and lived within the greater Vancouver region. Six participants were married and five of them had children. Two participants were of Chinese origin, one nurse was native Indian, and another was East Indian. Two of these nurses were hired as language designated home care nurses for the Chinese and East Indian...
populations in south Vancouver. The age range of participants varied from 31 years to 50 years with the majority of them between the ages of 40 years and 46 years.

**Ethical Considerations**

Ethical approval was obtained from the University of British Columbia and from the Vancouver/Richmond Health Board prior to the start of the study. The researcher met with the Home Care Nursing Clinical Practice Committee and outlined the study's purpose and the extent of the involvement of the home care nursing coordinators and participants. To ensure informed consent, both the Participant Information Letter and Participant Consent Form clearly outlined the purpose and nature of the study, the interview process, the means of maintaining confidentiality and anonymity, and the potential benefits and outcomes to the participants (see Appendices A and B). There were no anticipated risks to the participants as measures were taken to protect the ethical rights of the participants, such as assurances of privacy, confidentiality, and anonymity. Participants had the opportunity to ask questions about the study and received copies of the information letter and signed consent form. Participants were free to withdraw from the study at any time or to request erasure of parts of their interviews without personal or professional penalty.

**Researcher's Role**

From a phenomenological perspective, the researcher became totally immersed in the participants' experiences with the phenomena under study and endeavoured to understand the phenomena as they did through perceiving, interacting, reflecting, attaching meaning, and recording (Burns & Grove, 1993). Critical thinking or reflexive thought was necessary when constructing meaning between the researcher and the participants through active and reciprocal relationships and dialectical processes of interactions (Anderson, 1991). Critical thinking led to the practice of bracketing, an approach which controlled bias, assumptions, and suspended judgement or put aside what was known about the experience being studied (Munhall & Oiler Boyd, 1993). Bracketing was used to help the researcher avoid misinterpretation of the phenomenon as the participants experienced it (Sandelowski et al. 1989). Colaizzi (1978) believed that in order to identify and understand a phenomenon one needed to experience the phenomenon as people experienced it but only if one's presuppositions were uncovered first. Having done so, one's beliefs,
attitudes, and assumptions about the investigated topic have been revealed so that interpretation of data have not been influenced by personal feelings (Colaizzi, 1978). This investigator had extensive experience in home care nursing and conceivably had some presupposed ideas about the research topic and therefore utilized the concept of bracketing, and sought meaning from the participants' perspectives throughout the data collection and data analysis processes.

Bracketing occurred prior to and during data collection and data analysis with anecdotal documentation attached to each participant's interview. Bracketing occurred prior to and after each participant's first and second interviews as well as with the focus group interview that occurred after analysis of the data from the participants' preceding interviews. This process of bracketing assisted the researcher to reflect on each participant's experience with openness and without knowledge or preconceptions as her own personal assumptions and beliefs were identified so as not to influence the participants' perceptions. For example, the researcher suspended personal perceptions that were in conflict with participants' perceptions about specific aspects of home care nursing practice, such as boundaries of care, by analyzing these personal perceptions following each interview and preceding successive interviews. One participant with eight years of home care nursing experience believed that she could provide better nursing care to a client if the client's family perceived her as a member of the family. It was also important that the researcher bracketed when the respondents' perceptions and responses were consistent with the perceptions of the researcher. An example, all participants, and the researcher, believed that the complexity of nursing care in home care nursing practice had increased in the past few years. With her years of experience in home care nursing, the researcher found that bracketing was invaluable as it separated the researcher's perceptions from the perceptions of the participants, and allowed the researcher to obtain an objectivity that remained faithful to the phenomenon itself (Colaizzi, 1978).

Data Collection

Qualitative data collection and data analysis was a complex process as the researcher simultaneously gathered the data, managed the data, and interpreted the data (Munhall & Oiler Boyd, 1993; Sandelowski et al. 1989). Before data collection began, the participants were made aware of this study by their home care nursing coordinators who distributed participant information letters to potential experienced
participants (see Appendix A). Participants who indicated an interest in participating in this study initiated contact with the researcher. The researcher used this opportunity as a follow-up to the letter to provide participants with further information about the study and issues of informed consent and to clarify participants' expectations. Participants were informed that signed consent forms would be obtained from them prior to the initiation of the first interview (see Appendix B). At this time, mutual arrangements were made regarding the place and time of the initial interviews.

Data collection involved two informal, minimally structured indepth interviews that were limited to one hour in length (but actually varied from 45 minutes to one and a half hours, average length was one hour), audiotape recorded, and transcribed verbatim. Interviews occurred at the participants' place of choice and at a time that was mutually convenient to both participants and the researcher. The majority of the initial and follow-up interviews took place in the participants' homes and the rest at their workplace. A third interview involved a focus group of six participants and occurred at a health unit that was centrally located for all of them. In all interviews, the researcher provided the participants with a comfortable environment that enabled them to share their perceptions freely and to assist in the development of an open and trusting relationship. For instance, prior to the interviews, often a cup of coffee and general conversation transpired between the researcher and the participants that was appropriate and served to relax both parties. During the interviews, the researcher utilized reflection, requested examples and descriptions of events, and asked for clarification that indicated to the participants an attitude of interest and sensitivity as a listener. Also, setting aside one's own judgements and preconceptions about home care nursing practice and considering the participants as equals assisted the researcher in focusing on the participants' experiences. Colaizzi (1978) stated that imaginative listening that occurred in dialogal interviews required the researcher to be attuned to the participants' nuances of speech and gestures. The participants were considered the sources of data, they were individuals whose experiences could only be grasped when the researcher listened with the totality of one's being and entirety of one's personality (Colaizzi, 1978). Colaizzi (1978) further stated that the researcher and participants were persons communicating on an equal level without making a distinction between researcher and participants. The researcher was acutely aware that the interviews impacted the participants' time, professionally and personally, and
accommodated their requests for interview times and locations. Despite the infringement on their time, all participants verbalized at the end of each interview that they were surprised at how much they enjoyed their interactions with the researcher. Several participants stated that never before had they thought about their nursing practice in such a manner and continued to muse on it between interviews. Some participants also believed that these discussions of their thoughts about their practice with a person who does not work within their organization, assisted them to coalesce their ideas into a concept of home care nursing practice that somehow reflected their own home care nursing experiences. One participant initially attested that she felt positive and reaffirmed about her nursing practice after having to reflect on it from several different aspects. After each initial interview with the participants, the researcher also thought that her home care nursing practice was reaffirmed in a positive way as being important and worthwhile, and relived her own home care nursing experience with each participant's generous, spirited, and enthusiastic discussion about home care nursing.

For the initial interviews a set of open-ended trigger questions was developed and utilized which incorporated the methodological approach and established the focus of the participants' thoughts and encouraged free expression (Sandelowski et al. 1989) (see Appendix C). The use of non-directive questions was used to facilitate the interview process and to provide further clarification of specific points made by the participants. Trigger questions were useful in initiating discussion and assisting the participants to consider different aspects of home care nursing practice. All participants were willing to respond to the questions and most gave serious thought to their answers. If at anytime during an interview a participant was unable or reluctant to respond to a question, the researcher prompted the participant by rephrasing the question and encouraged the participant by allowing time for reflection. The participant was usually able to offer a perspective on the topic at hand. If the participant was unable to provide a response to a specific query, the researcher moved onto another question or redirected the participant to return to comments already made that required elaboration or clarification. For example, a participant who was a language designated home care nurse for a certain population group was reluctant to pursue the fact that on certain occasions she provided clients with her home telephone number. She thought that this action offered more consistent care to a client and family rather than burdening a
colleague who was unfamiliar with the client/family situation. Although the clients never abused this service, this participant was uncomfortable discussing it because she did not want her colleagues to think that she overextended herself. The researcher respected the participant's discomfiture by acknowledging her action and by not pursuing further discussion of this topic and went onto another point.

The initial interviews furnished an introduction to several common elements that started to characterize the participants' perspectives of their home care nursing practice. These commonalities or themes became more apparent as subsequent interviews occurred with other participants. For example, in the initial interviews, several participants identified a recurrent theme, the referral process in home care nursing. As this theme emerged spontaneously in the discussion as an area of concern for some of the participants, the researcher pursued the topic to gain a deeper understanding of its meaning for the participants. For one participant, in one of the initial first interviews, the referral process was an important component of home care nursing practice because it mattered who made the referrals from hospital to community. This participant voiced that hospital social workers did not have the appropriate medical or nursing background to know what information was important for home care nurses. Whereas, "a liaison nurse twigs to many things and will go after what's necessary". Another participant disclosed during one of the latter first interviews that the referral process often needed to include a discharge planning meeting so that the supports for clients and families were in place prior to client discharge from hospital. Also, for this participant, the referral process meant that hospital staff informed the home care nurse of certain "underlying family issues" that could influence client care. With the progression of the interviews, there was an expansion in the quality and quantity of data that facilitated the researcher's comprehension of the participants' home care nursing practice.

The second interviews occurred following data analysis of the first interviews and with the researcher, participants clarified, elaborated, and validated certain subjects that were discussed in these initial interviews. For instance, one participant during the first interview indicated that her client caseload was heavier, more acute, and required more complex care. At the second interview, the researcher requested this participant to explain what she meant by "more acute" and to expand on what this complexity of care meant to her nursing practice. In another example, during a second interview, a participant was asked to
clarify her comments that a home care nurse "gets the complete picture" when visiting clients at home and to elaborate on how the client and the client's environment influenced her nursing practice. In a second interview with another participant, the researcher denoted her understanding of the importance and rewarding aspects of this participant's interactions with palliative clients, and requested the participant to acknowledge this understanding of the participant's perceptions. In another case, derived from data from a first interview, the researcher indicated her comprehension of a participant's need to understand the client's decision-making process before making her own decisions about care needs. The researcher requested validation of her perceptions of the participant's perspective, and had the participant clarify and elaborate on her decision-making procedures.

The second interviews were useful as they offered the participants an occasion to clarify and elaborate on particular issues of concern or interest from a professional perspective. The rich data that resulted from all interviews represented the participants' innermost thoughts and basic beliefs and values about their home care nursing practice. The information from these interviews that the researcher sought to access and understand more profoundly through explanation and expansion of participants' descriptions was at a higher level of abstraction than in the first interviews. Participants were encouraged in the second interviews to explore their thoughts and actions in specific situations in more depth so that their perceptions could be as articulately expressed as possible. The researcher's genuine interest and consideration of the participants' comments assisted the participants in wanting to search for a more complete response for themselves. As an illustration, the researcher wanted to totally understand a participant's belief, also shared by other participants, that home care nursing was "unique" and pursued this belief in a subsequent interview. After some thought and discussion, this participant stated that her philosophical shift of how she understood the nurse/client relationship within the context of care delivery in the client's home and how it differed in a hospital environment of care delivery was what made home care nursing unique, "...that whole involvement with the client, in a very personal, intimate setting...changes the [nurse/client] relationship".

The willingness and cooperation of the participants and the interest and thoughtfulness of the researcher promoted the development of a trusting relationship between the two parties. As mentioned
previously, the participants were very enthusiastic and made every effort to proffer true accounts of their home care nursing practice in both sets of interviews and to ensure that their perceptions were articulated as clearly as possible. The quality of the data and the higher level of abstraction was also evidence of the regard the researcher and participants held for each other. For these reasons, the researcher and participants believed that at the end of the second interviews, participants had exhausted their descriptions of the phenomenon under study, and believed that their perceptions of their home care nursing practice in today's health care delivery system had been articulated.

The third interview transpired following analysis of the data from the second interviews and compilation of all the data results from both interviews. The third interview was a meeting with a focus group of six participants in order to conclusively validate the description of the home care nurses' practice based on their perceptions and experiences as home care nurses. By integrating the results of the analysis, descriptions of themes and their meanings derived from the interview data were presented to this focus group as the essential structures of home care nursing practice from the perspectives of the participants in this study. The validation of the findings with the participants was a method of verifying the participants' experiences as interpreted by the researcher (Colaizzi, 1978; Omery, 1983). As well, it could be considered a test of reliability and validity in that those persons who experienced the phenomenon under study could recognize the description as it was developed by the researcher (Colaizzi, 1978; Lauterbach, 1993). In this study, the home care nurses recognized the description of the phenomenon under study, that is, the meaning of home care nursing practice to home care nurses working in an urban community in the current health care system.

Following a presentation of the findings to the focus group, all participants agreed that their perceptions of their experiences were reflected and validated in the descriptive results of their home care nursing practice. During this meeting, the participants were requested by the researcher for aspects of their experiences that may have been omitted (Colaizzi, 1978). As far as they were concerned, nothing about their experiences had been omitted, in fact, all focus group members voiced their surprise at the veracity of the description, the diversity of their practice, and the degree of similarity in their thought processes and philosophical positions towards home care nursing practice. Once again, the participants expressed
gratitude in a process that assisted them in pondering their professional and personal views about their home care nursing practice in a manner that, for many, was a new and enlightening occurrence. The researcher, also, found this experience enlightening and rewarding as participants presented new ideas as to how nursing practice could be improved, and as personal viewpoints were stated about how their nursing practice was enacted. Just as the participants considered providing nursing care to clients in their homes a privilege, the researcher considered it a great privilege to share in the participants' storytelling and in their personal thoughts about their home care nursing experiences.

Data Analysis

Data analysis occurred concurrently with data collection using the Colaizzi (1978) methodological approach. The Colaizzi (1978) method was a systematic process which included seven steps. This method directed the data analysis of this study and is outlined in the succeeding paragraphs. Analysis of all the participants' first interviews occurred prior to that of their second interviews. Following the verbatim transcriptions of the audiotapes, the researcher first read them through for a general sense or feel of the interviews. In addition, the researcher initially read the transcripts while listening to the taped interviews. This action verified the accuracy of the transcriptions, and engaged the researcher in the analytic process as she relived the storytelling by the participants and became immersed in the emerging data that reflected home care nursing practice. The second step of this method was to return to the original transcripts, analyze the phrases or sentences that directly pertained to the investigated phenomenon, and extract from them the significant statements. The researcher perused every line of each participant's two interviews and identified the significant statements and phrases that applied to the home care nursing practice of each participant. The third and fourth steps provided a more vigorous process whereby the language structure was critically analyzed for general meanings and themes. The significant statements were analyzed for meanings by the researcher who used creative insight to move from what the participants said to what they actually meant. These formulated meanings were eventually organized into themes. The recurrent themes in turn evolved into clusters of themes and eventually categories were formed. Specifically, the meaning of each significant statement or phrase was identified by the researcher and coded in a column to the right of the participants' statement. These meanings were derived from
intense reflection and several readings of the participants' text by the researcher so that the researcher formulated meanings that went beyond what was given in the original data but did not lose the context of the participants' statements. For example, one participant stated, "Right now I'm having boundary problems] because he's seeing that I am advocating, I do a lot of this from his home. But he's taking me as part of his family, and we're discussing that". The researcher interpreted these statements to mean that this client saw the participant's professional role of advocacy for the client as more of a role that a family member would provide. As well, the participant had a responsibility with this client to clarify her professional boundaries and discuss any issues as soon as they arose. As statements were interpreted, the researcher became aware that some statements reflected more than one theme. The researcher also jotted to the left of the script any point that needed clarification, elaboration, or validation in subsequent interviews. The researcher noted to the left of the statements of this particular participant to pursue in a second interview whether the issue of establishing professional boundaries with clients posed an ethical issue for her.

The concurrent data collection and analysis was apparent at this stage in the study. The researcher collected data through an interaction called intersubjectivity, that is, the researcher built on the structure of the concrete language used by the participants. Intersubjectivity, a method by which the researcher reflected on the contextual meanings that participants attached to their experiences, and through imaginative listening built on these meanings to question the participants further (Anderson, 1991; Colaizzi, 1978). Thus, this approach encouraged the participants to reflect and find meaning for themselves concerning their experiences. No attempt was made in the initial stages of analysis to order the statements into similar essences or theme categories until all initial interviews were analyzed in this manner. Once this process of interpreting the meaning of significant statements was completed for each participant's interview, the researcher then returned to these meaning units to identify emerging themes. An example, in the previous illustration the researcher determined that the participant had discussed two themes, the theme of the client/family impact on home care nursing practice and the theme of the roles and responsibilities of the home care nurse. This process of analysis occurred for all eighteen interviews and also assisted the researcher to formulate questions for participants in additional interviews that might
produce more data that would further describe home care nursing practice from the participants' perspectives. Data saturation became evident to the researcher when no new themes developed within participants' interviews.

During data collection, the researcher and participants interactively were engaged in clarification, elaboration, and corroboration of information in order to ensure a shared understanding of the meaning of home care nursing practice from the home care nurses' perspectives. For example, a participant indicated that at times clients' behaviours around care were based on cultural beliefs and a lack of knowledge about specific health conditions rather than on abuse as was occasionally suspected by some health officials. She said, "We had been sent information that there was possible abuse...it's really easy to come to the wrong conclusions....Sometimes it's a cultural thing....It was strictly out of fear and he got the information that he wanted". The researcher summarized her understanding of the participant's comments, "So you're saying that it's really important that the clients that you're taking care of get all the information that's necessary for them to...make any kind of decision about their care and as long as...they've got all the appropriate information, then they can make an informed decision". The participant acknowledged the researcher's understanding of her thoughts and perceptions. She continued, "I feel I have done the best that I can and I think that's all any of us can do". This awareness of the importance that clients needed relevant information from the home care nurses and other health professionals in order to make informed decisions about their care, whether or not the nurses agreed with the decision, was a common theme among all participants. As well, several participants pointed out that health professionals must access accurate information from clients that reflected the clients' personal beliefs as it may impact on their care needs. The importance of the third and fourth steps of Colaizzi's (1978) method was the sharing of interpretations not only of the participants' articulations of their experiences, but of the researcher's interpretations of the participants' concrete language. Often validation of the researcher's formulated meanings and themes with the participants was useful at this stage to verify the actual meanings intended. In fact, validation was an ongoing process throughout the data collection and data analysis phases.

After the themes were applied to each meaning unit within each of the participants' initial transcripts, the researcher began to organize the data for each of the themes into clusters of themes. For each
participant, the researcher tabulated onto paper the coded meaning units under theme cluster headings. Nearly all of the identified theme clusters were shared by all participants after their first interviews. For instance, all participants offered views on two identified theme clusters, client and family impact on home care nursing practice, and knowledge and skill requirements, respectively. The researcher then corroborated all the theme clusters with the participants' original descriptions to ensure that all the data was accounted for in the theme clusters, and that the theme clusters did not imply anything that was not suggested in the original descriptions. Several times the researcher examined each participant's interviews and coded data sheets with the theme clusters to ensure accuracy and to gain insight and corroboration of the meanings and significance of the many themes. The researcher again returned to the participants' transcripts and data sheets with clusters of themes to outline any areas of concerns or issues that needed clarification, elaboration, or verification with participants in subsequent interviews. Also, the common themes that emerged from the data and that were shared by all participants were identified so that in successive interviews they were pursued for further clarification and/or validation of their importance (or lack thereof) as aspects of their home care nursing practice. For example, in the second interview, participants were asked to validate the importance of the client and the client's environment on their nursing practice, and to further clarify and elaborate how these factors impacted their home care nursing practice. As well, areas that needed more explanation or corroboration that were specific to a particular participant were explored further in the second interview. For instance, a participant voiced in the first interview that a community home care nurse required a special type of skill. The researcher thought that this comment was significant and needed follow-up in a subsequent interview with this participant.

Data analysis of the second interviews occurred in the same method as that of the first interviews. The researcher continued to bracket personal opinions throughout the analytic process in an attempt to avoid researcher bias. Information in the second interviews that clarified, elaborated, and/or validated data from the initial interviews was identified and incorporated under the specific theme cluster headings for each participant. Also, a few new themes emerged from the data from the second interviews as a result of clarification of data from the first interviews. The themes of the decision-making process and outcomes of
care, for example, appeared as important components of the participants' interactions with the clients and families. This observation was also included in each participant's data sheet of theme clusters. At all times, the researcher tried to ensure that the perspective of each participant was accurately portrayed. In order to better understand the data, the researcher then organized all the participants' data under the appropriate theme cluster headings. That is, all the data from participants that reflected the same theme cluster, such as knowledge and skill requirements, were listed together under that specific heading.

Analysis of the 18 theme clusters resulted in the development of three major theme categories. For example, the nature of home care nursing practice evolved as a category from several theme clusters that collapsed into three subcategories, such as the context of home care nursing practice, attitudes towards home care nursing practice, and the context of the client. Within each of these subcategories were several theme clusters that depicted the practice of home care nursing, the participants' personal beliefs and values, and the importance of the client and family relationship with the home care nurses. Two other categories emerged from the theme clusters, that is, prerequisites of home care nursing and organizational issues, with subcategories that explicated the essence of each category. These three categories together described the meaning of home care nursing practice to home care nurses who worked in an urban community in the current health care system.

The fifth and sixth steps of the Colaizzi (1978) methodological approach involved the summarization of results into an exhaustive description which embodied the essential structure of the perceptions of the home care nurses' experiences in today's health care delivery system. The researcher integrated the results into a comprehensive and meaningful description of home care nursing practice. Included in this description was the essential structure of this phenomenon as elucidated by the perceptions and experiences of home care nurses and contained within the three major categories. The final step by the researcher with the participants was the validation of the findings as their lived experiences as home care nurses. The researcher met with a focus group of participants and presented the findings as being representative of their experiences and perceptions as home care nurses. The participants validated the descriptive findings as being representative of their perceptions and experiences as home care nurses.
Reliability and Validity

Reliability and validity within qualitative research differed from quantitative research. Morse (1986) described appropriateness and adequacy as criteria for evaluating qualitative methodology where appropriateness reflected the extent in which the sampling method "fits the purpose of the study" (p. 185), and adequacy referred to the "sufficiency and quality of data" (p. 185). Colaizzi (1978) asserted that the validity of phenomenological research was measured with its own aim as the standard. He maintained that phenomenologic data were valid and reliable to the extent that the interview had tapped the participants' experiences of a phenomenon. Such data were not examined for accuracy but were viewed within the context of the participants' experiences as expressions of their singular view of the world (Colaizzi, 1978). Lauterbach (1993) stated that the real tests of reliability and validity were in the hands of the readers who had experience with the phenomenon either through professional or personal experience. Sandelowski (1986) viewed the criteria of scientific rigour, that is, reliability and validity in terms of confirmability. Confirmability was attained when consistency, credibility, and fittingness of a qualitative study was established (Sandelowski, 1986).

In order to assure rigour in this qualitative study, certain measures needed to be in place throughout the research process. Consistency or auditability of findings was accomplished when the researcher's decision trail was clearly and logically followed by other researchers, such as thesis committee members, and that they could make similar conclusions based on the researcher's data collection and analysis techniques (Sandelowski, 1986). More specifically, Sandelowski (1986) outlined how auditability was realized by the researcher with a description and explanation of how the researcher viewed the study's investigated phenomenon, the study's specific purpose, the impact the participants or the data and the researcher had on each other, the effect of the environment on the researcher and participants, how the data was collected and the length of time that data collection took, the manner in which the data was analyzed and interpreted, the inclusiveness and exclusiveness of theme clusters and theme categories created to contain data, and the explicit methods utilized to ascertain the credibility and fittingness of the data (p. 35). The research report reflected the process of auditability.

In addition, auditability was realized by the researcher with the selection of participants from as many
of the health units as possible so that the uniqueness of the participants' perceptions and experiences were accessible. This selection facilitated the opportunity for a variety of responses from participants who worked in different districts and with diverse demographic characteristics. As well, this selection ensured that all participants' descriptions were represented equitably and resulted in a comprehensive depiction of the meaning of home care nursing practice from the perspective of home care nurses. For example, all participants expressed their concerns that the workload had become heavier and more technologically complex, and that this change had affected how they implemented their nursing practice. In one example, a participant who worked in the downtown eastside part of the city indicated that clients in this area did not want control of their health care and refused to participate in this care. Whereas another participant who worked in the westside area stated that clients in this part of the city wanted control of their health care and as a result directed their care. The first illustration indicated consensus on a point of concern by all participants who represented all demographic areas of the health board. The second illustration demonstrated two differing viewpoints but each perspective was considered equally as valid as data because of the different populations served by the participants. Participants' perceptions from both examples were included in the data and added to the richness and comprehensiveness of the description of the meaning of home care nursing practice and how clients could impact home care nursing.

Threats to auditability occurred when the data collection process was inadequate, theoretical statements of meanings of significant statements were not linked to the data, and records of raw data were insufficient to make judgements related to themes, theme clusters, and categories. The researcher assured auditability by collecting sufficient data from the participants that was relevant and meaningful to both the participants and the researcher, and as the participants clarified and validated with the researcher that the information was accurate in its representation of the participants' perceptions and experiences.

The validity of a study within a phenomenological perspective relied on the credibility or truth value and the fittingness or applicability of the findings to the participants of a study (Sandelowski, 1986). Credibility was ensured with faithful interpretations of the participants' experiences and continuous clarification and validation of these descriptions by the researcher with the participants and with thesis committee members. The researcher demonstrated credibility of the data with reflection and validation of the
researcher's understanding of the participants' perceptions about home care nursing practice throughout the interview process. For instance, the researcher reflected her understanding of a perspective of a participant and requested validation from the participant, "I get the sense, correct me if I'm wrong, please, that you find palliative clients very rewarding to work with and a challenge". The participant agreed with the researcher's reflection and explained that, "One hurdle was the rights of the patient. You are in a position of control when you go in the [client's] house. The family gives it to you right off the bat whether you like it or not". Colaizzi (1978) advocated that the researcher utilizing the phenomenological method returned to the participants to validate that the findings reflected their perceptions of their experiences.

The credibility or truth value of qualitative findings were considered internally valid when the participants' experiences were verified by the participants as accurate descriptions of their perceptions (Sandelowski, 1986). The test of validity in qualitative research was the ability of the participants who had experienced the phenomenon to recognize it from the description developed through phenomenological analysis. As well, other researchers could come to the same conclusions based on the researcher's data collection and data analysis.

A threat to the credibility of a qualitative study could occur with the type of relationship that was shared between the researcher and the participants (Sandelowski, 1986). A collaborative relationship produced results in a research study and still protected the boundary between the researcher and the participant. However, the research relationship conceivably could have been threatened with the perceived openness of the researcher to the participants' experiences or with having known the researcher outside the context of the research study. Researcher bias was reduced when the researcher maintained a professional attitude and focused on the meaningful interpretations of the participants' perceptions. Subjective interpretations and personal opinions were avoided when they were brought to the researcher's conscious level as particular efforts were made to bracket during the interviews and data analysis phases, and with anecdotal documentation prior to and following interactions with participants. Evading any personal discussions with participants about any aspect of the study further limited the chance of researcher bias. Clarification and validation of the findings of the participants' perceptions throughout the interview process reduced this threat as well. The researcher avoided bias as the participants of the focus group in a final
interview confirmed the data analysis and description developed by the researcher.

Applicability or fittingness of the findings was assured when there was representativeness of the data or in other words, the findings of the study fitted with the data from which they were derived and the participants viewed these findings as meaningful and applicable to their own experiences (Morse, 1986; Sandelowski, 1986). Representativeness of data reflected the participant selection criteria and the extent and type of data collected during the study. Any participant who portrayed his/her experience well was considered a legitimate representative of the group under qualitative study (Sandelowski, 1986). In this research, appropriate participants were home care nurses who had the knowledge and receptiveness to describe what home care nursing practice meant to the home care nurses who lived and experienced it. The extent and type of data collected depended on the articulateness and experience level of the participants. Some participants in this study were more articulate and had more years of nursing experience than other participants and consequently provided more indepth data. The researcher was aware of this issue of elite bias and in an attempt to decrease this external threat to validity and during data collection and analysis, did not discount any participant's perspective or consider one participant's account over another one. In addition, during the data collection process, the researcher ensured that there was equal representation of home care nurses from as many health units as possible. The researcher also assured that there was a variety of participants in attendance at the final focus group interview to hear the findings so as to further avoid elite bias.

Fittingness of the findings was ultimately achieved when the findings fitted with the data from which they are derived, that is, the findings fitted into contextual situations separated from the study conditions. Throughout data collection and data analysis, the researcher interpreted the participants' significant statements into meaning units and connected these meaning units to the themes, theme clusters, and finally to the categories. The fit between the data and the findings has been exemplified in the discussion of this chapter. Applicability was achieved also when the participants confirmed that the findings accurately reflected their experiences. In this study, six participants in the focus group validated that the findings were applicable, meaningful, and illustrative of their perceptions and experiences.

Representativeness of data was limited to the participants of the qualitative study. However,
generalizability of the findings, another potential threat to the external validity of research studies, has not been pursued in qualitative inquiry (Sandelowski, 1986). Generalization was not considered an issue in phenomenological research because this method emphasized the acquisition of an accurate understanding and description of the phenomenon in its natural setting and with limited controlling conditions. The researcher in this study attained an accurate understanding and description of the meaning of home care nursing practice to home care nurses through clarification and validation during the data collection interviews and in the final focus group interview. When the phenomenologic analysis and interpretation of data used the strategies of auditability, credibility and applicability the requisites for scientific rigour or confirmability were fulfilled (Sandelowski, 1986).

The researcher utilized the expertise of the thesis advisors during this research study to offer important feedback and to ensure that this methodological approach was appropriately applied throughout the process. This guidance was especially useful when critiquing the researcher's analysis of the interviews and assisted the researcher to redirect subsequent interviews and to reflect more thoughtfully on the analysis of data.

Summarily, this chapter described the phenomenological perspective and how it was utilized for sample selection, data collection and data analysis, and the assurance of reliability and validity. The findings supported three major categories that reflected the meaning of home care nursing practice to home care nurses from the perspective of the home care nurse participants. The three categories are discussed in the next chapter.
CHAPTER 4: REPORT AND DISCUSSION OF THE FINDINGS

Three major categories emerged from the data analysis as being representative of the experiences of home care nursing practice and were based on the perceptions of the participants. These categories include the nature of home care nursing practice, the prerequisites for home care nursing practice, and the organizational issues of home care nursing practice. In this study, the categories and the subcategories are discussed from the participants' perspectives and in relation to relevant literature. The categories and subcategories are discussed separately but are considered inextricably interrelated in the depiction of home care nursing practice and what it means to home care nurses.

Category One: The Nature of Home Care Nursing Practice

All participants gave a generalized account of their home care nursing practice during the initial interviews, and often offered further elaborations in subsequent interviews. Generally they described home care nursing as meeting the acute and chronic care needs of clients and the needs of clients' families within the home environment. Inherent in this description was an appreciation of the client, the client's family, home environment, psychosocial resources, and neighbourhood, and the presence or absence of community services. Also, the client and the client's environment were identified as the controlling sources from which the participants and other community health care providers took direction.

One participant offered this summary description of her nursing practice:

I see home care nursing as very holistic, in taking in not just the client and whatever their illness but also their family, their support network, their circumstances, their environment and...drawing in the services you need to support them to bring them to the optimal level of their health.

Descriptions of nursing practice by the participants and the impact of the client and the client's family on their nursing practice were influenced by the participants' own personal beliefs and values about home care nursing practice. The three subcategories, that is, the context of home care nursing practice, attitudes and values about home care nursing practice, and the context of the client reflect the components of the first category, the nature of home care nursing practice. The first subcategory, the context of home care nursing practice, is discussed in the following section.

Subcategory One: The Context of Home Care Nursing Practice

The first subcategory describes the functions of the participants and encompasses the nature of the
participants' activities and the participants' responsibilities associated with these activities. Participants indicated that their home care nursing practice was autonomous, diverse, and involved direct and indirect nursing care, preventive, maintenance, and restorative activities that focused on the clients and their designated caregivers. This client centred, comprehensive, complex, and holistic nursing care, according to participants in this study, was furnished to persons who were acutely or chronically ill or who required episodic care, and to family members. This care was provided in the persons' places of residence (e.g., home, hotel, facility) as well as on a street corner, at work, at school, or in a clinic. It was provided primarily to adults who were 19 years and older although infants, children, and adolescents also received this service. The referrals for service came from many sources: hospitals; physicians' offices; community agencies; self; family; or friends. The community for home care nursing services was divided into specific geographic regions which were administered at the local health unit level, under a regional health board.

