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**ENABLING CHOICE: PUBLIC HEALTH NURSES'
PERCEPTIONS OF THEIR WORK WITH
CHILDREN AND FAMILIES**

**A thesis presented in partial fulfilment of the
requirements for the degree of Masters of Arts in
Nursing at Massey University**

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ABSTRACT

The purpose of this study was to provide understanding of the personal practice of public health nurses with their clients, in particular with children within the context of their family. A grounded theory approach was used for the analysis of the data and the generation of a theoretical description and explanation of the way public health nurses perceive their practice world. Data were gathered through in depth interviews with public health nurses and were analysed through the method of constant comparative analysis.

Enabling choice as a theoretical framework was formulated to describe and assist others to understand the possibilities that public health nurses aim for in their encounters or relationships with their clients. A number of concepts were identified from the data which contribute to the way public health nurses work to enable choice for their clients. These include the way nurses become accessible to their clients through a process of becoming known and accepted. The way public health nurses frame their practice, assess their clients, and use interaction with their clients within an encounter or a relationship is also described within the framework of enabling choice for clients.

Metaphors used by the nurses to describe their practice highlighted contradictions related to the influence of the social context. The consequences of the constraints implicit in the social context of community health nursing practice were discussed as they impacted on the ability of the public health nurses to enable choice for their clients.

Public health nursing has not been well documented or understood. The findings of this study go some way towards creating a framework within which to understand and explain aspects of community health nursing practice.

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INTRODUCTION AND OVERVIEW

There are few documented studies of nursing practice in New Zealand and even fewer in the area of public health nursing practice. Of the descriptions of public health nursing which do exist, few go beyond an orientation to tasks. Consequently the complexities of public health nursing practice are poorly understood. As a response to this gap in nursing knowledge the *aim* of the study reported in this thesis was to explore with public health nurses the day to day experiences of their practice, and in doing so to clarify the nature of the nurse-client interactions in this context, and to uncover the meanings which the nurses attach to their work.

Definition of public health nursing

For purposes of this study public health nursing is taken to be a specialist field of community nursing. Although public health nursing has its roots partly in epidemiology, population health and public health nursing science, this study is concerned with the personal health services component of the role. That is, the service public health nurses provide to their clients, in particular children and families within the context of the preschool, the school and the home.

A common way of differentiating fields of nursing practice is on the basis of location or setting. For instance there is a broad distinction drawn between nursing that is institution or hospital based, and that which takes place in community settings. The scope and function of community nursing practice has evolved in response to historical influences, government policies, societal expectations and specific patterns of health problems and treatment needs, and it continues to be shaped by them.

In New Zealand three distinct areas of community nursing practice have emerged, each with its own focus, identity and culture. These are District Nursing which continues the treatment focus of institutional nursing but takes this beyond the hospital walls; Plunket Nursing¹ which grew out of the concern for the health and the wellbeing of new mothers and infants; and Public Health Nursing for which the orientation is illness

¹Founded in 1907 the Plunket Society, initially a voluntary organisation but is now largely reliant on government funding has its own infant and preschool health clinics and training programmes.

prevention and health promotion. Traditionally the focus of public health nursing has been that section of the population which, for economic or social reasons, appears to be less able to access primary health care through avenues such as Plunket Nursing or General Medical Practitioner consultation.

The researcher's interest in public health nursing stems in part from a background in this type of practice. It is also relevant to her current position as a nurse educator in an undergraduate degree nursing programme, with a special responsibility for the practice areas of community health. Not only is it important that the educational programme accurately reflects the reality and currency of community nursing practice, it is also critical that the theoretical frameworks to which the students are introduced actually fit the practice world.

Significance of the study

In arguing for conditions and resources which facilitate high quality practice, nurses are often hampered by lack of documentation which captures in full both the depth and scope of their practice, and the health related outcomes which are achieved. A study such as the one described below is necessary in order to generate understanding of what public health nurses do. There is a need for a study to identify the requirements of beginning as well as more experienced public health nursing practitioners. There is also a need for research which captures the diverse content and the subtleties of practice which distinguish it from the functions of other related professional and non-professional health workers. However, in a time of severe fiscal restraints there is an even *more* urgent need for research that can make visible some of the taken for granted aspects of public health nursing. For any service to survive the wave of structuring and reform which recent governments have imposed on the publicly funded health care system it is imperative that accountability and cost effectiveness can be demonstrated. Any attempt to evaluate a service requires that its nature be clearly articulated. The low visibility of much of nursing practice leaves it particularly vulnerable to both misunderstanding and neglect by funders. Without the necessary research evidence to support the claims, arguments about the essential role of public health nurses in maintaining the health of children, families and communities may fall upon deaf ears.

The initial research questions used to guide this study were:

How do registered nurses working in the community context of public health nursing

describe their work?

Who do they consider to be their client or clients?

What are their perceptions to the nature of these ongoing interactions with client?

What is the context of their work?

How central is the nature of these encounters to community nursing practice?

What beliefs and conceptual frameworks give meaning to their work?

What kinds of knowledge inform their practice?

The *design and methods* adopted for this study consist of a qualitative research approach in which in-depth, largely unstructured, interviewing was used to obtain first hand accounts of the practice of public health nurses working in a New Zealand setting. Public health nurses from an urban, a semi urban and a rural setting were represented in this study. Transcripts of these interviews were then analysed according to strategies for generation of grounded theory.

Structure of the thesis

Having introduced the focus, aim and research questions for this study the account which follows is structured as outlined below. **Part 1** consists of four chapters, the content of which provides background for the study and a discussion on the proposed methodology and its implementation.

In *Chapter 1* there is discussion on the background to community health nursing. The literature relevant to community health is reviewed, particularly from an international perspective with the aim of locating New Zealand public health nursing within an international context.

In *Chapter 2* the literature relating to the New Zealand public health nursing scene is explored and discussed.

In *Chapter 3* the focus is on the research design and methodological issues relating to the study. Discussion includes issues relating to rigor and qualitative research.

In *Chapter 4* the processes of data analysis using grounded theory methodology, trustworthiness of the data and their interpretation are outlined and discussed.

In **Part 2** analysis of the data is presented, and the findings summarised in the form of a theoretic interpretation by descriptions of a series of categories, concepts and subconcepts, which illustrate the meaning grounded in public health nursing practice. Finally these categories are combined in an emerging theory relating to the practice of

public health nursing. The context as it impacts on the personal practice of public health nurses is also uncovered and discussed.

In *Chapter 5* the antecedent conditions of public health nursing, including accessibility, acceptability and visibility are surfaced from the data.

In *Chapter 6* the ways in which public health nurses conceptualise and frame their practice are identified, including discussion on who public health nurses see as their primary client.

In *Chapter 7* the assessment processes public health nurses use to collect and interpret meaningful data about their clients are discussed.

In *Chapter 8* the way public health nurses work with their clients is identified. Relationships with other professionals and the way public health nurses refer their clients are illustrated.

In *Chapter 9* the context as it related specifically to the personal practice of public health nurses is delineated.

In *Chapter 10* the emerging theory is described.

Part 3 consists of one chapter, *Chapter 11* in which there is a discussion and summary of the findings, including discussion on implications for practice, and nursing education. The study is critiqued and areas for further research are identified.

CHAPTER ONE

LITERATURE REVIEW.

In this chapter background literature is introduced relating to the practice of registered nurses working in the community. Particular emphasis is given to the literature relevant to the practice of nurses working in preventative and health focussed services. The chapter begins with an overview of the nature of community nursing, then considers the impact of the philosophies which shape community nursing practice. Historical, as well as current social influences on the practice of public health nursing are identified in the literature. Following this general introduction, studies from the international nursing community are examined for their contribution and relevance to the personal practice of public health nursing.

Overview of Community Nursing Practice

The aim of this section is to situate public health nursing practice, as it is carried out in New Zealand, within the context of community nursing practice both nationally and internationally. Philosophies which influence practice are identified and discussed, and the way in which the personal aspects of practice fit within the broader framework of health promotion and prevention of illness, will be outlined.

In New Zealand, as occurs overseas, there are a variety of nursing services provided by registered nurses working in the community. Williams (in Saucier, 1991), referring to apparent difficulties in defining or distinguishing between the different types of community nursing practice states that: *Many nurses seem to be in a semantic and conceptual muddle about the nature of community nursing practice* (1991:39).

Littlewood (1987) for example, writing in England, focuses on the role of the nurse, seeing a wellness orientation as opposed to a treatment modality as the distinguishing feature of nursing in the community. For Littlewood, nursing in the community is defined by the role of the nurse. In contrast Pybus (1983), writing about New Zealand nursing in the community, and McMurray (1990), writing about the English scene, avoid naming or describing a specific role for the nurse in the community, although Pybus does touch on a few speciality roles. Both are clearly using a health and wellness focus to define nursing in the community. Pybus, seemed to have the aim of editing a

book that met the needs of all community health nurses regardless of the focus of their practice or their role. Major social changes over the last decade make some of the content of that volume appear dated, so pointing to the need for a more contemporary statement.

Nursing services in New Zealand, developed in a haphazard fashion to meet identified health needs as they arose in the community. Kinross, Nevatt & Boddy classify these services into the *preventive and health oriented public health nursing service* provided by public health nurses...and the *clinical treatment service of district nursing which provides nursing care for ill or disabled people in the community* (1987x). Maternal and child health services are provided in New Zealand by registered nurses, named Plunket Nurses who are employed by the Royal New Zealand Plunket Society (see footnote, page 1). In rural areas in New Zealand there are public health nurses who function as generalist nurses, carrying out a health protection and health promotion function as well as providing clinical treatment services normally carried out by district nurses and infant and child health services usually provided by the Plunket Nurse (New Zealand Nurses Association Report 1980).

The focus of this study is the personal practice of registered nurses who are employed in New Zealand as public health nurses. These practitioners provide preventive and health oriented services, to individuals, families and communities. The literature relating to practice in these areas often refers to nursing practice with a wellness focus, as community health nursing practice. In spite of the ambiguities in defining community nursing practice identified by some writers, public health nursing and health visiting practice clearly fall into the area of community health nursing as described by Anderson & McFarlane (1988), Bullough & Bullough (1990) and Clark (1992). In their writing they emphasise the contribution public health science, epidemiology and health education and health promotion have to play in assessing and promoting the health of individuals, the family and the community. A WHO expert committee report (1974) on community health nursing has as its central focus and goal, the attainment of the concept of health for both the community and the family.

Outside New Zealand nurses who work with a focus on health, illness prevention and health promotion include health visitors in England and public health nurses in the United States of America. Although the scope and function of the practice of these

community health nurses varies from country to country, wellness and health promotion are commonalities. In this thesis nurses, such as health visitors and public health nurses who have a health promotion, wellness perspective are referred to generically as community health nurses. Relevant studies and literature based on the practice of community health nurses, including health visitors and public health nurses in countries other than New Zealand will be reviewed and critiqued in this chapter.

In New Zealand, public health nursing is strongly aligned with the primary health care model, initially described in the Alma Ata declaration (WHO 1978) and subsequently developed as a framework for practice by the Department of Health in New Zealand (Board of Health Standing Committee on Primary Health Care, 1988). Primary health care (WHO 1978) is described as 'a philosophy, a set of activities, a level of care and strategies' all of which are characterised by a commitment to 'social justice and equity, self responsibility and a belief in a broad concept of health.' The Ottawa Charter (1986) as a development of the Alma Ata declaration also provides an identifiable framework for health promotion as it is incorporated into public health nursing practice in New Zealand. The Ottawa Charter is concerned with the process by which people are enabled to improve their health by having more control over their environment at both a community and a personal level.