Participants travelled a great deal in their practice, worked from a pager, and frequently communicated by cellular telephone on the clients' behalf as often clients were without telephone access. This essential, non-emergency response nursing service was offered 24 hours a day during day, evening, and on call shifts to clients with varied and multiple needs. The clients usually had one or more health conditions that required the involvement of participant home care nurses, such as palliative care, pain control management, wound care, diabetic education and management, intravenous (IV) therapy, gastrostomy care, enterostomal care, tracheostomy care, to name a few. The clients' care often was complicated due to family, social, environmental, legal, or language and cultural issues.

Participants indicated that approximately half of their nursing practice at any one time involved nursing clients with palliative care needs and the rest of their practice included nursing activities that required the management of clients with acute and chronic illnesses, acute and chronic wounds, cognitive impairment, medication problems, and the need for referrals to other community resources. In an overview of her practice, one participant pointed out:

I do birth to death, I don't do home births but I will become involved frequently at the beginning if the client has, or is an ill child...or a mom who has a caesarean section, and any of the illnesses after that....I would say 50% of my practice is palliative care and basically doing all the symptom management and all the planning. I teach about chronic illnesses...diabetic teaching, wound care. 30% of our practice is wound care, medication management is really booming...caring for the
Another participant added that she worked in an area that had a high ratio of elderly frail clients and dealt with "medication management, home management, linking them up with resources in the community". However, this participant also noted a trend, that is, a change in client population with a younger client group moving into her region who required more diverse home care nursing services, such as young surgical clients, children with burns, and clients with lung transplants who required oxygen and IV therapies.

The geographical area in which they worked, the types of clients predominantly seen in their region, and their scheduled work shifts influenced the organization of their caseload each day. Although the number of home visits made each day by participants varied, participants did not think that the numbers of clients seen daily accurately reflected the activities that they were engaged in with clients. Visits were prioritized and often it was necessary, after assessment of the caseload each morning and at the end of the day, for participants to prioritize a caseload reduction. This practice accommodated clients who needed to be seen more urgently than others on any given day, such as clients with problems with diabetic management, pain management, or symptom control. At times, visits were scheduled to accommodate the nurse but also to ensure that clients received the necessary care. For example, a participant who worked in the downtown eastside region of the city scheduled client visits to occur before noon to make sure the clients were at home and eliminated evening visits to this area after three o'clock to ensure the nurse's personal safety. This participant was uncomfortable working in this specific area of the city and found that if she adjusted her morning schedule for these clients, then they were more reliable, less impatient, and tended to remain at home for her visit. However, the geographical location of home visits did not preclude the participants' concerns for personal safety. Another participant stated that any home visit could place the home care nurse at risk regardless of the geographical location, "You're going to see some things that put you at risk...and the address doesn't give you any protection. You could see this in Shaughnessy or you could see this in Mt. Pleasant".

The participants' concerns about safety are consistent with Tennant and Narayan (1997) who take the position that general safeguards must be in place to ensure the safety of nurses. These authors discuss
the need for the institution of several safety measures when implementing a night service in home care nursing. Such measures include using cellular phones, working from the nurses' homes and eliminating the necessity to enter or exit an office building at night and use an isolated parking lot, checking in with other night nurses frequently, and using a contract taxi service if the nurses feel unsafe in a particular neighbourhood (Tennant & Narayan, 1997). Certain agency policies and procedures should be in place that prevent nursing visits to homes in which there is a likelihood of unsafe and dangerous behaviour. These policies enable the nurse to define dangerous behaviour and allow the nurse to determine when a situation is unsafe, and provide appropriate direction for the nurse. The home care nursing service discussed in this study already had in place many of these suggestions as health board policies that guided the participants' practice.

Each health unit area had clients who spoke different languages but not all units utilized language designated home care nurses in client care. There were health unit staff who spoke different languages and participants often used these persons when needed. The participants who were hired as second language designated home care nurses worked in the same unit and found that they were affected by the client population that they served. One participant who was hired to manage the needs of a specific cultural group had a very busy practice. Often she was overwhelmed by the needs of this population and after she had assessed and planned for these clients' care needs, she referred many clients who required uncomplicated nursing care to the "mainstream nurses" so that she maintained a mixed caseload:

> My practice is actually pretty broad. It's a 50-50 kind of thing. I would go crazy if I had just [these] clients. I have four visits today to [clients of this cultural group], that's just enough because other than doing what I'm doing, they want me to sit and have tea and stuff, I'll be there forever, so it's kind of nice having a mixed practice.

Another participant who also was recognized as a second language designated nurse found her practice with a particular cultural population quite active as well. Her caseload was 60% to 75% of that cultural group and often seven out of eight visits in a day were to these clients. Both participants who were language designated home care nurses thought that they met specific client needs with their respective client groups. The first participant who was cited in the previous example stated that translators without a health background were not as effective as language designated nurses because "something is lost in the
translation". This participant considered that she made a difference to clients within her cultural group who needed palliative care at home as she met the clients' and families' need for "the expression of emotions in their own language even if they speak English". The other participant who also interacted with clients from her culture thought that she offered "comfort with communication" to this client group and stated:

I wouldn't say I offer something different. I think I offer whatever is needed. But I think speaking their language also makes them feel more comfortable and if they have any questions they certainly can ask. Because the language difficulty is not there. And so, I don't feel that I am doing more for, you know, the non-English speaking patients.

The views of these participants are reflected in the literature. Particularly at a disadvantage for health care are the immigrant populations who do not have English language skills and, therefore, have problems acquiring the help that they need from health professionals (Anderson, 1990; Anderson, Blue, Holbrook, & Ng, 1993). These authors purport that communication between immigrant families and health professionals usually occurs through interpreters, and families usually are expected to find a family member to interpret for them as most community health agencies do not provide trained interpreter services. As well, often the families' concerns and/or the health professionals' instructions to families are insufficiently expressed during the interpretation process as the family interpreter is frequently a different person at each visit or is not the person in the family who is able to make decisions about client care. It was of great concern to one of the participants with language designated status that her interpretive services were no longer going to be recognized because of the regional health board's interpretation of the nurses' melded provincial collective agreement. The loss of monetary recognition was not the issue for this participant although she considered it unfair to discontinue this payment as she had taken oral and written examinations through Mosaic community services in order to qualify for this job. The issue of concern was the loss of a benefit for this client population, that is, the participant's understanding of a specific culture and how this culture affected the health behaviours of this client group, as well as her assistance in other aspects of their lives. This participant explained:

It's not much but it is 4% and with the 4% I feel that we have been doing much more, you know. Sometimes we see a client, not just to deal with their health issues but they have some letters coming from the government that they can't read and ask us to read them for them, to let them know what they are about.
This participant was disconcerted that non-English speaking clients in her region now were going to have to use expensive telephone translation services, which were used in another health unit, and would not be as effective as the personal interaction of a trained interpreter. Also, this participant's colleagues still expected her to "deal with some of these issues and do the phoning for them because they find it very difficult to communicate" with these clients, as well as "carry on with the caseload that I have". Anderson (1990) believes that with very basic communication lacking between a translator and a non-English speaking client, there is little opportunity for discussion of potential treatment options or of disagreements about treatment procedures. This situation results in the inadequate allocation of resources, such as an expensive translation service, to assist non-English speaking clients and families from different ethnic backgrounds to deal with the management of health conditions. Accessibility to health services also becomes an issue as opportunities for these persons to improve their health decrease and inequalities in their health care services increase. Primary health care supports the notion that in order to promote positive health behaviours and appropriate coping strategies, individuals need to have the correct information available and to know the meaning of that information so that they can make appropriate and informed decisions (Epp, 1986; World Health Organization, Health & Welfare Canada, & Canadian Public Health Association, 1986). Language designated home care nurses are a means to accomplish this primary health care principle for non-English speaking client groups who require home care nursing.

Although there were changes in the participants' nursing practice to which they adjusted, such as the example just described, there were some aspects of their nursing practice that remained the same. Participants expressed that the management of the clients' medication regimes and wound care needs have continued as a stable part of their practice, and although the medications and wound care products have improved, the care principles generally have stayed the same. As a participant explained:

There's always going to be people that need some help with medication management. There's always going to be diabetics that need some teaching and those things aren't changing a whole lot....We keep evolving in our wound care. I think because we keep trying to grow and to learn, and I hope that we keep improving and changing our practice a little bit.

Participants also suggested that the basic nursing procedures have remained unchanged. For instance, catheterizations and injections, maintenance of client confidentiality, philosophy of self-care and holistic
nursing, and promotion of the client's well-being have remained a mainstay of their nursing practice. Participants offered fewer examples of nursing practice that stayed the same and indicated that current nursing practice reflected more changes than experienced earlier in their home care nursing practice.

There were many changes identified by the participants in their nursing practice that impacted how they now provided care to clients at home. With the dramatic changes in acute care institutions, prompted by the desire to efficiently and cost effectively manage the health care needs of many kinds of client groups, participants experienced the rapid movement of client care out of the hospital and into the community. Participants contended that their practice was now more complex and more technical in that the clients' physical care needs were greater with the increased technological care required (e.g., IV therapy), and the psychological needs were more intense following hospital discharge, as seen with same day surgery for breast removal. Clients overall were considered sicker, more unstable, and discharged home too soon. Also, there was pressure from hospitals to manage these sicker clients at home despite participants' assessments that many of these clients should be treated in hospital. The movement of increased technological care into the home had resource implications, both financial and human, as described by one participant:

We got a client home, he's muscular dystrophy, he's on a ventilator, he's trached, he's in a wheelchair, he has a lot of care needs, he has a tube feed, he has an attendant who provides a lot of his care...But we had to inservice several nurses to be able to do his trach changes and have some familiarity with his ventilator, they need some orientation around that, so the amount of technical skill that is required for clients right now in home care is higher....As clients are coming home sicker, so a lot of the equipment comes with them. There is a lot of up front costs, and I don't mean cost as far as money, necessarily, though that comes into it as well, but human cost as well, as far as getting everyone up and running with all the equipment and the stress levels for people.

The participants' workload was related to the acuity of the clients. Participants also now dealt with the increased complex symptom management of palliative clients, AIDS clients, and the frail elderly which resulted in longer nursing visits and clients who remained on service longer. These situations happened because these clients required more complicated care planning and organization of various community resources in order to stay at home. A participant explained:

Complexity of care for clients, regardless of technology, is much higher. You are getting much more complex palliative clients because people are coming home and staying home to die, where at one time they might have come into hospital because we couldn't cope with the level of care at
home. It may or may not involve technology, it may just be complex symptomology, so there are
several symptoms that are active at the same time that are difficult to control, those kinds of
people used to go back to hospital, and now you can't get back into hospital in the same
fashion....We are able to manage these clients better in the community....Complex elderly clients
can be just as complex or more complex than palliative clients as far as trying to sort out
distressing or complex symptoms....We are having them all sicker and quicker, but we are also
having them all longer, and the visits are longer because it is more complex to manage.

Access to such specialty programs within home care nursing services as the hospice and frail elderly
programs supported the participants' practice and assisted them in maintaining these clients at home.
However, there was no way to accurately reflect that their practice was more complex, their visits were
lengthy, and clients remained home longer. In a recent report on trends in Vancouver home care services
there was a suggestion that there was a trend towards increasing acuity and complexity of care in the
community but that there also was a lack of meaningful supporting data (Capler & Condon, 1998).

Technology in home care nursing practice has become more common as the participants directly
participated in the technical aspect of home care nursing and observed the effects of home technology on
clients and families. The technical care activities of the participants are evident in the literature as more
technologically dependent clients are discharged home (Carroll, 1995;Kenyon et al. 1990; Lieder &
Liebig, 1988; Rothkopf & Younger, 1992; Stulginsky, 1993; Wearing, 1994; Zenwekh, 1995). Carroll
(1995) and Zenwekh (1995), and the other sources, maintain the notion that 'high tech' home care is a
reality in today's health care systems and that home care nurses will be involved in high technology home
care for many clients, regardless of age or diagnosis. Carroll (1995) indicates that the skilled use of
technology ultimately enhances client care and can dramatically improve outcomes and the quality
indicators of care which are so important today. Participants indicated involvement with a variety of high
technological devices, such as ventilators, intravenous peripheral and central line catheters used with
pumps for antibiotic therapy, and subcutaneous catheters used with pumps for client controlled analgesia,
and monitoring devices, such as pulse oximeters and glucose monitors. These devices were intended to
improve client care, increase client control and satisfaction with care at home, and allow more efficient use
of the clients' and participants' time. Zenwekh (1995) is concerned with the impact of complex home care
technologies on the lives of clients, their families, and the community. Although participants stated that
technical care, such as intermittent or continuous IV antibiotic therapy, was now feasible at home and that
many clients were capable and unafraid of self management, there was concern expressed for a balance between the appropriateness and cost effectiveness of the varied treatments that occurred at home. Affordable and appropriate technology, a primary health care principle (Epp, 1986; WHO, 1978), supports the participants' claim that high technology home care nursing practice cannot and should not merely be care of the technology (the 'machines and tubes') at home; rather it should emphasize the care and needs of clients and families who receive technically complex therapies at home, and should reflect the best interests of these persons.

Advanced technology, the increased need for acute and chronic nursing services at home, and the variety of client care needs has redefined the roles and responsibilities of the home care nurse participants. The participants provided direct care and indirect nursing care to clients at home and were accountable to themselves, the employer, the clients and families for providing care that was competent, reasonable, and rational. All participants practiced at a generalist level in the client's place of residence with the focus of their practice on the client, family, and caregiver. Participants perceived that there was an educational advantage to their generalist practice in that they had potential access to a variety of educational opportunities that enriched their general nursing practice. They also experienced a psychological advantage to this kind of practice as the generalist practice offered diversity which decreased the possibility of burnout in any one practice area. As one participant clarified:

If you couldn't balance your careload or workload...I think it would be more difficult, because...often a very complex visit, whether it be palliative care or a complex geriatric patient, if you didn't have a visit where you could just...do the care and not have to be so involved in the complexities of the situation, I don't think you would have people being able to cope as well, and the burnout level would be much higher.

As well, all participants saw the benefit of the presence of specialist home care nurses within a generalist framework of home care nursing practice, who were not the same as clinical nurse specialists (CNSs). Several participants developed special interests and skills in particular areas of nursing practice that facilitated their practice and that of their colleagues, and that enhanced their job satisfaction and offered greater work opportunities. For example, several participants were identified as resource home care nurses for clients receiving IV antibiotic therapy, wound care, palliative care, and diabetes care. As well, several participants were members of clinical practice groups, chaired by CNSs, that created guidelines
for home care nursing practice. The participants viewed the resource nurses as an opportunity to more effectively manage particular client groups by empowering clients and families to be independent in their care, and to support home care nursing practice. The participants and home care nurses, in turn, were supported by their unit nursing coordinators, and by the CNSs who were responsible for the needs of certain pediatric, adult, geriatric, and hospice community client groups. The participants valued the roles of the CNSs and the coordinators. The CNSs were easily accessible for clinical direction in complex client situations, kept clinical nursing practice up to date, and supported the nurses during changes in nursing practice. The coordinators also were readily available for clinical direction for day to day problem situations as well as complicated client situations, and supported the nurses in circumstances where interpretation of home care nursing policy and philosophy was necessary with clients and families.

There were disadvantages to both the generalist and specialist approaches to home care nursing practice noted by the participants. The major disadvantage to a generalist approach was the fact that the nurses needed "to know everything about everything and it's hard to keep skills updated", as stated by many participants. The major disadvantage to a specialist approach within a generalist framework was that of a workload issue. With the support of the CNSs, nursing coordinators, and resource home care nurses available to enhance nursing practice and support clients and families, the participants did not consider it practical or a good utilization of resources if nurses were hired to provide only specialized nursing care to specific types of clients. It was appropriate only if nurses were hired specifically to provide care to clients as part of a particular program, such as the shift care nurses in the home care hospice program. It became a workload issue for participants if there was inadequate staff coverage to meet the needs of the general caseload because of the provision of specialized nursing care to specific clients. For example, the home IV resource nurse who unexpectedly was called to restart several clients' IV lines at the expense of her own caseload requirements and that of other nurses' as well, as they temporarily covered this nurse's caseload.

The participants' comments are consistent with the literature. Nemcek and Egan (1997) advocate the need for both generalists and specialists in home care nursing practice. These authors suggest that once agencies have identified groups of clients who require complex care and clients with the most recurring
diagnoses, then there are opportunities for specialty nurses within home care nursing. A specialist has
advance education and detailed experience adapted to function in a unique environment. Nurse
specialists are considered by these authors as expert caregivers in a selected clinical area, such as
cardiac rehabilitation and enterostomal therapy. Nemcek and Egan (1997) support the presence of the
generalist home care nurse who wants to specialize in a clinical area like diabetes management and also
support the need for the CNS who specializes in population health issues, such as gerontological health,
and can advance home care nursing practice. Marrelli (1996) differentiates between the responsibilities of
the generalist home care nurse and the specialist home care nurse or CNS, and indicates that there is a
need for both types of nurses as well. Marrelli (1996) believes that the generalist's focus of practice is the
client, family, and caregiver and whatever nursing care that the client requires at home. The specialist's
focus of practice, on the other hand, is on individuals, families, and groups with emphasis on complex
case management and consultation, evaluation of programs and services, and research of nursing
practices and health care delivery of complex clients. Tansey and Lentz (1988) state that it is difficult for
the generalist nurse to practice in today's health care delivery system without specialized knowledge in
specific client situations. Today's community home care nurse's practice is more than a generalist
practice, it is now characterized by knowledge and competency in other clinical specialties. Thus, home
care nurses practice at a level of sophistication beyond that of the nursing generalist.

Many times the participants' roles and responsibilities became blurred and they functioned in multiple
roles depending on specific client situations. Participants frequently assumed the role of case manager as
they facilitated client care decisions with clients, families, and caregivers through activities that included
education, negotiation, collaboration, and case management. To optimize client outcomes, participants
often liaised and coordinated with interdisciplinary members and other community services, and
advocated on behalf of clients and families. Participants elicited relevant information from clients, families,
and caregivers during initial and periodic assessments of the clients' and families' health care needs and
resources in order to develop and support specific care plans. Participants shared knowledge with clients
and families about the particular health issues involved and about appropriate and available community
resources. In addition, it was important that participants clearly explained to clients and families about the
type and availability of resources within home care nursing services and within the agency, the limitations of services, and what participants could offer to them. This information exchange and advocacy process was used to encourage clients, families, and caregivers to plan care and seek additional services as their care needs and resources indicated. A participant summarized how her interactions with clients took on various roles:

I'm more likely to try to become part of the client's recovery process, rather than orchestrating it myself. I try to guide it, show them what's there and become one of the tools the client would use to recover to whatever ability they would like to. I try to be there as a referral source, a knowledge base, and sometimes as a doer. Sometimes as an advocate as to what I think is the best scenario for this client, if they are unable to speak for themselves, and sometimes just as a counsellor, and again as a teacher.

The increased need for care in the community has resulted in the participants placing a greater focus on clients and families and their needs during the care planning process. Clients in need of 'high tech' care or complicated care, who in the past were admitted for therapies as inpatients, now wanted to stay at home. They expected to receive training by home care nurses in specific, complex procedures so that their wishes were acknowledged, personal integrity remained intact, and independence was maintained or increased. Participants perceived that the care of the dying client at home and of the client's family members was complicated and challenging, and required special attention to the client's and family's needs. For example, clients who wanted to die at home and needed subcutaneous infusion of analgesia were educated and supported by the participants, as were family members, in the management of the medications and side effects, and of the infusion pumps. Families were also prepared by participants for the death of their loved ones. A major responsibility of the participants with this client group was teaching families about the natural stages of dying and informing them of the physiological changes that occurred during the dying process. Another responsibility of participants was to counsel and support clients and families in the acceptance of the inevitability of the clients' deaths and to assist families to relax their need for intrusive activities, such as feedings or IV therapies. As well, participants encouraged families in the care that they provided, commended, and reassured them of their good work with the clients. One participant described her role with a palliative client and his family as "the thread of continuity" between the client and family members as she promoted continuous interactions among them during the client's
difficult and emotional process of dying, and facilitated the client's need to complete unfinished business. Participants also acknowledged the importance of the nurse's role in recognizing and supporting the family's and/or caregivers' needs, knowing when to withdraw their presence as the client/family situation became more stable and as family members and caregivers became more confident in their abilities to cope with the circumstances. When families required respite, participants arranged for respite care at home or in a palliative care unit, whatever was appropriate for the clients and their families. Participants also supported clients and families if their decisions changed about the actual place of death, and in collaboration with physicians, organized admissions to palliative care units.

Participants' comments are consistent with the literature. Brogna (1996) and Stulginsky (1993) assert that caregiver burden becomes evident if caregivers do not receive adequate education, support, and referral to appropriate services when needed. The demands of caregiving place caregivers at risk for becoming ill themselves and possibly necessitating hospital admissions of clients and/or caregivers, actions that are avoidable if caregivers have enough support at home and relief from care activities (Brogna, 1996). Many times family members or caregivers have unrealistic expectations of themselves or feel that the clients' demands are excessive. Stulginsky (1993) indicates that families and caregivers need to be assessed for their capabilities to care for clients with chronic illnesses, and need to know from the outset what is expected of them and the extent of the services that can be provided. Caregivers and/or families must also understand that it is important to meet their own needs and to receive emotional support themselves, otherwise they cannot give clients adequate emotional support. Both authors believe that the best way to resolve caregiver stress is to lessen or prevent it by assisting caregivers to accept responsibility for their personal health and well-being. Respite from care activities should be planned, episodic, easy to obtain, and available throughout the caregiving process, not just when families are in dire need of it. Home care nurses assist caregivers and families to deal with issues as they arise and support them in their care decisions, and to gain proper perspectives on client and family situations so that they experience less frustration.

Although participants considered themselves to be independent practitioners who delivered direct primary nursing care in clients' homes, such as wound care to immobilized clients, they acknowledged that
they did not work in isolation. Participants considered themselves as active members of an interdisciplinary health team that cooperated together to assist and support clients and families to attain their goals of care as well as support themselves as a team. The interdisciplinary team included the home care nurse, long term care case manager, rehabilitation therapists, nursing coordinator, and physician. It was important to participants that the nurse took a leadership role with this team, ensured that all team members worked with the clients' and families' goals, and if necessary, restored the balance between clients and their perceptions of health professionals involved in their care. One participant described her perspective of a team member:

I think collaboratively as a team you have to work at what is the client’s goal, and although you may be working on different things, for instance, physio may be working on getting the client more mobile in order to make them more self-sufficient at home. I may be providing more nursing care in one way, but also putting in home support hours in order to help support them when they are at home. So it is all working towards the common goal to making them more self-sufficient at home, though we may be working from different aspects of that.

Frequently participants directed the team’s involvement and organized the utilization of resources for certain clients so that consistency in care was assured, such as with palliative clients:

You are the hub....You are liaising with the family, liaising with the family doctor, you involve the hospice doctor....You're liaising with and organizing either the home support workers or the shift care workers [nurses]. You're organizing your charts so that if you're not there someone else can take over and know pretty well what you're doing and who's supposed to do what.

Participants usually negotiated care plans and activities with clients and families, but occasionally it was also necessary to act as a liaison and negotiator between clients and other, over-zealous team members who did not take the clients' circumstances or wishes into consideration, and pursued their own goals for clients instead. Integrity between team members and between clients and team members was important for successful client care, a participant explained:

I felt that I was restoring the balance there a bit and that is what he [client] felt and expressed too, but I did it in a way that maintained my colleague’s efforts....And he would maybe be at least open to working with her [therapist] another time if we just kind of smoothed those feathers a little bit.

Many participants found that there were social work aspects to their nursing practice that often complicated the nursing care and were time consuming but necessary because, as one participant voiced, "It is so much quicker to deal with it [situation] yourself". Some of these activities depicted by participants included locating a larger, subsidized apartment for a client unable to make his own living arrangements,
interpreting legal documents and assisting clients with immigration issues, and counselling and supporting clients and family members during emotional situations, such as verbal abusive occurrences within families. Participants saw their roles as having expanded beyond the traditional picture of nurses who focused on 'doing to' or 'doing for' to that of a focus of a more holistic, family nursing approach. One participant with more than 30 years of nursing experience and eight years in home care nursing indicated that she had never been trained as a counsellor to clients and families and that this aspect of nursing evolved with time and experience. As she explained:

You will be a shoulder to cry on, sometimes...they throw their anger at us....The kind of training I have...you are told this is the injection...you don't do anything else...you didn't even look at other aspects of the person's well-being so I think we are doing more of that....[now] I end up talking to the person and try and find out what else is going on in their lives, and that is when you get into the complex situations.

At times, extra non-nursing activities occurred out of necessity among participants. For example, participants acted as couriers for clients unable to mobilize and pick up needed supplies or medications, and one participant purchased orange juice for a diabetic client who experienced lightheadedness in an attempt to have the client avoid an insulin reaction. These non-nursing activities happened by exception but nonetheless added to the role of the participants. Language designated participants more frequently performed these activities because their clients were new immigrants, non-English speaking, and needed assistance with their transition into Canadian society. These activities were previously mentioned and comprised interpreting clients' legal documents and bill statements, as well as, sorting local community newspapers and junk mail from the clients' relevant mail.

The many roles and responsibilities described by the participants attest to the complexities of their nursing practice and how their practice has evolved and changed. The participants' descriptions are evident in the literature (Cloonan & Shuster, 1990; Green & Driggers, 1989; Rice, 1996; Stulginsky, 1993) as these sources and others previously cited attest to the various roles and activities that characterize community home care nursing practice. For example, these authors agree that home care nurses' roles are varied and include, among others, care coordinator, educator, and direct care provider. Also, advocacy, negotiation, and complex and technological care are but a few of the many activities and functions that home care nurses must provide to clients and families at home.
In summary, participants indicated that their home care nursing practice was diverse, autonomous, and complex. Home care nursing practice became more complicated as clients with acute and chronic needs required increased technological support, complex symptom management, organization and provision of care, and community resources in order to remain at home. Participants found that the many needs of clients and families were well-served by a generalist nursing practice, which also was supplemented with specialized nursing functions. Many different roles and responsibilities were enacted simultaneously by participants so that client care was provided in a holistic and family focused manner.

**Subcategory Two: Attitudes Towards Home Care Nursing Practice**

Participants indicated in their discussions that certain attitudes and values about home care nursing influenced their home care nursing practice. This second subcategory, attitudes towards home care nursing that affected home care nursing practice, emerged as participants described specific practice situations and discussed their personal thoughts and reactions about their nursing practice.

The participants thought that home care nursing was the most rewarding and challenging nursing job of all their nursing experiences because of their interactions with clients and families within the home environment. Despite the changes in nursing practice and the increases in workload, participants indicated that they would never return to hospital nursing if they could avoid it. Participants enjoyed the flexibility and variety of the client visits, the satisfaction of sharing and meeting with different people in their own environments, and the fulfillment and confidence of knowing that a job was done well at the end of each day. Home care nursing epitomized "true nursing" for one participant in that she considered home care nursing "an independent practice" where "a group of independent practitioners worked effectively" for the benefit of clients and families in the home. Another participant suggested that home care nursing fit best with her philosophy, which would make it difficult for her to return to hospital nursing, as it "allowed me to be autonomous to an extent, and independent, and learn more about client care on a broad base than any other area that I've worked in". Participants valued the personal autonomy and self-sufficiency of home care nursing practice, and the opportunities available to them to provide nursing care in a manner that was acceptable and comfortable, not necessarily in a way "that the institution I worked for mandated that I do things", as expressed by a participant. This attitude did not mean that participants did not adhere
to the appropriate policies and procedures in their practice. Indeed, participants acknowledged the value and importance of the many research based policies and procedures that guided their nursing practice, generally and specifically. Participants experienced how clinical practice guidelines, when implemented consistently, directed, validated, and improved their nursing practice as well as improved client care:

The clinical practice group has started....We're creating some of the guidelines and...patient care is improved....We have guidelines and policies and procedures and we're not just doing this helter skelter, we actually have some research, articles people can read....And...patient care has improved [because of this approach].

Working independently, participants identified that a big asset to their practice was the availability of clinical support. Although home care nurses were primary caregivers and knew their clients the best, participants pointed out that nurses did not work alone. Participants respected their colleagues' experiences and often relied on them for support or direction, as a participant explained, "One of the best resources is your cohorts". This participant further elaborated:

You're going by your protocols but you're also using your cohorts' experiences as far as how they might approach the problem. Then if you need more clinical expertise beyond that, then you'd get in touch with your CNS or talk it over with your coordinator.

Another participant valued working with colleagues who trusted her judgement because this trust instilled confidence and her judgement reflected competence in her nursing practice. Participants utilized the nursing team meetings as an opportunity to focus on clients and discuss problematic client issues and to share relevant client information required by other nurses who might also become involved in specific client care. The expertise of the interdisciplinary team members was also used to augment the participants' practice and as integrated team meetings occurred, in some units, there was another occasion to discuss case management of certain clients and to refer clients to one another or to other resources. As a result, participants appreciated the collegial support of their nursing colleagues and administrators and of other disciplines as they worked together to provide optimum client care.

Home care nursing was considered unique and a specialty area of nursing by the participants because of their understanding of the client and the client's needs within the community environment and how this understanding affected the home care nurse/client relationship in a variety of clinical situations. The unique nurse/client relationship was client centred and participants valued client centred care as a home
care nursing concept. The uniqueness of home care nursing was expressed by the way that this client centred care was provided in the home, by the intimate personal setting of the client's home, and by the interactions shared with the client and family. These characteristics of client centred care at home were different from other health care settings and influenced the home care nurse/client relationship. According to participants, a complete and accurate assessment of the client was not possible until the nurse entered the client's environment. Participants stated that once they experienced the client's environment then they were able to see the broader picture of the client and family situation and understand the client's and family's behaviours toward health care practices. Participants heard client stories, shared client histories, and determined a sense of the clients' lives, all of which gave a purpose for the participants' nursing practice. Over time and with prolonged interactions with clients and families, participants developed unique relationships with them that were unlike any relationships that occurred between other health professionals and clients and families in other health care settings. Participants believed that they were sent into clients' homes to assess difficult clients and arduous client/family situations instead of other health professionals because of their broad based practice and experiences. From the participants' perspectives, home care nursing has encompassed the most effective care aspects of other health professionals and participants have incorporated these effective care activities into their practice which assisted them with problematic client circumstances. A participant summarized:

Often we are called the generic worker and...that bothers me...but that is one of the reasons we are the most effective workers...but if you have a very difficult client....The first person I would send in is a home care nurse to decide who else is needed, and does that make her the generic worker or does that make her a very effective worker who has a very broad based practice and has many interventions from many other disciplines? I don't think that makes her a generic worker, I think that makes her a very effective one.

The many and varied client and family situations experienced by participants affected how they viewed life generally and how they practiced home care nursing. Participants liked the clients and their families, enjoyed the shared home environment, and felt privileged that clients opened their homes to nurses and that participants could offer nursing services to the clients and families. Certain situations were more meaningful to the participants than others. Participants particularly valued their involvement with palliative clients and their families and caregivers because their biggest rewards, best learning opportunities, and
greatest challenges in their nursing practice came with their experiences with these individuals. Often the
participants' level of comfort and understanding of death and dying improved with their interactions with
these clients, both professionally and personally. Assisting clients to die at home was considered a gift
and an honour by participants, especially if they were chosen by the dying persons to discuss the clients' concerns and wishes about the dying process. Participants learned to accept clients' deaths as an end to suffering, as their time, and to reassure families that there would be good memories of their loved ones after death. It was important for participants to ensure that the care and integrity of the family was also supported so that conditions were as positive for them as possible, and death in the home could occur uneventfully. Experiencing the emotional aspect of palliative care was important for the clients and families, as well as for the participants. Many participants learned about death and not to fear death when working with this client group as they had to deal with the death and dying of clients every day. As one participant articulated her viewpoint:

So often when you are dealing with palliative care patients, you are seeing them at their very best. They are vulnerable...in a very weak condition and yet they are very strong because they're looking back on their life, and it is really powerful to see someone do that and to see the strength that some people have, but it is really emotional...it is so wonderful to be part of this...monumental experience.