Prescriptions and guidelines for the practice of public health nursing in New Zealand often use a primary health care philosophy and framework based on the Alma Ata declaration and the Ottawa Charter, for instance the guidelines for practice developed by the Palmerston North public health nursing service (1992). In a position paper developed by a working party of public health nurses (Wellhealth 1992), the underlying philosophy is clearly based on primary health care and the Ottawa Charter. Writers commenting on the area of community health nursing practice in countries other than New Zealand, such as Meleis (1991) and McMurray (1990, 1992) have stated that nurses are key personnel and pivotal in the planning and delivery of primary health care. Littlewood (1987) writing about community health nursing practice in developing countries where there is a shortage of appropriately educated health professionals, identifies that community health nurses act as team leaders, assessors and teachers of other care givers. The researcher saw this happening during observation of primary health care provision during a recent trip to Indonesia.

Common concepts identified in the literature focusing on practice at a community level, are involvement, partnership, choice and empowerment. These are key concepts in the underlying philosophies of the Alma Ata declaration and the Ottawa Charter. Authors such as Woods (1991), who use a primary health care model as a framework in their exploration of community health nursing utilise these concepts when prescribing methods of practice for working in the community. Other authors such as Steuart (1985), Abbott & Wallace (1990), Clare (1991), Eng, Salmon & Mullen (1992) all of whom write about aspects of nursing in the community and whose work is based on a critical social science philosophy are also concerned with aspects of empowerment, in particular, to highlight why current methods of working inhibit or disallow empowerment of communities. Abbott & Wallace (1990) echo this theme in their work on health visitors when they argue that public health goals of prevention of infectious diseases and the strategies employed to avoid contamination of healthy people, led to a philosophy of community health practice grounded in control and disempowerment of groups of people. In reviewing the literature, the use of primary health care as a model and critical social science as an underlying philosophy in describing or analysing community health nursing seems to be much more common in England than in the USA.

Generalist or specialist practice?

For the purpose of this study public health nursing has been identified as an area of specialist practice. In 1987 ICN proposed a definition of specialisation:... *implies a level of knowledge and skill in a particular aspect of nursing which is greater than that acquired during the course of basic nursing education:* (cited in ICN report, 1992).

An ICN report on guidelines for specialisation in nursing (1992) states that no universal pattern for regulating specialists is found, however evidence should be provided that certain criteria can be met. Although public health nursing in New Zealand meets many of the criteria, other criterion such as the demonstration of advanced preparation through a recognised education programme does not occur at this time. Kinross et al (1987) in a New Zealand project undertook a study where the practice of district nursing was combined with that of public health nursing. Following one year of generalist practice, the nurse then worked only as a public health nurse. In addition to the different aims of the services differences in the way the practitioners thought and practiced were revealed:

District nurses and public health nurses have some overlapping skills and a common knowledge base, but both develop expertise in particular areas, and both have their own specialised knowledge and experience. There are also differences in pace, approach and even in thought patterns. (1987:199)

Focus of Practice

Community health nursing is concerned with the provision of a community based, wellness focused preventative health service provided by nurses. Although the intention of this study is to examine the personal practice of New Zealand public health nurses, because of the nature of their practice it is important to at least review the literature which considers other perspectives or aspects of their role. The literature identifies that intervention by community health nurses, including public health nurses, may be at a community level, at a family level or at an individual level.

Practice at a community level

Some authors describe community health nurse assessment, planning and intervention occurring at a community level. They tend to adopt the population health, rather than the personal health model. The focus of practice of nurses working with communities is strategic planning, policy formulation and health promotion in an effort to enable groups of people to attain their health goals. It is not intervention at an individual or family level. Anderson & McFarlane (1988) writing about community health nursing, describe the use of an epidemiological, or population health approach in their prescription for working as a community health nurse. In a very general statement, unsubstantiated by evidence, they highlight their beliefs about community health nursing practice.

The nursing profession has declared public/ community health nursing a speciality area of practice, differentiated from other nursing specialities by the client that it serves, which is a community, an aggregate of individuals who share a common characteristic, be it geographical, health or social condition. (1988:ix)

Other writers also focus on the community as an agent for intervention. Eng et al (1992) described a critical social science approach to working with the community, using concepts such as primary health care and empowerment. Clare (1991) also used a

critical social science approach in her paper on primary health care and the provision of community health nursing, with the community being considered as the client. Woods (1991) writing in New Zealand linked primary health care and the concept of the community as the client. Chalmers & Kristjanson (1989) in an article which explores the theoretical implications of viewing the community as the client, identify key issues in the debate. Their statement, that although nursing literature identifies a role for nurses intervening *at a community level* the lack of clarity regarding specific aspects of nurses' work and its outcome, indicates the gap between theoretical perspectives and practice applications.

While many authors identify issues relating to practice at the macro level, the link between theory at a community level and the practice of individual nurses is not well described. There are very few studies which test theory at the macro level, where the client of the community health nurse is the community. Finnegan & Ervin (1989) and Schultz & Magilvy (1991) are researchers who have carried out studies at a macro level. Both studies test methods of community assessment by applying different data collecting models to a community and analysing the results. Shultz & Magilvy (1991) in their study focused on the community as the client, and analysed whether data collection by one of three methods was more effective in assessing the health needs of a sub-population aggregate consisting of one hundred people aged over sixty years living in a particular geographical location. Unsurprisingly, the findings identified that the best information included data from all three assessment methods.

Sometimes, definition of the community as the client seems to be simply rhetoric. After defining the focus of community health nursing practice as *the unseparated mass*, Rankin & Leversage (1991:21) writing about public health nursing in Canada, continued to define their practice by citing six paradigm cases, five of which described how the practice of community health nurses made a difference to the health status of individual or family. Other authors such as Williams in Saucier (1991) discuss the dissonance between the 'discourse' of community health nursing practice which focuses on nursing the community, and the reality of practice described in many studies which is concerned with intervention at an individual and family level. The dissonance identified by Williams is illustrated in the work of Bullough & Bullough (1990) and Clark (1992) who, while presenting a view of community health nursing from an epidemiological, population health perspective, propose a model of the nursing process

to be used as a tool at an individual level.

In identifying the community as the client as a perspective in community health nursing practice, the literature which advocates this approach tends to be theoretical, abstract and untested in practice. In reality, community health nursing practitioners, including New Zealand public health nurses, function at more than one level. They may be active at a policy making level but they are certainly involved in the provision of personal health care for individuals and families.

Examination of other literature where the community is identified as the focus often highlights a predominant theme which is the potential for community change and attainment of health through interventions aimed at individuals and families. The clients of nurses who work in the community are perceived to be these individuals and families within a community setting. Litchfield (1991) in a discussion of Primary Health Care argues, that even within a primary health care framework where the focus may be seen to be on community action, 'self responsibility' as individual action is advocated. She comments, *Yet an individualistic view of health is found in the ethical basis for the World Health Organisations's presentation of primary health care* (1990:50). McKay & Segall in Saucier (1991) present an alternative point of view, stating that the community may be considered to be the target or the focus of community health practice, or it may be seen as the social context in which individuals and families live and interact.

Practice of nurses with individuals and families

Community health nursing practitioners work with individuals within a family context and with families within a community context. This work constitutes the personal practice of public health nurses. Community health nursing practice with its emphasis on health promotion and wellness, as presented in the literature, tends to down play the individual as the client. However, research studies in this area present a different picture. There are many studies which focus on the individual as the client of the community health nurse. Clark (1984), Kinross et al (1987), Luker & Chalmers (1989), Cowley (1991) and Luker & Chalmers (1990) all report studies where the individual has been the focus of the community health nurse's practice.

Some studies describe how the nurses use their relationship with the individual as a means to another end. Luker & Chalmers (1990) described using a relationship with an

individual family member to access the family. Zerwekh (1991a, 1991b, 1992) in one of the findings following an analysis of the data collected from thirty public health nurses in a study carried out in the United States described how the nurses work with mothers to ensure safety for children perceived to be at risk.

Other sources suggest that community health nursing practice is family nursing practice, and the primary unit to be considered in the delivery of community health nursing care is the family. Friedman (1992) in her ongoing work focuses on the knowledge and skills nurses need to work with families. Although Friedman is commonly cited as an appropriate text for nurses who work with families in the community, her work is based on a sociological perspective and draws little on nursing theory. Kristjansen & Chalmers (1991) in a report which examined the issues facing public health nurses who do preventative work with families, identified the family as the primary concern of the public health nurse. Lapp, Diemert & Enestvedt (1991) describe an intervention model based on the family as the client of the public health nurse.

Some authors assert that working with the individual as the client or working with the family as the client are two different things. Gillis & Davis (1992) state that:

*Family members are individuals with the properties of individuals.
Family groups are groups with the properties of groups. Family
members are not interchangeable with the family group though they are
often treated as if they were. (1992:29)*

Many studies while stating their focus as family centred, on analysis are actually describing contact with an adult member usually the mother. Examples of such studies are the following: Clark (1985) in a study on health visiting with families interviewed mothers over a twelve month period; and Sefti (1985) in another study also focuses on the analysis of the interactions between health visitors and mothers. Vehvilainen-Julkunen (1992) a Scandinavian researcher, introduced an added dimension into her study on client-public health nurse relationships by analysing the possibilities of all the relationships between the public health nurse, the mother and the child.

Twinn (1991) presents a different view, in her analysis of the underlying philosophies of the practice of health visitors She argued that the focus of practice is not the family but the individual, usually the mother. Abbott & Wallace (1990) also argued in their

analysis of the work of the health visitor that the focus of practice is the caregiver of the child, predominantly the mother. Gillis & Davis (1992) identified that many reports of studies found the mother to be the primary caregiver in the family, and as such, the focus of the community health nurse's practice. They stated that if community health nurses describe their practice as family practice, the mother and her pivotal role in the provision of family health may be rendered invisible. McMurray (1990) in her book, which melds theory on public health nursing, family care and change theory in order to analyse the role and scope of practice of the community health nurse, neatly side steps the issue by describing the nurse working in the community as; *simultaneously considering and enabling the health care needs of individuals, families and aggregates in total* (1990:8).

Theory and Knowledge for Community Health Nursing Practice.

The literature identifies different approaches to both the development and application of theory that is relevant to the practice of community health nursing. Hamilton & Bush (1988) in an article which reviews a variety of sources in the literature, identifies different kinds of theory that is either used by community health nurses, or has been identified by authors as being able to provide a framework for community health nursing practice. They identify the following approaches

- * the synthesis of two different bodies of theory.
- * transforming theory from a non nursing discipline into community health nursing theory such as the use of family theory.
- * generic nursing theory transmitted, modified and used as community health nursing theory.
- * theory generated from a unique community health nursing perspective.

Synthesis of nursing theory and public health theory as a basis for practice

The synthesis of two different bodies of theory such as nursing theory and public health theory, is used by some authors, to provide prescriptive guidelines for community health nursing practice. Examples of this approach can be found in texts on community health nursing practice such as Freeman (1981), Anderson & McFarlane (1988) and Bullough & Bullough, (1990). Other writers, for example Hanchett & Clark (1988) writing about frameworks for community health nursing practice, have

identified some of the difficulties arising from an approach involving synthesis of two, often disparate, theories. These difficulties arise from the inconsistencies in the synthesised framework which occur through combining public health theory based on a received view supported by research processes that favour quantitative methodologies, with nursing theory derived from a non received view. The inconsistencies arise, because the public health theory philosophies of reductionism, prediction and objectivity are incompatible with uncertainty, holism, pattern recognition, subjectivity and human values which can be recognised as the central philosophies or beliefs underpinning current nursing theory.

Synthesis of nursing theory and primary health care as a framework for practice

In New Zealand, as in several countries overseas, primary health care is an important framework in the provision of community health nursing care. The synthesis of a primary health care model with existing or developing nursing theory seems to hold promise as a framework for the provision of public health nursing practice. Several papers, for example, Chick (1991), Woods (1991), Litchfield (1991), presented at the 1990 International Conference, on Nursing Theory and Primary Health Care held at Massey University in New Zealand, addressed some of the issues arising from this approach. Chick (1991) in her introduction acknowledged the difficulties experienced in the reconciliation of nursing theory with its focus on the individual, and primary health care with a focus on community. She called for a development of nursing theory in partnership with primary health care, from research grounded in practice. Chick (1991) reminded nurses that the development of nursing theory had the positive outcome of redefining nursing in relationship to health and that primary health care also shares with nursing theory a focus on health rather than illness.

Clare (1991) took a different approach, she acknowledged that primary health care is situated within a sociopolitical and cultural context and that nursing theory which does not take account of the context has little to offer primary health care. Litchfield (1991:43) in an important paper at the same conference identified key elements of both nursing and primary health care theory, highlighted differences in their philosophical underpinnings, and suggested that theory which is able to connect their opposing sets of factors would be best able to meet the challenges and *express a coherent framework for practice*. The opposing sets of factors she identified as, the focus on the client as an

individual within the personal private dimension of their lives and the focus on communities and populations which includes the public domains of people's lives.

The use of non nursing theory as a framework for practice

Public health theory and primary health care models are examples of non nursing theory used to inform community health nursing practice. Family theory has also been considered important by researchers who study community health nursing practice. Whall (1986) in a historical review of *the family as the unit of care* found that public health nurses were the first nurses to emphasise service to families. She claims that families as a focus of care and analysis need to remain central to public health nurses' practice.

Many authors, writing about public health nursing or health visiting have described how family theory informs community nursing practice. Friedman (1992) used structural functionalism, systems theory and developmental theory, as models for family assessment and intervention in family nursing in the community. Lapp et al (1991) also used family theory in the development of an assessment, intervention model for community nursing practice. Vahldieck; Reeves & Schmelzer (1989) describe a model designed to be used by public health nurses in order to plan and provide a comprehensive nursing service for their clients. In their model they describe a methodology for integrating assessment of health needs and families coping abilities. Using a model focussed on intervention with multiproblem families Lynch & Tiedje (1991) also develop family theory into a framework for use in the resolution of potential areas of conflict between providers and clients.

There are problems associated with the use of borrowed theory as a model for nursing practice. Borrowed theory may not 'fit' the nursing context, and most theories have not been adequately tested or are not necessarily congruent with the practice of nursing. Kristjanson & Chalmers (1991) in an extensive literature review on the application of 'family theory' in nursing practice identified that there has been inadequate testing to determine whether the nursing intervention should be at the family or macro level. They state that there has not been enough evidence to support the assumption that positive outcomes from intervention result from prevention or at least early intervention in family problems. They also highlight their belief that the work with families requires nurses with specialist expertise. Gillis & Davis (1992) in their critique of the way

community health nurses work with families, also identify some of the assumptions that are made in family theory which may hinder the nurse practitioners' work with families. The work of Kristjanson et al and Gillis et al is valuable in that it illustrates the inconsistencies between saying one thing, for example 'working with families' and doing another 'working with the mother'. Both reports are concerned with the uncritical application of borrowed theory to nursing practice and both provide evidence of the need for the development of theory which has a *nursing* focus within a community family context.

The use of generic nursing theory transformed and transferred to community health nursing practice

Nursing theory which has been developed in or for other nursing situations has been proposed and used as a framework for nursing in the community. Orem's Self Care Model (1980, 1991) is an example of nursing theory which has been applied and tested in the community. In the application of nursing theory in the personal practice of community health nurses, frameworks must be consistent with a health promotion, illness prevention orientation as well as accommodating the necessary consideration of population health or primary health care.

Extant nursing theory that has been developed in practice, albeit practice in a different area of practice than the community, and with individual clients seems to provide a possible framework for community health nursing practice. One theory that seems to hold possibilities for public health nurses working in a New Zealand setting is that developed by Christensen (1990) in a qualitative study in a surgical area in a New Zealand hospital. 'The Nursing Partnership' is the patterned outcome of the interrelationship of the elements of 'lived experience' (which is the experience of change over a period of time), mutual work and the context. Christensen describes 'mutual work' in which the expertise of both parties is utilised in a patterned interaction, and the contextual elements as factors within the context of the nursing experience, the lived experience and the environment which influence the nursing partnership. The nursing partnership theory was developed in an acute care setting through analysis of the interactions between nurses and their patients. While it does seem to be a theory which is philosophically congruent with beliefs about public health nursing, further testing by applying the concepts inherent in the theory to community health nursing practice, would be necessary.

Theory generated from a unique community health nursing perspective as a framework for practice

An overview of the literature and research relating to community health nursing has revealed that much of the literature provides theoretical propositions and prescriptions for community health nursing practice. However, it is encouraging to discover an increasing number of studies which have been concerned with generating theory from the observation or the immersion of the researcher in the practice world of community health nurses. The literature includes a core group of nurse researchers who are concerned with community health nursing practice. In England there have been several qualitative studies concerned with the practice of health visitors, and much of this work has direct relevance to the practice of public health nurses in New Zealand. Canadian nurse researchers, some with identifiable links to their English colleagues have also studied community health nursing practice and in the USA there have also been important studies which have contributed significantly to the knowledge surrounding and embedded in the practice of public health nurses. These studies have the potential to generate theory which provides understanding and explanation of community health nursing practice and are discussed in the next section under the heading - *studies on community health nursing practice*.

Studies on Community Health Nursing Practice.

An early significant published study on community health nursing was a quantitative study using a survey method, which looked at one aspect of the work of the health visitor, the home visit (Clark 1976). Her study provided a model for at least one other study namely the research project carried out in New Zealand by Blakey & Bradley (1980) looking at the work of public health nurses in Dunedin. The findings in the English study showed that the focus of the health visitors' work was not individuals but the family, and by analysing the records for the reasons of the home visit, it was shown that there was tremendous variety for the visits. Problems related to physical health were important but a large number of visits were also concerned with what Clark termed as 'social care.' Clark's study was important in that it provided an impetus and a model for future studies. However, it did not capture the essence of health visiting, probably because of the choice of methodology.

Another important study was that carried out by Field (1983) in which an ethnographic

approach was utilised to analyse four Canadian public health nurses' perceptions of public health nursing practice. Her findings highlighted the significance individual experience has in influencing the way in which public health nurses practice. The nurses' own priorities also determined their practice focus. Field identified that the nurse's perspectives seemed relatively resistant to change in spite of subsequent educational preparation. Other situational factors such as lack of feed back from clients or peer group *did not lead nurses to question their model*. Questions arise from Field's study relating to the impact of individual experience of nurses on health outcomes.

There appear to be a number of studies on health visitors work reported in unpublished theses; Clark (1985), Chalmers (1990), Zerwekh (1990). In most instances critical issues arising out of these have been cited in subsequent published studies. Clark's 1976 study used quantitative survey methods, in an endeavour to identify the work of health visitors. Luker and Chalmers (1990) in their article on 'gaining access to clients' report that there has been an increasing move towards qualitative studies. Clark (1985) cited in Luker and Chalmers using a content analysis method developed a conceptual framework for health visiting. Robinson (1987) also cited in Luker and Chalmers (1990) used Clark's data to analyse home visits.

Recent qualitative studies in the area of community health nursing practice seem to favour a grounded theory approach. Luker and Chalmers (1989) report a comprehensive study using such an approach in which they interviewed forty five experienced health visitors. In a report on some of the findings of the study they discuss the issues surrounding the referral process in health visiting. The way health visitors manage the referral process for their clients is highlighted and documented. Boundary issues, previous experiences with health visitors and with authority influenced the encounter as did the assistance given by other professionals who sometimes 'paved the way'. Occasionally an authoritative approach was used to gain entry this approach was seen by the authors to occur if there were concerns for the welfare and the safety of the children.

In another article expanding on the same study they explore the data relating to entry or access to client/family situations (Luker and Chalmers 1990). The findings suggested that many strategies were employed by the health visitor to facilitate entry and re-entry. Analysis revealed the processes inherent in the 'entering' and 'reentering' into client

situations to begin or continue the work of the nurse. Chalmers now writing in Canada has continued to report on the findings from her PhD thesis. In a recent paper (1992a) she discusses and conceptualises the findings of her original study relating to working with men within the family context of health visiting practice. She identified four approaches which enhanced or restricted interventions in working with men in families that were used by the health visitors (Chalmers 1992). She makes the important point that much of the work in families that is described by health visitors, is really conceptualised from interactions with women, these interactions become generalised to describe work done with families, but they really pay no heed to individual contributions that may be gender dependent. She also points out that little is known about how the contribution of the way in which health visitors work with their clients impacts upon which family members may become clients. Chalmer's study and her subsequent reports are important in that the research questions are congruent with the research method used, enabling description of health visiting practice to arise from the data. The resulting findings have freshness and believability conveying a sense of reality to practitioners who have worked in a similar area of practice.

Kristjansen & Chalmers (1990) carried out a study in Canada in which they used computer generated content analysis to reveal the detailed elements of public health nurse-client interactions. The integrating conceptual model developed from the findings was described as 'creating common ground'. Kristjansen & Chalmers believe that the conceptual model captured the give and take *as each participant defined territory and revealed information* (1990:215). While the concept creating common ground has 'grab', the author appears to have used it as a 'catch all' concept. Careful reading of the study indicates that the contributing categories may have more to do with negotiating a relationship within terms that were comfortable to both parties, rather than necessarily sharing meanings that the term 'creating common ground' suggests.

In a more recent paper (Chalmers 1992b) the author discusses her 'empirically' derived theory of health visiting practice which she conceptualised as 'giving and receiving'. Her emerging theory provides explanation and understanding of how health visitors work with clients in the community during their day to day visiting practice (1992:1317). The central idea is that both clients and health visitors manage the interactions by regulating what they offer and accept from each other. As in her 1990 study with Kristjansen (Kristjansen & Chalmers, 1990) regulation of the process is

complex and is influenced by the context as well as factors within the client and the nurse.

Zerwekh, an American nurse, working as an educator in the area of community health nursing practice has reported on aspects of her doctoral dissertation in several journal articles (1991a, 1991b, 1991c, 1992). She has published some of the findings of the study in which she interviewed thirty experienced public health nurses and asked them to describe examples of their practice where they felt they had made a difference in the outcome. The families described were high risk families who were visited at home. She based her work on the methods developed by Benner (1984) and used a *phenomenological perspective and constant comparative methodology* (1992:101) to interpret the clinical anecdotes.

Two spheres of public health nursing competency described by Zerwekh were 'family caregiving' and 'nurse preserving' (Zerwekh 1991b 1992). The central concept of the competencies is seen by Zerwekh to be encouraging family self care or self help. Sixteen other competencies associated with the aim of achieving self care were identified. These competencies are encompassed and influenced by timing and detecting (1991c) or locating. She describes empowerment as promoting client choice and self determination, and she recounts strategies public health nurses use to encourage and facilitate empowerment.

Contrasted with the strategies public health nurses use to encourage families to be independent and autonomous are the methods expert public health nurses use when they feel they need to persuade their clients to do something that they do not want to do. In her study these occur.... *when the nurse discovers compelling concerns about children in peril that are not being resolved by strategies to foster family self care and responsibility* (Zerwekh 1992:103). Such strategies she defines as coercion and are contrasted with the strategies used in empowerment of families. They are located in three levels of public health nurse approaches to persuading. She names and describes them as 'reasoning', 'confronting' and 'requiring' (1992:103).

In another article (Zerwekh, 1991) describes the sphere of nurse preserving by using competencies the nurses identify in their stories. These nurses have identified that many of their clients are high risk, disturbed, socially impoverished and invariably affected

negatively by change in government policy. The competencies identified are 'struggling with adversity,' 'confronting the threat of violence' and 'preserving nurse wellness'. In this article she uses extracts from the nurses stories to convey rich meaning about the reality of working in public health nurse practice in the United States of America.