Interactions with palliative clients and their families was hard work for participants and meant that nurses needed to keep an open mind and try different care activities. This approach was useful in other client care circumstances as participants believed that they utilized all their nursing skills and knowledge to meet the many care needs of the dying client and family. Palliative care nursing in the client's home was a positive challenge for participants even if client/family situations did not turn out the way the participants wanted. A peaceful death at home was rewarding for participants as well as for clients and families. However, participants accepted that this outcome was not always feasible and sometimes what the nurses considered a negative situation was actually a positive one for clients and families as things were done their way. Some palliative care experiences were better than others and as with other client situations, participants claimed that the more positive experiences always balanced out the negative experiences, and that they learned from both types of experiences. As a participant pointed out, "Part of the value of the job is the constant learning that occurs". For one participant, nursing these clients also
affected her understanding of control and letting go and impacted her nursing practice as well as her personal life, "ultimately you don't have control. People make their own choices...and that's fine".

Many client situations influenced the participants' nursing practice as well as the many changes in home care nursing. Participants found that as their workload became increasingly busy, it became more difficult to practice in the holistic manner with which they were familiar. Time constraints often limited the type of interactions participants had with their clients and families, and frequently affected the extent of their involvement. Too often, participants thought that there now was a tendency to focus on the client's diagnosis and the physicians' orders despite the clients' need for more care so that caseload demands were met. One participant described how this change has affected her nursing practice:

I like to do a full assessment to see if there is anything else that I can work with the people....We don't want to ask too many open ended questions because you really don't have time to deal with them now. When I started you did. It was great....Now...sometimes if we go to someone's home ...you definitely just look for the diagnosis and what you've been asked to do and that's kind of what we may focus on, which is too bad...because usually there's a lot more you could do.

Participants were concerned that with this change, the quality of nursing care that they wanted to provide would be compromised, would not be equitable for all clients, and that the home care nurses' morale and positive attitude towards their nursing practice would decrease if unable to continue to provide effective and consistent nursing care. Many times, participants found it necessary to overextend themselves at work in order to ensure that clients received effective and equitable nursing care but worried about their abilities to continue to provide care at the same level of quality that they used to provide. A participant summed up:

There are days I probably stay late in order to do the kind of care that I want to give because to me it's important to follow through and if I can't follow something through, I wouldn't feel satisfied with the job that I was doing.

Participants highly valued the autonomous, varied, and unique interactions with the clients and the clients' families. Participants valued their abilities to consistently provide high quality nursing care to their clients despite workload demands as they believed that they were good at what they did and that the clients' lives improved with their nursing involvement. Within this subcategory, participants voiced the importance of clinical practice guidelines, peer support, and nursing and interdisciplinary meetings that directed and supported their client centred care. Personal beliefs and values influenced the participants'
nursing practice and they were aware that they needed to be cognizant of their attitudes when they interacted with clients and families. The participants' attitudes towards clients and families and to home care nursing practice often impacted and directed their nursing activities as they assisted the clients and families to meet their needs.

Subcategory Three: The Context of the Client

The third subcategory explains the importance of the client and the client's environment to the participants' home care nursing practice as perceived by the participants. Participants identified that their practice centred around the client and the client's needs for health care, and that the client was responsible for the decisions made about the care needs and for the participation in the care to satisfy these needs. As well, this process actively involved the participants and impacted the outcomes of care.

The client, as perceived by participants, was the person who required nursing care, and included the client's health care issue(s), family (as identified by the client), environment, support system, and general circumstances. Knowing the client was significant to the participants' nursing practice as participants took direction from the client and were influenced by the client's decisions, actions, and environment. Knowledge of the client as a person was important to the participants because this knowledge affected their interactions with the client beyond that of understanding the client as just a diagnosis or case.

Knowledge of the client's personal history and who and what was significant in the client's life, knowledge of the client's environment and which comprised more than the client's physical space, and knowledge of the client's social network, social and spiritual community was necessary as well. This knowledge enhanced and offered rationale for the participants' clinical decisions and nursing actions. Liaschenko (1997) states that knowing the person requires the nurse to subjectively interact with the client. However, participants indicated that this subjectivity had to be tempered with a certain degree of objectivity. Although their personal experiences, beliefs, and values influenced their nursing practice, participants had to consciously divest themselves of these beliefs and values, if possible, in order to truly understand what the clients were communicating to them. This degree of objectivity was necessary so that participants could establish meaningful relationships with clients and families.

Participants entered clients' homes with an understanding that they were guests offering services that
clients and families were free to accept or reject. Being sensitive to and acknowledging the client's health issue or illness experience set the tone for the home care nurse/client relationship. Often clients and families voiced anger and confusion at the early hospital discharge and the need for ongoing care at home, or at the inability to access needed hospital care. Participants and clients negotiated and defined the home care nurse/client relationship on the admission visit and continued to re-negotiate and re-define this relationship in subsequent visits as circumstances changed or progressed, and the motivation and perceptions of the clients altered. The family was viewed by participants as part of the client and as a participant attested:

It's one of the first things that I learned when I came to home care and it was quite a shock to me....But that's one of the things that I really like about it, is that we're not just treating this individual....Who they are is kind of interdependent on all these people around them. That the care they receive has to acknowledge everybody as well.

Participants clarified that 'family' did not necessarily mean biological family but whomever the client defined as family, such as partner, significant other, friend. As well, participants indicated that the client/family/partner/significant other could not be separated in the plans for care. Clients saw the home care nurse as part of their environment and of their lives as important personal information was shared with the nurse. In the home setting, the definition of family as client could not be denied as the boundaries between family and home care nurse could become blurred as both provided client care. The ability to maintain a therapeutic relationship in the home could often be compromised by the informal atmosphere and the natural tendency of many clients and families to integrate the home care nurse into their lives.

One participant cautioned that clients and families at times considered the home care nurse as a member of the family because, "You're in the home, you're intimately involved...but you have to make sure that the boundaries are clear for yourself and then for your client". Participants needed to be aware of their responsibilities at all times and sensitive enough to know that client and family responses to the home care nurse were often part of the client's healing process. For example, a participant stated:

This client...began calling me his daughter and my children his grandchildren...I think it is also a process of growth and counselling and if you put yourself in the role of counsellor, then it's actually part of his healing mode to do that. You have to take care not to feed into it.

It was crucial then that home care nurses continually assessed their relationships with clients and families
to ensure that the nurses' involvement remained therapeutic and objective. Maintaining a professional distance included setting boundaries that established the role of the home care nurse, client confidentiality, and the amount of personal information exchanged. Participants recognized that their presence could interfere with family processes and hinder their relationships with clients and families. As a participant explained:

You have to be very cognizant of your boundaries because if you don't have any, you are going to become so enmeshed with the client that you're not going to be able to provide any kind of objectivity, as far as looking at what their care goals are and to work towards those.

One participant found that she often had to establish boundaries and work on one problem at a time when she worked with certain needy client groups, such as children, lonely old men, and vulnerable young clients, and thus had to take care with her interactions with these client groups. Several participants did not like the idea of becoming a member of a client's family but thought that as they became involved in family issues, that their relationships deepened with the clients and families. A participant with language designated status asserted that she was "honoured" to be considered a member of a client's family within her cultural group and that this relationship was not a professional boundary issue for her. This participant saw this status as an opportunity to "provide better care" to these clients and families as she understood their cultural beliefs and fears. This participant also lived within the same community as her clients from this culture and advocated for this client group as a community citizen outside of her work environment. As well, the amount of personal information shared by participants with clients and families was limited and occurred occasionally, only if it was appropriate, to assist in client care. One participant justified her selective sharing of personal information:

Sometimes I will tell personal things to look at caregiver stress and you can use it therapeutically, as long as I can see a therapeutic goal to use a personal fact, then yes. But if I can't, if it's only a friendly thing, then I think you've crossed the line.

Participants were only too aware of their responsibilities to provide care to the client and were keenly cognizant of the importance of the family in the client's life and in the management of the client's health condition. Participating in the intimate setting of the client's home and with the client's family implied friendship, familiarity, and caring. Participants indicated that home care nursing practice fostered the sharing of a "human relationship rather than a traditional nurse/client relationship" with clients and families.
because of the nature of the home visit, the length of involvement, and the type of interactions shared. Also, participants reported that the longer and more intense was the shared relationship, as with palliative and ongoing medication management situations, the more involved the nurses became with these clients and families. Frequently, the home care nurse was the sole supporter of these clients and their major link with other health care resources. Participants asserted that to maintain a professional stance with clients they required a degree of emotional distance so that they did not lose their therapeutic effect and become vulnerable in their relationships with clients, and yet they needed to remain caring and supportive of clients and families. However, participants experienced loss, just as families did, when clients died and this feeling of sorrow was considered acceptable by participants as a normal aspect of their mutual relationships with clients and families. These long term relationships were differentiated from others that required short term, episodic care. Some client visits were short term and task oriented, and did not have the same degree of involvement by participants or clients as compared with the ongoing, complicated client/family relationships. Participants found the complicated client/family situations increasingly emotionally demanding but, paradoxically, more satisfying than task oriented client situations. Also, participants pointed out that they did not want to complicate their relationships with clients and families by becoming "another responsibility for them and then they have to worry about your feelings". This thought is further explicated by a participant:

You want to be a vehicle for them to discover something about themselves. So always you want to be sensitive to what they might want to communicate, and be available to that so that they can investigate and discover more about what's happened to them.

The participants' views on establishing boundaries within the client/family and home care nurse relationships can be found in the literature. Halldorsdottir (1997) states that the relationship that develops between the nurse and the client is one of attachment and professional distance when the nurse maintains a separateness throughout the development of the nurse/client attachment. This separateness must exist so that the nurse's caring remains within the professional realm. Coffman (1997) contends that blending with the client and family is necessary for success in home care nursing but also points out that too much blending results in a loss of objectivity and professional judgement. Stulginsky (1993) states that shared humanity is intrinsic to being in the home and that being allowed into a person's home encourages a
sharing of self, and not only that of sharing professional nursing knowledge and skills, contrary to the understanding of many health professionals. By creating a healing environment for clients and families, often participants became the healing environment as clients and families progressed along the health continuum.

Participants expressed that their nursing practice promoted self-care and independence of clients and families so that clients were supported and maintained in their own environments, and that it focused on client-centred care that reflected client control and client choices about their health care. Knowing the client as a person was particularly important for the participants in which collaborative decision-making was required for meeting the goals of client care. Participants worked within a collaborative decision-making framework that incorporated clients, family members, and other external sources of support. Clients were expected to participate in decision-making about client care, and whenever appropriate, assume responsibility for their own care. Families were encouraged and relied upon to provide most of the care to clients when clients were unable to care for themselves. Acknowledging the family as part of the client's needs was an important aspect of the participants' practice. Family issues needed consideration in the client's care as well, and the involvement of the family in client care could often complicate, impede, or enhance this care. Therefore, participants saw the necessity of forming partnerships with families as well as with clients. Clients and families needed time and support to come to terms with specific health and care issues, and participants did not force them to provide care when they were not ready. Participants related that sometimes it was easier to provide the care for clients and families rather than coerce them to do this care in the interests of saving time and energy from negotiating with them. This action allowed clients and families the chance to adjust to the present health situation. As well, participants could step back from the client/family situation and reflect on it to gain further insight into the dynamics of the circumstances, and how best to assist the clients and caregivers to understand what was happening to them. One participant explained the need for this reflection:

You really have to understand the family. You also have to give them time. Just because they refuse we can't...play hard with them. We have to give in a little bit and then they have to give in a little bit, and then we just work it out together. I don't think you can just say, I'm not coming in anymore because this is not our mandate. Sometimes you just can't do that. Because the patient is jeopardized here. Not the husband, not us. But the patient. In order for the patient to get the
care, we have to work together with the family members in order to have the patient care looked after.

Courtney, Ballard, Fauver, Gariota, and Holland (1996) support the importance of establishing a partnership approach to relationships between home care nurses and clients and families. In order to promote and maintain health and to prevent disease, these authors suggest that an increased emphasis on active involvement in health care decisions and self-care activities by individuals and families is required. As a result, the capabilities of these persons to act on their behalf are enhanced. A partnership is developed between home care nurses and clients and families when there is a negotiated sharing of power between all parties, and when clients and families agree to be active participants in mutual goal setting and self-care activities that promote health and well-being (Courtney et al. 1996). However, these authors acknowledge that when clients and families choose not to actively engage in partnerships with home care nurses, the relationships, although therapeutic, are not considered partnerships. Ultimately, the goals of the partnership process, the personal empowerment of clients and families and the ability to make effective health care decisions and perform self-care activities, are not achieved. Study participants have already indicated that as the home care nurse/client relationship was initiated, it was important for home care nurses to understand the effects of the care activities and decisions on the partnership and on the clients and families.

Participants recognized that caregiving was a complex activity, required adjustments to daily routines, imposed financial burdens, and caused caregivers to re-evaluate their relationships with clients. Home care nursing was only as successful as were the supports in place for clients. Usually these supports were elderly spouses, relatives, friends, or children who may themselves have disabilities or jobs with limited opportunities for time away from work. Participants noted that most clients and families were capable of managing their health care at home and were prepared to do so if their preferences were taken into consideration and that there was room for compromise and negotiation, and a great deal of support. These remarks by participants about families and caregivers are reflected in the literature (Aday & Wegener, 1988; Dellasega & Cutezo, 1994; Lieder & Liebig, 1988). These authors and other sources clearly indicate that the caregivers' needs have to be included in the clients' plans of care and adequate supports have to be in place to avoid caregiver stress and to decrease caregiver burden. As long as
clients, families, and caregivers believed that they were part of the decision-making process about client care, then they were willing to participate in care activities as reported by participants.

Decision-making about health care with clients and families had a major impact on the home care nurse/client relationship. A basic premise that influenced the participants' nursing practice was the client's right to make decisions about one's health care. Another premise held by the participants was that the client was in control of this health care in the home, a fact that also impacted their interactions with clients and families, and that was unlike other health care settings. These two premises and others, such as the right to live at risk and the need to empower clients, affected how mutually acceptable decisions about health care issues were made between participants and clients and families. The participants' acceptance of the client's right to make decisions and to live at risk was "part of working in the client's home environment", as a participant stated. There was a decision-making process that participants generally followed in order to establish and achieve nursing interventions that expedited the clients' abilities to enhance or improve the level of their health. These nursing interventions were considered within the context of what clients were willing to accept, the clients' personal, cultural and spiritual beliefs, the client's environment and support system, the agency's mandate and policies, the availability of resources, and were planned and implemented over time.

Participants frequently interacted with clients and families that lived with chronic illnesses and found that decisions about health care often reflected issues of quality of life for these persons. Unless the nursing care of clients was straightforward and short term in nature, such as post-operative wound care, participants were more commonly involved in planning care that assisted clients to enhance or improve the level of their health rather than trying to improve the clients' health. Participants saw the demanding realities of life for many clients and set out to assist them to have a life within the reality of their environments. When clients were encouraged to actively participate in care decisions, they were more likely to be committed to these decisions. Participants usually visited clients with a tentative plan of care in mind that gave some organization to the visit but also allowed for flexibility and adaptability if needed. Sometimes participants had to creatively problem solve on the spot, particularly if the nurses' and clients' perceptions of care differed or if a family member was in crisis and needed immediate attention.
Participants used an intuitive template for decision-making about client care. This template included an assessment of the client and the client's environment that focused on the client's physiological, psychosocial, and environmental status. Utilization of a standardized client assessment form assisted this assessment process and self-care theory provided the framework for the participants' assessments of the clients' abilities and social supports, and decisions made about client care. Safety of the client and of the nurse and the degree of the nurse's comfort with the client's circumstances were assessed as well as the status of the client's resources, that is, financial, social, and the support system. The client's capability and willingness to manage health conditions and environmental issues was also addressed. Assessment for safety and comfort of the situation occurred quickly in case participants had to remove themselves or the clients from potentially unsafe conditions. Dirty, cluttered, and at times, unheated homes were common occurrences and often were concerns for participants as the existence of these conditions detracted from providing safe care. However, dirty homes were not a reason to not provide nursing care to clients, unless safety was a major issue for the nurse and interfered with client care. Participants found ways to create a clean space from which to work and, also, suspended personal judgements and values when in clients' homes. Participants accepted and developed realistic expectations of their clients' lifestyles and planned and provided care accordingly. From the assessment, participants identified actual and potential problems as well as immediate, midterm, and long term goals that were realistic for the clients and nurses. Nursing decisions about client care, according to participants, were based on knowledge, intuition, previous nursing experiences, experiences with working with people, best nursing practices, and nursing research. Decisions were also influenced by the client's knowledge about the health issue, the client's ease and experience with making decisions, and the client's and family's wishes. It was important that participants validated the appropriateness of the goals of care with clients, refined them as necessary, and identified with clients which problems to work on first:

If you don't start where the client is at, as far as trying to deal with issues that are important to them, they are not going to put any credibility or validity into anything you say....I am going to lose in that situation and not set it up for success for the client or for me, because he is not going to listen to anything I have to say, and/or we are not going to benefit from a relationship as far as improving his level of well-being.

Planning interventions with clients was a slow process as participants developed a respectful and
trusting relationship with clients and families, assisted them to understand their health care requirements and to realize that they would benefit from the nurses' assistance, and encouraged them to accept this help. Participants looked for common ground with clients and families and understood and accepted the value that they placed on certain matters in specific situations before mutual decisions about care could be made. Participants gained insight into the clients' cultural backgrounds, beliefs, and concerns by listening to their stories and valuing and validating their lifestyles. Allowing clients to verbalize their needs, plans, and goals and to raise their concerns, feelings, and prejudices to a conscious level enabled participants to comprehend the clients' wishes and choices for care. By working slowly with them, participants helped clients and families to understand the nursing care that was needed and could be provided and the client and family involvement that was required in the care provision. Participants' comments are consistent with the partnership process discussed by Courtney and colleagues (1996). These authors purport that a health professional is most effective in a partnership with clients and families when these persons are permitted to discover and exercise their own power at their own pace. As clients and families are assisted in acquiring insight and knowledge of health care situations by health professionals, who listen to their needs and strengths, encourage shared decision-making, and involve them in the process of setting goals and care strategies, partnerships are formed, founded on trust (Courtney et al. 1996). Finding ways to empower clients and families was critical to the participants' relationships with these persons. Self-care and choices about nursing care were interrelated, from the participants' perspectives. Although clients' choices about care may not have been the same as the nurses' choices, participants supported the clients' right to choose their care options. Participants wanted clients to have more control over their decisions about care but, as one participant clarified, "You can't allow complete free autonomy as far as client decision-making, their choices are paramount to their care but are within certain limits". Clients, families, and participants collaborated together within the structure of agency and professional policies and procedures, appropriate and necessary care, and client choices and wishes. All parties negotiated and compromised about specific client care so that the clients and families, as well as the participants, sustained their integrity, dignity, and respect for the other, and that the clients and families were as self-care capable and independent as possible.
Enhancing client control included providing clients with the needed information that enabled them to make decisions. Participants indicated that when clients received accurate information about their care needs, felt supported and trusted by home care nurses, and believed that the nurses held their interests at heart, then clients were able to make sound care decisions. If clients chose not to participate in the suggested health plans and had different goals than the nurses, participants pursued why these goals of care were different from the nurses' goals of care and further discussed care options. If the clients' goals were harmful to themselves or to family members, participants provided the clients with more information that would clarify the unsafe situation so that the clients' goals became less harmful and more acceptable to them. Clients had to view themselves as part of the care plan and participants needed to see that clients were physically and mentally able to function independently with specific care activities before any decisions about care provision were finalized or withdrawal of services was contemplated. Participants creatively chose interventions with the clients and families that best served the clients' and families' needs. Sometimes, participants adapted the focus of a care plan from curative treatment measures to that of maintenance and comfort, such as in chronic wound care situations, as an acceptable alternative to all concerned. Participants viewed each client situation individually so that care demands were justifiable for both clients and families and for the nurses, as pointed out by one participant:

There are cases where somebody is not being that reasonable, and if it is something that you can cope with on the short term, then I think you need to look at it as a case by case exception, as to is it reasonable for the client to put these demands in, can we meet those demands and can we meet them in the period that they are requiring the care for? If it is very long term and the implications are very huge, as in it's a one and a half hour visit for years ongoing, can we provide that care? So, I think the implications are different depending on what care is needed, what kind of workload impact it has…and look at the ethical implications in each case.

Under certain circumstances, participants discontinued services with clients as they could not continue to provide the type of care that clients wanted, or nurses wanted for that matter, and it was not safe or appropriate. Participants reported that this action was very uncomfortable for them and indicated that once the home care nurses accepted responsibility for care planning with clients, it was very rare to withdraw services without a great deal of discussion and many attempts at alternative care options with clients and families, other health care providers, and health professionals. Participants emphatically stated that they always kept the door open for further negotiation and discussion with clients despite
specific client situations because client circumstances may have changed over time.

Informed decision-making by clients, according to participants, was based on a good understanding by the clients of their health care issues, and the implications of their health care decisions and actions on their health and on other persons, such as families and caregivers. It also included the clients' knowledge that their physicians were aware of the clients' choices and actions and that ultimately their physicians were responsible for the clients' care. Families were included in the decisions as often the client, as a family unit, decided on a course of action. If the client's family was unavailable, participants often involved the client's family physician, executor (if necessary), friends, and even neighbours in the decision-making process in order to ensure that the client's wishes were respected, assured, and the implications of the decisions were understood by all persons involved with the client. Decisions made about care that pertained to a cognitively impaired individual were more complicated and entailed the services of many persons who were directly and indirectly involved with the client's care, such as family members, physicians, home care nurses, homemakers, long term care case managers, human resources, lawyers, public trustees, to name a few. Participants usually worked with the family physician and an identified caregiver who may or may not have been a family member, and other health providers who could offer input when planning, implementing, and evaluating client care.

Having made an informed decision, a client's choice to live at risk was weighed against all the risk factors to both the client and the home care nurse. Participants frequently worked with the least threatening risk factor in a client situation as it was within the realm of the participants' practice and it was often in the best interests of the client. Eliminating the risk might not have been possible but participants facilitated the client situation, client choice, and client control by providing some supports that maintained the client situation and lessened the risk for the client. Often participants controlled some aspect of the clients' environments as part of the care decision which assisted the clients to function independently within their own homes. Instead of facility placement for a frail elder at risk for setting a house fire from burned food on the stove due to forgetfulness, as an example, a participant arranged for the client's stove to be permanently turned off, a microwave oven purchased and installed for use instead, and a homemaker organized to assist with advanced meal preparations. Although the risk was still present, the
degree of risk was minimized and the client remained in her own home, and both the client and the nurse were satisfied with the outcome.

Participants tailored their nursing care to the clients' goals and expected outcomes. As the care episode advanced, participants and clients evaluated the clients' progress against agreed upon outcomes and changed the plans as necessary. Successful client outcomes were achieved if the mutually agreed upon goals were achieved. Examples of successful outcomes articulated by participants included client satisfaction with healed wounds, palliative clients that were painfree and comfortable and had families that were well supported and able to cope with their loved ones dying at home, clients and families that voiced the importance of the home care nurses' involvement in the clients' healing process, and clients and families generally pleased with their status because of the continued education and support of their health issues. Sometimes there was no tangible evidence of outcome achievement as seen with chronic wounds that continued to recur and remain infected or when medications were not taken consistently by clients and resulted in numerous medical problems and hospital admissions. Participants expressed frustration with these occasions and queried the value of their involvement with these clients over the needs of other clients. A participant described her feelings:

There are long term patients like that, especially with quads who abuse drugs and they get burned with coffee and tea while they are stoned, you know, you just have to deal with it every time when it arises...it's a long term thing and sometimes you just have to live with it....We can't just neglect them.

In situations like the one just described, participants had to remain focused on the reason for the nursing involvement with the clients, that is, the maintenance of wound care and a reasonably safe environment for the clients rather than the expectation of providing high quality nursing care all the time to all the clients. Participants did not always agree with client choices despite providing the clients with the necessary information, education, and support that would affect their decisions and make them less harmful. Also, participants were cognizant that decisions made about care were not static and that care decisions changed as the relationships between participants and clients changed and the clients' motivation changed. Participants saw themselves as assisting and empowering clients to make their own decisions, with the ultimate choice resting with the clients. As long as participants were certain that clients
made informed decisions and would not unduly harm themselves or others, participants were willing to accept the clients' decisions to live at risk, and adapted their nursing care and care plans accordingly. These views of the participants are endorsed by Courtney et al. (1996) and by Vivian (1996). Courtney et al. (1996) believe that the desired outcome of the partnership process between health professionals and clients and families is that clients and families become more empowered, capable, and active in promoting and improving their health and well-being. Vivian (1996) reports that home health care nurses expected and accepted less than total compliance of clients as long as clients did not jeopardize their overall health. According to Vivian (1996), home health care nurses believed most clients wanted or tried to be compliant but numerous obstacles and circumstances made total compliance difficult or impossible to achieve. Furthermore, home health care nurses did not see themselves as responsible for or in control of client behaviours. The participants' expectations of client actions and personal expectations for successful interventions became realistic once the participants understood the client and family situation, their needs, and their goals of care.

Participants acknowledged and valued the client's right to exercise autonomy about health care through informed decision-making. However, this right was tempered by the participants' responsibility to provide reasonable and competent care, utilize resources efficiently, promote the welfare of others, and be honest with clients and families. There were many occasions where participants were challenged on a daily basis to determine the right course of action for certain clients. Some of these situations, though subtle and complex, required decisions that could have been considered within the realm of ethical decision-making but were not always recognized as such by participants. Clinical decisions varied and were dependent upon the participants' experiences with clients and families, the health care needs of clients, and the client and family situations. Most times, care decisions were straightforward, easily agreed upon, and did not require a great deal of deliberation by participants or clients. Some care decisions made by participants were "quick, band-aid fixes" until other resources could be put into place and a full assessment of the client situation and further decisions about care could be completed, as in the case of clients at risk for falling in the home. Many care decisions were complicated because of the clients' many health care needs and the expectations of and interactions between clients and family
members. Participants voiced that sometimes they had to advocate for certain risk behaviours for clients which complicated the decision-making and the organization of care for these clients but also enhanced their quality of life. For example, one participant found that she advocated for smoking privileges for a client, "I felt I had to really fight for her to enjoy a little bit of freedom...in her home...just having pleasure with two cigarettes a day". Another participant changed her decision-making process with elderly clients at home from "an initial knee jerk reaction of facility placement...of rushing in to fix things" to one of acceptance that clients had the right to make decisions to live at risk in their own homes. Decisions that seemed logical to this participant, such as facility placement, were rejected by clients as unacceptable because of the participant's initial lack of understanding or appreciation for the clients' circumstances, wishes, and what was right for them. With changes in the participant's perceptions of client situations, decisions and interventions focused on supporting these clients at home.

Some care decisions caused internal conflict for participants as they attempted to support the clients' wishes and meet their own expectations of care. Even with support and experience, occasionally participants found it difficult to accept the consequences of these decisions. One participant explained:

I think I made the right decision....My supervisor obviously had a lot of faith in me....I felt that was a big thing to place on my shoulders because I felt that I would let down not just the unit but the client....Sometimes you do go away and it's not your family that's sitting making decisions ...when something goes wrong you live with yourself. That becomes a bit of an ethical issue, but that comes with experience and I guess we all make mistakes...but this one fortunately wasn't ....Sometimes I've gone away at the end of the day, what have I done here? Am I doing the right thing? Sometimes you wonder, should you be making decisions that way.

The most frequent situations that participants encountered that challenged them each day were, as previously mentioned, the competent clients who chose to live in environments that staff deemed unsafe. For example, the frail elder who fell often or was forgetful when cooking or smoking, and the client who refused to adhere to a wound care regime. In both these examples, participants experienced conflict between the client's right to choose and the participants' duty to prevent harm and to provide safe care. Another common occurrence that created tension for participants was the family of a palliative client who made it clear to participants that the client was not to know the diagnosis or prognosis of imminent death. In this situation, participants had difficulty between acknowledging the client's right to know the truth about the diagnosis and prognosis and to complete unfinished business, and respecting the family's wishes to
keep hope alive for the client. A further circumstance that bothered participants was the client who informed them of the intention to commit suicide at some point when the client no longer could tolerate the pain of a terminal illness. In this example, participants were challenged with the client's right to decide to end one's life and the participants' duty to prevent harm to the client. These situations and others, such as the blurring of boundaries between personal and professional relationships with clients and families, and conflicts between clients, physicians, and home care nurses with issues about client care, affected the participants' practice, decisions made about client care, and their shared relationships with clients and families. Participants articulated that each client situation was handled individually and sensitively, and that some guiding principles were followed when making decisions about client care. Participants viewed the ethical implications of each client situation from their own perspectives because of their own personal beliefs and values. However, participants agreed that all their clinical decisions were based on several guiding principles. These guiding principles ensured that participants: thoroughly understood the client's situation; never made promises of silence to the client; appropriately informed their supervisors, colleagues, and the client's family physician about the client's decision; worked through a process of assessment and evaluation of the situation before a decision was made; ensured that the client clearly understood the implications of the decision and actions, and that the physician was responsible for the client's care; made sure that the client's decision was a rational one; and accepted the decision as the client's decision. Although participants did not have a formal framework for ethical decision-making and used their own methods, they also utilized other colleagues to assist them in the process of considering alternative choices in such situations. One participant explained how she made decisions in ethical situations:

It takes more than one to assess that client, and it's a process, it's not a decision, the decision comes at the end but you have to go through the process. I probably have got a model of this in my brain, but pretty much I come to, does that client understand the implications of what they are doing? Are they able to make that decision? Would it help if I offered any intervention, and if no, this is a rational decision, not one I may come to, but one they have come to, and they don't have any intervening mental illness that would prevent them from making that decision, then the decision is theirs....You have to be comfortable with uncomfortable decisions that someone else is making.

Decision-making was an important component of the participants' practice and of their interactions with
clients and families. The decision-making process was complicated and was influenced by the clients, their families, and their environments, and by the many factors that affected the clients' circumstances. Participants incorporated into their decision-making the contextual factors that influenced their nursing practice, such as the client's clinical status, the client's family and social status, the nurse/client interactions, and the nurses' knowledge and experiences. There is little information in the literature about the decision-making process of home care nurses and yet this is an area identified as important to the participants' practice. O'Neill and Pennington (1996) purport that knowledge and experience affects decisions made by novice and expert home care nurses, which is consistent with the participants' comments. These findings also support dela Cruz's (1994) description of the different decision-making strategies used by home health nurses that are based on the varied client situations. dela Cruz (1994) states that decision-making strategies of experienced home health nurses, such as skimming, surveying, and sleuthing, utilize an intuitive thinking method for poorly structured decision-making situations and a logical and analytical thinking method in well structured decision-making situations. Participants relied on intuition and logic as their decisions progressed from the quick, band-aid fixes (skimming) and straightforward client circumstances (surveying) to the complex and complicated client scenarios (sleuthing) that required time and thoughtful planning and organization of client care. Rooney (1997) suggests the notion that home care nurses often are faced with daily ethical challenges and are at times unaware that an ethical situation has occurred when a conflict arises about care issues between the home care nurse and the client and family. This author supports the benefit of a framework for decision-making for home care nurses that is based on commonly understood and agreed upon ethical principles so that nurses can confront the conflicts and challenges that they encounter with clients and other health professionals every day in the workplace. Participants clearly reported that their interactions with clients and families necessitated a partnership in mutual goal setting and decision-making and that this partnership was the foundation of their practice. These findings are consistent with Courtney et al. (1996) who state that mutual goal setting and action planning are dynamic components of the partnership process between health professionals and clients and families. As well, this partnership is facilitated by home care nurses as clients and families are empowered with knowledge, skills, and abilities to enact self-
care activities. This mutual and cooperative process of providing and sharing information with clients and families and supporting clients in their decision-making so that informed decisions can be made about health and health care issues is in keeping with the primary health care principles of essential, accessible, acceptable, and collaborative health services (Epp, 1986; RNABC, 1994; WHO, 1978). An ethical framework for decision-making from which all home care nurses based their practice may be useful as it may assist staff with difficult decisions about client care, competency, and responsibility.