Zerwekh's work complements that of other studies quoted in this research report, and to date it provides the most comprehensive conceptual analysis of the work of community health nurses who are working with families in a variety of settings. Through her use of grounded theory she is able to demonstrate and build a convincing analysis of the practice of public health nurses and their families. Although her work originates in the USA, it is meaningful and relevant to practitioners in the New Zealand setting. A recently published book of simple stories of public health nurses' practice, edited by Zerwekh (1993) provides a poignant picture of the reality of public health nurses work. Her conceptualisation of public health nursing practice is borne out by these exemplars of practitioners.

Vehvilainen-Julkunen (1992) also in a qualitative study described the patterns of interaction in relationships between mothers and children, public health nurses and children and mothers and public health nurses. She saw the relationship between the public health nurse and the child as one of persuasion and entertainment, whereby the public health nurse aims to keep the child occupied and happy during the interview. The relationship between the mother and the public health nurse she described as one which supports self confidence. Patterns of interaction such as information sharing, confirming, encouraging, calming, negotiating, joking and listening were identified and which the public health nurse used as strategies to enable the development of self confidence. Vehvilaine-Julkunen's study identified the importance of public health nurse-client interaction particularly interaction which involved the use of mutual negotiation. The identification of the processes of interaction involving the child has implications for practice, because it acknowledges this further dimension revealing the child's presence in the interaction, something other studies have not done.

Cowley (1991) in a grounded theory study involving participant observation and interviews of fifty three practicing health visitors identified factors in the socio-cultural context which influence 'receptiveness to adopting health enhancing behaviour.' Basic social processes that she identified were, 'timing', 'continuing' and 'knowing.' She

states that a focus on knowing generated the 'symbolic awareness context.' This is the context within which experienced health visitors use their interpersonal skills, receptiveness and negotiate the complexities 'embedded in the process of developing health awareness'. Cowley's (1991) findings indicate that it is counterproductive to separate interaction from the context if nurses want to facilitate health. Although this study is more difficult and less compelling to read than previously mentioned studies, the strength is that it overtly acknowledges the effect of considering participants within their context. The latter is an assumption which underlies the research reported in this thesis.

Summary

The literature review in this chapter has focussed on community health nursing. Initially the meaning of the term community health nursing was discussed, and clarified. The results of defining it as a health focussed service were noted, and theory development in this area has been highlighted. This literature review reveals that community health nursing appears to parallel the development of nursing theory in other areas. There is evidence of a shift from theorising which produces prescriptive models to the development of theory that is grounded in practice. Prescriptive models provide a conceptual demonstration of what might be. Chick (1991) intimates that nurses who may not be comfortable with freedom at an individual level seek the consolation of rules and guidelines albeit developed from some of the theoretical thinking. *Too often the promise of theoretical thinking is destroyed by those who would turn models into a conceptual tasklist in the form of prescriptive theory* (Chick 1991:17).

Some studies convey valuable information on the nature of the work of community health nurses (Clark 1976, Kinross et al, 1987). However, apart from the anecdotal evidence which has crept into the recording of the studies, little of the richness of meaning that is inherent in community health nurses' practice is conveyed. There are a small number of studies which convey some of the realities of the community health nurses' practice world and the skills and experience they bring to bear in coping with it. Abbott & Sapsford (1990) in their writing on health visitors in England, identify the problem of 'deskilling' which arises when there is little recognition of the highly developed professional expertise of health visitors, as is evidenced by the direction and prescription of practice by non nurse managers.

Recent overseas qualitative studies indicate the promising beginnings of research which enlighten our understandings of some of the meanings of the encounters and aspects of the work of community health nurses. New Zealand with its unique cultural context has so far provided little in the way of reported studies that describe how community health nurses conduct their practice lives or explain their work. The identification of this hiatus provided impetus for the present study. In the next chapter literature more specifically relevant to the New Zealand context is examined more closely for its contribution to the practice of community health nursing, and in particular, public health nursing.

CHAPTER TWO

PUBLIC HEALTH NURSING IN A NEW ZEALAND CONTEXT

In the previous chapter the philosophies and frameworks of community health nursing practice were identified and discussed. Studies were analysed for their contribution to this area of practice. The preventive, health focussed services of public health nursing and health visiting were identified as specialised areas of practice within the generic category of community health nursing. Although all practitioners working in this area have a health and wellness focus, descriptions in the literature of public health nurses' practice, indicates that the scope and function of public health nursing practice varies from country to country. Public health nursing is shaped by the socio political and cultural context of its national environment. In this chapter the contribution of the New Zealand context is discussed as it influences public health nursing.

Historical Developments

The origins of public health nursing can be traced to a concern with the health of the Maori, the indigenous people of New Zealand. Burgess (1984) states that it was *the need for nursing care in Maori communities and teaching of improved methods of sanitation, nutrition, infant feeding and welfare - that sparked off what were the beginnings of the Public Health Nursing in New Zealand* (1984:215). Burgess (1984), Wood (1992) and Holdaway (1993) all described the initiation of a public health nursing service, aimed at *an effective means of spreading knowledge of Western ways of treating the sick and basic laws of hygiene* (Holdaway, 1993:26) amongst the Maori people of New Zealand who were considered at the turn of the century to be in danger of dying out. It was initially proposed that young Maori women be trained in this role, and scholarships were set up to enable appropriate education of suitable candidates. As Burgess notes it proved to be a slow process with the result that sometime after 1909 European or Pakeha² nurses began to be appointed to work with Maori Communities.

McKegg (1991) provides a more detailed analysis of the work of rural New Zealand

² Pakeha is the Maori term for non Maori, but is commonly used to describe people of European origin.

community nurses between 1900 and 1939 while Burgess specifically identified the development of a separate group of nurses whose role was to work in schools to help improve the health of school children. Following the establishment of a school medical service, with the appointment of school medical officers in 1912, the first of these school nurses was appointed in 1917. In a 1927 report in *Kai Tiaki, The Journal of the Nurses of New Zealand*, the school nurse is described as a visitor, who bridges the gap between home, school and the medical officer, and who is particularly concerned with the health and welfare of children. In 1927 in another issue of the same journal, Dr Watt, Deputy Director of Health in New Zealand, defined what he interpreted as the recently developed area of public health nursing. From his description he clearly saw school nursing falling into this category. Burgess states that in 1930 the two roles of Native Health Nurse and School Nurse were combined into that of the District Health Nurse, but it was not until 1953 that the name was changed to Public Health Nursing which under the auspices of the New Zealand Department of Health continued to provide a community health nursing service (Burgess 1984).

Current Issues

With the changes in the provision of New Zealand Health services, through a massive reorganising exercise prompted by a major philosophical change in relation to the provision of health services instigated by the Labour Government in 1987, and continued by successive governments, public health nursing moved from central government control, into the ambit of individual Area Health Boards. Each Area Health Board was responsible for the provision of health and hospital services specific to geographic regions of New Zealand, and public health nurses became absorbed into wider community health structures and in some instances were moved physically into institutional settings where previously they had been separated physically and philosophically from their treatment focussed nursing counterparts (Shaw 1991). The reform and restructuring continues, and public health nurses along with all other health services face further changes now the Health and Disabilities Bill has been enacted in July 1993. The philosophy behind this legislation is to remove decision making regarding allocation of funding from health service providers. Currently several possibilities seem to exist in regard to responsibility for the provision of the public health nursing service. It may become the responsibility of the Public Health Commission, a proposed new organisation responsible to central government. Alternatively, it could fall within the ambit of services provided by the Crown Health

Enterprises, the name proposed for hospitals under the new legislation, or there is a further possibility whereby public health nursing services become fragmented the responsibility for the service resting with of a variety of providers.

Statistics on Maori health identify that the Maori people are significantly over represented in several categories of health problems (Hauora - Maori Standards of Health Special Report, 1988). In spite of having a long involvement in working with Maori people, the role of public health nurses in this area also seems increasingly uncertain. With several Maori groups having identified their health needs and having proposed a health plan, the functions of the public health nurse in regard to Maori health may well fall within the domain of Maori health workers.

The Core Health Services Report (1992) identifies children's' health as a priority to be considered in the funding and provision of health services. Following the identification of issues relating to the health of New Zealand children, (Maori and Pakeha), both in the Hauora - Maori Standards of Health Special Report (1988) and the Tamariki Ora report (1993), questions arise as to how the government proposes to provide a health service which will improve the health status of New Zealand children. Public health nursing because of its focus and developed expertise has much to contribute in the area of children's' health. However, whether this will be recognised or utilised in the proposed new structures and mechanisms for the provision of health services is unclear. Public health nurses, due to changes in their organisation, decrease in numbers and increasingly isolated from each other remain largely invisible and unheard in the proposed changes.

Public Health Nursing Practice in New Zealand

Historically public health nursing in New Zealand has responded to changes in the socio-political arena, to changes in health need in populations and to changes in knowledge and philosophies relating to health. This knowledge is gleaned from reference to material used as prescriptions or guidelines for practice, from review of the *New Zealand Nursing Journal* as it relates to public health nursing and from archival materials.

In addition to Kinross et al, already cited, there are few studies in New Zealand which focus specifically on community health nurses work. Blakey & Bradley (1980)

surveyed home visits carried out by public health nurses in the Dunedin Health District. Their research which was based on an earlier study on health visitors, carried out by Clark in England (1976), and cited in chapter one, identified the reasons public health nurses visit the homes of their clients. Some issues raised in the discussion section of the study were, the identification of the increased number of visits due to 'social' rather than health concerns; the reason for some families remaining permanently on the nurse's case list; and the disproportionate amount of work with families from the lower socio-economic or solo parent group. These issues are still current when considering the work of public health nurses in 1993.

Following the New Zealand Nursing Manpower Report (1977) which recommended amongst other things an innovative approach in the organisation of community nursing including a suggestion that community nurses could be responsible for a group of persons in a specified geographical area, the New Zealand Nurses Association published a report (1980) on community health nursing in New Zealand. One of the recommendations was that; *Immediate action be taken to ensure a fully functional and objective integration of community nursing services.* (1980:15)

These reports probably acted as stimuli for a number of studies including the Blakey & Bradley (1980) study, undertaken to look at the integration of community nursing services. Another early study was the Onerahi nursing trial, carried out for six months in 1980 and reported on by the Northland Shadow Service Development Group (1981). The six month time frame of the study was identified as being too short for accurate outcome evaluation.

MacInnes & Glover (1985) reported on a project where nurses worked as 'generalists' meeting the needs of a population group in a suburban area of Wellington. The conclusion of this report was favourable regarding the outcomes of 'generalist' nurses who are community based. In 1984, a longitudinal study was carried out in Palmerston North, which analysed the day to day practice of one nurse working in an urban area. In the first year the nurse worked as both district and public health nurse, and in the second year, as a public health nurse only. (Kinross et al 1987). The findings of the study revealed a difference in both the practice and the philosophical orientation of the two services, and although there was a guarded support for the use of generalist nurses in certain areas, overall the study findings identified that due to *the specialised*

preventive/ promotive aspects of their work (1987:197) the public health nursing aspects would either be secondary to the treatment priorities of some clients or be unable to be provided unless the nurse practitioner had appropriate expertise and specialised knowledge.

Hawken & Tolladay (1985) in an innovative project, carried out a descriptive study of the delivery of services run by two independent registered nurse practitioners at a New Zealand seaside resort, over the summer months. While this is not a study of public health nursing practice, descriptions of their practice incorporating health education and based on frameworks which incorporated a primary health care philosophy and Orem's Self care model, have relevance for the practice of public health nurses in New Zealand.

Although the studies questioning generalist practice versus specialist public health nursing practice are either inconclusive or generally not supportive of generalist community nursing practice, personal observation reveals ongoing support from management for generalist community nursing practice. Whether this support will continue with the proposed changes in the New Zealand health service delivery with its focus on identifiable core health services is debatable. The emphasis on children's health and Maori health identified as priorities in the Core Health Services Report (1992) could mean that the expertise and knowledge of public health nurses may be valued and utilised or it could mean the development of entirely new services.

In New Zealand, public health nursing has been strongly identified with primary health care and health promotion philosophies and strategies of health and wellness (Shaw 1991). Evidence for this identification can be found in three prescriptive documents relating to the practice of New Zealand public health nurses. Public Health Nursing: Functions and Activities; Public Health Nursing: Standards for Service, and Public Health Nursing: Standards for Nursing Practice (1985) are documents designed to be used to provide a 'clear picture' of public health nursing and its scope and function, as well as the development and articulation of standards that were designed to be used by the public health nursing managers, planners and providers in each geographical area in New Zealand providing a public health nursing service. Examination of the documentation developed in local areas, for example Otago region in the South Island of New Zealand demonstrates that this prescriptive documentation was used as a guideline in the ongoing development and monitoring of public health nursing services

(Public Health Nursing: Standards for Nursing Practice, Otago Area Health Board 1990). These guidelines identify that although public health nurses carry out specific tasks such as those related to the monitoring of infant and child health, much of their work has as its aim the promotion of health for their clients.

Decisions about the scope and function of the work of public health nurses are based on public health policy, determined by central government, local health policies and the recognition of the need to deal with specific problems as they arise in the social context. Public health nurses working in different areas have been proactive in documenting and prescribing practice which is seen to be able to meet the needs of their specific area. Some of this documentation has a broad focus, clearly influenced by primary health care and health promotion philosophies. In the Wellhealth Position paper, developed by a working party of public health nurses in Wellington, the scope of practice that was described encompassed the following areas:

- assessment of individuals/communities to identify health needs and issues.
- planning to address population health issues using health development strategies.
- implementing interventions or programmes in partnership with others
- ongoing evaluation.
- networking and liaison with community to address community issues and to market wellness.
- creating supportive environments
- advocating for Healthy Public Policy
- empowering individuals, families and groups to address their health needs. (1992: 3.)

The report goes on to say that; *Public Health Nursing Practice includes health promotion, health protection, communicable disease control and child and family health.* (1992: 3) and follows with descriptions of both population and personal health.

In a document developed to act as a guide for public health nursing practice in Palmerston North (1992), both the Ottawa Charter and work by Zerwekh (1991) are used to provide a framework for the provision of public health nursing services. These guidelines are interesting in that they highlight families who are likely to be at risk through social deprivation, lifestyle and economic policies as a target for the public

health nurses personal practice.

While the documentation that has been developed as guidelines for service and practice provides important knowledge about the values and beliefs which underline the practice of public health nursing it indicates little about the realities of public health nursing practice or how individual nurses frame their world. Although glimpses of how the nurse interprets her practice are also conveyed in the anecdotal records that are sprinkled throughout the study reported by Kinross et al (1987) there is clearly a need for further studies which describe and promote understandings of the practice of public health nurses as they carry out their work in the New Zealand context. Two recent studies make a significant contribution. Lungley & Barnett (1991) focus on the work of public health nurses in schools and Pybus (1993) who has reported on a study of public health nurses working with stressed families. The findings of Pybus's study provide abundant evidence of the difficulties inherent in public health nursing in the current New Zealand context. In a New Zealand study on client satisfaction McDrury (1992) noted that clients were less likely to be satisfied with their interactions with public health nurses and Plunket nurses than they were in their contact with practice nurses. Practice nurses in New Zealand, are registered nurses who are employed by general medical practitioners to provide a nursing function complementary and supportive to the doctor's role. The author noted that contact with the practice nurse is likely to be initiated by the client at a time of need where contact with public health nurses or Plunket Nurses is very likely to be nurse initiated (1992:58)

Summary

In this chapter issues relating to the area of community health nursing practice as they apply specifically to New Zealand have been identified. Historic and current literature is reviewed and the need for further and ongoing research is noted. With the proposed changes and the requirement for improvement in Maori and children's health in particular, primary health care services may be seen to have much to offer. It is important that the contribution which registered nurses are able to make through the provision of such services are researched and documented.

CHAPTER THREE

RESEARCH METHODOLOGY

Introduction.

Following identification of a deficit in the understanding and knowledge about the work of public health nurses in New Zealand, this study was devised to explore and describe the meanings public health nurses attach to their work, and in particular to explain their relationships with their clients. In order to do this the researcher planned to enter the world of the participant's practice and through the study of their interactions come to understand how these nurses framed the reality of this practice. The intention is that following analysis of the data, the researcher will be able to present a model or theory which clarifies or extends our present understanding of the public health nurses' work with their clients. A qualitative research approach using grounded theory was chosen as the method to achieve this aim.

In this chapter the reader is introduced to a brief overview of research methods which includes the researcher's rationale for choosing qualitative research and grounded theory method for the study. Grounded theory methodology will be discussed in some detail. Information will be provided about the selection of participants, their profile and the social and practice context of the study. Ethical considerations will be briefly highlighted followed by discussion of the interviewing techniques used in the data collection. Issues such as 'rigor' in qualitative research will be addressed. Following this chapter the reader is introduced to a summary of the data analysis as it occurred in the study.

Rationale for the Use of a Qualitative Study

The purpose of research is to generate, discover, verify knowledge or to develop and test theory. The two traditions of research which have been evident in the development of nursing knowledge are quantitative and qualitative research. Quantitative research focuses on measuring the phenomena which are under scrutiny, on determining relationships between cause and effect, and ultimately has as its aim the discovery of truth about the phenomena. It supports the belief that the researcher must be objectively detached from the phenomena under study and is reductionist in nature. One can expect

a high degree of generalisability from the findings and from this generalisability the ability to predict and control similar situations.

Qualitative research methods have in part risen from the dissatisfaction with the ability of quantitative methods to produce nursing knowledge that is relevant to much of the world of nursing practice. The complex nature of nursing practice grounded in, and influenced by the social context, open to interpretation by the participants and with a strong emphasis on process rather than outcome does not readily lend itself to capture by quantitative methods. Many situations in nursing practice are not well understood, and it seems appropriate that research methods which serve to describe and understand aspects of practice may be an important adjunct to the discovery of knowledge about nursing practice. Nursing science is a human science and the questions that are asked about aspects of practice *reflect the human aspects of nursing* (Meleis 1992:112).

A human science focuses on human beings, their responses and their interpretations of situations. It is predicated on understanding the meanings of daily lived experiences as they are perceived by the members or participants of the science. To understand these perceived meanings, participants have to be involved in in-depth dialogues. (Meleis 1992:112)

The debate continues about the appropriate use of qualitative and quantitative research methods. The choice of a qualitative or quantitative research design is not simply a technical choice but one which facilitates consistency between the practice world of the participants and the nursing view of the researcher and the underlying paradigm of nursing (Moccia 1988, Munhall & Oiler 1986).

As the above discussion identifies, the argument about the appropriateness of either quantitative or qualitative methods in nursing research centres around paradigmatic and epistemological issues and includes considerations of consistency when the focus of research is on the relationships between nurse and client and the meanings of these relationships (Munhall & Oiler 1986, Meleis 1991). Important paradigmatic considerations related to *shared experience, shared language, interrelatedness, human interpretation and reality as experienced* (Munhall 1982:245) favour choice of a qualitative approach for this study on the experiences of public health nurses in a New Zealand setting. In this study the writer is interested in what is going on in the world of

community health nursing practice, how nurses attach meaning to their activities and following on from this, how to develop reality based theory (Christensen 1990; Field & Morse 1985).

Philosophical notions about scientific truth help to define the research question which in turn determines the research method (Packard & Polifroni 1992). Meleis (1991) identifies that nurses, if they are to enhance theory development in nursing must 'know' and 'understand' their practice world and the world of their clients. Public health nursing is (as is all nursing) a practice discipline grounded in the social context and is a social phenomenon (Greenwood 1984). The literature identifies that community health nurses share meanings and thus the social phenomena surrounding their work. The questions to which I sought answers in this study, required that the research method chosen be one that would make visible and create understanding of the practice of public health nurses which is grounded in the social context.

The literature review at the beginning of this study reveals that much of the prescriptive literature on community health nursing reflects a conceptual or theoretical view that is deductively derived and represents a view of community health nursing as it ought to be rather than as it is. There is evidence of considerable debate about these conceptual frameworks, much of the debate occurring at an abstract theoretical level. In spite of what appears to be evidence of development and support for the use of theoretical frameworks in practice the reality is that they do not appear to be well understood or utilised in practice.

As the earlier chapters illustrate, alongside the conceptual theoretical frameworks there are also demonstrably an increasing number of studies on extant community health nursing practice. As with the prescriptive models, there is little evidence in New Zealand that the findings of these studies are having a major impact on either the practice of community health nurses or the context within which community health nurses work. Reasons for the lack of impact may be varied, dissemination of information may be erratic, the studies may not be relevant to the New Zealand practice scene, or the environment within which New Zealand public health nurses are currently working, may not be conducive to attempts to apply research findings.

I would argue that the lack of impact springs from a more fundamental issue, that is, in

spite of the development of conceptual frameworks for practice and a small but increasing number of studies on extant practice; the way public health nurses work and their area of expertise is not well articulated by public health nurses nor understood by their managers. Overall, much of the public health nurse's work still remains unconceptualised, unrecognised or invisible. So, although it may seem important to test or perhaps to challenge the prescriptive theoretical models there is still a clear need for exploratory, descriptive and explanatory studies. In New Zealand where there has been a paucity of such studies the need is even greater. Therefore, since it seems the practice world of public health nurses is not well understood in New Zealand it was appropriate to plan and implement an exploratory descriptive and interpretative study using a qualitative research design.

The above discussion advocates use of qualitative research as an appropriate method for this study. In support, this is an exploratory descriptive study seeking to understand and articulate aspects of the community health nurses' world. Qualitative research methods demonstrate congruence with a philosophy that recognises the holism of individuals, supports subjective and shared meaning, the significance of event and actions and sustains the concepts of advocacy and choice (Munhall & Oiler 1986). The questions which must be asked to engage the participants in dialogue to surface understandings about their practice in a complex context are congruent with qualitative methods. The data are collected and analysed using the words of the participants, and the knowing and understandings which arise are dependent upon meanings articulated and interpreted by the participants and researcher in a cooperative venture. The qualitative research method which is used for the study is grounded theory.

Grounded Theory Method

In the previous section it was suggested that the underlying philosophy of science influenced the type of research question. Morse & Johnson (1991) suggest that the question itself may suggest a research process. Grounded research method is appropriate when there have been few studies on public health nursing practice within the context of New Zealand society and there is a need to discover and explain 'just what is going on here'. Baker, Wuest & Stern (1992) state that the purpose in using grounded theory method;

is to explain a given social situation by identifying the core and subsidiary processes operating within it.....It generates inductively

based theoretical explanations of social and psychosocial processes.
(1992:1357)

Grounded theory method was developed by sociologists Glaser and Strauss (Glaser & Strauss 1967) in the 1960s. It is the method of developing theory from the systematic collection and analysis of data. *The term grounded theory refers to data grounded in fact and generating theory from that data. The grounded theorist looks for processes involved rather than static conditions* (Stern 1986:150).

Its sociological roots are found in symbolic interaction theory. *Symbolic interactionists believe that people interact with each other through meaningful symbols. Meanings evolve over time from social interactions.* (Hutchinson 1988:124.). All behaviours as they take place in natural settings, or grounded in the realities of nursing practice are examined and analysed for self and group definitions and shared meanings. The social context of the participants in the study is also examined for common rules, beliefs and actions which serve to illustrate the shared meanings held by the participants in the interaction (Chenitz & Swanson 1986). Behaviours are observed in context because the meanings are derived from the social interaction of the participants (Baker et al 1992).