Participants have indicated, within this subcategory, that the complexity of the client and the client's home environment cannot be underestimated. Knowledge of the client is tempered by a caring objectivity and the maintenance of a therapeutic relationship. Defining the boundaries of the home care nurse/client relationship is instrumental to home care nursing practice, ethical and mutual decision-making, and the empowerment of clients and families. The uniqueness of home care nursing practice is experienced when both professional autonomy and collaboration with clients and families is emphasized and the abilities and choices of clients and families are protected and encouraged, which are crucial for effective home care nursing practice.

Category Two: Prerequisites for Home Care Nursing

Participants indicated that home care nurses required certain prerequisites in order to practice effectively in home care nursing. These prerequisites are discussed in each of the subsequent two subcategories, knowledge and skills requirements and strategies for home care nursing practice.

Subcategory One: Knowledge and Skills Requirements

A broad knowledge base and a variety of skills were important for home care nursing practice. Participants reported that home care nursing required a different knowledge base and skills level that was unlike any other health care setting, such as acute care hospital nursing practice. Participants emphasized that a strong, generalist background in medical, surgical, and oncological nursing was absolutely essential, as well as a substantive knowledge of the pathophysiology of the varied disease and illness processes that home care nurses were exposed to in the management of the care of clients and families at home. Home care nurses had to understand how the physical processes and implications of illness related to clients and affected family members. Also required, according to participants, was
knowledge of the various treatments, procedures, and medications utilized in the management of the assorted diseases and illnesses that clients experienced at home. As well, participants often had to update their knowledge of unfamiliar diseases, conditions, and treatments when needed. Specialized knowledge about specific client groups was also identified by participants as a necessary component of their generalist practice. Clients who required technically complex therapies, such as IV antibiotic care, subcutaneous pain management, or ventilatory care, had particular needs with which nurses had to be familiar and understand. The CNSs and resource home care nurses were available to the nursing staff to educate, support, and assist the nurses in the care of these clients as needed. However, participants pointed out and accepted that clients sometimes knew more about their health conditions, specific treatments, and medications than the nurses, and that acceptance of this fact was considered a strength in their practice. It was critical to the participants' practice that they conceded their lack of knowledge and where there were gaps in their knowledge and skill bases. A participant summarized:

As generalists, we can't keep up with everything. And we learn so much from clients. They bring knowledge back...about something new that might be happening with their particular illness so that I think we can be aware of what we don't know....Then you see where you may be inadequate...and you can make sure they are getting all the information that they need from other sources if you don't have it....Other people need me to know more than them or they don't feel secure....So I would read...a med/surg book....Or there are people at work that know more about certain areas so I would ask them...or I will phone the library and ask them to do a search for me and send me material on it...and I will attach it to the chart for other people.

Participants attested that it was important that nurses were willing to access and knew how to access the requisite information because of the time constraints of the job and the contemporaneous need for it. Knowledge of the available resources in the community and of the agency's philosophy, policies and procedures, and the rules and regulations governing nursing were paramount to home care nursing. This knowledge gave participants direction when organizing, planning, and coordinating client care. Knowing when to refer and use other agency services and community resources appropriately, and integrate the different services' perspectives into holistic client care that met the clients' needs was a necessary skill for home care nurses.

Knowledge of the principles of self-care, holistic nursing, community health nursing, and family nursing was useful and important to participants. Participants emphasized that knowledge of self-care theory and
practices and a holistic approach to home care nursing practice was crucial to the relationship between nurses and clients. This emphasis encouraged clients and families to assume as much control as feasible over health related decisions. Knowledge of the concepts and practices of health promotion and illness prevention, stages of family development, the psychosocial and emotional dynamics of families were also pertinent to the participants' practice. This knowledge was important so that actual and potential client and family health problems were identified, client and family perspectives were considered, and client and family concerns related to the clients' health conditions were recognized and attended to during interactions between the nurses and the clients and families. Knowledge of the community at large, and of community assessment and community development became important to participants as various community/hospital partnerships occurred, collaborative programs developed, and a better understanding of each other's needs and services was achieved:

Collaborative programs, where you have clients flowing from the hospital to the community and are part of that team as far as collaborating for that program...Collaborative partnerships can be helpful because at least there's an understanding then, because there's some kind of continuum that clients are moving back and forth, hopefully it's more seamless than not for clients and that we have a better outcome for client care. And that we also achieve an understanding...from the community side...and then they get some sense of what community is about.

Knowledge gained from their home care nursing administrators, coordinators, and CNSs was meaningful to the participants' nursing practice just as was knowledge from other disciplines, such as medicine, psychology, sociology, rehabilitation therapy, and pharmacy. Participants incorporated this knowledge into their practice and found that it provided a more complete picture of the client's situation, and influenced client care outcomes. As well, participants reported that multidisciplinary collaboration was enhanced with this awareness of the different disciplines' responsibilities and resulted in better client care and client outcomes. Knowledge related to such topics as different cultures and cultural practices, alternative medicines and therapies, politics and government, legal and environmental issues was also useful and augmented interactions between participants and clients and families, and facilitated client care.

Knowledge acquired through nursing experiences and interactions with a variety of clients and families was considered very important to home care nursing practice by the participants. Participants stressed
that home care nurses required several years of nursing experience prior to entering home care nursing, "You must have some experience to come out here, you can't just come completely green", as pointed out by one participant. Knowledge of many kinds of care strategies, based on many years and varied nursing experiences, was necessary in order to function independently in home care nursing. Another participant suggested that home care nurses required a minimum of five years experience of medical/surgical nursing combined with oncology nursing and wanted nurses to be aware of this fact before contemplation of moving to home care nursing from another area of nursing. Home care nurses also needed a certain degree of maturity that accompanied their nursing experiences so that they could make specific clinical decisions when they encountered difficult and new client situations. At the time of this study, it was noted that the educational requirement for entry into home care nursing was a baccalaureate degree in nursing. Originally, nursing degrees were not mandatory for home care nursing practice and many nurses who entered home care nursing had enhanced their nursing diplomas with certification in other nursing specialty areas, such as critical care, midwifery, psychiatry, and public health. Although participants were aware of this requirement, they also voiced the value of their years of nursing experiences that provided the knowledge necessary to practice in home care nursing that was not, and could not be, acquired from formalized nursing classes. Burbach and colleagues (1991), Marrelli (1996), Pender and cohorts (1992), and Thobaben and Bohanan (1990) acknowledge the significance of specific nursing experiences that are necessary for home care nursing, but also maintain the need for a baccalaureate degree in nursing as the foundation for community home care nursing practice.

Intuitive knowledge or 'instinct', as termed by some participants, was critical and valuable to their nursing practice because it directed their assessment and decision-making processes, and client and family interactions. Participants also perceived that with experience in home care nursing and with knowledge gained over time, nurses innovatively and immediately problem solved and made decisions, and planned and implemented care more appropriately and directly, often without a great deal of thought. For an experienced participant who usually worked in an area no longer than two years and now was an eight year veteran of home care nursing, knowledge and experience were gained from every clinical situation:
I find that working in an area long term, that you absorb all as you go....It's accumulative knowledge so that you start to, it's not that you ask questions less, in fact you probably ask questions more, but you have more a sense of direction with your care planning and how to solve and be creative in problem solving, kind of on the spot.

In some clinical circumstances, gathering client information was a difficult process and frequently affected the client's discharge from hospital. A participant expressed that home care nurses and home care liaison nurses instinctively knew what information was useful for planning care in the home prior to discharge, whereas other disciplines, such as social work, did not know what information was necessary for home care nurses or what its effects were on client care when referring clients to home care nursing. Referrals from home care nurses and liaison nurses were based on clinical judgement and knowledge of many nursing concerns that had an intuitive basis, as explained by this participant:

Many social workers...scan the charts and copy down whatever the medical person has put in and frequently it makes no sense at all. They've written down everything because there's no filter, there's no screen, they don't have the medical background to say, well this is important to this client but the appendectomy in 1912 is not...it's sometimes so complete that it's unusable or vice versa, where they don't know what to put down, they can't plan. I think a home care nurse twigs, a liaison twigs to many other things and will go after what is necessary....A home care nurse would react to someone who says that they are allergic to preservatives in things whereas a social worker may not...and this may be a major thing.

One participant clarified that good instincts were based on nursing and life experiences and that she had an unconscious "bag of tricks...that comes from experience and from practice and instincts". Although this participant stated that she was sometimes unable to articulate the knowledge and skills acquired with her years of nursing experience and practice in home care nursing or the rationale for a particular action when preceptoring new nurses or students, what had become automatic could be explained when she stopped to contemplate her actions. Another participant used intuition to validate nursing judgements that were based on her experiences and own nursing beliefs and values:

I get a sense of what is acceptable to them and often it is not just verbal, they haven't actually told me what is acceptable to them, sometimes I determine that from seeing how they are living, so I probably do come to some conclusions that I haven't validated with them that are based on my own beliefs and values, I am sure I do....I am probably using intuition as well. People tend to...want me to come back, so I guess that is my validation.

Intuitive responses by participants were often a result of thoughtful reasoning about the clinical and social facts of client conditions, knowledge of nursing, medical and psychosocial conditions, and of past experiences with similar client situations. Experienced nurses with expectations about a specific clinical
situation usually were willing to reconsider these expectations once they met and got to know the client and to understand the client's circumstances. Benner (1996) suggests that expert practice is characterized by the heightened intuitive links between observing the salient issues of a situation and finding the means to respond to them. Experienced home care nurses were attuned to the clients' status and circumstances, often responded without conscious deliberation in many situations, and utilized other knowledge sources to support their clinical decisions when appropriate.

The knowledge requirements reflected by the participants as imperative to their practice were intricately related to the necessary personal and professional skills and abilities of home care nurses in their clinical application of these concepts. The participants' remarks about their knowledge requisites are in accordance with the views expressed in the literature. Kenyon and colleagues (1990) and O'Neill and Pennington (1996) assert that home care nursing presents a broad range of physical, psychosocial, developmental, and environmental challenges to home care nurses that necessitates specific knowledge and skills. In addition, the rich examples of contextual influences or family scenarios enhance the participants' knowledge and skills and impact the provision of care. Participants expressed the importance of certain personal skills and characteristics and professional skills required by home care nurses that, in conjunction with the knowledge requisites, effectively influenced their nursing practice.

Personal skills emphasized by participants included an array of characteristics whereby home care nurses were self-confident, trustworthy, flexible, assertive, independent, experienced, and creative. Important to building a trustworthy and supportive relationship with clients and families was the participant's ability to work patiently, honestly, and consistently with these persons during their time together. Participants perceived that confidence and trust in their abilities to perform safe and competent nursing care encouraged clients and families to become less anxious about their situations and more involved in self-care activities, and to develop a sense of independence. It was also necessary to portray one's self as a "very patient, calm, and confident person because patients pick up right away if you don't know what you are doing", as a participant remarked. Often participants had to be resourceful and creative in ascertaining the best solutions for clients and families so that clients were kept at home, accepted care from nurses, caregivers, and/or family members, and allowed continued nurse involvement.
Assertiveness was often associated with advocacy for clients and families. For one participant, assertiveness occurred with maturity, nursing experiences, independent decision-making, and the acquisition of knowledge in such areas as people's rights for health care in a community setting and in wound care practices. The recently discovered sense of power for this participant gave her the strength to advocate for clients, support their needs, and pursue her plans for client care when, in the past, she "ended up in tears" whenever she was challenged by other health providers.

Participants stressed the significance of having a good sense of self as a personal skill. This skill represented the participants' abilities to personally assess themselves as nurses and as individuals, and to accept and be comfortable with these assessments. Also, it meant that participants were cognizant of their own preconceived assumptions, personal beliefs and values and of the affects that these attitudes had on client care decisions. This understanding of one's self assisted participants to understand their reactions to certain clients and families and client/family situations, and the reactions of clients and families to the home care nurse, and to accept that these reactions would be dissimilar in different client circumstances. One participant voiced her view in this manner:

You have to realize that you are going to see a whole bunch of different types of people and they're going to make you feel different ways. Like some people are going to make you feel really inadequate and some people are going to make you feel like you are a really good nurse. You have to really be able to see or just...understand why you are feeling the way you are....And then you can accept it better.

Participants tolerated clients and families yelling at them at times and accepted that this type of behaviour was not meant personally, that it was more often than not a response to particular client circumstances. Not all clients were receptive to the presence of the nurse in the home or appreciated the plans for client care. Participants were realistic about the care that they offered to clients:

Not everybody is going to love you. Not everybody is going to find your approach useful to them. It is enough that many people do. You just can't win them all. You try to win as many as you can and not torture yourself about the ones that don't work out.

Personal insight, by participants, into their motivation for client care decisions resulted in a greater understanding of client and family needs, an adaptation of the goals of care so that they were acceptable both to the client and family as well as to the nurses, and a more effective home care nursing practice.

Professional skills, as perceived by participants, comprised skills in direct and indirect nursing care
activities that included psychomotor, intellectual, and interpersonal communication capabilities that were comprehensive, interrelated, and often enacted simultaneously. An example of a direct nursing care activity skill that involved psychomotor capability was the application of wound care products to clients' wounds by the participants. An example of an indirect nursing care activity skill that involved intellectual capability was the clinical decision-making process of the participants. The capability of participants to discuss the process of decision-making about wound care treatments with clients and families was an example of the participants' interpersonal communication skills. Participants emphasized the importance of strong assessment and clinical decision-making skills necessary for the holistic plan of care for clients.

Assessment of the physiological, environmental, and psychosocial characteristics of the client and family was an important capability of the home care nurse, according to participants. As mentioned previously, environment included not only the immediate home but also the availability and adequacy of resources in the client's identified community. Psychosocial components included the coping abilities of the client and family, and the social, cultural, and spiritual resources in the community that supported the client and family. Information was solicited from clients, families, and other health care providers quickly or over time, sifted through for immediate action if necessary or retained for later use, and documented contemporaneously in the client record. Also necessary in the participants' assessment of clients and families was the capability to know how to approach clients and families, and to discover what was important about the clients' health care, and to incorporate their psychosocial needs into the client care.

Decision-making, an indirect nursing care activity, that included the accurate identification, analysis, and prioritization of the clients' and families' health issues, the planning and initiation of interventions acceptable to them that resulted in positive outcomes for clients and families was also an important skill of home care nurses, as perceived by participants (and discussed earlier). Consideration of the clients' special needs, utilization of available resources, and orderly organization of daily work schedules that were based on the assessment of client need and client risk level were deemed relevant aspects of the decision-making process by participants. Often, participants made difficult decisions and as appropriate client care was provided, it was also necessary that participants continually evaluated and reassessed their care decisions. As client situations changed, decisions changed also, and care plans were rewritten,
as described by one participant:

You have to be able to bring out not so obvious lines of care and see how they work, and then be able to go back and assess whether or not that is where you need to be, if you are down the right path. You have to choose some different roads, and not only do you have to choose them, you have to make them, and then walk down it, and then evaluate it.

Sound clinical judgement, also an indirect nursing care activity, was another skill that was required and valued by participants as countless, client care decisions were made independently with the varied and increasingly sicker client populations that were faced by participants every day. For example, wound care practice required knowledge and skill, that is, awareness and judgement about the phases of wound healing and the appropriate use and application of wound care products. Pain control management of palliative clients and other clients with painful, debilitating diseases required knowledge of and skill in the various medication regimes and administration methods. On occasion, the independent aspect of home care nursing practice and decisions made about client care weighed heavily on participants, as expressed by a participant:

You really have to take time to assess them [clients] and do all the coverage and cover yourself. Because we're alone out there and sometimes you feel that your judgement, you know, you have to have really good judgement in order to save the person. And what discretion that you have to have, what is the best treatment for them. You have to make a lot of decisions for them.

Another participant at times felt "awkward" with the responsibility for certain palliative client care decisions that were based on past experiences with similar client situations and with the fact that often she had more experience than some of the clients' physicians in the management of morphine administration. This participant preferred that these decisions were based on scientific evidence rather than from an anecdotal basis:

A lot of the GPs that we work with don't know [about pain control], they are reluctant to use morphine at levels that are being used for pain control so...the decision to increase someone's morphine or whatever is often made on the basis of past experience [nurse's], rather than having something that you could read to someone that would be more meaningful.

Although participants indicated that they needed the time to accurately and sufficiently assess clients and decide on specific client care, they often found that with the early hospital discharges of clients and the inability for clients to access hospital care easily, client assessments and care decisions at home had to be thoroughly and hastily accomplished to ensure client safety, appropriate client care, and adequate
client support:

They're pushing clients out more now, they are quite at risk when they come home, so we have to do our assessments pretty well, pretty quickly. Pretty quickly to find out if they need to be returned to the hospital or if it's safe to come home.

Organizational skills and technical skills were mentioned briefly by participants as important aspects of their nursing practice. Health assessment skills, analytic skills, and decision-making skills of participants also reflected the need for organizational skills as participants were required to prioritize their daily caseload, adjust the caseload as problems unexpectedly arose, prioritize the client problems, and manage time efficiently as decisions about client care occurred concurrently. Technical skills were viewed by participants as necessary for nursing practice and included such direct nursing care activities as wound care, pain management, continuous and intermittent IV antibiotic therapy, gastric feedings and nutritional support, TPN, management of various computerized pumps, foley catheter care, insulin and other medication administration, and blood glucose monitoring. Indirect nursing care activities or intellectual capabilities, such as client status assessments, interpretation of results, and problem solving were utilized simultaneously by participants with these direct nursing care activities. Participants needed these skills to provide efficient and competent nursing care and to teach clients, families, and caregivers to perform specific tasks in a manner that would promote self-care and independence of these persons.

Participants also identified the need for effective professional interpersonal communications skills that were necessary in all interactions with clients, families, and other health care providers. These skills also were required with the appropriate use of referrals to other community agencies and resources as well as the timely, relevant, and factual charting in client records that outlined care plans and measurable goals, and followed standardized record format and agency requirements. Necessary to any relationship with clients and families was the establishment and maintenance of professional boundaries by participants. With professional boundaries in place, participants provided an emotional connection with clients and families that stopped short of enmeshment but remained compassionate. The effectiveness of the nurse was incumbent on this ability of the nurse and affected not only the well-being of clients and families, but that of the nurse as well. Clients and families were assured that the nurses knew their responsibilities and that they cared about the clients' and families' needs. Also, reassurance and validation of clients' and
families' feelings and experiences often facilitated interactions between clients, families, and participants during assessments and subsequent interviews, as pointed out by a participant:

I don't know if it's something I do really consciously, I try to be reassuring...maybe I can say, yeah, this is bad. You have to acknowledge I think where they are coming from, what they feel. You can't always diffuse that. But, I think often times by going in and being very, very calm, and at the same time you validate what they are feeling....There are some people that you can deal with humour and get a lot further, and there are other people when that's absolutely wrong, the wrong approach. So it's a matter of instinct...assessing them out the first visit and seeing how their approach to their health care is.

The ability to be nonjudgemental, respectful, sensitive, empathic, and non-controlling was viewed by participants as having the essential qualities of a good listener and a good communicator, and as the basis of a meaningful relationship between the home care nurse and the client and family. Participants recognized that clients had control over the home environment and their families and carried out activities in their own way. It was important to participants then that nurses were sensitive to, respectful of, and understood the clients' need to maintain a sense of power and control over their health care conditions and decisions, allowed clients to have some control, and were comfortable with clients having that control. Participants worked with clients and families to restore and maintain their control of their health situations, and participants remained within the parameters of home care nursing practice. For one participant, non-controlling meant "working with people, not doing to, sometimes doing for" after all other care options had been explored. This participant did not see herself as a "jail warden" who forced clients and families to do certain activities because of established policy. Another participant stated that sensitivity and empathy for what was meaningful and relevant to clients was a necessary interpersonal communication skill for nurses in their interactions and care decisions with clients and families. To remove clients from a familiar environment and from objects and friends that mattered for the sake of safety was not always the best solution for some clients. According to this participant, if nurses remembered these details and "little lessons that just come to humble us" and "help our sensitivity", then the nurses would grow professionally and their nursing practice would be enhanced as, "it gives us certain empathy when we're out there with patients". It was useful for participants and also required their sensitivity to understand specific cultural behaviours and customs when organizing, planning, and implementing care activities. Interactions with ethnic clients and families were affected by certain customs as one participant with language designated
status explained of a specific culture:

When you go into an [ethnic] house they always offer you something to drink. And if I don't drink they think I'm pretending to be superior to them. Because I'm being disrespectful, because the only place you won't drink or eat is an untouchable's house. So, I really have to explain to them my reason for not partaking of their offering because it is time limiting. If I sit down and start eating with them, I've lost time for the other clients I have to see, so I really have to say thank you for offering, I appreciate it. Another day...I will sit and have tea with you but not today.

Participants indicated that making time, listening carefully to what clients said, and clarifying the subject matter with them demonstrated to clients that they genuinely cared about the clients as people. The timing of specific conversations between clients, families, and participants was also an important interpersonal skill and was critical in the care of community clients, especially those clients who were dying at home:

They make a choice about who they'll speak to...you should feel honoured if it's you. You should be ready to listen if it's you and you should be alert to encourage other people to be ready to listen or, to be aware of what somebody is trying to say and help them through that.

One participant voiced the need for 'being with' clients and families so that important and personal client information was shared and discussed openly. In this manner, participants validated and empowered the clients' and families' lives through open discussion of important issues, and felt empowered themselves in these relationships. As described by this participant, this kind of sharing validated her role with clients and families:

Communication was important because...all family members had to feel safe to be able to say what they wanted to say about her when she was dying and when she died....So when people do tell me things that I feel are really important to them or really deep, I feel like I've done a good job. That's where you get your rewards from the job. People say some really amazing things that I don't think that they only say when they are in a crisis at the end of their lives.

As well, participants were aware of the need to balance the amount of time that was spent listening to clients and families with the effectiveness of the shared relationship:

People so much want to tell their stories. If they find someone that listens and is empathic and encourages them to talk and they feel comfortable with, then that's when they begin to rely on you, they want you to come back and that's when you have to be really careful because in our system of diminishing resources....We can't make those visits so much as we could have before.

Teaching skills were identified by participants as significant elements of the home care nurses' nursing practice so that clients could be as independent and as self-care capable as possible in their health care activities. Generally, clients in home care nursing were aware that self-care practices were an expectation
of the nurses and that the goal of self-care was to empower clients with increased control over their health and their health situations. Participants looked for ways to empower clients which involved appropriately providing clients with needed information that enabled them to make legitimate decisions about their health care, teaching them the necessary skills and procedures that allowed them to become independent in their care, preserving their integrity, and supporting them throughout their decision-making and care processes. The teaching skills of participants incorporated the aforementioned personal skills and characteristics, direct and indirect nursing care activity skills, and the interpersonal communication skills that participants used to facilitate client care situations, provide clear direction to clients, and plan and implement activities that are based on shared treatment goals for clients. Participants indicated that in order to successfully assist clients to meet their specific health needs, become independent in their care, and understand and accept their health issues, home care nurses needed to have an understanding of the values, beliefs, and perceptions that affected the clients' health. The personalities, cultural norms and values, environmental factors, and patterns of social interaction of clients and families that influenced the interactions between participants and clients and families also affected the circumstances for learning self-care activities by the clients and families. Participants had to determine the self-care capabilities of clients, families, and caregivers before strategies for teaching could be selected and implemented. Intellectual ability, emotional maturity, age and age related changes, such as physical, sensory or mobility issues had to be taken into consideration when planning specific teaching strategies for self-care activities. Participants were cognizant that they were guests in the clients' homes and planned strategies that were individualized and client specific. Similar cases required different approaches as the health issues were the clients' issues and the nurses had to find the paths that worked the best for each client and adapt the teaching strategies accordingly. Also, the willingness and motivation of clients and families to take on specific self-care tasks influenced the participants' process of self-care education of clients and families. Learning is usually most effective when an individual is ready to learn and wants to know something. Participants assessed the client's and caregiver's willingness to listen to the nurse and to participate in the development of care plans. The client's past experiences with health care or home care and knowledge of specific self-care activities often affected their willingness to learn a specific procedure.
For example, often post-operative clients discharged home the same day as surgery, and their families, were extremely anxious when teaching occurred with regard to monitoring post-operative bleeding and were reluctant to be responsible for this activity. Similarly, some clients who received home IV antibiotic therapy, and their caregivers, refused to learn to self-administer these medications because of the personal perspective that this activity was a service that should be provided by health care providers. Participants were very sensitive to the client’s readiness to learn self-care activities and did not force change on the client unless the client was ready to learn a new activity. One participant described her approach in supporting a client through change:

You cannot make it happen. She [client] has to want it. She has to want the results. If it’s important for her to do it then she will do it and we can help support her doing it. We can help her access resources or provide an environment. We can do all those things but unless she wants it, either the successful conclusion or the satisfaction of having done it. You know, forget it. It has to be important for her. She has to realize that or it’s no good.

An essential aspect of teaching clients was teaching psychomotor skills to clients and caregivers. Coordination, manual dexterity and sensory function were particularly important areas of physical ability related to learning such tasks as wound care procedures, home IV therapy, and self-injections. Fine motor skills were necessary for clients who had to flush IV catheters following medication or nutrition administration. Impaired sensory functioning such as visual changes with aging or the progression of diseases like AIDS, and auditory changes also influenced the learning capabilities of clients and caregivers and whether participants provided some care or total care of these clients. As well, the client’s ability to read, articulate, comprehend and follow instructions, and problem solve were essential attributes for clients and caregivers who participated in self-care activities. If clients were unable to actively participate in self-care tasks, participants were involved in teaching family members and other appropriate caregivers who were considered by the clients as acceptable to perform these tasks. Participants evaluated these persons in a similar manner and, as with clients, adapted the teaching and the procedures to suit them and to achieve self-care and independence whenever possible.

Participants served as facilitators in promoting, improving, or restoring health to clients with the goal of teaching clients to take responsibility for self-care. This goal was not always an easy task nor was it always applicable. Participants first needed to develop a trusting relationship with clients and their
families and to listen to and understand the clients' and families' needs before discussion of other issues occurred. Participants recognized the clients' and families' readiness to learn, took advantage of those opportunities to teach them, focused on maximizing their independence and satisfaction with life circumstances, tried to ensure that their dignity was intact, and provided them with information necessary to enact care decisions so that they remained at home. Promoting self-care required developing, implementing, and evaluating comprehensive care plans, teaching specific care activities, and being available to support the clients, families, and caregivers. Once clients and/or caregivers learned the self-care activities and assumed responsibility for the care, participants became less involved and spent less time with these persons. Clients and families who perceived themselves as active participants in their care decisions and in their care were more likely to feel empowered and effective decision-makers who were in control of their health.

The knowledge and skills requirements of home care nurses are varied and many, and are focused on care strategies that reflect health promotion, health maintenance, and illness management of community based clients (dela Cruz, 1994; Kenyon et al. 1990; Wearing, 1994). These and other sources, such as Bohny (1997) and Gorski (1995) acknowledge the importance of specific knowledge and skills for home care nurses in the home setting. Bohny(1997) discusses the importance of self-efficacy and self-responsibility in personal health and that home care nurses are required to be knowledgeable of the teaching-learning process and supportive techniques for ongoing care when promoting self-care. Gorski (1995) states that home care nurses' knowledge and skills in client education are equally as important as their skills in performance of any technical procedure, and that a certain potential for learning and self-care by clients or caregivers must exist to safely carry out self-care activities at home. Home care nurses historically have focused on the client's and family's right and responsibility to be included in the plan of care (Bohny, 1997; Humphrey & Milone-Nuzzo, 1996; Kenyon et al. 1990; O'Neill & Pennington, 1996) and this focus was a major factor in the participants' decision-making processes. Increasing responsibility has been placed on clients and families for self-care in today's health care system, and yet self-care has always been a part of family life and home care practices. Bohny (1997) and Gorski (1995) suggest that home care nurses facilitate the self-care initiative of clients and that home care nurses need an
understanding of the concepts related to self-care and their application to practice. O'Neill and Pennington (1996) and Wearing (1994) posit that the goals of care are directed primarily toward long term rather than short term results, and that home care nurses are concentrated on empowering clients and families to meet their own needs so that they feel in control of their lives and their health issues. The participants' comments were consistent with these authors' comments and although long term results were a primary focus due to client care needs and multiple problems, goals of care also included short term and midterm goals as clients, families, and caregivers progressed towards self-care and independence. O'Neill and Pennington (1996) also indicate that creative and innovative health teaching abilities are crucial in the home where caregivers are non-professionals and home care nurses are in attendance only for a short period of time. Davies (1992) suggests that the goal of nursing care must be the preservation of integrity for both the client and the nurse. In this regard both the client and the nurse share a human interaction and are empowered as they establish and maintain a trusting relationship, find meaning together in the client situation, and value each other's worth. Often clients are dying and nursing interventions are effective only if the nurse sustains her own integrity and if the goal of care is identified as the maintenance of client integrity for the extent of their relationship (Davies, 1992). Halldorsdottir (1997) states that caring and compassion are the underlying forces that comprise true professional competence. That is, compassionate competence, genuine concern for the client, and undivided attention when the nurse is with the client are some indications that a caring nurse is skillful, knowledgeable, and aware that the personal integrity and dignity of each person must be protected. Comments from the participants supported these authors' observations and, in practice, participants adapted their interactions, nursing activities, and teaching strategies to the clients' varied cultural, educational, and socioeconomic factors that affected the clients' decision-making, learning, and sense of well-being, and that restricted client choices.

Within this subcategory, participants asserted that home care nurses utilized a distinct knowledge base and specific professional skills, such as direct and indirect nursing care activities, and personal attributes as self-confidence and flexibility. These requirements necessitated a different process of decision-making and care planning that empowered the client and family, and that focused on the needs of the client and
family in the home environment.

**Subcategory Two: Strategies for Home Care Nursing Practice**

Participants indicated that there were various methods that they used to assist them in their nursing practice. These strategies are included in subcategory two: strategies necessary for home care nurses to sustain their home care nursing practice. It was noted by participants that certain professional and personal strategies were utilized to better understand and accept client situations and reactions that resulted from these situations. These strategies were learned as their home care nursing practice progressed, and were needed in order to function in the role of home care nurse and to enact their responsibilities.

There were conventional methods of learning relevant information necessary for the job such as: attendance at educational conferences, courses, and inservices; Internet access; and reading policy and procedure manuals, applicable nursing, medical and pharmaceutical texts, and various journals. However, one of the major professional strategies for learning, identified by participants, was acquired from experience on the job. Participants reported that it took more than one year of experience in home care nursing before they began to feel at ease in the role of home care nurse. One participant was ill at ease in this role for "at least a year and a half" because she needed this time to "feel comfortable going into people's homes and making judgements" on her own. Another participant expressed that after six months of acclimatization to home care nursing practice, it generally took another year "before I had a sense of the resources and how to access them completely". After five years of home care nursing practice, an additional participant asserted that she finally understood the realm of home care nursing practice. For this participant, and others, experiences shared with clients and families helped them to acquire knowledge and develop skills important to their nursing practice which often influenced future interactions with other clients and families. Some circumstances that were perceived by participants as negative ones frequently turned into positive learning experiences as participants learned from these cases and used what was learned to assist them in other client situations. For instance, a participant ascertained that in order to prevent the repetition of a specific client situation, such as the hospital committal of a client, she needed to communicate more often with team members, advocate more for the
client and explain the situation more clearly, offer more services at home, allow the client more leeway, and not abandon the client when services were refused. This participant learned a great deal about her interactions with clients and the opportunities in home care nursing when the case started to unravel. Similarly, satisfying experiences with clients and families encouraged participants and helped them to cope with and accept sad circumstances, such as the deaths of their clients. Knowing that everything that was possible was done for a dying client and the family by a participant reinforced to the participant that there were positive aspects in a shared relationship that had an inevitably sad outcome.