Grounded research has a particular contribution to make because it enables the discovery of theory from data, especially in the areas of undeveloped or unclear phenomena (Field & Morse 1985). It is suitable where the area of study is relatively undefined or if *few adequate theories exist to explain or predict a groups behaviour* (Hutchinson 1986:112.) Christensen states that *it supports the researcher seeking to generate theory in a situation where there is a dearth of theory, as in nursing practice,* (1990:230) or it enables the researcher *to gain a fresh perspective in a familiar situation* (Stern 1980:20).

The theory that is generated from the analysis of the processes and the social context identified in the data, provided that the identified rules and procedures are carefully followed, has both accuracy and applicability (Stern 1980). Munhall and Oiler (1986) identify that grounded theory has value at both the descriptive and explanatory level and if the theory arrives at the reality of the social processes under study it has value in that it is able to predict (Stern 1986). The theory should be; *plausible, useful and allow its own further elaboration and verification* (Strauss 1987:11). Feedback of the findings of

a grounded theory to the participants or to practitioners familiar with the practice area of study should result in the recognition of the social process described by the researcher in the findings. The sense of recognition and 'telling it as it is' is described by Glaser (1978) as 'good' grounded theory which has 'grab'. Grounded theory, however, does not presuppose only one correct answer to the research question, other interpretations of the data will be possible.

A constraint to the development of grounded theory may arise through the researcher having to prematurely foreclose the research process due to time restraints or external limitations placed on the study. The result of premature foreclosure may be that the study may lack density (Christensen 1990; Hutchinson, 1986). Lacking density, means that although codes and categories have been identified from the data, they may not be saturated thus impacting negatively upon the level of theoretical analysis.

There is some debate over the use of literature in grounded theory. Although some researchers prefer a only a brief initial scan of the literature, favouring the literature to be used in the data analysis as the categories and codes are surfaced, that scenario is not a practical one for a nurse researcher who is working in her own area of clinical practice. Christensen (1990) discusses the issue of nurses doing research in the domain of nursing, acknowledging the implications but at the same time asserting that it is possible for a researcher to do grounded theory research while having familiarity with the applicable literature. Because the number of studies in the sphere of community health nursing practice, specifically `in the spheres of health visiting and public health nursing is limited, some of the studies were already familiar to the researcher. Other studies emerged in the preparatory literature search. The significance of the previous statements relates to the possibility of concepts emerging in the study which are similar to the findings of some of the studies identified in the literature. In hindsight, this indeed was the case. So although the researcher attempted to compensate for having read some of the relevant studies before the data collection and analysis, by putting aside the literature located in the review, some of the literature will appear in both the literature review chapter and in the data analysis chapters.

In grounded theory the researcher chooses a particular study setting and methods of data collection and sources of information are chosen for their relevance to the area of study. Unlike other research methods both the research problem and the participants'

actions which are aimed at creating meaning and providing solutions to the problem are uncovered in the data. Data collection and data analysis occur simultaneously throughout the study in a process called constant comparative analysis.

Constant comparative analysis is a systematic process of coding, hypothesising, categorising and analysing the data. It occurs as a matrix operation rather than a linear process (Stern, Allen & Moxley 1984). The researcher's aim, through a process of selective sampling and searching for patterns is to provide an explanation of a social phenomenon which emerges from the data.

Initially the researcher identifies what are known as substantive codes, that is they capture, often in the participant's own words, the conceptual meanings located in the data. Theoretical coding is the development and conceptualisation of the relationship between the substantive codes. The researcher's insights and inspirations are guided by the data and assisted by the process of memoing. Memoing is the process of thinking, reflecting and recording the researcher's thoughts in the process of analysis and theorising about the data. Further abstraction and comparison of the codes results in the emergence of more complex patterns and integrating themes which are named core categories. Core categories integrate the other categories in the emerging theory.

Each code is compared with the coding of previous similar incidents. Memos (which are ongoing notes of the researcher's ideas) are sorted, codes are grouped and, eventually, a core integrating category or social process will emerge which seems to explain the data (Christensen, 1990:233). Finally, if the categories are saturated the researcher is able to present an emerging theory which arises from the data.

The Present Study: Method and Procedure

Having described the appropriateness of qualitative research methods, in particular, grounded theory for the study, I will describe how the study was carried out.

Participants

The study sought to look at aspects of community health nursing practice, in particular the practice of a number of nurses who are employed in the New Zealand setting as public health nurses. Although New Zealand is currently experiencing further reorganisation in health, at the time of the study public health nurses were employed by

Area Health Boards. For the purpose of the administration and delivery of health services New Zealand was divided into fourteen Area Health Boards, each Board being responsible for the provision of primary, secondary and tertiary health services in its area. One Area Health Board area was chosen as the location of a possible group of participants in the study. Following permission by the Area Health Board Ethics Committee to undertake the study and after discussion with the Senior Nurse Advisor in Community Health and the Public Health Nurse Clinical Nurse Specialist, the researcher spoke at a Public Health Nurses' study day about the proposed research. If nurses were interested in participating in the study they were asked to contact the researcher individually at her home address. Public health nurses from the whole geographical area which made up the Area Health Board were present at the study day. In grounded theory development participants are chosen for their first hand involvement in the phenomena (Chenitz and Swanson 1986). Copies of the study proposal, an information sheet for participants (Appendix one) and the informed consent form (Appendix two) were available for all nurses at the study day to read and take away if they wished. Volunteers contacted the researcher either by mail or by telephone.

Profile of Participants

There were eight participants in the study. All had spent varying lengths of time in public health nursing practice, ranging from eighteen months experience to fourteen years. Most of the participants had spent in excess of four years as a public health nurse. All of the participants were female and for this reason the participants will be referred to as 'she' in the remainder of the report. Two of the participants had qualifications in advance of their original nursing training, others were in the process of studying for a degree. All had participated in ongoing education in the area of public health nursing. Several had previous experience working as a practice nurse and all but one had commenced their public health nursing practice in a rural area. Some of the participants had special responsibilities related to the practice of public health nursing, such as coordination of special programmes involving aspects of child health.

The Setting

A wide geographical area serves as the setting for this study. It fell within the area of one Area Health Board as described in a previous section. Two participants worked in part of a large urban area with a population of approximately 115,000, two participants were based in a town with a population of 5,000 but their practice includes people

living in a rural area the total population of which is around about 12,000. One participant worked in a town on the outskirts of the urban area with a population of about 10,000. The other three participants worked both in rural towns as well as serving a large and often remote rural population. There is a clinical nurse specialist who is located in the urban area and who has contact with the nurses on study days and is available for consultation by the nurses. Nursing matters were the responsibility of the senior nursing officer in each area, though these are now advisory positions with no line management responsibilities, and the senior nursing officers in the rural areas do not necessarily have a background in community health usually being primarily responsible for nursing in hospitals.

Ethical Considerations

This study involved collecting data from public health nurses. Clients were not approached. Neither were records accessed or read, nor was the practice of the nurses observed. The research focussed on the *perceptions* nurses have about their practice. In this sense there were no risks to the participants providing that confidentiality was maintained and informed consent was obtained. Permission was obtained from the Massey University Human Ethics Committee and the Otago Polytechnic Ethics Committee and although permission was obtained from the ethics committee of the Area Health Board, and the project was discussed with the senior nurses there was no identification of participants to their employers.

Informed Consent.

The study was explained to public health nurses who indicated an interest in participating in the study and a copy of the proposal as well as an information sheet was given to the potential participants. Informed consent was obtained from individuals in a written form following opportunities for discussion and questions at the initial meeting. The right of participants to withdraw at any time was guaranteed and arrangements were discussed regarding the availability of the written report.

Confidentiality

The interviews were tape recorded. Permission was sought and given at the beginning of each interview for recording. The tape recorder was turned off for part of one session at the request of the participant. A coding system was used to identify the participants and their tapes. The coding system was known only to the researcher. Transcription of the tapes by a transcriber other than the researcher was discussed with the participants, and steps to be taken to maintain confidentiality during transcription

were explained and discussed. Tapes went to the transcriber with an identifying number and an identifying initial (not that of the participant) in order to facilitate recognition of the change in speaker during an interview. Transcription was carried out by a reliable and trustworthy transcriber who had no contact with the participants. Participants were not identified by name on the tapes, however, because the researcher could not discount the possibility that a participant may provide identifying data on the tapes this possibility was discussed with the transcriber, such information was not to be included on the transcripts of the tape recordings. Tapes and transcripts were kept separately from one another and in a secure location.

Data Collection

Data were collected through the use of focussed or semistructured interviews with the public health nurse participants. Focussed or semistructured interviews are defined as interviews with particular predetermined scope and boundaries, but which allow a considerable amount of flexibility (Morse, 1991; Polit & Hungler, 1987). The research questions provided direction for the interviews which were focused on the perceptions public health nurses had about their practice with their clients. The initial interviews were less structured as the aim of the interviewer was to discover the participants perspective on their practice. As the data analysis commenced and categories began to emerge the successive interviews developed more structure as analysis of the participants' 'stories' continued. Morse (1991) highlights that the challenge in interviewing in qualitative research is to maintain a balance between flexibility and consistency. The interviews needed to be flexible to elicit the individual public health nurse's perspective on her practice world, yet consistent to achieve comparison between the participant's stories. Each participant was interviewed twice, the first interview was largely exploratory the second interview much more focussed, though still allowing flexibility for the participant to develop their own narrative. The use of multiple interviews has been identified by Reinharz (1992) as enabling the opportunity to ask additional questions and clarify original perceptions. More informal interviews were carried out with participants, following their reading of the chapters describing the emerging categories.

As already mentioned there has been some debate over the use of literature in the area of grounded theory development. The researcher requires knowledge of the general theory in the field of study (Glaser and Strauss 1967). A nurse researcher will be well

grounded in the general literature of the discipline of nursing, and for the purpose of the study a literature search was carried out before the writing of the research proposal and the development of the research question. Once the data had been collected and data analysis commenced the literature was reviewed as part of the data. Its purpose is to add to the data, to clarify issues and to aid in thinking and reflection and ultimately to expand the emerging theory by enabling the exploration of relationships between concepts or other theories. The use of literature is part of the process of constant comparative analysis and care must be taken that it does not precipitate foreclosure or inhibit thought arising from the data (Christensen 1990). Studies in the area of community nursing practice are not abundant, studies identified in the initial literature review have sometimes supported categories and concepts revealed in the data of the study. Some studies may therefore be cited twice in this thesis, in the literature review and in the data chapters.

Interviews were tape recorded then passed to a selected typist for transcription. Following transcription of all the interviews the researcher listened to the tapes while simultaneously reading the written records of the transcripts, some corrections were made and significant pauses or conversations were documented.

During the interview process a journal was kept by the researcher, memoing also started as soon as the interviews commenced. Sometimes significant events from the journal were recorded as a memo, at other times insights or reminders about themes to follow up provided the substance of the memo. The interviews were carried out over a period of four months, the first round of interviews being transcribed and listened to before the second round commenced.

Trustworthiness of the Study

Lincoln & Guba (1985) refer to the trustworthiness of the study. This is the process of ensuring rigor. Baker et al (1992) warn that in order to ensure rigor through credibility of the findings, the research methods must be clearly described and justified in each step of the research process. There must be consistency with the research method which, in grounded theory, includes both the collection and analysis of the data and findings of the study. The specific questions that must be asked in grounded theory study about the findings, are to do with the usefulness of the theory, the 'fit' of the theory to the world of the participants, the meaningfulness of the theory to the

participants or to people who share similar experiences and the ability of the theory to 'work'. Glaser (1978) describes the theory working by its ability to explain, predict and interpret.