Another learning strategy identified by participants was gaining knowledge from more experienced peers, colleagues, nursing coordinators, and CNSs when they discussed difficult client situations. Participants learned from their peers by observing the nurses' interactions with clients and families and asking questions of them with regard to their varied clinical experiences and backgrounds. Role modeling by their peers and one on one discussions with peers and colleagues encouraged nurses to seek out the resource home care nurses for information and assistance when unsure about the direction to take with specific client care issues. Often, discussions with peers or resource nurses about problematic client encounters assisted in the resolution of the participants' practice issues. If peers and colleagues were unable to meet the participants' needs, then further clinical direction and support was sought from the nursing coordinators or the appropriate CNS, depending on the specific clinical expertise required. The nursing coordinators and CNSs were considered by participants as mentors to the nurses and offered more definitive direction with regard to agency policies and procedures and clinical practice guidelines. Participants often resolved certain clinical issues and gained understanding of specific client situations and resources through discussions with the coordinators who offered them guidance, encouragement, reassurance, and further direction. The coordinators ensured that the nurses appropriately used the policies, protocols, and other regularly updated tools, and attended the inservices provided by the CNSs that directed their nursing practice, and maintained and enhanced their skill competency, especially with difficult and complex clients. As well, the use of a standardized format for charting and monthly publication of clinical newsletters for specific client groups, such as clients with IV antibiotic therapy, supported their nursing practice.
Reflection was also presented by participants as a nursing practice strategy for home care nurses. Participants frequently utilized their nursing colleagues as vehicles to enhance their professional growth and improve their nursing practice. Debriefing with team members about challenging cases often facilitated the provision of nursing care in future client situations for participants. Peer group support and discussions of difficult client and family situations were important to participants as they wanted to learn from these cases so that they would be better informed and would provide more complete care to other clients and families. As participants acquired more experience and exposure to complicated client situations, they gained more confidence to tackle other difficult, complex clients. For example, one participant indicated that "we do have good support in discussions with difficult clients in our nursing meetings" and that during the height of the AIDS epidemic she "learned the support that was necessary" to function independently, make good judgements, and trust one's self that only came from experience. This participant also expressed that these experiences propelled home care nurses forward in their practice:

I learned how much we can stretch the system to make changes....I think it gave me maybe a bit more confidence which I think we all need from time to time....There is a part of any of these really difficult cases where you sort of think, my God, what am I going to do now and what have I gotten myself into....We just learn from every case that we have and move on. Sometimes we are not as aware about maybe how we've grown a little bit. Certainly, if I had another case like [this client], I would certainly know better how to deal with it.

Some participants found that personal reflection as a strategy for nursing practice, such as journaling was at times more valuable than participating in debriefing sessions with their colleagues. Also, the participants expressed that journaling lead to a greater self-understanding than did discussions with colleagues about certain troublesome client issues. One participant utilized journaling to help her to understand her reactions to specific client interactions:

You have to really be able to see or...understand why you are feeling the way you are. I think journaling is really good for that...if you are feeling really bad about a client try and look at what is happening....What's going on in this situation that's making you feel that way....No one can really know you as well as you know yourself...by thinking things through yourself.

Personal reflection for another participant was used to examine her role as a home care nurse and to assess what care could be provided differently and better to clients and families:

I go out with my best intentions and I know my role is to give them information, to give them
feedback, to give them support but I certainly could not fix all the problems, that's not my role, I know that for sure....I like to reflect back on this case and get the best out of this case, how I could manage, like in the future if I came across a similar case or a less complicated, less complex case, I think these extremes can teach me what to do more for the family, what to do for the client.

Another participant, upon reflection, was aware that she came to home care nursing with a set of preconceived assumptions about the provision of nursing care and the available resources in the community, and realized that she had to revise these assumptions as her attitude about nursing in the community changed. This participant found that her philosophy of nursing had changed as her community experience increased and that she needed to "incorporate a change in attitude as far as how you deal with clients, families, and how that impacts their care". With this change in attitude, this participant then refocused her energies in finding ways to utilize the resources to support clients and families in their homes. The process of reflection through observation, discussion, or journaling captures one's insights about a situation at the conscious level and results in increasingly reflective thoughts and actions at the practice level (Hayes, 1997). Participants applied the processes of reflection in their nursing practice, and with clients and families as well so that these persons better understood their own circumstances and actions.

Participants made it clear that learning was a two-way street regardless of the type of interactions in which they were involved. Their nursing practice was influenced and shaped by their involvement with the various clients, families and caregivers, students, other health professionals with whom they shared responsibility for client care, and professional colleagues with whom they planned programs for targeted client groups. One participant learned to appreciate the coping abilities and strengths of clients and families in dealing with difficult and stressful health care situations. With time and experience, this participant also accepted that dysfunctional families had their own strengths and coping mechanisms and had the right to remain dysfunctional:

You're in their homes, you watch them cope, you watch those strengths come out. Even if they are dysfunctional, you still watch strengths coming out to maintain what they could do at home. It's not right but it is right in their own atmosphere, and it works for them....How much do you as home care come in and interfere...according to our standards. This dysfunction to them is quite normal and function[al].

Another participant felt privileged that clients opened their homes to nurses and especially respected the elderly with their life experiences and the effects that these experiences had on their health situations.
This participant appreciated that the elderly were knowledgeable about many topics and had a great deal to offer the younger generation, and after specific nursing treatments were completed she often sat with these clients and learned more about them as persons and about their experiences. Also, participants enjoyed working with nursing students and new home care nurses because of the challenge students and new nurses presented to their nursing practice and of the exchange of information and questions shared between them. As one participant explained, "It keeps you on your toes and makes you reflect a little bit" about nursing and how new ideas could enhance her own home care nursing practice.

Participants used other personal strategies to cope with the workload demands. The intenseness and stress of the job was frequently balanced with self-care activities. Participants usually offset the heavy daily caseload and visits to difficult and complex clients with visits to a variety of clients with different needs, such as diabetic care, simple wound care, or palliative care. Clients who required wound care procedures that were simple and quick were often maintained by participants. This decision was made so that the participants' emotional involvement and level of stress with clients was lessened and that their sense of accomplishment and competence amidst other difficult situations increased. Home care nursing practice had become increasingly emotionally demanding for participants on many occasions with the heavy care demands and concerns for palliative clients and their families and other complex care situations. Balancing the emotional burn that was experienced with these particular clients and families by the participants came with "maturity in nursing", as several participants suggested. As mentioned earlier, participants claimed that nurses who sustained a sense of emotional well-being had learned to maintain their professional boundaries with their clients and families which helped to alleviate job stress. Participants indicated that another method to cope with workload demands was to share the heavy clients between primary and secondary home care nurses. Thus, the pressure to see the many clients that had to be seen daily by specific nurses was diminished somewhat without compromising client care. In effect, the stress of some clients was spread around to other nurses so that certain nurses could get some relief from the daily challenges of these clients. One participant indicated that if she was stressed at work then this stress reflected on her ability to cope with workload demands and she then had to limit the number of client visits she was able to accomplish in a day. This participant also expressed that in order not to feel
overwhelmed with the increased complexity of client and family situations and changes in nursing practice, she coped with these stresses by challenging herself to become involved in the implementation of new nursing practices, like the home IV program. Participants offered other self-care activities that were useful and beneficial, such as alerting the coordinators and other nurses when they were unable to take on new or more clients, decreasing feelings of frustration and inadequacy by lowering expectations of themselves, avoiding the use of overtime to deal with troublesome client situations, understanding and accepting that comfort with the client's need for control came with time and experience, and allowing time between client visits to prepare and deal with the impact of stressful client and family interactions. Extracurricular self-care activities were individualized and included such actions as running, attending exercise classes, organizing social events unrelated to work, and avoiding discussions about work with friends and family members.

This subcategory reflects that participants were aware that professional and personal strategies to acquire the necessary knowledge and skills to sustain their home care nursing practice were required, took a long time, and came from many sources, and that home care nursing practice was an ongoing learning process. It was important to all participants that they continued to learn and to keep their knowledge and skills updated so that they would continue to grow professionally and provide clients and families with the best practices in nursing.

Category Three: Organizational Issues

Participants identified many issues that were related to their home care nursing practice. These issues are discussed in each of the following two subcategories, professional issues in home care nursing practice and recommendations for home care nursing practice.

Subcategory One: Professional Issues

Concerns raised by participants that impacted their nursing practice are comprised in subcategory one: professional issues that affected home care nursing practice. There were many issues from the participants' perspectives that reflected differences in nursing practice between community home care nursing and hospital nursing and several issues with their health care organization that influenced their nursing practice.
A major issue for participants was the fact that very few individuals understood what home care nursing practice entailed. Participants indicated that neither health professionals outside of the home care services organization appreciated the extent of the home care nurses' responsibilities, especially hospital personnel, nor did the management of their own organization. Participants also expressed frustration that these health care providers and organizations did not understand that home care nursing practice was vastly different from other areas of nursing practice. Although participants were aware of the extent of hospital nursing practice, because at some point all home care nurses had worked in an acute care setting prior entry to home care nursing, it was clear that hospital nurses and staff did not reciprocate an awareness of home care nursing practice. As one participant stated, "A lot of my friends who work in the hospitals still think I drink tea with these old grannies and have a cookie". According to participants, hospital staff and administrative staff did not comprehend the complexity of care that participants contended with in clients' homes and the time expended in the organization and implementation of nursing care and support services for these clients. The education of appropriate staff, the initiation, administration, and maintenance of therapies for clients at home with needs for IV antibiotics, tracheostomies, gastrostomies, and ventilators went beyond the understanding of hospital and administrative staff that home care nurses provided only basic nursing care, like wound care.

The impact of the discharge planning process on client care also was not understood by these health care providers and organizers, according to participants. In addition, participants emphasized that the key difference between their nursing practice and hospital nursing practice was the provision of care within the context of the client's environment. Participants remarked that hospital nurses and other hospital personnel saw only a narrow aspect of the client and could not place the client and the client's needs into the context of the client's circumstances, and could not see how the family dynamics affected client care. For example, a participant lamented her frustration with hospital nurses who did not comprehend how family factors could influence a positive client outcome for a post-operative client who was the primary caregiver of a cognitively impaired spouse:

They didn't see this whole piece of working with the family and how that can impact the client's care...a lady that I had went in [hospital] for a femoral/popliteal bypass and one of the big concerns was, she was the primary caregiver for her husband who was an end stage cardiac...
patient and was demented, and so the impact for that lady's care as far as sending her home was not just straightforward surgical patient that comes home and is just dressings. There's all the impact of the fact that she's the primary caregiver for her husband, who is very, very heavy care, and so it's a matter of building in all the supports to that situation so that she can have time to do her healing and deal with her illness let alone her husband's illness as well. So that kind of stuff they didn't understand.

Due to this lack of understanding of the client by hospital staff, participants indicated the importance of the home care liaison nurses in the discharge planning process of clients from acute care settings. The use of home care liaison nurses in this process was critical because of their screening abilities from a community based perspective, knowledge of community resources, and understanding of the clients' and families' needs at home. One participant succinctly stated that a good referral from a liaison nurse was worth "gold in your pocket" as too often information was missing when clients were discharged without liaison nurse involvement. Ideally, information on clients who were discharged home was gathered and processed for the community staff by the liaison nurses. Referrals included the appropriate compilation of the client's history to date, identified health and social problems, immediate treatment plans and support services and resources that were needed and/or arranged at the time of the client's discharge. Participants respected the role of the liaison nurses immensely and emphasized that they were the necessary planners in the clients' transition from the acute care setting to the home environment, particularly now that clients were being discharged earlier and with many needs. Participants clearly stated that hospital employees, unlike home care liaison nurses, could not provide the information that home care staff required for client care in the community. Hospital staff who arbitrarily discharged clients did not know the clients' realities or if clients would follow through with directions given at discharge. A participant described the value of home care liaison nurses to home care nursing practice:

Having liaison presence in hospitals has been very important because the liaisons...are community based, though they live in the hospital, they have that community focus and...their presence has been very important as far as discharge planning. Without them, we would be having a lot more inappropriate discharges because you need somebody with that community understanding to know what this person is going to face when they go home, and what level of care community nurses can provide, what kind of care they can provide, and within what context.

The location and physical layout of a client's home was often taken for granted by hospital staff when care was given in the hospital, and liaison nurses were useful in screening and assessing clients for the appropriateness of referrals to the community. Home care nurses were innovative and adaptive in their
caregiving at home and ensured that the care provided to clients was as safe as possible, and also was provided within a safe atmosphere for the nurses. Sometimes hospital staff insisted that clients were discharged regardless of the client circumstances and then it was often difficult to arrange for client care at home:

For us, if hospitals don't understand the issues of safety concerns, and I have run into that several times, where I will say I have to check and see if it is a safe area and they don't understand why that would be a concern for us, because they don't have to go out at 10 o'clock at night to run somebody's IV in a neighbourhood that has IV drug users in it or drug deals going down...and that area is not one that we can get into at night, so we might have to make alternative arrangements. It doesn't mean that we might not be able to look at being creative and saying how can we deliver care to this person whose home you can't get near to in the evenings because it's a bad area, or it's an apartment building and we know it is not safe to go even on days, and we send two persons on days. That is the kind of stuff they don't understand.

Another important difference between community home care nursing and hospital nursing practice asserted by participants was the issue of control. Although this issue of control was already mentioned, its presence pervaded and influenced all aspects of the participants' nursing practice. In the hospital setting, the client's environment was carefully controlled by hospital staff, particularly by nurses and physicians, unless clients were especially strong willed, as suggested by one participant. Participants also indicated that hospital staff saw only parts of the clients' relationships with families as they had less exposure and involvement with families. In the community, from the participants' points of view, the client was in control of the home environment, not the home care nurse. The nurse saw the total family picture and experienced the client and family relationship as they worked together within the context of the environment to achieve mutual agreement in decisions about client care. Participants made this distinction between nursing practices because what a client was able or not able to do at home was not properly assessed by hospital nurses because they did not know the client, the client's family, or the right questions to ask the client. As well, participants were dissatisfied that many clients were discharged home without home care liaison involvement due to decisions made by the management of their organization to decrease the number of liaison nurses working in the hospitals. Although referrals from liaison nurses provided appropriate information, completely accurate assessments of clients did not occur until clients were in their own homes, as explained by one participant:

Once you're behind that client's door, in their home situation, they may have made adaptations
that don't become apparent in Emergency or on the ward. They may be able to handle things quite nicely whereas in the hospital, it looked like it was a problem. On the other hand, in a structured environment, such as a short stay assessment unit, they may be quite oriented and quite able to handle things, get them in their home situation, where there are a variety of problems, some of the unsafe situations that we've come against...some of the abusive situations, you don't know what the family situation is like, so that some of the things are not the same when they're in an acute care situation and in the home setting....As a home care nurse, I get the complete picture.

Despite this narrow focus of hospital nurses and staff towards the community, participants suggested that some hospital staff were starting to view client care in the community differently as they participated in several collaborative programs that they shared with the community, and that "it was not all hopeless". By working together on common projects, the collaborative partnerships between home care nursing and the hospitals that focused on and included specific client groups began to comprehend the extent of each other's services and of the need for ensuring that the client's continuum of care was as seamless as possible and resulted in better client outcomes. Participants were hopeful that these opportunities to focus on common goals would improve the hospital nurses' and staff's understanding of home care nursing practice. The interactions between these health care organizations and specific client populations about health care policies were consistent with the primary health care principles of public participation and interdisciplinary and intersectoral collaborations (RNABC, 1994; WHO, 1978).

Other differences between community home care nursing and hospital nursing voiced by participants were that: hospital nurses needed more technical skills than home care nurses who needed more creative and innovative nursing interventions in clients' homes; hospital nurses were more likely to focus on the technical aspects of client care than recognize caregiver stress as a plan of care as home care nurses were likely to do as they focused on the holistic aspects of client and family care, unless hospital nurses worked on palliative units; and hospital nurses were not likely to follow-up and evaluate the appropriateness and effectiveness of their discharge directions to clients unlike home care nurses who continually assessed and evaluated their nursing care plans.

Participants acknowledged frustration and concern that some physicians and many potential clients were unaware that home care nursing existed as a health care service and that many physicians utilized the available resources at too late a date for some clients. According to participants, early client referrals to home care nursing were often beneficial to specific clients and families as well as to the nurses.
Referrals for palliative clients from family physicians frequently came too late and with little or no information which caused a problem in client care and required nurses to probe clients and families and other sources for adequate information in order to deal with the clients' and families' needs. Participants wanted the opportunity to discuss the available services and resources with specific individuals and families early on in their health care continuum, especially with clients undergoing treatment for cancer or palliation. Once participants contacted these persons and arranged for follow-up care as needed, a relationship was initiated so that when these individuals required home care nursing at a later date, they were familiar with the services and already developed some rapport and trust with a home care nurse. Too often participants found themselves in intensely emotional situations with dying clients and their distraught family members and were expected to sort out their problems in a very short time. A participant described her discontentment with a client's referral to home care nursing for palliative care:

We had to discuss DNR. I had only been in the house twice. That's a big jump to have to do that. That client could have been referred a long time ago....There was no reason why this man was such a late referral. He was in some denial. He had been doing quite well and this deterioration was quite rapid. It wouldn't have hurt to have referred him to us six months ago to outline the program and services and do a phone call once a month to see how he was doing. So that at least he would know us when he crashed and then we could have gone in. We would have had some kind of rapport so that within two visits when I discussed DNR, we knew each other a little bit. At least he'd seen me and talked to me a few times before we had to go 0 to 60 in such a short time.

Frustrations like the one just described were frequent occurrences for participants although participants were also aware that unless people needed to access specific health services, they often did not want to know about these services. However, participants wanted physicians to utilize their services more effectively and appropriately, particularly with this client group.

Participants expressed their concern and dissatisfaction that the management of their organization did not appear to appreciate or understand the extent of the home care nurses' responsibilities in their nursing practice. This lack of understanding was seen during the recent restructuring of the health department's organization. From the participants' perspectives, one of the first changes made by management and experienced by home care nursing staff and other staff members was the disintegration of the nursing infrastructure that supported their practice. Not only had the home care nursing administrator position become redundant very early on in the process but, latterly, so had the home care nursing coordinator.
positions in each of the health units. These nursing coordinators served as the participants' clinical supervisors, mentors, resource, and support persons. The CNSs that were originally program focused now were primarily unit based and replaced the coordinators' positions. The interdisciplinary home care clinical practice committee also had been disbanded, and the home care nursing clinical practice group and subcommittees had undergone several leadership changes that gave the impression to participants that clinical practice could not move forward because of these frequent shifts in responsibilities of the CNSs. Also, participants voiced their concern that management would disband these committees as well. Participants clearly articulated their distress that management had removed the home care nursing infrastructure and replaced it with new supports that did not provide the same administrative or clinical supports for the home care nurses. With the previous home care nursing coordinator and the long term care coordinator positions now deleted, two new positions were created, a non-nurse manager and a CNS for a specific population, such as adult and older adult health. The participants expressed dismay at the obvious lack of nursing management support for nursing issues and the apparent inability of the CNS to advance clinical nursing practice because of the expected excessive workload. The new CNS role for home care nursing in each unit appeared to have some of the same responsibilities as the previous role of nursing coordinator and caused great confusion and uncertainty among the participants.

Initially, participants did not anticipate that the reorganization would affect their practice. However, throughout this study as structural transformations occurred, participants began to feel the effects of these changes. Morale decreased and stress increased because participants were unsure of what to expect with the changes and wanted reassurance that the provision of nursing care would continue and would be supported in the manner that it had in the past, especially with the increased complex clients being seen. Participants stated that the vision for home care nursing had not been articulated to the general staff nor had there been a clear plan articulated for implementation of this vision. Staff were feeling unsettled because "we haven't been kept abreast of what the plan is, how the changes are going to occur, and what the final outcome is looking to be", as pointed out by a participant. Participants were cognizant that some changes were necessary but they expected the changes to be appropriate and workable. Some participants did not think that they had the power to make an impact on the changes because the changes
"were so massive and almost impossible to stop", as suggested by one participant. Other participants were not threatened by change and looked forward to it, particularly if it was going to make their practice more efficient and satisfying, and if there were going to be opportunities to be involved in decisions that would affect their practice. However, participants experienced a sense of feeling devalued by management because most of the decisions about the reorganization of home care nursing had been made without their input or feedback as to what was needed or was happening in their nursing practice. Communication between management and staff was unsatisfactory as participants indicated the need for information, good direction, and support from management as the changes occurred and continued to occur. With the dissolution of the nursing infrastructure in home care nursing, participants were worried that management would not hear their voiced concerns, support their clinical practice, or understand their need for validation in their clinical practice from a supportive nursing manager or CNS when they requested it.

Participants also perceived that management had not considered the effect that the changes would have on staff or what practices had worked well in the past. More than one participant asserted that management had not done enough to ease the stress of the changes for staff, had not built on the strengths in home care nursing as they should have, and had "thrown the baby out with the bath water". Participants experienced the change most acutely with the disappearance of their nursing coordinators who provided not only administrative support but also clinical support for their nursing practice. Two participants indicated that their nursing coordinator was very supportive, a good resource, and valued the nurses. The fear of these participants and of other nurses under this coordinator was that management would remove a good administrator and clinician and replace her with a non-nurse manager. Indeed, management replaced this coordinator with a non-nurse manager and the coordinator was displaced to another unit, in a different position. Another participant was upset as well, along with her nursing colleagues in another unit, as their nursing coordinator was replaced with a non-nurse manager. This participant was dissatisfied with a non-nurse manager because of the concern that if faced with a nursing issue this manager would not be able to satisfactorily assist or advise the nursing staff. However, the participant was hopeful that the CNS would be a "good resource" for the nursing staff, if she had the time,
especially when discussions were needed about "really complex cases".

With the move toward integrated health services within home care and long term care, the new organizational structure needed to ensure that there was meaningful participation of the interdisciplinary team members. Participants wanted their colleagues to be open, willing, and flexible as much as possible as they started to interact as teams and to work productively together instead of resisting the changes on principle. Some participants who had already experienced the restructuring of the organization in their units were tired and exasperated with the additional changes and the reactions of the rest of the staff to these changes. Participants who had experienced management changes as well as other organizational changes, such as displacement within a unit, expressed unhappiness and frustration with their jobs. Two participants wondered why it was necessary to be physically relocated within their unit as home care nursing, rehabilitation, and long term care staff were integrated into teams. With this new configuration, these participants experienced decreased emotional support and communication with their nursing colleagues, and decreased access to client charts and clinical supplies. One participant explained the concerns:

Before we had our own little corner, all the nurses. We could sit at our desks and still communicate with each other...and there is a lot of that emotional support, because we could talk to each other and discuss cases. Now, I find I am kind of lonely. I am sitting in this corner, I don't see any of my co-workers and I have to get up and see one of them if I have any concerns ....I get up to go and pick up charts or supplies and I miss calls, so it is a real headache ....So, this to me is not really integration because we are scattered all over the place. It is just, the morale goes down.

As participants endured the changes within the organization and within their nursing practice, they identified workload issues that indicated that management did not understand the context of their nursing practice and the nature of home care nursing as a clinical specialty. Participants perceived that management needed to comprehend that nursing care provided in the home was multifaceted and multilayered and that the increased acuity, chronicity, and complexity of clients added to the demands on the home care nurses. Management needed to appreciate that home care nursing practice did not distinguish between the context of the client's total environment and social dynamics, and the holistic aspect of providing complex nursing care. As a participant explicated:

In the hospital you can easily divorce what is happening with somebody in room 212 because you
are taking care of their gall bladder or doing their dressing, but you don't have to put that in context, other than you can deal with the whole person as far as dealing with their pain, as well as what this dressing means, and what the surgery means, but at home, the picture itself becomes more complex because you have the family and friends, the social environment, you have them coming home to a house that has no food in it and very little furniture, is very cluttered...providing care in that kind of situation itself makes a situation more complex. Then if you add into that increased complexity of client need as far as their care level demands on the home care nurse, beyond the every day demands of sorting out that kind of situation, it balloons into something much bigger.

Participants kept the clients' goals of care in focus as home care nursing procedures became more technologically complicated in the clients' homes and participants were expected to know how to manage these clients with the latest technology, frequently without advanced preparation or education. These tasks had a learning curve for which participants were often ill prepared but many times the client situations complicated matters rather than the technology in the home. Participants felt unsupported by management because of the lack of available resources and necessary information for the care and support of these complicated clients. A participant summarized the situation:

Sometimes it is not even the task stuff that has become more complicated, even though it has, because more technology has come out so there are different pumps to learn, different sets of IV's or even feeding tubes. I had to whip out to do teaching with a family with a feeding tube that was running on a pump that I had never seen before. And the daughter who had been taught who was supposed to meet us there to do this didn't get home from work. So I was working with a Vietnamese family that didn't speak English, the one informed daughter wasn't there and the only instructions I had...were at the back of the package of the tubing and some bits of information on the referral, so yes, sometimes it is very complicated. Things like that are just more stressful because you're not well prepared...The depth and breadth of knowledge that you need to have is always increasing as you are frequently being sent to deal with some bit of technology you haven't come across in the community.

As the stress levels of participants increased with the ongoing involvement with complex clients and their need for 'high tech' care, participants' stress levels also increased with the need for the coordination of services for clients and for communication with appropriate health professionals in a fractionated health care system. This participant further elaborated:

A lot of it [stress] is the more complicated client, the frail elderly, safety assessments, and medication management...so those can be very time consuming and it is ongoing assessment and evaluation and negotiation and setting up some kind of system that works...try and pull that care together that is so fragmented in the system too...and communication is a very interruptive thing for us as well...we are always on the move.

Continuity of care and communication between health care providers is necessary so that clients and families moving through the health care system are not lost and services are not interrupted or fragmented
(Beddome et al. 1993; RNABC, 1994; Wearing, 1991; WHO, 1978). The participants were concerned that clients were slipping through the cracks and were not receiving services or could not easily access services because they did not know who or how to access the system and no one knew they needed assistance. Health care was not easily accessible to all clients and it appeared that home care nursing was not always accessible to clients who were in need of it as well.

Another issue identified by participants was that management needed to value their clinical expertise in home care nursing. Home care nurses were expected to provide nursing care to a generalized caseload and meet the needs of targeted client groups, which required a broad knowledge base and varied skills as well as specialized knowledge and skills for specific clients. In order to offer safe and competent nursing care, participants acknowledged that it was difficult to remain updated on everything as they may not see a similar complex situation, such as tracheostomy care of a ventilated client, for an extended period of time. Participants stated that when they first started in home care nursing, management had been very focused on keeping the nurses' skills current. Participants also asserted that home care nurses had more opportunities with their community background than hospital nurses to experience and understand the different aspects of nursing practice. With this knowledge, participants gave exemplary nursing care to a variety of clients. Participants appreciated the diverse case mix and were challenged to provide care to such a varied group of clients. Now, if inservices were offered, participants found that due to workload requirements and time constraints that it often was difficult to attend them. If they did attend inservices participants usually worked overtime to complete their work. However, inservices apparently were terminated due to budget restraints and organizational changes, and participants questioned their abilities to remain current about new practice issues with the decreased opportunities for educational inservices.

As well, participants expressed concern that there was not enough free time at work to read pertinent nursing practice articles so that they could update their knowledge and research problem situations on their own. In fact, participants did not think that they had enough access to information on nursing research to support their nursing practice. One participant was frustrated that there was not adequate support information available in her unit about new medications or technologies, such as insulin management, nor were the applicable policies and guidelines that should accompany them. Another
Participant remarked that discussions about client situations with physicians would be more effective if appropriate articles were known and then cited to support particular modes of treatment. Participants were aware that there were gaps in nursing policies from a system's perspective and that CNSs were kept busy updating these policies and procedures as well as the staff. With the changes in the organizational structure, that is, the CNSs were now primarily unit based instead of systems based, participants queried how CNSs would keep the systems updated that supported their practice with the changes in home care nursing. Home care nursing practice was not considered stagnant and participants knew that it was imperative to keep their knowledge and skills current at all times. It was, therefore, important to the participants that management supported the nurses in maintaining and enhancing their knowledge and skills.

Participants noticed that the work atmosphere was not as positive, supportive, or satisfying as it once was. Although participants valued their independence, at times home care nursing was lonely for many participants and the work culture did not necessarily support all nurses equally. With the increased demands at work, participants found it hard to find the time to support one another and listen to their nursing colleagues' stories and client concerns. One participant voiced that the loneliness in home care nursing could only be alleviated by another home care nurse who understood what home care nursing entailed. The importance of sharing stories with other home care nurses lay in the fact that these nurses could "assume a lot...and you don't have to explain every little thing", according to this participant. Participants also wanted time at work to do their jobs properly, to continue to learn and develop, and to realize their own goals and feel as if they could meet these goals at work. A participant remarked that work should provide the opportunity for nurses to meet these needs. Another participant indicated that in order to regain job satisfaction, she needed "more time and less...energy drained throughout these changes and grievous decisions", and needed to find ways to decrease the pressures of work. Paradoxically, this participant did not want to think of self-preservation at work as she preferred to focus on the clients' needs but she rarely had the time for either. Participants were concerned also that the flexibility of their nursing practice was in question with increased cutbacks as nurses often had to respond quickly to unplanned occurrences and reorganize their client visits around these changes. In addition,
participants were anxious that they now could not provide the same level of nursing care to clients as they had in the past because of the increased daily workload demands, the increased complex needs of clients and families, and the lack of resources available to clients and families. The morale of the participants was affected when they were unable to provide good nursing care and then it was "not a nice place to work", stated a participant.

The issues of a shortage of home care nurses and the retention of home care nurses were of concern for participants. The workload demands and the stress of the many changes were stated by participants as reasons for some nurses wanting either to quit or to retire early from home care nursing. In the past, the workload was fairly balanced and the staff turnover in home care nursing was slow. Today, the participants asserted that every work day was busy and stressful, and that there now appeared to be a shortage of available home care nurses. The pressures in the hospitals to reduce costs and to discharge sick clients home as soon as possible had been transferred to the community and to the home care nurses and other staff, and participants were worried that client care was potentially compromised.

Management had hired some nursing staff, primarily as relief support, to assist with the workload demands. However, participants remarked that casual nursing staff did not normally manage clients with heavy care needs or consistently make difficult decisions about client care, and their presence did not necessarily lessen the burden for permanent staff. Participants also pointed out that it was not always appropriate to share the complicated clients with the casual staff because of the need for continuity in care. As a result, the straightforward visits that would often ease the load for the permanent staff were assigned to the casual staff, which delayed the casual nurses from experiencing and gaining expertise in the challenging and complex client and family situations.

Participants emphasized, too, that the new nursing staff required experienced mentors so that they developed into effective home care nurses. The nurses who planned to retire or leave home care nursing practice were the mature and seasoned home care nursing mentors to the young and inexperienced new staff, and to the other experienced nursing staff. Participants expressed dismay that the newly employed nurses did not have enough of a general nursing background or adequate nursing experience to enter home care nursing. One participant discussed her concerns that home care nursing was losing "the
creme de la creme crop" of nurses with 20 years of experience for new nurses with only "two years experience behind them". This participant worried about the effect of this lack of nursing experience on the clients, "I feel the clients may be compromised a little bit while they learn on the job". This lack of nursing experience and knowledge of these nurses often resulted in greater demands on the participants' time, time that was in short supply, and meant more work for them as they tried to support the new staff as well as manage and maintain their own caseload. Participants enjoyed mentoring new nurses and nursing students as it was a chance to share the home care nursing experience with nursing colleagues and to discuss the vast opportunities offered to them as nurses. However, there was a limit to what participants could endure over time. Sometimes, participants were overwhelmed by management's expectations for orienting new nursing staff and students because of their own workload demands, the needs of the learners, and the lack of coffee and lunch breaks. It was felt that management should be responsible for ensuring that new nurses received the appropriate preparation to function independently in the community. The responsibility did not rest with the participants although they believed that there was an obligation to do the best that they could to prepare these nurses for community home care nursing.