Sandelowski (1986) describes a series of strategies which together determine the attainment of rigor in qualitative research including grounded theory. The criteria outlined are, *credibility*, *fittingness*, *audibility* and *confirmability*. Credibility is where the descriptions and interpretations of the world of the participants, as they are presented in the study, are recognisable to people who have similar experiences as well as to the participants. The criteria of fittingness is achieved when the findings of the study can be applied to situations beyond the context of the study. An important issue related to the criteria of fittingness is that the findings of the study clearly fit the data from which they were derived. Audibility is attained when the researcher clearly documents the decision trail and another researcher could easily follow the methods used by the researcher and in doing so arrive at similar or complementary conclusions. Finally Sandelowski (1986) describes confirmability. Confirmability relies upon the determination of audibility, fittingness and applicability and is the criterion upon which neutrality of qualitative research rests. An assessment of the achievement of these criteria will be outlined in the final chapter.

Summary

Discussion in this chapter centred on the choice of research method for this study. Grounded theory method as used in the study was outlined. Issues relating to the selection of participants, ethical issues, and the collection of data were highlighted. The participants were profiled with brief descriptions of their areas of practice. Finally the processes for ensuring rigor in the study were addressed.

CHAPTER FOUR

THE PROCESS OF DATA ANALYSIS

In the previous chapter grounded theory method was outlined. Now, in this chapter the process of data analysis and generation of grounded theory as it pertains to the practice of public health nurses is described. Examples from the study will be used as an aid to understanding.

Data Analysis

Data were obtained through interviews. In the first interview the researcher asked the participants to describe their public health nursing practice. Although this seems a very broad question it provided a good launching point. In grounded theory *discovery* is central to the research process, the developing theory emerges from the empirical world (Bowers 1988). The initial question then provided a focus for the rest of the interview. The process of each interview was different in that subsequent questions emerged from the information given in response to earlier questions and discussion. I was interested to know who the public health nurses perceived as their clients so each participant was asked to describe their work for a typical week. I was also curious to explore with the participants their impressions of their practice as a public health nurse. The second interview explored and clarified some of the themes and patterns identified in the analysis of the first interviews. Although subsequent interviews may focus on patterns and themes identified in previous interviews, there needs to be a conscious endeavour on the part of the researcher to avoid imposing their developing suppositions on the participants. Interviewing finished when there were no new themes coming through in the data, however, I did go back to some of the participants as the conceptual framework began to take shape to check out or confirm categories. Stern (1986:156) describes this strategy as *selective sampling of the data*.

Constant Comparative Analysis

The fundamental method of data analysis in grounded theory generation is constant comparative analysis. The data are initially broken down into the smallest unit of information that is, *substantive codes* and then are reconceptualised through a series of processes with increasing levels of abstraction until the development of a theoretical

construct is achieved. Hutchinson (1988:135) describes the process of constant comparative analysis as; *the comparison of incident with incident, incident with category, and finally category with category or construct with construct*. The comparisons operate on all the codes, categories, properties and constructs developed from all the data collected from all the participants over the period of the study as well as the information gleaned from selective sampling of the literature.

The result of constant comparative analysis is the development of a dense dimensional map or matrix which indicates how all the codes, categories and their properties relate. *The resulting theory will be molecular in structure, rather than causal or linear* (Hutchinson 1988:135).

Substantive Coding

Substantive coding is the discovery, description and labelling of the smallest meaningful units of data. The researcher carries out a careful line by line analysis of the interview transcripts. Substantive coding begins with the words that describe the action in the setting or context, the words of the participants which describe the action often provide the label of the code.

The following is an excerpt of an interview with one participant, where each action is considered as an separate dimension but before codes have been assigned.

Well you see its all new entrants

with their parents, maybe one parent.

I like it, why do I like it?

You're a new person often to the family

so it's a challenge to get accepted as well.

You know I think I've got better at that

over the years

I don't think I was terribly good at it when I first started.

Experience has certainly taught me a lot here.

I like dealing with the children

I like seeing the interaction between the parents and the children.

The second example is line by line analysis from several interviews with different participants with the label assigned to the code occurring in bold type after each excerpt. Each action may have more than one substantive code, depending upon the actions or properties, permitting greater theoretical coverage of the data. [Note; the use of..... between excerpts indicates that the examples have arisen from interviews with different participants. This convention will continue through out the report.]

It probably takes a year to get known. **Getting Known**

.....

They actually know my name, and I think they must remember me then. **Getting known. Taking time.**

.....

And I listened to her, for probably about six weeks. **Listening. Spending time.**

.....

I was the first one really who'd decided to take the bull by the horns. **Taking the bull by the horns.**

.....

Coming here within a year I felt reasonably accepted. **Becoming accepted. Taking time.**

.....

No she just said little bits and then I started sort of clicking because I know a lot about that particular problem from an experience level. **Using cues. Using intuition. Using past experience.**

Substantive codes catch the imagination of the researcher, gerunds often used to label the codes tend to convey action and involvement. Basing substantive coding on the data

helps prevent the imposition of the researcher's previously held impressions. As the codes are assigned to the data, they are constantly compared with other coded data for similar properties.

Theoretical Codes

The elevation of substantive codes to more abstract levels is termed theoretical coding. Theoretical coding is the next step in the process of data analysis. Often theoretical codes are achieved by the combination of more than one substantive code and they shift the analysis of the data from a descriptive to a conceptual framework. Some of the substantive codes identified from the analysis of the data had to do with the processes public health nurses worked through before becoming credible to their clients. Thus the *theoretical* code **being credible** is generated from several substantive codes. Examples of these substantive codes are being trusted, demonstrating honesty, taking time, building a rapport, having positive outcomes, networking between clients.

Examples of data from interviews which generated the substantive codes but when conceptualised supported the more abstract notion of **being credible** were:

If you work successfully on some cases within the school, those networks open up for you.

And also families, they network that in the sense that if you have a good outcome within a family they tell their friends and you have people ringing up directly.

.....

And actually making regular visits here until you build up a rapport with the mothers

.....

You probably actually spend a lot of time in the new entrants class and sometimes you read a story to the kids so the kids do get to know you.

Categories

As theoretical coding continues, recurring themes or salient concepts appear to emerge. The researcher hypothesises that groups of codes sharing common properties can be grouped together as categories. Grouping and defining the codes as categories is the next step in the research process. Categories are generally more inclusive and more abstract than theoretical codes and occur at varying levels of conceptual abstraction.

One category to emerge from data analysis of the public health nurse interviews was **using the relationship**. Many theoretical codes manifested the properties of the category.

Some of the codes were:

Working within the context of the family

Timing

Being ordinary

Creating common ground

Being a nurse

Being blunt

Relating to other professionals

It is the description of the relationships and connections between the categories that leads to the emerging theory. In the subsequent chapters connections between properties of, and consequences relating to the categories will be explored and explained as the grounded theory arising from the researcher's dialogue with the data, is presented.

Memoing

Throughout the process of collecting and analysing the data the researcher constantly records ideas, hunches and questions by the use of memos. Memos are the way the researcher spontaneously captures and records the elusive and shifting relationship with the data. Initially the memos tend to be simple and brief, often cues or observations, but as the researcher becomes immersed in the data analysis the memos increase in number and become more abstract theoretical explorations of the relationships between the categories.

When I directed unstructured questions to public health nurses about the nature of their

work and their clients one of my early memos noted: *Participants always respond to enquiries about their work by describing actual practice situations, don't describe in an abstract hypothetical way.*

Another of my early memos recorded an insight into the amount of autonomy and accountability public health nurses have: *All participants so far have the ability to make very far reaching decisions However, very clear that they must accept responsibility for their decisions, there is no back up or structure that removes the onus of responsibility.*

In the process of data collection and data analysis the need to memo to capture ideas becomes very compelling. The researcher has had to stop the car as well as get up in the night to record ideas as they come to mind. One of the crucial points in my analysis of the data came when I realised the dilemma between the necessity of the public health nurses promoting their practice to get work and the need for confidentiality, even secrecy about a lot of their work. Here is the memo: *Have just realised why public health nursing is so hard! They've got to get out and sell themselves yet have to 'hide' a lot of their work.*

Another memo on the same theme: *They're constantly being judged, not just on performance but also on ability to keep things quiet. How do they balance the two?*

The result may be hundreds of memos. Memos need to be dated and kept because the insights they generate provide a framework for the emergent theory. Memos also provide a valuable role in confirming audibility of the study. It is through documentation of critical junctures and decision points that the researcher is able to reconstruct the research process. The following is an example of another memo which I believe illustrated a critical insight in the development of my theory: *Public health nurses work with children, all the stories they tell about their practice include children. But always within the context of their families or schools.*

Finally I offer a memo which threw some light for me on the relationship between empowerment and the difficult decisions public health nurses have to make when children are perceived to be at risk: *Turning the concept around (protecting children) focuses away from the policing aspect and gives the children choices, choices to grow and develop as they should.*

Summary

Discussion in this chapter focuses on the data analysis procedure carried out in a grounded theory approach. Examples from the study which illustrated the various steps were used in an attempt to elucidate aspects of the analysis, including the increasing abstraction of the ideas and concepts. Memoing as an adjunct to documenting the process was discussed and examples given which illustrate crucial points and decisions in the study.

In the next section of the report the findings of the study will be presented as they emerged from the data. The relationships and connections between the categories will be explored and developed and finally the properties and characteristics of the linking theoretical construct or grounded theory will be reported.

CHAPTER FIVE

BEING ACCESSIBLE

Introduction

This chapter is the first of four in which the findings of the study will be presented and conceptualised. Categories which emerge from the data go some way towards explaining how public health nurses become personally known and trusted, seemingly a prerequisite to becoming accessible to potential clients. *Being accessible* is identified by the participants as a necessary component of effective practice. The categories of *getting known*, *becoming accepted*, *using opportunities*, and *being available* together make up the concept of *being accessible*. The subcategories of visibility and invisibility relate to *getting known*.

It takes time to become an effective fully functioning public health nurse. Being assigned to an 'area' and given a job description does not confer expertise or even beginning skills to the new public health nurse. The participants all described their educational preparation as a nurse or orientation programmes in public health nursing as minimal preparation for working in the community. Although beginning public health nurses are given broad guidelines for practice, the preparation and development of skills for public health nursing happens on the job and through life experience. Working as a nurse in an institutional setting was not perceived as preparation for public health nursing. One nurse with previous experience as a senior nurse manager in a hospital setting described her reactions to her new job as a public health nurse:

I didn't know what it was it was all about.....I don't know why they accepted me because I didn't know what [public health nursing] was. But it took me twelve months to justify that what I was doing was actually work.

Being Accessible

Being accessible implies that public health nurses are visible, readily available and useful to their client and potential client group. To become accessible the participants describe their practice as *getting known*, *becoming accepted*, *utilising opportunities* and *being available*. The categories are interdependent and interactive rather than discrete units.

Becoming accessible is not a simple process because public health nurses' work is not well understood nor by the nature of it, highly visible in the community. For much of her work, the public health nurse is dependent upon the vigilance and readiness of others to identify problems and to refer clients. Participants reported that the most likely source of work was through referrals from the school although clients may refer themselves if they perceive that the public health nurse can meet their needs.

The participants identified that they work very hard to be accessible to children and adolescents, a group which has minimal access to health services other than via their parents. Nurses stated that sometimes parents, either, through lack of knowledge, lack of resources or neglect do not always meet their children's health needs. Several of the nurses commented that as health care is becoming more expensive their accessibility may be related to their ability to provide a free service.

Being confident that the public health nurse can provide appropriate help depends on potential clients being able to acquire a knowledge of the service and of the individual public health nurse. The nurses in the study believe that the results of their work are being continually evaluated by clients and by the people who are the source of referrals. Positive outcomes appear to encourage further referrals or further help-seeking from clients. Poor or invisible outcomes appear to affect credibility and impact negatively on the nurses' work.