Participants faced many challenges in their nursing practice and attempted to keep pace with those changes as client care needs became more complicated and time consuming. With no apparent relief from the changing practice issues that they encountered in the community and the expectation that they accept this situation, participants experienced still more changes of a different magnitude that affected their support system within the home care nursing organization. The participants' reflections are evident in the literature with regard to hospital and community differences and issues. The home care setting is vastly different from other areas of nursing practice and providing care in the home requires one to overcome, or accept, obstacles that do not exist in any other care setting (Burbach & Brown; 1988; Green & Driggers, 1989; Kenyon et al. 1990; Tansey & Lentz, 1988; Stulginsky, 1993). Change is a continual process that affects individuals in all aspects of life and in different ways. Coping with change was of particular importance to home care nurses who not only orchestrated and supported change in clients and families, but who also adapted to changes in nursing practice and within their organization. Davidhazar, Giger, and Poole (1997) and Mangan (1996) state that it is important that the person undergoing change
and the person instigating the change need to be flexible and responsive to the change process. When negotiation is an option, persons involved in the change perceive some control and change then becomes more acceptable. Offering appropriate information, allowing opportunities for input and decision-making, actively listening, and displaying genuine interest and respect assist the plan for change to become a reality for those who have to change (Davidhzar et al. 1997). These authors posit that if change is to occur in a positive manner, each phase of the change process, that is, clear objectives, adequate preplanning, proper timing, and tracking the change must be strategically implemented. Mangan (1996) asserts that change has to go beyond management by decree and that change should not destabilize, demoralize or destroy the persons involved in the change process. The findings in this study are consistent with these authors' comments. Participants were aware of what they needed to do to facilitate change in their clients and requested the same consideration from their management as the organizational changes occurred and began to affect them personally.

This subcategory describes the participants' concerns that there was a lack of awareness by management and hospital personnel about the scope of home care nursing practice, the client, and the impact of the client's environment on nursing practice. This lack of understanding was reflected in the diminished role of the liaison nurses in hospitals, the dramatic changes in the nursing infrastructure of home care nursing, and the decreased morale and increased stress levels experienced by participants as they continued to deal with increased workload demands, decreased resources, and perceptions of minimal support from management.

**Subcategory Two: Recommendations for Home Care Nursing Practice**

There were many professional issues that concerned the participants that were expressed as needs and that would assist them in attaining a sense of fulfillment as home care nurses. For these issues the participants offered a few suggestions. These suggestions are reflected in subcategory two: recommendations that can influence home care nursing practice.

Participants experienced many changes in their nursing practice since they began a career in home care nursing. Interactions between participants and clients, families, and caregivers were now more intricate and time intensive as the clients' and families' care needs became more complicated with the shift
in focus from hospital to home based care. The transfer of care from hospital to community occurred without the concomitant transfer of resources that were necessary to meet the health care demands of the clients and families and to eliminate the fragmentation of services. Until recently, participants indicated that home care nurses managed to keep up with the increasing demands for client care at home by using the existing, albeit diminishing, resources. Nevertheless, participants reported that they were still working on how best to respond to client care needs and to continue to provide optimum nursing care when staffing levels remained low. The utilization of staff resources had to be balanced with the acuity and complexity of client care needs, that is, the service to clients was based on available staff resources and caseload prioritization. Today, home care nursing services require more support and more resources with the health care focus shifted to the community. In order to deal with this resource issue, participants recommended that management demand from the provincial government the necessary resources for home care nursing services. These resources included funding for numerous nursing positions. Participants suggested that more full time nursing positions were required to take responsibility for the increasing number of clients with complex care needs and more relief staff to relieve some of the workload issues. Participants insisted that all auxiliary staff were considered a needed and important aspect of home care nursing practice; nurses could not function without their support. One participant went so far as to suggest that management may have to relax its requirement of a nursing degree for home care nurses and again hire non-degree nurses with extensive and diversified nursing experiences. This participant believed that management may not have a choice when there was a shortage of eligible nurses for home care nursing already and a nation wide shortage of nurses that was expected to continue for several years. Another recommendation offered by participants was that management needed to reconsider its work practices and find ways to retain existing, mature, and knowledgeable home care nurses in the work force. It was proposed that management create more part time positions and allow more shared positions so that other options would be available to nursing staff at different points in their careers, and then retention of nurses would not be an issue. This recommendation also would alleviate the pressures on participants as more mentors would be available to more nursing staff. In the review of acute and rehabilitative services (ROARS) in Vancouver, recommendations were made to ensure that
both hospital and community services were used appropriately and effectively (Vancouver/Richmond Health Board, 1998). The report found that by expanding home care, transitional care, and ambulatory services, the region could improve client care and take pressure off the hospitals. One solution was to enhance and expand home based care services and provide funding to continue providing home care services to clients at home and avoid hospital admissions. Other recommendations included the expansion of hours of professional services, and of the skill set of staff providing community services to allow improved/increased management of specific client types and to support earlier discharge from hospitals. It was expected that all changes recommended in the report would take place over the next five years, with enhancement to community services completed during the first 18 months. Fyke (1994), Jodouin and Brown (1990), and Wearing (1994) support the need for enhanced nursing hours so that adequate care can be provided to clients at home but not without the increased resource allocations to home care nursing. However, participants have reacted to demands for home care nursing services without changes in the staffing complement.

Participants expressed that if more nurses were exposed as students to the concepts of home care nursing practice, separate from preventive health nursing, and to the practice of home care nursing in the community, there would be more opportunities for these nurses at a later date, and that this exposure to home care nursing might also impact the shortage of home care nurses. Participants wanted the management of health care organizations, and schools of nursing to understand, like other specialty areas of nursing, that home care nurses required specialized knowledge. This knowledge was not only acquired from nursing lectures and community health nursing texts, but, most importantly, it was acquired with time, community experience, different interactions with different people, and understanding of the client's perspective on health issues within the client's environment. Hospital nurses who planned to relocate their nursing practice to the community needed to be aware that they would encounter a sharp learning curve as they made the transition from an illness oriented focus to one that included illness care but also focused on health promotion, prevention, and maintenance. Participants recommended that home care nursing was considered as a specialization in nursing and was included as such in nursing education programs. Also, participants recommended that management needed to endorse the previous
recommendation, ensure that home care nursing became part of nursing curricula, and participate more in
the planning of home care nursing experiences for nursing students. These recommendations by the
participants are supported in the literature and many sources cite the importance of recognizing home
care nursing as a specialty in nursing and including it in the education of nursing students (Burbach &

Participants reported that the home care nursing issues that occurred when meeting the day to day
care needs of clients and families and with the shifting of care to the community had not been addressed
and needed to be supported by management. Discussions with applicable government health officials
and management representatives were given as a means of getting the nursing issues addressed and
supported. Participants strongly suggested that the government and management of their organization
should have assessed carefully how they made changes to an already successful health care delivery
system, such as home care nursing, been less critical and more supportive of the systems and programs
that were functioning effectively, and never removed the home care nursing infrastructure. Participants
maintained that home care nursing was a community system that was already in place, well established,
and worked well. Participants acknowledged that improvements were needed in the provincial health care
system, such as an overall coordination and integration of health services, a more collaborative and
holistic team perspective at the local level, and more specifically, the consistent and frequent evaluation of
their nursing practice guidelines and policies. However, participants asserted that any type of health care
delivery system could identify areas for improvement and that management, in its reorganization, first
needed to build on the strengths of the current system and then focus on the areas that required
improvements. There were many strengths in home care nursing, from the participants' viewpoints.
These strengths were found in the concept of community care, that is, the participants' interactions with
clients, families, and caregivers within their environments; assessment of difficult client situations; holistic
perspectives and client focused care; enhancement of the clients' and families' self-care abilities; and
development of nurse/client relationships that were based on mutual respect. Participants recommended
that management, in some manner, indicate its support for home care nurses, validate the nurses' good
work, acknowledge the value of the home care nurses, and reinstitute and provide inservices for the
nurses so that their practice was supported with the necessary information. As well, participants expected to actively participate in the change process instead of having change enacted upon them and decisions made without their knowledge or participation, with little understanding of why the change occurred in the first place or feeling that their input was irrelevant in any case. Participants recommended that before further changes were made that pertained to home care nursing, management needed to include and encourage the participation of the home care nurses in the process, listen to their concerns, and assist them with the planned changes. Mangan (1996) and Davidhzar and colleagues (1997) agree with the participants' remarks and state that when change occurs abruptly and staff have little time to adjust to the idea, a different set of skills and coping methods are required to become accustomed to the change, and the change agents need to lessen the trauma of change by supporting staff through the process.

With more available resources and a better understanding of the services of home care nursing by the public and health care professionals, participants reported that home care nursing would be accessible to more people. Knowledge of the various programs offered and of the eligibility criteria for these services would assist in the appropriate referrals to and utilization of home care nursing services. For example, an individual who required IV therapy nursing services at home must be under the care of a responsible physician who was licensed to practice in this province, reside in the city of Vancouver, and have a refrigerator to store the medications. Participants advised that the public needed to be informed in some manner of the available home care nursing services in order to utilize these services appropriately. To accomplish this task, participants recommended that certain sources be targeted for education of the various services offered by home care nursing. These targets included hospital nurses and other hospital staff, such as program managers, schools of nursing and medicine, physicians and their office staff, senior's centres, and other health care professionals in the health care system who accessed or might access these services. Before this process began, participants clarified that it was necessary first to: identify the nursing services that were already provided and could continue to be provided; establish the services that were the most appropriate, should be provided, and focus attention on these areas; and ensure that these services could be delivered to the clients and families by the nurses. Second, participants thought that it was appropriate to identify the client situations that could be provided in
alternate settings, such as clinics staffed by home care nurses, and/or assess the particular issues of a given client population or geographical area and see how best to address those needs. In addition, it was pertinent to investigate whether streamlining the care that appeared to be in the best interests of home care nursing was, in fact, accessible, affordable, and in the best interests of a given population. For example, when establishing a walk-in wound care clinic it was necessary to identify such variables as who would benefit from and would attend the clinic, what was the best location of the clinic, what were the costs associated with maintaining the clinic, and what were the staffing requirements. Finally, participants emphatically recommended that home care nurses had to be involved in the discussions and decisions made regarding the nursing services that would or would not be offered to clients and families.

Within this subcategory, participants suggested that more resources, human and financial, were required to meet the increased demands for home care nursing services. Exposure to home care nursing concepts and practice by nursing students, other health care providers, and management would indicate to these persons that home care nursing requires specialized knowledge and skills. This acknowledgement advances the idea that more appropriate use of services can occur if more people understand the scope of home care nursing practice and the variety of available services, and recognizes the value of home care nurses to the health care system and includes their participation in the health care decisions relevant to their home care nursing practice.

Despite frustrations and concerns about the changes in their nursing practice and within their organization, participants voiced that home care nursing practice was very rewarding and afforded numerous opportunities and positive challenges. As long as they sustained a sense of control over their nursing practice, maintained their independence and flexibility within their work environment so that they would continue to meet the clients' and families' needs and to provide the high standard of nursing care that they preferred, participants saw a future for home care nursing. The future of home care nursing was also dependent upon appropriate nursing leadership and staff participation in the development of a five or ten year vision and plan for direction for home care nursing practice. As well, it depended upon the acknowledgement by management, and others, that home care nursing was a unique and valuable service in the client's health care continuum. Therefore, in order to continue to support and maintain
clients and families in the community, more nursing care resources were required by home care nursing. In addition, home care nurses required regularly scheduled educational inservices on applicable topics and timely inservices on new nursing practice issues. If management and government officials endorsed home care nursing as an effective community based health service and supported its strengths, and home care nursing continued to evaluate the appropriateness and effectiveness of its services, the participants were hopeful that home care nursing would move forward into the 21st century.

In summary, this chapter offered and discussed the three major categories together with the subcategories that arose from the data of this study that reflected the meaning of home care nursing practice to home care nurses in today's restructured health care delivery system. These categories and subcategories represented the participants' perspectives and experiences in home care nursing and were addressed in relation to primary health care and relevant sources of literature. The categories and subcategories were discussed separately but in reality were considered inextricably interrelated within the context of home care nursing practice. Chapter five discusses the conclusions and implications for home care nursing that emerged from the findings of this study.
CHAPTER 5: SUMMARY, CONCLUSIONS, AND IMPLICATIONS FOR NURSING

Summary of the Study

The purpose of this study was to explore and describe the experiences of home care nurses concerning the scope of their nursing practice in the current restructured health care delivery system. As there were no nursing studies discovered that articulated the lived experiences of home care nurses in the provision of nursing care in people’s homes, this study offered these nurses the occasion to discuss their perspectives of home care nursing practice. Home care nurses who currently practiced in home care nursing were selected to participate in this study.

Phenomenology was the methodological approach utilized to acquire and ascertain the perspectives of the participants in this research study. Phenomenology is the study of everyday life as it is actually lived and experienced (Omery, 1983). The phenomenological method was useful and appropriate in this study as it was a means to discover, interpret, and describe the experiences of home care nursing practice in the current health care delivery system from the home care nurses’ perspectives. Selection of participants by the researcher occurred according to the Colaizzi (1978) phenomenological approach. Using a purposive sampling method, participants from four district health units within a large urban health department were selected with regard to their interest and ability to articulate and provide comprehensive and pertinent information about home care nursing practice. All participants had diverse hospital nursing backgrounds prior to entry to home care nursing, normally worked in full time positions, and accumulated more than five years of home care nursing experience at the time of this study.

The researcher interviewed all participants twice so that a comprehensive understanding of the perspectives of the participants about their home care nursing practice was achieved. Interviews were audiotape recorded and transcribed verbatim. Data analysis occurred concurrently with data collection and the researcher was keenly cognizant of the issues of reliability and validity throughout these processes. Transcriptions were critically analyzed and reflected upon prior to subsequent interviews in an effort to interpret the meaning of significant statements, identify recurrent themes and theme clusters, and ascertain data saturation. Major theme categories emerged from the analysis of the eighteen interviews. Three primary categories and subsequent subcategories were derived from the data provided by home
care nurse participants. The first category identified the nature of home care nursing practice and its three subcategories: the context of home care nursing practice; the attitudes of home care nurses towards home care nursing practice; and the context of the client in home care nursing practice. The second category identified the prerequisites for home care nursing practice and included two subcategories: the knowledge and skills requirements of home care nurses and the strategies needed for home care nursing practice. The third category identified the organizational issues within home care nursing and comprised two subcategories: the professional issues pertinent to home care nursing practice and recommendations for home care nursing practice. The three categories; the nature of home care nursing practice, prerequisites for home care nursing, and organizational issues of home care nursing described the experiences of home care nursing practice from the perspectives of home care nurses. In a third interview with a focus group of six participants, the findings were presented by the researcher, and were validated by the participants as being representative of their perceptions and experiences as home care nurses. The three major categories and the subcategories were reported and discussed in relation to primary health care and relevant literature.

Conclusions

The home care nurses in this study indicated that the nature of home care nursing practice embodied direct and indirect nursing care, preventive, restorative, maintenance, and palliative activities that centred on the clients, families, and designated caregivers. Geographical districts within an urban health department setting provide home care nurses with a busy, diverse, and autonomous nursing practice that serve the specific needs of the community within that district. Participants' home care nursing practice is now more complex and more technical as the level of nursing care activities has increased and the need for technological care at home is necessitated. The workload of home care nurses is affected by the acuity of the clients and by the needs of the clients and their families. Clients are sicker, more unstable, and are discharged from hospital sooner or, in many cases, are not admitted to hospital soon enough. The psychological and physical needs of clients and family members are more intense following hospital discharge and when clients require increased complex symptom management or more complicated care planning and organization of community resources so that they remain at home.
The roles and responsibilities of home care nurses are redefined to meet the increased need for advanced technology and acute and chronic nursing services at home. Home care nurses practice as generalist nurses who utilize specialized knowledge and skills in specific client situations. Home care nursing practice is supported by CNSs, peers, and colleagues, and previously by nursing coordinators. Home care nurses act as direct care and indirect care providers, assessors of health care needs and resources, educators and sources of health care information, counsellors, case managers and advocates for clients and families, liaisons between clients and health care providers, and leaders within the interdisciplinary team. Language designated home care nurses offer an added benefit to the care needs of specific client populations as well as a support to the organization because of their understanding of specific cultural beliefs, fears, and behaviours.

Home care nursing practice is influenced by the home care nurses' personal attitudes and values about home care nursing. Home care nurses value the independence, flexibility, diversity, and available opportunities within the scope of home care nursing practice and the fact that they provide nursing care in a manner that reflects their own beliefs about nursing in general. Home care nurses believe that home care nursing is unique in its practice and is a specialty area of nursing because of the shared relationships with clients and families within the intimate and personal home setting, and of the focus on client centred care. Home care nurses also believe that their understanding of the client and the client's needs within the community environment enables them to appreciate the client and the family situation, comprehend the client's and family's health related behaviours and factors that influence these behaviours, and provide appropriate and relevant nursing care. Interactions between home care nurses and clients and families impacts their nursing practice and, in some instances, their personal views on life. Home care nurses especially value their involvement with palliative clients and their families because they believe that these shared interactions enhances their nursing knowledge and skills in this area particularly, but also affects other clinical situations. They believe that they learn a great deal about life as these clients teach them about death and not to fear death, and to accept the inevitability of death and the specific circumstances surrounding clients' deaths. In turn, these nurses teach clients and families that dying is part of living and that this time in one's life does not have to be lived without dignity or in unnecessary pain and one's life
can still be meaningful. As well, home care nurses believe and appreciate that these clients, more than others, pose the greatest challenges and offer the most rewards in their nursing practice as these nurses attempt to consistently meet the many care needs of this client group.

Although home care nurses value their independent practice, they also value the clinical support that they receive from their nursing colleagues and administrators in home care nursing, and from consultation with interdisciplinary team members, particularly when they encounter the numerous and varied difficult client circumstances. Clinical support is valued by home care nurses because they believe that this clinical support and expertise from the CNSs, coordinators, and resource home care nurses provides them with research based policies and procedures, validates their nursing practice, promotes optimum client care, and encourages job satisfaction as home care nursing practice becomes more standardized, consistent, and relevant. As well, individual nurses pursue special interest areas in home care nursing and develop specialized skills that supports home care nursing practice and the practice of others.

Knowledge of the client as a person is paramount to the home care nurses' practice. The client in home care nursing is described as the person who requires nursing care, and also consists of the client's health care issue(s), family (as recognized by the client), environment, support system, and general circumstances. Home care nurses' clinical decisions and actions are affected by the client's personal history, physical, social, and spiritual milieu, and by the client's behaviours and decision-making abilities. Clients, families, and caregivers are expected participants in the plans of care because home care nurses cannot make decisions in isolation nor can they provide all the care on an ongoing basis. Home care nurses require a degree of objectivity with clients and families in order to establish and maintain therapeutic relationships with these persons. Professional boundaries are necessary as home care nurses provide the appropriate emotional distance between them and the clients and families, but continue to allow the nurses to respond in a caring and supportive manner.

Knowledge of the client as a person is significant to the home care nurses' practice because collaborative decision-making is required for meeting the goals of client care. Support of self-care activities, the independence of clients and families in their own environments, and the consideration of personal wishes, cultural and spiritual beliefs encourages client control and client choices about their
health care. As clients and families participate in care decisions and assume responsibility for their care, it is important that these persons believe they are part of the decision-making process or else they will not become committed to these decisions. Home care nurses ensure that their decision-making process is client focused because they want clients to achieve independence in self-care activities and to do it well. A format for clinical decision-making is required for home care nursing practice and home care nurses use an intuitive template for assessment, identification of actual and potential problems as well as realistic immediate, midterm, and long term goals, and decisions about plans of care. Discussions with clients and families about the goals of care empowers these persons as their choices for care and expectations of care are understood, respected, and accommodated by home care nurses, and at the same time this process validates the home care nurses' decisions about client care. Client control is enhanced as home care nurses provide clients and families with appropriate information to make informed decisions about specific care options. Important components of home care nursing practice are the recognition and acknowledgement by home care nurses that they are guests in the clients' homes and that suggestions for client care can as easily be rejected as can be accepted by clients. Also, home care nurses need to remain receptive to clients for further negotiation and discussion about client care. Successful client outcomes are achieved by home care nurses when the mutually agreed upon goals of care are achieved, and when home care nurses understand the client and family situations, their needs, and their goals of care. This partnership of mutual goal setting and decision-making between home care nurses and clients and families is at the foundation of their home care nursing practice. However, home care nurses frequently encounter many complicated care decisions that are related to the clients' many health care needs, the expectations of clients and families about the care, and the clients' right to choose to live at risk that cause them some discomfort during the decision-making process. A formal framework for ethical decision-making for home care nurses is not part of their practice but would be appropriate for home care nursing practice. Rather than relying only on certain, relevant guiding principles in specific client and family situations or on colleagues as they do now, an ethical decision-making framework could assist home care nurses to logically and ethically make decisions about difficult client care that would reassure them that the clients' and families' best interests and wishes are always respected.
The home care nurses in this study identified specific prerequisites required by home care nurses for effective home care nursing practice. The first prerequisite for home care nursing practice is a broad knowledge base and a variety of personal and professional skills. The knowledge requirements for home care nurses emphasize a strong generalist background in medical, surgical, and oncological nursing that is supported by a substantive knowledge of pathophysiology. Specialized knowledge about specific client groups is also necessary for home care nurses as relevant to their generalist practice, especially with the increased numbers of clients who are discharged from hospitals and need specific treatments and medications at home. Knowledge of the concepts, practices, and principles of community health nursing and primary health care recognize the importance of family health, community assessment and development, and collaborative partnerships between health care providers. Home care nurses are actively involved in collaborative activities with clients and families and other health care providers but also are increasingly engaged in partnerships with health providers which focuses on specific client populations who would benefit from home care nursing services and shared resources. Intuitive knowledge or instinct is valuable to home care nursing practice because it directs the process of assessment and decision-making and allows for creative problem solving of client and family situations.

Personal skills that are required by home care nurses and are pertinent to home care nursing practice include such characteristics as self-confidence, trustworthiness, patience, flexibility, assertiveness, creativity, independence, and a sound sense of self. These skills aid the home care nurse/client relationship in conjunction with the professional skills that are needed to enact their responsibilities. Professional skills necessary for home care nursing practice incorporate direct and indirect nursing care activities and comprise psychomotor, intellectual, and interpersonal communication capabilities which are interrelated and, frequently, synchronously executed. Skills in indirect nursing care activities, such as analysis of information and data, decision-making and sound clinical judgement, and care coordination impact the implementation of all direct nursing care activities, and are critical in the prioritization and organization of the home care nurses' workload and management of client problems. Technical skills are also essential in the provision of efficient and effective direct nursing care activities. Effective interpersonal communication skills influence the professional home care nurse/client relationship because
specific nurse capabilities, such as nonjudgement, respect, sensitivity, and empathy assist clients in maintaining a sense of power and control over their health care decisions, self-care activities, and reflect the attributes of a good listener and communicator. Home care nurses require teaching skills that embody both personal and professional skills and reflect their understanding of the client's readiness to learn and the factors that impact this learning, such as the client's health status, environment, personality, cultural norms and values, knowledge, and physical and mental abilities.

The second prerequisite for home care nursing practice is the need for home care nurses to develop and utilize specific professional and personal strategies to sustain their nursing practice. Experience and knowledge that are acquired on the job, from role models amongst nursing peers, colleagues and managers, other disciplines, and from reflection on client situations are professional strategies that augment and improve the home care nurses' practice. Personal strategies include activities as balancing a heavy daily caseload of difficult and complex clients with visits to uncomplicated clients, sharing complex care clients between primary and secondary nurses, lowering personal expectations of themselves on the job, and participating in extracurricular self-care activities. These strategies are important for home care nurses so that they can provide consistently effective nursing care and maintain a sense of emotional well-being in their home care nursing practice.

Professional issues within the organization of home care nursing affect the home care nurses' practice. A major issue is a general lack of understanding of the practice of home care nursing by the management of home care nursing, administration and clinical staff in hospitals, physicians, and potential clients. This lack of understanding caused frustration, distress, job dissatisfaction, and stress among the home care nurse participants in this study and negatively impacted their nursing practice. Home care nurses believe that management and hospital personnel do not appreciate the complexity of their home care nursing practice, the extent of their responsibilities, or the emphasis of the client and the client's circumstances on their nursing practice and their abilities to enact their nursing care. Home care nursing practice is primarily different from hospital nursing practice due to the effects of the client, the client's family, and the client's environment on the goals of care as well as the client's need for control over health conditions and health care decisions. These effects greatly influence the home care nurses' interactions with clients, families
and caregivers and the varied and difficult decisions that are made about client care, all of which adds to the complexity of their nursing practice. Home care nursing practice is also different from hospital nursing practice in that it focuses more on the aspects of holistic client and family care and possible caregiver stress and less on the technical aspects of care in the home. It is also concerned with frequent assessment, evaluation, and effectiveness of care plans and the self-care abilities and activities of clients and families at home.

Another professional issue is the frequent and inappropriate, or lack of, use of home care nursing services as seen with the decreased presence and utilization of home care liaison nurses in the hospitals. Liaison nurses from home care nursing prevent inadequate discharge planning and improper referrals and the use of these services decreases the number of inappropriate referrals of clients by hospital nurses and social workers who are unfamiliar with home care nursing services and other available community resources. As well, community liaison nurses situated within hospitals ensure that clients who need services are made aware of and know how to access these services prior to hospital discharge, and have access to these services after discharge. Management's reduction of liaison nurses in hospitals increases the workload of home care nurses who then have to search for relevant client information from many sources in order to plan and implement client care.

Home care nurses often track information from various sources on palliative clients who are referred from physicians in the community who, in turn, do not have the needed information. Many times, these clients are not referred soon enough by general practitioners to home care nursing so that home care nurses can outline and establish appropriate services and resources, and meaningful nurse/client relationships can be developed without pressure from the stresses of client and family situations. Physicians and other health care providers require knowledge of the available services within home care nursing and from other community resources that support the needs of these clients and families, as well as the needs of other clients and families in the community. Potential clients require this information also and the home care nursing organization's ongoing obligation to provide this information to the public is necessary.

A further issue that concerns home care nurses is management's apparent lack of appreciation or
consideration of the effects of the reorganization on their nursing practice. Disintegration of the nursing infrastructure and replacement with a new framework does not provide the same administrative or clinical supports for home care nurses. This change adversely affects morale and consequently impacts their nursing practice. Home care nurses in this study felt devalued by management because changes occurred without adequate input or feedback as to what home care nurses thought relevant or needed in their nursing practice, and that management's vision for the future of the home care nursing organization was unarticulated and unclear. Home care nurses also fear that their need for support in their clinical practice is not heard or met with the new organizational and management structures in place.

There are workload issues that affect home care nursing practice and reflect that management does not understand or appreciate the specialty nature of home care nursing. The diverse mix of clients with different needs and the increased number of technologically complicated clients at home requires that home care nurses have the appropriate knowledge and skills to provide the necessary client care. Home care nurses keep their knowledge and skills as current as possible but often are unable to upgrade themselves due to increased workload demands, time constraints, lack of resources, and inadequate educational support and opportunities. A lack of available resources, both human and financial, workload demands, and the stresses of change also affect the retention of home care nurses. Home care nurses believe that there are inadequate numbers of permanent positions in home care nursing to manage the caseload demands or support the needs of inexperienced nurses, all of which impacts their nursing practice.

Home care nurses in this study offered some recommendations to the professional issues that influenced their nursing practice. These nurses suggested that not only were extra resources needed for nursing positions, equipment and supplies, and educational sessions but also that creative methods were necessary to utilize these resources. As well, home care nurses recommend that when management includes home care nurses in the change process and supports them through it, acknowledges the strengths of home care nursing and the complexity of home care nursing practice, and endorses home care nursing as a specialty of nursing, then home care nurses believe that they are valued employees.

In summary, these conclusions reflect the components of the three categories, the nature of home care
nursing practice, the prerequisites for home care nursing, and the organizational issues in home care nursing as well as the respective subcategories.

**Implications for Home Care Nursing Practice**

This study's findings offer implications for home care nursing practice, administration, health care policy, education, and research. Although the implications of these five elements for home care nursing are discussed separately, they are considered interconnected and can affect one another.

Efforts to keep individuals out of hospital and to enhance their abilities to care for themselves at home has stimulated the growth of home care nursing and encouraged many changes in home care nursing practice. The trend for community based health care has resulted in a need for more complex and increased technological nursing care in the home. This complex and 'high tech' care has implications for home care nursing practice. Home care nurses require certain competencies that will facilitate the provision of this care in an efficient and effective manner. In addition to a broad knowledge base in nursing, pathophysiology, and in the principles of self-care, holistic, community health and family nursing, home care nurses require specialized knowledge and skills in the management of certain client populations as part of their practice in home care nursing. Home care nurses in this study indicated that the clients' increased physical care needs and intense psychological needs impacted their relationships with clients and families and their abilities to provide efficient nursing care. Home care nurses use a variety of personal and professional skills as clients, families, and caregivers are assessed to determine their capacity for self-care, such as the ability to monitor care and equipment, recognize the signs of complications, and administer treatment. The motivation and capability of clients and the willingness and availability of families and/or caregivers to accept and participate in the care at home are necessary determinants for successful 'high tech' care in the home. In order for clients and families to perform these activities, home care nurses must have the knowledge and skills appropriate to meet the clients' technological care needs and must use the applicable teaching and interpersonal communication skills that facilitate the clients' and families' learning needs. Home care nurses that do not acquire such knowledge or skills cannot provide competent or effective nursing care to these clients and families, which then impacts the workload of other home care nurses with these competencies and increases their
frustrations as these clients and families become their responsibilities by default. As well, the nurses without these competencies become dissatisfied and afraid to respond to these client care needs because there are limited or no opportunities for them to learn these skills while at work. It is important, therefore, that home care nurses have the appropriate knowledge and skills prior to entry to home care nursing and that there must be a system in place at work for them to obtain the requisite knowledge and skills in order to perform the necessary nursing care activities.

The physical home environment also has to be suitable for 'high tech' care, as in IV antibiotic administration, with the necessary utilities of heating, refrigeration, running water, and electricity in place in order to deliver this care. Home situations are often fraught with safety risks and other hazards that influence the provision of nursing care, such as situations with unsafe fire issues, unsanitary conditions, and infestations. Whether the nursing care is 'high tech' or not, it requires careful planning and discussion between care providers and clients and families before implementation of nursing care occurs. Also, the location of the clients' residences may be dangerous for home care nurses to deliver 'high tech' care, and the many other types of nursing services, because they and the clients and families may be vulnerable to crime in that local area. At all times, home care nurses need to be aware of their surroundings when interacting with clients and families, and need to know the agency's policies and procedures for ensuring client and personal safety, and where and from whom to seek guidance in this regard if required. If home care nurses do not have access to this information then they cannot provide safe, competent care and may be reluctant to continue to do so, which impacts their nursing practice.

The unique home care nurse/client relationship as described by study participants has implications for home care nursing practice. This client centred relationship, that develops over time, is affected by the nurses' understanding of the client as a person, the issues and concerns that are important to the client and the factors and people that influence the client's decisions, actions, and environment. Home care nurses' interactions with the client and family are impacted by the client's environment and its influence on the client and family. Home care nurses who do not understand the importance of specific aspects of the client's environment, such as one's spiritual or cultural community, on the client, on the client's behaviours and on the client's health issues, and who do not attempt to know the client as a person (which includes all
these elements), will find that the nurse/client relationship is superficial and one-sided, no longer unique. When home care nurses are unable to establish and maintain a degree of objectivity in their caring relationships with clients and families or keep professional boundaries in place, then they put at risk the benefits of providing professional caring, promoting therapeutic interactions, and ensuring improved client well-being. As a consequence, these nurses impede the clients' abilities to take control, make care decisions, and develop independent, self-care practices.

Collaborative decision-making between clients and families and home care nurses is crucial to home care nursing practice, according to study participants. Implications of collaborative decision-making are that it encourages shared governance, shared responsibility, and shared control among clients, families, and home care nurses when decisions are made about client health care. Home care nurses must enter into partnerships with clients and families and jointly create goals of care that reflect the clients' and families' choices for care options and appropriate care, and that fall within the agency's and professional nursing association's policies and guidelines. Families' and/or caregivers' needs must also be taken into account and adequate supports established for them as part of the clients' plans of care. It is important that these persons actively participate in the decision-making process so that they are committed to the final care decisions and are physically, mentally, and emotionally prepared to provide the care. Another implication of collaborative decision-making is that successful client outcomes can occur if mutually agreed upon goals are achieved as part of the decision-making process. Outcomes are defined from the perspectives of the clients and families and home care nurses must respect the fact that the clients' goals of care may not reflect the nurses' expectations for goals of care. Effective negotiation and communication skills as well as acceptance and understanding of the clients' situations are necessary for home care nurses if they want to achieve successful client outcomes. Home care nurses achieve successful outcomes if clients and families receive relevant information about health issues, clients' and families' wishes are expressed, understood and included in care decisions, self-care abilities are adopted as soon as possible by clients and families, and self-esteem and dignity are reinforced and maintained. It is helpful and of consequence that home care nurses comprehend and apply the premise of self-care and self-efficacy in an effort to empower clients and families for increased control over their health. Self-care
focuses on increasing client responsibility and competency for health care. It also encourages clients to acquire the knowledge and competencies or actions directed toward restoring, enhancing, or maintaining their level of health and minimizing threats to personal health and personal growth. Self-efficacy focuses on the client's belief in one's own capabilities to perform the behaviours needed to control events that affect one's existence. In conjunction with self-care, self-efficacy links knowledge and action because belief in one's ability to perform self-care occurs before self-care can be attempted. That is, self-care can be initiated if clients and families/caregivers perceive that specific behaviours lead to desirable results and believe that they have the abilities to successfully accomplish these behaviours. With the increased pressure on home care nurses to meet the demands for client care, more clients and families are involved in care activities. A concern for home care nurses, then, is that the quality of care for clients could be affected as they try to provide necessary care, meet the needs of clients and families at different stages of acceptance and willingness to participate in care activities, and teach clients and families self-care abilities. Home care nurse participants in this study supported the clients' and families' wishes and need for control, supplied them with appropriate information to make informed decisions about health care, involved them in decision-making, and taught them the necessary skills to self-manage their health issues. Wherever possible and without compromising quality of care, home care nurses must ensure that clients and families and/or caregivers are empowered to learn techniques to manage symptoms, and to gain the confidence to control their health conditions and to make better health care decisions.

Home care nurses who utilize the principles of self-care and self-efficacy, family and community health nursing, and the applicable knowledge and skills pertinent to specific clinical situations when collaborating with clients and families and/or caregivers over health care decisions, also require a framework for ethical decision-making. The increase in the frail elderly and medically unstable clients maintained at home, the terminally ill who want to die at home, the technological requirements of community clients, and the early discharge of clients from acute care to home based care have resulted in client situations that have tested the decision-making abilities of home care nurses. Study participants did not use the term 'ethical dilemmas' to describe the problems that they encountered with specific clients and families. Generally, they identified these client situations as challenges or frustrations for which mutual solutions had to be
found. Not recognizing the ethical implications inherent in home care nursing can impact the nurses’ practice. Home care nurses often face ethical dilemmas whenever they make decisions that affect the clients' need for control and the nurses' need to provide necessary client care. Home care nurses require encouragement, support, and guidance to think more about the ethical questions in difficult client circumstances and to identify these situations as dilemmas. A dilemma is a choice between two equally balanced alternatives (Webster, 1984) and strong arguments can be made for either alternative, often there are no right or wrong answers. It becomes an ethical issue when conflict or distress arises between one's values, obligations, interests, or needs (Rooney, 1997). Home care nurse participants dealt with difficult client situations individually and made client care decisions based on guiding principles, and frequently used team members to assist with these problematic client situations. It is significant to home care nursing practice that home care nurses observe their code of ethics and understand and can articulate the ethical principles of: autonomy -- the right to self-determination; respect for persons -- the duty to uphold the inherent dignity of all human beings; beneficence -- the duty to do good or promote the welfare of others; nonmaleficence -- the duty to avoid harm; veracity -- the duty to be honest; and confidentiality -- the right to protection from disclosure of private information (Rooney, 1997). Utilization of these principles, together with the agency's philosophy and policies and the nursing code of ethics, as the background to a framework for decision-making, Rooney (1997) suggests that a simple model of inquiry is useful in the home care setting. The elements of this process includes analysis of the facts (identify the details/conflicts of the case, persons involved), exploration of potential choices (identify possible alternatives, outcomes of actions), reflection on ethical principles, values, and duties (identify competing principles, duties of nurse), and determination of the best possible solution (based on all the facts, identify the best outcome for client) (Rooney, 1997). Home care nurses could benefit from this kind of systematic approach to ethical decision-making that focuses on sound ethical principles rather than on one's personal opinions and beliefs or what might be ideal but not necessarily best for the client or caregiver. Another important source of support in ethical decision-making for home care nurses that could influence their nursing practice is the development of an ethics advisory committee for the organization. This committee could advise on organizational policy and on specific ethical conflicts between nurses and clients and
families and educate these nurses about ethical reasoning processes. This committee would be an adjunct to the home care nurses who possess and use the ethical tools available to them and to the interdisciplinary team members who support the nurses, if solutions could not be easily found.

Collegial peer support was expressed by participants as a substantial component of the autonomous nature of home care nursing practice. Conferences with nursing peers and colleagues during work hours has implications for home care nurses as they offer useful opportunities for them to reflect on their nursing practice. Although participants often discussed client issues with other nurses, informally and individually, regularly scheduled nursing team meetings offer home care nurses the chance to deliberate together on problematic client circumstances. Home care nurses with more nursing expertise and experience with similar client situations can provide support and suggestions to other nurses in the management of these clients and families. Nursing team meetings also can be used for client case presentations and as learning opportunities for all home care nurses as nursing practice issues, client concerns, and ethical questions are put forth for discussion. Such interactions could more effectively utilize the expertise of home care nurses and CNSs as client and family needs are identified that might reflect the needs of specific client groups, and that might impact home care nursing practice generally. Learning to think about problem situations as dilemmas could also help relieve home care nurses of the responsibility that they often experience in their practice, that is, to fix things and make them right. With the time constraints at work, participants were not consistently able to meet with their nursing colleagues to discuss client issues. Acknowledgement and endorsement that these meeting are of value as learning opportunities, and expectations that they need to routinely occur are required of management so that home care nurses can resolve the increasingly complex client situations and ethical issues surrounding these client situations, and thus advance their nursing practice.

Clinical support has diminished within the home care nursing organization of the participants in this study. The nursing infrastructure changed as home care nursing managers and coordinators were replaced by non-nurse managers. A lack of adequate clinical support has implications for home care nursing practice. Effective leadership is critical in the current health care environment. Participants indicated that they utilized various levels of nursing clinical support in their practice depending upon their
needs and the clinical direction required, and that each level enhanced their nursing practice. The loss of the home care nursing administrator suggests that no one at that level of management now represents the collective needs of home care nurses when collaborative partnerships with various health care providers are formed to discuss and plan for the needs of the many client populations requiring the services of home care nurses. As well, there now is no nursing administrator who can advocate for home care nursing services, adequate resource allocation, and the development of internal systems that support nursing practice. The nursing coordinators and the regional population focused CNSs, who formerly acted as mentors to participants and provided them with clear direction and guidance about policy and clinical practice issues, no longer function in the same capacity. Many participants stated that their unit nursing coordinators had taken an interest in them personally, were able to accentuate their personal capabilities and those of others, and conveyed personal concern for them in certain situations. With the reorganization in home care nursing, participants felt the loss of their nursing leaders and its impact on their practice, and queried the advancement of home care nursing.

The implications of this change in clinical support suggests that home care nurses need clinical nursing leaders who are visionaries, articulate images of the future for home care nursing, and invite other nurses to share those visions. Leaders in home care nursing need to demonstrate concern for individual nurses and their need for personal growth. Also, these leaders need to foster intellectual stimulation by encouraging home care nurses to creatively resolve problems and improve the work environment. At the time of this study, participants believed that much of their clinical support as it existed previously had disappeared with the restructuring of their organization. Home care nurses will have to rely more on themselves and each other, on the resource nurses, and on the new, unit focused CNSs for clinical support when facing clinical problems in their practice. Mechanisms will need to be put in place to enable the nurses to assume more control of their practice and to become more self-regulating rather than relying on the organization and CNSs to regulate their practice. The unit CNSs likely will have to find the time, from managing the day to day activities, to focus on clinical practice issues and the need for nursing practice guidelines, policies and procedures, and to work with the other unit CNSs in order to support the home care nurses' practice.
With the trend in nursing practice requirements focused on competency based standards, home care nurses have to continue to meet the high practice standards of the nursing profession. As home care nursing practice changes with the increased need for technology in the home and with sicker, more unstable clients who remain at home, home care nurses have a professional responsibility for continuing competence. Home care nurses who identify a special interest in a particular area of home care nursing can further develop competencies specific to a nursing area, such as palliative care, cardiac care or diabetic care, and become resource nurses for other home care nurses. In this way, they have opportunities to build on their strengths or gaps in their nursing practice, learn more about a particular area of interest in home care nursing, enhance their nursing practice and that of their colleagues, provide better care to specific client groups, and advance home care nursing practice. Management has an obligation to provide the essential support systems and resources that enable home care nurses to meet the standards of practice (RNABC, 1998), especially after removing and reorganizing the clinical supports once available to home care nurses. In so doing, management would benefit from this competency based approach as home care nurses incorporate new competencies into their nursing practice and which enhances and improves their practice, offers better nursing care to clients and families, ensures continued learning, and provides more nursing leaders within home care nursing. Home care nurses, in turn, would experience increased job satisfaction and personal growth and gain professional expertise in home care nursing.

Continuing education was identified by participants as a necessary requirement for home care nursing practice. It is not realistic to expect that home care nurses are entirely responsible for their knowledge and skills to remain current with the rapidly changing and new technology, medications, and treatments. Participants utilized many learning strategies to keep up with the constant modifications in home care nursing practice and the knowledge and skills requisites. However, management has a responsibility to support the nurses' practice and to ensure competencies by providing regular and relevant continuing education sessions that focus on the clients being served by home care nursing. The diverse and independent practice of home care nursing necessitates the need for these educational opportunities, time allotted for attendance, and funds that encourage expert speakers to provide the education and that pay
tuition for staff to attend specific courses. As well, regular access to appropriate nursing material in the organization's library and in each unit is required in order for home care nurses to enact effective and efficient nursing practice. By facilitating these opportunities, management is assured that home care nurses maintain their competencies and job satisfaction, and remain productive employees.

Summarily, home care nurses require management's ongoing support in order to maintain their competencies, enhance the nurse/client relationship and ethical decision-making processes, and to meet the increased technological and complicated client care needs in a safe, competent manner. If there is a lack of nursing leadership, collegial peer support, and clinical support for home care nurses, then home care nursing practice is adversely affected.

**Implications for Home Care Nursing Administration**

Participants repeatedly indicated in this study that the increased workload demands, increased complex care needs of clients and families, and lack of resources available to clients and families as well as to home care nurses affected their abilities to provide the same level of nursing care to these persons today as compared to past practices. It is very important that home care nursing administrators acknowledge these concerns and recognize that the participants' recommendations for home care nursing practice focus on the needs of a well established community nursing system and offer valid solutions to the identified practice issues. The implications of the increased use of technology and highly skilled professional services in the home that are necessary to meet the complicated client and family needs emphasizes the need for expanded quality assurance strategies in the home care nursing organization.

Participants appreciated the many policies and procedures that were in place for generalized and specialized nursing care and that guided their home care nursing practice. The establishment of sound policies and procedures promotes consistency among all home care nurses and ensures quality service, a benefit to the organization. Important areas for administrative policy consideration when planning services for home care nursing clients are resource issues, staff training and continuing education, and ethical issues encountered in the clients' homes.

Home care nurse participants articulated that there was a deficient number of home care nurses to meet the demands of home care nursing and that retention of home care nurses was also an issue that
impacted the effectiveness of their practice. In order to provide particular services to specific clients, administrators need to ensure that there are sufficient staffing levels, staff with the required expertise to respond to specific clients' needs, and mechanisms established to undertake more detailed staff training. This researcher agrees with the participants' recommendations that more full time nursing positions are needed to assist in the management of clients with complex care needs and that more auxiliary nursing positions are required to relieve the workload demands. The implications for administrators requesting increased funding from the government for such positions would be that: more nursing services would be accessible to more clients and families who need these services and may not be receiving them or are receiving minimal services; the transition from hospital to community can occur more smoothly and contemporaneously for clients as more nurses are available to respond to the more urgent needs of these clients and families; more time can be spent with those clients and families who need more education and support; and more occasions can be made available to nurses so that they can attend regularly scheduled nursing team meetings to discuss complex client care cases and nursing practice issues, as well as attend pertinent educational and client specific inservices.

Another relevant recommendation made by participants that might retain existing home care nurses in the organization was the creation, by management, of more part time positions and shared positions. The implications of this suggestion clearly offer opportunities for management as mature, knowledgeable and expert home care nurses who are near retirement can continue to remain in home care nursing longer than they might have planned, contribute valued services to clients and families, community and nursing profession, mentor new and current home care nurses, and preceptor nursing students who may become future home care nurses. All these activities can ease the burden and workload demands on the current home care nurses, provide support to staff and management as practice evolves and changes, and can advance home care nursing practice. Home care nursing needs expert home care nurses to act as role models for other home care nurses and to guide nursing practice, and administrators need more experienced home care nurses to practice effective and efficient home care nursing, and who can advance the practices of home care nursing.

Participants voiced concerns about the increased workload demands, the time constraints that
impacted their interactions with clients and families, the inadequacies of the referral process, and the effect that these concerns potentially had on the quality of nursing care provided. Participants believed that they were working to capacity, often without breaks in their days, frequently in an overtime basis, and with increasingly more demands added to their daily caseload. Administrators need to be aware that the probable implications of continued workload stress on the nurses are decreased morale, limited job satisfaction, and increased negativity towards nursing practice. Indeed, participants articulated these sentiments as they were not congruently able to practice nursing care in the home in the effective and consistent manner to which they were accustomed, and believed that with the increased expectations to care for more clients at home, the quality of nursing care was jeopardized. Compromising the quality of nursing care rankled participants because they knew that they had difficulties in balancing the required nursing care activities with the clients' care needs under increased workload expectations and current time constraints, and felt powerless in preventing a decline in the quality of their nursing care. Home care nurse participants utilized professional and personal self-care strategies at work and at home to deal with the stress of the increased workload but management could further assist this workload problem with improved resource allocation, as previously mentioned, and with attention to the referral process and utilization of services. Home care nurses need not be put in the situation of feeling that they always must work overtime or feeling guilty that they are not able to meet the caseload requirements due to a shortage of home care nurses. Improved resource allocation would offer the nurses a better chance to meet the workload requirements and maintain their consistently high quality of care, support their nursing practice with time to attend nursing team meetings, interdisciplinary team meetings, and inservices, and read pertinent nursing practice research articles, as well as restore job satisfaction and morale.

Changes within the organization affected the home care nurses in this study and concerns were raised that those changes impacted their nursing practice. There are implications for management with the reorganization of the nursing infrastructure and removal of the administrative and clinical supports which are perceived by participants as necessary for their nursing practice, with the absence of a clear and articulated vision for home care nursing or a plan for the implementation of this vision, and with the lack of shared communication between management and home care nurses. Home care nurses feel a sense of
loss, decreased job satisfaction, and devalued and demoralized by their administrators. Nurses who feel this way are less likely to work to their potential. They perceive that their efforts are wasted and that management does not care about them as employees otherwise the current situation might never have occurred. Their behaviours impact their nursing practice and their abilities to meet the workload demands and ultimately reflects negatively on home care nursing and on the administration of the organization as nurses increasingly become ill, require stress leave, and eventually leave home care nursing.

Administrators can begin to resolve some of these issues and acknowledge to home care nurses that they appreciate and understand the complexities and diversities of home care nursing practice, the knowledge and capabilities of the nurses who deal with many difficult and complicated client and family situations, and the strengths in home care nursing, such as the concepts of community care and the holistic and client focused perspective. A further validation by management that the context and nature of home care nursing as a specialty area of nursing could indicate their support for the nurses' work, offer an opening for discussion between management and nursing staff about needed home care nursing services, and could rebuild morale, confidence and a positive working relationship between management and home care nurses. When nurses perceive that administrators, through their actions, express genuine interest and concern toward them, they are more likely to remain with the organization (Davidhzar et al. 1997; Mangan, 1996). Staff who are respected and treated with dignity by management will have more positive job attitudes which then impacts home care nursing practice in an affirmative manner. Administrators can assist home care nurses to develop a strong sense of self-worth and organizational involvement by including them in work practice reviews, encouraging free exchange of ideas, listening to their views, respecting their opinions and attitudes, and involving and valuing them in the decision-making and change processes. In these ways, home care nurses can control how change will affect them emotionally as they choose their responses to the change process. These seemingly insignificant and basic actions are worthwhile efforts by administrators who promote quality work settings.

Better utilization of home care nursing services would result if there is a better understanding of the services offered by home care nursing. An important recommendation for administrators in home care nursing to consider in this regard, as put forth by participants, is the education of targeted audiences about
the varied and available services, and includes institutional and community health professionals, nursing and medical schools, and seniors' representatives, for example. Once current and needed nursing services are identified and the services' appropriateness are established by management and home care nurses, and assurances are made that these services can be sustained and provided to clients and families, then information sessions can occur. This process would afford administrators, educators, health care providers, and the public the opportunity to learn and appreciate the complexities of home care nursing practice, the responsibilities undertaken by home care nurses, and the inimitable differences between home care nursing and other nursing practice areas. Administrators could also collaborate with home care nurses on decisions that are made to add, modify, change or delete nursing services after proper assessments are done of the current services. This review of services would show if any alterations in the care provision or available services are required and if changes are in the best interests of specific client groups.

Community home care liaison nurses are significant to the referral process and appropriate utilization of home care nursing services as they are knowledgeable of the eligibility criteria and of the various programs offered by home care nursing. Participants held community based liaison nurses in high esteem, preferred their assessments, and trusted that their referrals were complete and relevant to the clients' care needs and nurses' care plans as compared to hospital staff referrals. Referrals from home care liaison nurses have implications for home care nursing administrators. Liaison nurses, with a community perspective, consider the clients' and families' needs and environments, community resources, and appropriateness of home care nursing involvement. If liaison nurses perceive that services can be provided by other community agencies or resources, then clients are suitably referred elsewhere. If these nurses perceive that services can be provided by home care nursing and often only after certain supports are in place, then clients are appropriately referred to home care nursing. In both situations just described, there is an impact on home care nursing services that is reflective of the importance of the screening role of the liaison nurse. These nursing services and other health services frequently are not made known or are not accessible to the many persons discharged from hospital if there is no liaison nurse involvement prior to discharge. Without assessments done by liaison nurses, some of these
persons manage well on their own and others do not manage at all at home. Often they become sicker and access further health services either by readmission to hospital and then to home care nursing or through physicians' offices who then refer these persons to home care nursing. Either way, the delay in needed health services for these persons could be prevented if liaison nurses are initially available to screen potential clients in hospital and to refer to home care nursing. The impact on the home care nurses is the precious nursing time spent on searching for relevant client health information.

Administrators could increase the number of community home care liaison nurses in the hospitals to ensure a better utilization of home care nursing services. These nurses would facilitate client discharge plans, use their screening abilities, intuition and knowledge to smooth the transition of acute care clients to the community, prevent inappropriate referrals from hospital staff, and educate physicians and other hospital personnel in the available nursing services, programs and other resources.

Staff training and continuing education are areas within home care nursing practice that should be considered mandatory and non-negotiable by administrators in home care nursing, and this stance is supported in the literature (Bryan et al. 1997; Daley & Miller, 1996; O'Neill & Pennington, 1996). These sources endorse that home care nurses regularly need to upgrade their skills and knowledge of various treatments, illnesses, and health issues. Management's role for ensuring quality nursing practice does not finish once home care nurses are hired. Continuing education is fundamental to the best practices of home care nursing. The type of continuing education is dependent upon the type of nursing service required. For example, the provision of 'high tech' services, as in IV antibiotic infusion, requires home care nurses trained in the use of specific equipment and procedures, specific client education, clinical decision-making in ambiguous situations, and dealing with conflict resolution and ethical issues.

Treatment modalities frequently change and technological equipment is often modified and becomes more complex to operate. As well, client conditions are more acute and care needs become more intensified and complicated with the shift to community care. Therefore, home care nurses' skills and knowledge must be current to ensure that they are providing competent and informed nursing care to clients. Daley and Miller (1996) state that home care nursing develops along a continuum of levels within certain domains of practice, such as assessment and use of physiologic and pathophysiologic data and
assessment and use of family and environmental data, and that home care nurses need staff development and continuing education programs that constantly enhance and advance their knowledge, skills, and abilities in these domains. Nursing practice in home care nursing exists at multiple levels and growth within this area of nursing is developmental as home care nurses immerse themselves within the context of the client and the client's environment and apply effective nursing care. It is only through experience, augmented with applicable knowledge and skills, that home care nurses develop and understand the multiplicity of interrelationships between clients and families and the clients' environments (Daley & Miller, 1996). This practice situation affects administrators as they need to arrange for appropriate learning opportunities to occur that fosters the development of home care nurses to a sophisticated level of expertise and, therefore, places these nurses in positions to provide quality care to more clients and families.

Many nurses now entering home care nursing are highly experienced and consider themselves to be experts in a particular area of nursing specialization. However, their previous experiences may not have given them the perspective and skills necessary for optimal functioning in home care nursing. Many unknown elements confront them in their new work setting, and they may find themselves as novices again. Bryan and colleagues (1997), Daley and Miller (1996), and O'Neill and Pennington (1996) suggest that a comprehensive program of orientation, skill development, and continuing education is required to ease the transition from hospital settings to home care nursing. Orientation programs in home care nursing usually comprise basic information with regard to the organization's policies and procedures, standard documentation practices, work assignments and schedules, and safety issues. Mentors provide new nurses with observational field experiences and then supervise the new nurses in client care as they gradually assume responsibility for clinical caseloads. Sometimes this orientation process is as less as three days and as great as several months at which point new nurses are expected to be completely independent in the varied areas of home care nursing practice. O'Neill and Pennington (1996) assert that many orientation programs in home care nursing do not meet the needs of experienced acute care nurses, frequently demoralize permanent nurses as they precept new nurses while their own caseloads increase and become unmanageable, and suggest that the administration of home care nursing
organizations develop programs that build on these nurses' acute care skills and incorporate community health nursing principles. Daley and Miller (1996) and Bryan and cohorts (1997) advise that home care nursing administrators cannot employ nurses from different practice settings to home care nursing without a formal orientation program and an appropriate transition period. These actions allow new nurses to identify current skills and new skills that need to be learned, and assures integration of the knowledge and skills necessary for functioning in a primary nurse role in home care nursing.

Although participants requested the employment of more nurses to offset their workload demands and mentoring responsibilities, perhaps what they did not articulate was a need for a formalized orientation program that clearly delineated management's expectations of new staff and the responsibilities of all persons involved in a home care nurse's orientation. Administrators in home care nursing could approach the transition from acute care to home care nursing by collaborating with hospital and nursing educational institutions to develop competency based orientation programs especially as participants have identified certain competency requirements for home care nursing. Competency is the ability to simultaneously integrate and apply the knowledge, skills, judgement, and attitudes required for performance in a designated role or practice setting (RNABC, 1998). A competency based orientation program would demand standards that emphasize quality care outcomes. This collaborative effort could favourably impact the recruitment and retention of skilled professional home care nursing staff, delivery of quality client care, and job satisfaction of current and newly hired home care nurses. Other benefits from a comprehensive orientation program for the administration of home care nursing include a more efficient use of nursing time, an improved performance evaluation process, satisfied clients and families, and an enhanced image of the home care nursing organization.

Ethical issues and legal challenges pose problems for the administrators of home care nursing with the increased use of technological services in the home and the increased population of older adults and persons with chronic illnesses requiring home care nursing services. With the use of 'high tech' procedures and specific medications and treatments that permit persons with chronic conditions to live longer, questions often arise around clients' rights, right to die with dignity, competency, and delegation of authority during the delivery of home care nursing. At the present time, consent for home care nursing
services is implied as clients do not sign a consent form although signed physicians' orders are routinely sought for all client treatments once client assessments are completed. However, clients are entitled to provide informed consent to any nursing procedure during the course of involvement with home care nurses. This process has implications for administrators because prior to initiating nursing services, they should know if home care nurses inform clients and families about the purpose of the procedure, benefits and shortcomings of the procedure, alternatives to the procedure, specific risks related to the procedure in the home, limitations of nursing and other services, and expectations of self-care involvement. Client and family education is important for informed care decisions and at the very least should include knowledge of the health issue and/or disease process, understanding of and ability to perform self-care activities and the operation of equipment, and recognition of signs and symptoms of problems and appropriate activities to respond to problems. Also, the documentation of client and family education is as significant as the documentation of direct nursing care activities because it indicates the willingness and abilities of these persons to perform self-care activities, as well as illustrates the required nursing time and care activities involved. Administrators could assist home care nurses in the management of the complex care needs of clients and families by ensuring that policies and standards are established that direct or guide nurses in decisions made about the types of client care that can be provided and that deal with clients and families who have questionable decision-making abilities.

Participants in this study valued their collaborative decision-making process with clients and families and identified that this process was a major and complex component of their practice, but at times they experienced difficulties with this process with certain clients. Administrators could develop with home care nurses and the professional nursing association an ethical decision-making framework that is relevant, workable and guides their nursing practice and supports the philosophy and mandate of the organization. Perhaps the introduction of such a decision-making framework would educate the nurses about ethical practices, principles and decision-making, how to identify and resolve ethical concerns that arise in care, and would decrease the emotional demands on the nurses which may improve their level of work related stress. Other opportunities for administrators to assist home care nurses in their arduous client care decisions and to ensure effective nursing practice are: to consider the use of ethics committees to develop
policies that address common ethical practices and to review and advise on difficult client cases; the creation of interdisciplinary case conferences to which staff identify and discuss concerns and dilemmas that cannot be resolved informally; and the organization of annual community based educational programs with ethicists and legal consultants. An atmosphere in which ethical issues can be openly discussed and pursued without fear of recrimination to home care nurses begins with the administration of the organization and its leaders. Administrators and leaders who are committed to this kind of work environment and encourage ethical practices among home care nurses can establish an ethical milieu through the demonstration and integration of their personal ethical values and decisions made during the operational requirements of their jobs within the organization. Thus, they facilitate the home care nurses' ethical decisions.

In summary, implications for home care nursing administration exist with regard to workload issues and retention of home care nurses, utilization of community liaison nurses, changes in organizational structure, staff training and orientation, and decision-making processes of home care nurses.

**Implications for Home Care Nursing Health Policy**

The deinstitutionalization of health care to the community has to keep pace with the allocation of funding in order to provide necessary health services. It is clear from the findings in this study that participants faced increased pressures to provide the same level and quality of nursing services to increased numbers of clients and families who required nursing care in the home, without adequate resources. Services within institutions and the community are becoming fragmented as clients and families requiring care fall through the cracks, unable to receive or access necessary services when needed. Until recently, home care nursing organizations have been cooperative and relatively silent partners in health care delivery and have maintained quality nursing care to the community with budgets that have not really expanded with the demand for services. Today, home care nursing organizations no longer can remain silent as the focus of health care shifts from acute care to home care and the requests for nursing services at home far exceeds the organizations' abilities to meet the need for these services. Policy makers within home care nursing organizations must assure that there are sufficient resources available, both financial and human, to meet the physical and psychological needs of clients and their
families, as clients are discharged from hospital earlier, sicker, and more unstable. These policy makers also have a responsibility to inform other policy makers within acute care institutions, municipal and provincial governments that the health care of community clients and families is at risk. The needs of these persons cannot be met if there is not the appropriate transfer of resources to the community.

The acute care work environment is changing with efforts to reduce the lengths of stay for hospitalized clients and as a result of reduced revenues, downsizing, and decreased admissions. Hospitals continue to increase the number of admissions and to reduce the lengths of stay despite any reduction in the current use of beds as the means to retain and generate revenue. It is unacceptable for administrators in acute care institutions to assume that they alone require more funding and do not have to share resources with home care nursing organizations and other agencies. In many cases, there appears to be little opportunity for hospitalized clients to recuperate from acute health care episodes prior to discharge, and consequently they are in need of more, intensive, and frequent nursing care at home. It is no wonder that there is skepticism among community health care providers when partnerships supposedly exist between institutions and communities but disparity in cost sharing for health care occurs. Alliances and networks that are intended to serve clients from the acute phase of illness through the recuperation at home appear rather hypocritical and, in the long term, do not support the primary focus of health care, the clients, when there are inadequate resources in communities to provide necessary care. Resource allocation must reflect the now subacute nature of nursing care required in the home. Adequate staffing, access to appropriate equipment and ancillary services, and availability of staff development opportunities are now absolute requirements for safe and effective nursing services in the home and for the maintenance of client and family focused care.

Health care policy makers and health care providers from institutions and community agencies, together with representatives from local and provincial governments and users of the health services, need to continue to meet and discuss the health issues that face each community in order to reduce the gaps that exist between and within each health care organization. Hospitals and community health organizations must work together in a responsible, coordinated, efficient, and effective manner (Morfitt, 1998; Vancouver/Richmond Health Board, 1998) to find ways to deliver existing and expanding health
services and to share current, additional, and/or new funding. Policy makers in home care nursing must articulate clearly their expectations for resource allocation and their concerns about workload issues and quality of care, and develop performance and outcome measures within the context of the organization's vision and strategic direction. The provision of quality health care services to clients and families is dependent upon the understanding and acceptance by members of the home care nursing organization of a shared vision and direction for health care delivery. This vision and direction must also be consistent with and understood by other health care organizations within its region so that sufficient resources are reallocated appropriately, services are accessible, and the health care needs of the community are achieved.

Health care needs of communities can be achieved if primary health care principles are followed. One principle of primary health care is the building of self-reliance of individuals and communities. Other primary health care principles include health as a fundamental right, shared participation in health care decisions, and appropriate, accessible, and affordable health care and technology (Epp, 1986; World Health Organization, Health & Welfare, Canada, & Canadian Public Health Association, 1986). In order to actualize these principles, clients, families, and communities need suitable coping mechanisms and positive health behaviours, and increased knowledge and access to applicable information which are sensitive to their beliefs, preferences, skills, and expectations. Home care nursing services do not discriminate against any ethnic or cultural group and tries to accommodate specific needs whenever possible. Language designated home care nurses are effective in reaching certain non-English speaking client groups and assisting these persons in accomplishing their health care goals. Policy makers in home care nursing organizations would benefit from another look at their plan of using costly telephone translation services instead of the personal interactions of professional interpreters, such as the language designated home care nurses. These nurses are able to share with the non-English clients and families their knowledge of pertinent health issues and their understanding of specific cultural beliefs, traditions, and attitudes. These nurses can develop culturally relevant and trusting relationships so that these clients and families are not denied the right to health services. Non-English speaking communities have unique needs and clients, health care providers, and organizations need to find the most effective methods of
meeting those needs. Utilization of language designated nurses can meet those needs and fulfill health restorative, promotive, and maintenance activities within the clients' homes as well as within a community setting, such as culturally specific and sensitive diabetic education classes focused at a particular ethnic population. These language designated services respond to the needs of client groups, better utilize home care nursing resources, positively promote the home care nursing organization, decrease the fragmentation of health services, and support the principles of primary health care.

Remunerative acknowledgement for these services by language designated home care nurses is not what motivates these nurses. However, they appreciate it. Their knowledge and skills in personally and directly addressing the needs of specific client populations are not comparable to the knowledge and skills of English-speaking home care nurses who use family members of clients for direct translation or to the lay person or health professional at a telephone translation service. Discontinuation of the remuneration for these few nurses is not going to improve the cost effectiveness of home care nursing services or provide a better utilization of nursing services. These nurses will continue to offer this service to particular client groups, despite the remuneration issue, because they are professional nurses who want the best for their clients and because their colleagues and management will expect them to continue to do so. However, denial of this financial acknowledgement could indicate to these nurses and other members of the organization that management does not value the special skills and abilities that these nurses offer the organization and particular clients and families in the community. This lack of acknowledgement could result in decreased self-esteem and job satisfaction, and decreased client satisfaction in home care nursing services.

As communities grow and cultural diversity flourishes within these communities, policy makers in home care nursing organizations need to be aware of the social inequalities and inadequate information sharing and decision-making processes that often occur between health care organizations, health care providers, and cultural groups. With a focus on strengthening social networks and social supports and promoting healthy behaviours and attitudes of the various clients and families, policy makers in home care nursing organizations, regardless of ethnic origin, can develop pertinent organizational policies. These policies would empower all clients and families in care decisions and self-care activities, ensure specific needs of
client groups and cultural populations are recognized and supported, provide educational development of home care nurses and other health care providers of the particular practices and needs of various client populations, and encourage collaboration and coordination between home care nursing organizations, health care institutions, and client populations in the provision of care in the home.

Home care nursing health policy can influence the health care of clients and families. It is, therefore, important that appropriate resources are provided to home care nursing organizations, that health care providers effectively and efficiently work together, and that sufficient numbers of language designated home care nurses are available to ensure that services are accessible to the community and specific community and client needs are met.

**Implications for Home Care Nursing Education**

The findings in this study demonstrate that for effective and efficient nursing practice to occur, home care nurses need a broad, comprehensive educational base in medical, surgical, oncological nursing and in pathophysiology of these areas. Their practice is supplemented with knowledge of the principles of self-care, holistic, family and community health nursing and other sources, and influenced by knowledge gained from various nursing and personal experiences. The knowledge and skills requisites of home care nurses have implications for nursing education. The traditional methods of undergraduate nursing education are changing to accommodate the delivery of community based nursing care (Murray, 1998). Trends continue to indicate a shift from institutional health care delivery to home care and that nursing must prepare to meet the challenge. According to Murray (1998), nursing educators must understand and accept that tomorrow's nurses will provide nursing care in a system that is community based and community focused, and which includes home care nursing. Participants in this study recommended that the management of their organization consider and endorse the idea that home care nursing is an area of specialization in nursing and be accepted as such by schools of nursing, and included in nursing education programs. Many sources cited in this study support home care nursing as a specialty in nursing and recognize the importance of its inclusion in nursing education. Definitions of home care nursing practice are confusing. Many nursing educators have differing views on the make-up of home care nursing practice, and many nursing educators teaching in this area have not developed their clinical
practice in this field, which impacts the education of nursing students (Burbach & Brown, 1988; Daley & Miller, 1996; Murray, 1998; Tansey & Lentz, 1988). Study participants articulated that home care nurses required specialized knowledge and believed that nursing students needed more exposure during their nursing education to home care nursing concepts, distinguished from preventive health nursing, and to the practice of home care nursing. This exposure as part of their nursing education has implications for administrators in home care nursing. Nursing students may become future employees who can affect the ongoing home care nursing shortage, understand the competency requirements for home care nursing, and pursue and acquire these requirements during their nursing careers, all of which could favourably impact their orientation needs. These students also would be prepared for the autonomous and accountable nature of home care nursing practice, have an understanding of the context of the client and the impact of the client's environment on health issues, and certainly know whether they wanted to function in such a capacity. Therefore, it behooves home care nursing administrators to work more collaboratively with nursing educators to ensure that home care nursing is included in nursing curricula and to participate more actively in the planning of nursing student experiences in home care nursing.

Murray (1998), Tansey and Lentz (1988), and Green (1994) suggest that the goal of nursing education is to assure that nursing graduates are ready to meet the present and future societal health care needs. These authors and others endorse that more community based clinical experiences in home care nursing need to be integrated into the baccalaureate curriculum and encourage home care nursing administrators to be more receptive to clinical placements of nursing students in this practice arena. Expanding the learning opportunities of nursing students to comprise home care nursing equips the new graduate nurse with skills that address the health issues of individuals, families, and communities across the health-illness continuum. Students who are provided with the educational opportunity of community home care nursing can integrate the specialized knowledge and skills gained from these experiences and from acute care experiences and can develop a holistic nursing practice, wherever they practice nursing. The hospital experiences of clients can be reinterpreted and appreciated differently by nursing students as they visit clients in their own environments. Students need to experience the clients' health care continuums and understand that home care nursing practice is guided by the clients and families, and is impacted by the
clients' environments and social and spiritual support systems, which are different from acute care nursing experiences.

Tansey and Lentz (1988) believe that a nurse with a philosophy of community care can practice in any nursing specialty with a narrow focus, such as intensive care, without losing sight of the cultural and biopsychological wholeness of the client. In the home, nursing students need to learn that priorities are established by the client and the client's circumstances and are not manipulated by medical regimes as seen in hospital settings. As the context of the client's situation at home cannot be controlled, nursing educators need to include in the nursing curriculum methods to assist students to understand that the client and family are active partners in the care decisions. Students also need to understand that the home care nurse/client relationship is negotiated and collaborative decision-making is an important facet of home care nursing practice, and that successful outcomes of care reflect the client's and family's choices, goals of care, and abilities in self-care activities. As well, nursing educators can help students to become aware and accept that the client and the client's physical and psychosocial milieu are key to a successful and therapeutic relationship. By sharing in the lives of clients for whom they provide care and by concentrating on the focus of home care nursing practice, nursing students can indeed comprehend issues such as healthy environments, lifestyle choices, and social and ethical problems. Green (1994) claims that home care settings allow nursing students and nurses opportunities to be creative in their responses to the personal choices of clients and families and to the needs of vulnerable individuals, families and communities, and to learn concepts of culturally sensitive and competent care. Nursing educators can arrange with home care nursing administrators for students to have indepth, mentored experiences in the home setting so that they can learn about cultural diversity and cultural expression, which often is not seen in acute care institutions and is difficult to teach students. Issues related to cultural diversity, health care and social responsibility, access to care at home, and personal client experiences become real to nursing students when they interact closely with clients and families in their homes.

As nursing students learn about health and the nursing activities associated with health promotion, restoration and maintenance, illness prevention, disease processes, palliative care, and treatment
modalities that are necessary for home care nursing practice, nursing educators can relate these actions to the contextual factors that influence clients and families within home care nursing. Educators need to assist students to understand the importance of knowing the client as a person, the impact of the family relationship on the client, and the significance of the client's environment on health care decisions. For example, to prepare nurses for home care nursing practice nursing educators could incorporate in nursing educational programs such content as: chronic illness and its implications for clients and families at home; the management of complex family dynamics in the home care nursing environment; the home care nurse/client relationship in home care nursing practice; professional boundaries and therapeutic relationships within the home setting; collaborative decision-making process; problem solving of complicated ethical issues in the home; to name a few. Nursing students who acquire effective interpersonal communication skills can develop positive and meaningful affiliations with clients and families that remain therapeutic and professional. Establishing professional boundaries and therapeutic relationships with clients and families in complex health situations at home is difficult. Participants indicated that having a good sense of one's self and knowledge of one's qualities and limitations was an important and a necessary personal skill for home care nursing practice. Assisting nursing students to explore their own personal and family backgrounds and relationships in conjunction with family nursing concepts, nursing educators can facilitate and prepare these students to work with clients and families in the home. Identifying frequent and common ethical problems that occur in home care nursing and including these issues with clinical and collaborative decision-making processes, nursing educators can help nursing students to explore and problem solve the ethical implications of 'high tech' care in the home, caregiver burden, client competency in care decisions, inadequate care of the client by self, family or caregiver, and client's rights, for example. Providing an ethical decision-making framework that is user friendly and portable within any nursing practice area, nursing educators can assist nursing students to acquire knowledge of ethical principles, issues, and practices so that they can develop skills in determining what is in the best interests of clients and families. This framework is of significance for nursing students as they enter the nursing realm and learn to navigate the ethical minefields of early discharges of sick clients, complex and technological nursing care, and caregiver stress.
The unique aspects of home care nursing as a specialty area, and as described by participants in this study, need to be addressed in the education of nurses transferring from hospital to home care nursing. Continuing education programs in nursing, such as planned learning experiences and certification programs beyond the basic nursing educational programs, are available to advance nursing careers, facilitate transitions between workplaces and minimize transitional stress, and increase job satisfaction. Nurses who seek employment in home care nursing come with a variety of educational and clinical experiences and whose skills may not be sufficient to function in the home. In addition, they may be unfamiliar with the concepts of home care nursing and community health nursing, documentation requirements, client centered care and care management, and community resources. New home care nurses are novices and develop expertise with time and exposure in home care nursing, regardless of their previous nursing practice (dela Cruz, 1994; O'Neill & Pennington, 1996). Frequently, many new home care nurses do not understand or expect the client and family situations that could be confronted in the field. Green (1994) and Murray (1998) state that novice home care nurses often struggle to cope with the demands of practice and become discouraged early in their home care nursing careers. The learning opportunities then need to focus on and encourage the development of knowledge, skills, judgement, and attitudes for the enhancement of home care nursing practice, thus, improving health care to community clients and their families (RNABC, 1998).

Inclusion of the concepts of home care nursing within the nursing curricula at universities and colleges, a recognized home care nursing certificate program as a continuing education program, and a formalized, comprehensive orientation program provided by home care nursing organizations are possible suggestions for nursing educators to plan to meet the learning needs of home care nurses. Study participants were active in the orientation process of new home care nurses and in the preceptoring of nursing students from university nursing schools. The orientation process for participants often was considered onerous as they contended with other workload issues and priorities, and it did not appear to be a formalized agency program. These factors have implications for nursing educators and administrators with home care nursing organizations. Administrators want efficient and competent home care nurses at the end of the orientation process who intend to remain with the organization, and the
collaborative interactions with nursing educators can facilitate these outcomes. Participants indicated in this study the required competencies that they thought expert home care nurses needed to possess, and administrators and nursing educators need to indicate their expected competencies of home care nurses as well. With the focus towards competency based nursing practice as directed by the professional nursing associations, nursing educators can assist home care nursing administrators to develop competency based orientation programs. Identification of generalized and specialized competencies in home care nursing is important in order to provide opportunities for home care nurses to acquire these skills, and to develop criteria and methods to measure the effectiveness and efficiency of their nursing practice. Too often the orientation of new home care nurses includes a few observational visits with other, more experienced home care nurses and the presumption that within days these new nurses are as independent and productive as the rest of the home care nurses in the organization. Consequently, many new nurses feel overwhelmed and unprepared to deal with the demands of home care nursing practice, and can become inefficient and ineffective home care nurses.

In order to prepare efficient and effective home care nurses, orientation programs for home care nursing should consist of educational information related to the home care nursing organization's philosophy and goals, policies and procedures, expectations of the home care nurse's role, the geographical boundaries and demographic characteristics within these boundaries, available services and community resources, specialized nursing care activities specific to client groups, personnel issues, and agency and community facilities. Murray (1998) and O'Neill and Pennington (1996) contend that the purpose of orientation programs is to teach or to reinforce the knowledge, skills, abilities, and attitudes that are necessary for home care nurses to successfully practice in the home setting. In addition, the goals of these programs are to ensure the positive transition for nurses from one organization to another and to provide them with enhanced competencies in home care nursing practice which are enacted in an efficient and cost effective manner. Orientation is the first step in the validation and achievement of competency.

Educators in nursing and administrators in home care nursing need to address the challenge of transitioning competent nurses from one practice area to another early in the orientation process. Nursing educators and nursing administrators can jointly or individually be responsible for aspects of the
educational requirements for home care nursing but they need to cooperate and develop together all phases of the orientation process and continuing education programs pertinent to home care nursing practice. For example, a home care nursing organization in association with a local school of nursing that offers a recognized certification program in home care nursing could use this program as a major part of the orientation process of new home care nurses to home care nursing. Financial responsibilities for managing the program would have to be negotiated between the organizations. Perhaps instructors of this program could be employed by both organizations so that wages could be shared, material costs relatively contained, and the program could be offered at specific times of the year, such as anticipated recruitment periods. If this nursing education program is used as the orientation to home care nursing from an educational perspective in conjunction with the home care nursing organization's local orientation process, and is required for newly hired home care nurses, then there should not be any cost to these nurses. However, the expectations of both organizations are successful completion of the education program and well-prepared, competent novice home care nurses ready to practice in the community. If this program is available to potential nursing applicants for home care nursing who might be interested in moving to this type of nursing practice at some point, then financial responsibility for this educational program is up to the applicants. The fact that these potential applicants successfully complete this recognized home care nursing certificate program could be a consideration for employment by the home care nursing organization as these nurses' orientation needs would be minimal.

In another example, nursing educators within nursing schools could develop, in collaboration with home care nursing management and hospital educators, continuing education courses that supplement the comprehensive, competency based orientation programs within home care nursing organizations. These programs could be part of the new home care nurses' orientation process and could focus on the needs of specific client groups, such as care of the frail elderly, medication issues of the incompetent older adult, palliative care, ventilator care. As novice home care nurses progress in their abilities to provide nursing care to these and other clients, they could request funding from home care nursing administrators to attend appropriate continuing education courses that would supplement their orientation process, and as a result they would become more proficient in their nursing practice. In this way, certain continuing
education courses are regularly offered and are available to new and current home care nurses, and are specifically based on the home care nurses' learning needs. These and other sources of nursing education can furnish the home care nurses with up-to-date and relevant information, skills, knowledge, and confidence to practice efficiently and effectively in the home care nursing setting.

With the development of competency based orientation programs, nursing educators need to continue to work together with home care nursing organizations to assure that the required competencies for home care nursing are used for ongoing assessment and evaluation of new and mature home care nurses. As nursing practice changes, mechanisms must be in place to identify new competencies, to update current competencies, and to measure the expected outcomes most often associated with these competencies. Performance expectations and the evaluation of outcomes are not only critical to the orientation process but also to the ongoing performance and evaluation of home care nurses. Self-evaluation, manager and peer evaluation of strengths and learning needs, formal periods of coordinated education and learning of the required clinical competencies and concepts for effective practice, and informal but planned preceptoring experiences are components of the orientation and evaluation processes. Nursing educators, in cooperation with administrators and CNSs in home care nursing, could devise preceptor courses for home care nurses that are relevant to home care nursing practice and that incorporate various methods for preceptors to exchange clinical information and nursing practices, and that evaluate patterns of nursing behaviours and activities. New home care nurses require preceptors or mentors who have skills and knowledge in all aspects of home care nursing practice. Preceptors, such as home care resource nurses, CNSs, nursing clinical coordinators and managers, require skills and knowledge in their area of expertise as well as in areas of education, group process, and organization and management concepts. Participants who were involved with the orientation of new nurses, and the preceptoring of nursing students, needed an orientation process that was organized in a systematic manner so that as mentors or preceptors they could understand and discuss their roles and functions as home care nurses, provide clinically relevant and current information, and demonstrate appropriate nursing care activities to the new nurses, and students, in a timely and ordered manner. An orientation process should be of sufficient duration so that competencies can be achieved, and identifies the specific competencies which
are time limited or time related so that they can be achieved when anticipated. In this regard, mentors or preceptors and new home care nurses are able to understand the organization's expectations of the orientation process and new home care nurses can focus on their learning needs.

Performance evaluation begins during the orientation process and focuses on the improvement of positive nursing care activities of the home care nurses. Administrators and mentors encourage and strengthen the home care nurses' positive performances, identify areas where knowledge is needed and standards of practice need to improve or nursing care activities need to change, and monitor or mentor these changes. Mentoring and peer support is ongoing as home care nurses continue to learn new competencies and as nursing practice changes. When competency based orientation programs are established by nursing educators and administrators together, performance standards of all home care nurses can be evaluated. The knowledge and skills of home care nurses that are the most valued by home care nursing organizations are those competencies that enable home care nurses to enact their duties in the most effective and efficient fashion. When nursing educators prepare nursing students for home care nursing, support the transition to home care nursing, meet the learning needs of home care nurses with nursing education and preceptorship programs that are germane to home care nursing practice, and assist new home care nurses to identify current skills which can be transferred to the new practice area and new skills which need to be learned, then nursing educators foster practice development and excellence, professional growth and satisfaction, decreased job turnover in home care nursing, and administrative acceptance of these programs.

**Implications for Home Care Nursing Research**

Study findings contribute to the overall understanding of the experience of home care nursing practice from the perspectives of home care nurses working in an urban community in the current health care system. The findings provide a basis for future research activities. Current changes in home care nursing, such as increased technological care in the home, increased numbers of clients requiring home care nursing services, suggest that home care nursing is in a dynamic state and will continue to evolve and change. With home care nursing's apparent dynamic nature, further research is recommended to track the changes in home care nursing practice, investigate the subsequent changes in knowledge and
skills requisites for home care nurses, and pursue the client complexity issues. Participants asserted that they had no method to accurately or relevantly reflect the increased complexity of their nursing practice, the lengthy client/family visits, and the time clients remain on service. It is advised that a more specific and consistent client data classification measurement tool is developed that identifies such areas as: the characteristics of clients seen; types of nursing care required; significant changes in nursing care required; client complications or issues; other services and care required; characteristics of family members/caregivers; abilities of clients, families, and/or caregivers to provide care; urgency of visits; amount of time taken to respond to requests for urgent visits; length of visits and reasons for visits' length; numbers of and reasons for clients' admissions to home care nursing; numbers of and reasons for clients not admitted; reasons for discharge from services; visit safety; and client outcomes. Other relevant client data to collect includes: preferred language spoken by clients and if translation services are required and received; sources of referrals; time between referral and first nursing visit; number of visits per client/month/year; number of client visits per shift/day/month/year; number of visits to client specific groups; frequency of client conferences; frequency of inservices for client specific care; and frequency of orientation episodes and length of time involved per day. Home care nursing would benefit from a client classification system that indicates the changes in acuity and chronicity of clients and demonstrates the reasons client care is complex and time consuming. A study to further document the direct and indirect nursing care activities of home care nurses would provide baseline information on their daily activities. It would begin to detail the nature of the client care requirements at home that are critical for management to know so that appropriate decisions are made about future home care nursing programs and resource allocation. This research could start to establish the acuity and chronicity levels of clients and identify the resources necessary to maintain these persons at home. As well, the impact of indirect nursing care activities, such as decision-making, communication, care coordination, might reflect the time home care nurses spend on these types of activities. For example, as client and family needs increase, so does the time required by home care nurses to coordinate client care. This activity is an aspect of their practice that is not documented and, thus, does not reflect the impact of client care needs on their nursing practice or the resources that are necessary to manage ongoing workload demands.
It is also important to note how the home care nursing organization is responding to the rapid rates of technological change and the needs of sicker, more unstable clients at home and to inquire how delivery of home care nursing services has changed because of the increased technological care in the home. Have home care nursing organizations kept pace with the demand for new technologies and client and family care needs in the home? Are nursing services accessible to all clients? Are home care nurses subsequently prepared in the management of these technologies and of complicated client and family situations so that the delivery of effective and efficient nursing services is sustained? Other questions to pursue include: what competencies do these organizations expect of home care nurses and how will they ensure that these nurses maintain these competencies? Studies in these areas of practice requirements would be useful for administrators and policy makers as they plan for future home care nursing services and for nursing educators who plan for the educational needs of home care nurses. The roles and activities of home care nurses may become as dynamic in nature as their nursing practice with the ongoing changes in health care delivery. Accordingly, it is necessary to identify the educational needs of home care nurses and to see if their needs are consistent with the expected competencies for home care nurses indicated by home care nursing administrators. In addition, it is of significant relevance to establish the evidence based nursing practices that are currently considered acceptable in home care nursing. These practices need to be identified and studied as to their pertinence and consequences to home care nursing practice. Home care nurses need to be assessed as to their current knowledge and skills in these nursing practices and whether their application of these practices are consistent, and whether any changes in practice needs to occur.

Research activities to pursue the effects of technological care on clients, families and/or caregivers, and home care nurses would be useful to examine whether client care is enhanced, client control is increased, and client outcomes are improved in the home, and if this type of care is appropriate and cost effective. The perceptions of clients and families/caregivers of the personal effects of 'high tech' care in the home setting on their lives are important for home care nurses who are involved in and who support client and family decisions about whether technology in the home is appropriate. Affirmative claims of client satisfaction and independence in self-care activities may reflect positive client outcomes and
favourably impact home care nursing practice. Further research could be developed to investigate the impact of client outcomes on the effectiveness of home care nursing practice, identify expected client outcomes of clients, families and home care nurses, and determine whether home care nurses' outcomes are consistent with client and family outcomes. Also, it is important to discover the criteria used by home care nurses to evaluate client outcomes, discern whether the criteria is used consistently by home care nurses, and find out how this information is documented in client files. Other research questions that could impact home care nursing practice and client outcomes might include: are there acceptable measurements of quality of life outcomes and if so, what are these measurements? Are there standards of nursing care developed that positively affect client outcomes? Can evaluation of the indicators of quality nursing care occur? The data acquired from such research may be of value to administrators in home care nursing as programs and services are planned, and may influence decisions made by policy makers regarding the allocation of health care funding from governments.

Research in the area of client and family involvement in care activities may also indicate that home care nurses have more available time to undertake other nursing care activities which could lead to more efficient use of home care nursing services and, thus, favourably impact administration. However, does the time involved in teaching clients and families to be self-care capable in technological care and complex care activities reflect a focus on the cost of nursing services, possibly at the expense of client outcomes? Do clients and families have to be self-care capable in 'high tech' care at home in order to have client care enhanced, client control increased, and client outcomes improved? This research has implications for increased client stress and caregiver burden as more difficult and complex tasks are expected of clients and families as clients are released home from hospital sooner than anticipated or prepared. As well, this research has implications for administrators in home care nursing as resources must be available to provide this care at home if clients and families do not participate in these care activities. Home care nursing practice is also affected in that a great deal of nursing time, for indefinite periods, is spent with these clients and families in providing this 'high tech' care, at the expense of other needy clients. In addition, research results could unfavourably impact home care nursing practice as home care nurses indicate that they are untrained in the management of technically complex therapies
and feel increased pressure to provide this care before they are ready, before they learn new knowledge and skills, or before clinical practice guidelines and protocols are established.

This research may also provide initial insights into home care nurses' reasoning abilities and may offer further research opportunities to examine clinical decision-making processes of home care nurses and to identify the factors in home care nursing that influence their decision-making. Participants expressed some concern about issues of client choices and client control when certain care decisions were made together. For example, home care nurses may ask: what elements affect client control over the decision to initiate the technology in the home, such as IV hydration for palliation or IV antibiotic infusion for treatment? What are the options and what would be the natural course of the illness without the technological intervention? Home care nurses make an impact on clients and families by advocating for their decisions, recognizing when technology is inappropriate, and assisting them to weigh the benefits and burdens of treatment regimens. Home care nursing organizations that examine the increased use of technology and its burdens and stresses on clients and families may find this research beneficial to home care nursing practice and to home care nursing administrators. Organizational guidelines, which direct the home care nurses' decision-making processes, may be an end result of this research.

With the increased use of sophisticated technology and complicated client care in the home, home care nursing organizations need to explore the ethical implications of the economic, demographic, and clinical changes in care in the home. The changes in types of services and clients in home care nursing complicate the home care nurses' practice. Research activities could be pursued to discover what specific ethical problems are encountered by home care nurses in home care nursing practice. This research could prove useful to home care nursing administrators as home care nurses identify the ethical issues and their perceptions and experiences related to these situations, the frequency of occurrences of ethical problems, and the factors that influence their decisions about ethical problems. Ethical dilemmas are stressful, frustrating, and often uncertain. Administrators may want to know if there is a relationship between job satisfaction, stress, and the frequency of ethical issues in home care nursing practice. It is unlikely that the frequency or occurrence of ethical problems in home care nursing can be diminished because of the nature of home care nursing practice. However, as mentioned earlier, home care nurses
need to be provided with the necessary tools to identify ethical dilemmas and with the support to individually and collectively resolve these issues in an effective manner. Research results could indicate that there are distinct ethical problems in home care nursing as compared to ethical issues experienced by hospital nurses within acute care settings. Home care nursing administrators could then identify common ethical problems in home care nursing practice and develop policies and procedures for the most commonly occurring issues, which in turn could impact and support home care nursing practice.

Job satisfaction is critical to the retention of home care nurses who provide excellent nursing care in the home. Research to study the requirements for job satisfaction of home care nurses could be important for home care nursing administrators in order to promote retention of home care nurses, effective utilization of home care nursing services, and quality home care nursing practice. Knowledge of the elements of the home care nurses' work that offer job satisfaction or cause dissatisfaction is useful for administrators in this area if they want to make changes that will lower dissatisfaction and will retain and attract qualified nurses. This research could have implications for the organization as a whole as the quality of working life, productivity, and quality of performance by home care nurses may be affected by stress and a lack of job satisfaction. Participants related in this study that the organizational restructuring created more than a feeling of uncertainty in their jobs but also a concern for the quality of their nursing care with the impact of the reorganization on their home care nursing practice. As well, participants felt a need for being part of the change process rather than being changed by the process. This research may produce further research activities that could inquire into the effects of professional and workload issues on the home care nurses' practice. For example, how can administrators recognize the unique aspects of home care nursing practice? How can administrators support home care nurses in their unique nursing practice as they work with interdisciplinary team members? How can administrators determine what workload issues will affect the retention of home care nurses? Such investigations may offer further insights into home care nurses' perceptions of work related stress, self-esteem, as well as job satisfaction and the coping mechanisms of these nurses which can positively or negatively affect the unique nature of their nursing practice. Administrators need to understand what levels of stress and self-esteem promote job satisfaction among home care nurses faced with the expectation that the quality of nursing care cannot
be sacrificed as workload demands increase, complex home technology is more evident, and complicated, sicker clients are the norm. These research activities, and others just discussed, not only impact the administrators and policy makers in home care nursing, but also the educational and professional needs of home care nurses, and ultimately the future of home care nursing practice.

In summary, this research investigation presents an initial introduction to the nature of home care nursing practice from the perspectives of community home care nurses who work within an urban health care setting. It also offers some direction for future activities in home care nursing practice, administration, health policy, education, and research. Additional research is required to articulate the significance of this specialty area of nursing practice. Although participants detailed their perceptions of home care nursing practice from an urban community perspective, it is important to pursue the perspectives of home care nurses working in rural areas in this province as well as in other areas of Canada. At some point in the future, home care nursing services could be transferable between the provinces of Canada. Information from home care nursing colleagues across the nation could provide a more complete representation of the experiences in home care nursing practice in a changing Canadian health care system, facilitate the health care delivery of Canadians, and advance home care nursing practice in Canada.
REFERENCES


APPENDIX A

Participant Information Letter to Home Care Nurses
Participant Information Letter to Home Care Nurses

My name is Nancy Keyes. I am a student in the Master of Science in Nursing Program at the University of British Columbia. From my work as a community home care nurse, I have become interested in the perceptions of other community home care nurses regarding their experiences as home care nurses. For my Master's thesis, I am studying these perceptions of home care nurses so that other nurses and health care professionals will understand what home care nurses experience when providing nursing care in clients' homes. The title of my thesis is, "Home Care Nurses' Perceptions of their Nursing Practice in Today's Health Care Delivery System".

Community home care nurses who are currently practicing in permanent full-time or part-time positions in home care nursing and have a minimum of three years of home care nursing experience are invited to participate in this study. As a participant, you will be interviewed about your experiences as a home care nurse today, the issues of practicing in a changing health care delivery system, and you will be free to add your own perspectives. Participation in this study will involve two or three interviews of approximately one hour in length, at a time and place convenient to you, either at your home or at the health unit. The interviews will be audiotape recorded and transcribed so that the information collected from you is accurate for analysis. These tapes and transcriptions will be stored safely in my home and will be destroyed upon completion of the study.

Any and all information that you provide will be kept strictly confidential. Any names or identifying information will be omitted from all the transcriptions and any research reports. You are under no obligation to participate, you may withdraw from the study at any time. Withdrawal or non-participation in the study will not jeopardize you professionally or personally.

Participation in this study will not cause any risks. Benefits may include personal understanding and clarification of the meaning of home care nursing practice to you. Professionally, your perspective of home care nursing may assist others to understand home care nursing practice in a changing health care system and provide information that will assist in the preparation of nurses for home care nursing practice.

If you are interested in more information about this study, please call me or my faculty thesis advisor, Connie Canam. I will answer any questions that you have about the study and if you are interested in participating in this study, we will arrange a mutually convenient time to meet. At that time, I will obtain a written consent form from you prior to the interview. I appreciate your interest and participation in this study.

Thank you for your consideration.

Nancy Keyes  BSN
Graduate Student
UBC School of Nursing

Connie Canam  MSN
Assistant Professor
UBC School of Nursing
APPENDIX B

Participant Consent Form
Participant Consent Form

Title of Study: Home Care Nurses' Perceptions of their Nursing Practice in Today's Health Care Delivery System

Investigator: Nancy Keyes BSN
Graduate Student, UBC School of Nursing

Faculty Advisor: Connie Canam MSN
Assistant Professor, UBC School of Nursing

I understand that the purpose of this study is to describe my experiences as a home care nurse in the present health care system. Nancy Keyes, the investigator of this study and a candidate in the Master of Science in Nursing Program at the University of British Columbia, has explained the study to me.

I understand that I will be interviewed two or three times for approximately one hour each time and that I will be asked questions about my perceptions of home care nursing practice and my experiences as a home care nurse. I understand that these interviews will be audiotape recorded and that at any time during the interview that I can ask for the tape, or portions of the tape, to be erased. I understand that I can refuse to answer questions and can withdraw from the study at any time. If I withdraw from the study, I understand that I will not be penalized professionally or personally.

I understand that any and all information that I provide will be kept strictly confidential and will not be used for any other purpose than for the study or reports of the study. Furthermore, transcriptions of the audiotapes will have all identifying information removed prior to submission to the thesis committee members and my name will not be used in any research reports.

I understand that only Nancy Keyes and her thesis committee members will review the transcriptions of the audiotapes. All audiotapes and transcriptions will be stored safely and destroyed upon completion of the study.

I have read the above information and have had an opportunity to ask questions. I understand that I can ask further questions of Nancy's thesis advisor, Connie Canam. I freely consent to participate in the study and acknowledge receipt of the Participant Information Letter and a copy of the Participant Consent Form.

Signature of Participant_________________________ Date___________

Signature of Witness____________________________ Date___________
APPENDIX C

Sample Trigger Questions
Sample Trigger Questions

1. Based on your background and experiences in home care nursing, describe your practice as a home care nurse. (Tell me about your experiences in delivering health care to clients at home).

2. Can you describe an experience that stands out for you in your practice?

3. Can you think back on a rewarding experience and tell me about it? (Can you describe an experience that was not rewarding but it stands out for you?).

4. How has your practice changed over the past couple of years? (In what ways?).

5. What things have stayed the same in your practice?

Non-directive questions that can facilitate the discussion might include:

6. Can you elaborate on that? Have you anything else that you would like to add?