The processes that contribute to being accessible are described by all the participants as taking a considerable length of time. Three participants seemed surprised by the time the process took:

Looking back it took me two years to get into it, it's a hell of a long time really.

There were times when I nearly gave up, the work was so slow in coming.

.....

It took me ages to get going, I nearly fled.

Getting Known

Analysing the data reveals the category of *getting known* as a critical element in becoming accessible. The ability for the individual public health nurse to obtain work

depends upon becoming known personally and becoming accepted. Most of the nurses who participated in this study were experienced in public health nursing. The maximum length of time in practice for the nurses was fourteen years and the minimum length of time was eighteen months. Although the beginnings of their public health practice was remote for some nurses, all could remember the difficulties and the length of time it took to become established during the initial stage of their employment, or when they changed geographical areas. The time factor is illustrated by the following comment:

The more you are in a community the more you get known. More people come and ask for your help. And I don't think that happens in the first year you're in the community. It just builds up very slowly. By the end of the year, into the next year, you're just starting to get known.

Some spoke of being disheartened over the length of time it took to become known, to the extent of thinking about giving up public health nursing, for example:

It took me ages and ages. Even in schools I had to keep coming back and back. Sometimes I thought why do I even bother. And I did actually wonder if it was worth carrying on at one stage.

Participants identified that they have to be individually known. Each time the nurses change areas the process needs to occur again. Being individually known contrasts with Christensen's (1990) findings which are related to the practice of nurses in an institutional setting. Christensen describes the concept of *anonymous intimacy* (1990:152) where patients may come into contact with many nurses during the period of their hospitalisation and where *it was exceptional for an individual nurse to be recalled by name* (1990:174). It appeared that clients in the community have much more choice and control over their contact with the nurse. Being called by name was one way public health nurses recognise that they had become known. One nurse described her feelings about being remembered and called by name:

I've been here long enough to have met some mothers who have had a child start school and now a second child has started school and they actually know my name and that takes me aback sometimes.

Luker and Chalmers (1990) in an article on gaining access to clients describe becoming known over a period of time as having a snowball effect which encourages others to seek the public health nurse's services. Cowley (1991) describes the process of getting

known as crucial to being able to establish a relationship with a client.

Getting known according to the participants is a lengthy process in both rural and urban areas. The process appears to be longer for nurses beginning public health nursing than for nurses moving to practice in a new geographical area. Two of the participants stated that it took a year to become known when they moved to another area. This indicates that factors other than the length of time impact on the process of getting known. One nurse related that living in the rural community which is also her workplace makes the process easier. Living in one rural community does not guarantee acceptance in other communities which are part of the same practice area.

Schools and preschools provide the context for much of the nurse's work. Many teachers have considerable contact with public health nurses. Public health nurses in the study reported that they need to work hard to get personally known in the schools. As one said:

I think it's a matter of getting known but it's also a matter of what judgements are there already about public health nurses too, I think.

It appears from the nurses' accounts that different schools have different ways of working with nurses and, that the individual philosophies of principal teachers and classroom teachers impact upon public health nursing practice. Participants also indicated that *visibility*, and *being accepted* are important factors which influence the way schools utilise public health nurses and permit access to children. Principals and teachers have a powerful gatekeeping role in relationship to public health nurses' work.

Although there is not a large Maori population in the areas in which the nurses in this study work, two of them commented on the visit of the Maori health unit (the Whaka) to their area. They considered that the involvement with the Whaka has increased their understanding and involvement with the Manu Whenua (the local Maori of their area). They believe they have become known and acceptable to the Manu Whenua.

Visibility/ Invisibility

Nearly all of the participants talked about being visible in the community. Visibility is a result of *being known* and is a prerequisite to the community's accepting and availing itself of the public health nurse's services. All the nurses in this study describe being consulted in the street and in the supermarket, for instance:

They know where my room is and people pop in, also they ask me things in the butchers and places like that.

.....

They stop me in the supermarket and bail me up for a consultation.

One nurse describes how she is often approached by the public when she buys her lunch in her area:

So the more you get known and the more you're about the more you get asked to do things.

Some participants referred to the tension between the need to be visible, in order to get work, and the need to keep some details of their work confidential and invisible from other members of the community. Often public health nurses are involved with families during times of crisis and stress. Not all the visits from the public health nurse are welcomed and one nurse recounted the advantages of having an unmarked car. There is a paradox between the need to be visible in order to be accessible to their clients and the need to keep much of their work which is of a sensitive and personal nature, invisible.

Examples of the need for invisibility as two participants describe it, follow:

It's generally things that are very personal and private. You can hardly go round in a small community and say 'great I saw fifteen cases of child abuse this week.'

.....

You are working with things that are uncomfortable, things that society doesn't want to know

The need for confidentiality creates a greater dilemma now that public health nurses are required to be more accountable for their practice. In order to ensure a position in the changing health services it has become expedient for them to promote and market their service. One participant describes this dilemma as follows:

Well that's worked for us in the past [invisibility] but unfortunately its not working for us at the moment because everyone says 'what do you do?' I'm not sure how else we can do it because we don't want our work to be visible

Another participant describes the same dilemma:

There wasn't the same scramble for money. So there weren't the questions being asked on what the health services were and was the country prepared to pay for them. So that's why we survived in the past but we're not going to survive like that in the future. BUT I'm not sure how else we can do it because we don't want our work to

be visible.

Kristjanson and Chalmers (1991) also allude to the tension between visibility and invisibility. They describe the dilemma that public health nurses' face in resolving the conflict between the visibility and accountability required by the community and the professional code of ethics which requires confidentiality. Potrykus (1992) in an article about school nurses in Britain highlights how the need for confidentiality leads to lack of recognition for the work school nurses do with secondary school children. She states that the reduction in the numbers of school nurses follows from their low recognition and believes there are no comparable alternative services for children with the health needs common to adolescent school age children.

Invisibility can also be attributed to the way public health nurses work. One of the goals participants describe as being important for their clients is empowerment.

Empowerment in the words of one of the participants is:

Giving them the tools to make their own decisions and to feel its their own decision.

This participant stated she works hard for her input to be invisible so the clients would perceive that they were making their own choices and decisions. As she puts it:

Because we don't want them to know that we're helping them, if they think it's us we haven't done our job, we haven't made it their choice

Reconciliation of the perceived need for visibility of public health nurses in the community and seeming invisibility of practice is an issue that needs to be recognised in the undervaluing of the practice of public health nurses.

One of the factors which participants reported as contributing to the invisibility of public health nursing is change to the structures which support its delivery. One participant identified the need for public health nurses to be more 'upfront' in talking about their work since the senior public health nurses who largely provided administrative and professional support under the previous system, no longer exist. As she sees the situation:

Maybe that's our problem that we're not out there being more political. But when you're working with people you're feeling drained at the end of the day. And we don't have, like we had a sort of career structure, which the Principal public health nurse and the supervising public health nurse actually had the time to do that political stuff.

Becoming Accepted

Being accepted is defined by the readiness of clients and other professionals to refer and share concerns and problems with the public health nurse. It is different from *being known* in that it encompasses an evaluative aspect of public health nursing practice which was coded in the data as credibility. Being accepted impacts positively on the public health nurse's ability to obtain work with clients, which for these nurses could mean individuals, families or groups. The following examples illustrate their concern with acceptance:

Being an effective public health nurse depends upon getting known and getting accepted

.....

I think being accepted has to do with trust. I think they've got to try you out first

.....

Families network in the sense that if you have a good outcome within a family they tell their friends and you have people ringing you up directly

The process of becoming accepted may take time, as it is illustrated on the following excerpt. The participant describes this process in her relationship with a solo mother, a young woman with multiple problems and responsibility for the care of small children:

At first she would just talk to me on the doorstep about all sorts of intimate things. Then after I'd been working with her for a while she'd be dressing and she'd tell me to come into her bedroom. The baby's lying on her bed and she'd give me her to hold. We really made progress then.

This strategy of perseverance with unreceptive clients has been described by Luker and Chalmers (1990) as a way of facilitating acceptance.

Acceptability is described by several participants as being related to individual characteristics such as having children, for instance:

I think a lot of my credibility is due to the fact I'm older with children.

Sometimes being accepted is difficult to achieve especially if the outcome may not be the result everyone in the family desires. One participant describes the ambivalence she thinks a mother feels about her after she initiated the removal of an abused child from the family:

She still seemed to accept me, although it's really a reluctant acceptance.

According to the participants it is important to be acceptable to people who refer clients. School teachers and principals are key people in the work of public health nurses. The participants describe strategies that they use to become acceptable to the school teachers. For instance:

I identify a couple of teachers that are really concerned about the kids, I build up good liaisons with them until I get accepted and the other teachers use me more.

Another stated:

I involve the Principal, let him know what I'm doing, the results that I get. Then I don't have any problems getting referrals and being accepted.

Schools judge the practice of public health nurses, and they judge it from their own perspective. Often the goals of the school and the philosophy of the nurses may be different. Two participants describe working in schools as like 'walking a tightrope':

Meeting the needs of the children and getting where the teachers want may cause a conflict, its a bit like walking a tightrope.

In the words of the other participant:

They ask me to visit and sort out a child who's smelling at school, has poor hygiene, and they want it sorted out. I've got to somehow juggle getting on OK with the mother so hopefully we get somewhere and ensuring the kid is instantly acceptable. Sometimes I wish the teachers were more tolerant and that they realised how some people live and their difficulties, and there aren't instant solutions.

Having outcomes and work judged negatively impacts on the acceptability of the public health nurse to her clients and ultimately on her work. Luker and Chalmers (1990) discuss the impact other professionals can have on the acceptability of the public health nurse. Their findings indicate that if these other people value the work of the nurse then they will effectively 'pave the way' for the public health nurse. If they do not support the nurse they may hinder her work. This is described by three participants:

I don't know what went wrong, I don't think the teacher supported my point of view. If the parents see that the teachers are supporting what you are doing, we're all together, if the teachers don't support you, and it only needs one thing to go wrong and you can't get anywhere.

.....

We don't survive that way, if our work isn't up to scratch we don't get any. Simple

as that really. If our credibility goes down in the community you might as well kiss public health nursing goodbye.

.....

If the school thinks you're working well you get a lot of referrals but if you're not working well you don't get a lot.

Schools have a long standing relationship with public health nursing. However, each time there is a new public health nurse in the school acceptability and credibility need to be reestablished. One participant described problems she encountered following a rapid succession of public health nurses through an area. The result was:

The schools weren't prepared to trust me, they'd had too many changes. It took me a while to establish my credibility.

Another participant described what it is like returning to schools after she had a break away.

'Cause with my being away and coming back only now am I getting back to where I was.

Some of the participants describe good relationships with other professionals such as General Medical Practitioners or Social Workers. In chapter eight there is further development of the discussion on these relationships with other professionals. Other nurses described more problematic relationships where they do not always feel either accepted or credible. All in all, being credible and being acceptable to clients and with schools seems to be identified by the informants as most critical for the success of public health nurses' work. The way one nurse summed up the situation was:

I think teachers respect our work as long as we remain credible, that if we make one mistake we're down the road. Not a high tolerance for human error. If we make a mistake in their eyes, or an unpopular decision we would wear that for quite a while. We would probably not repair that relationship in the school.

Using Opportunities

The public health nurse is often the health professional who has first contact with or recognises a child or a family with health problems. This may come about through the opportunities and strategies the nurse develops to have contact with and to monitor her potential clients. In their interviews participants described the way they used opportunities for monitoring and identification of problems and potential problems in their clients. They also described strategies which help them become known and

accepted. For instance:

I go to the preschool when the parents are arriving with their children, or when they come and pick them up. I talk to the mothers.

For much of their work public health nurses depend upon the vigilance and referrals of others. In the study the interviewees identified the main sources of client referrals to be preschools, primary schools and secondary schools. Involvement in health education and health promotion programmes in education settings is a strategy participants consciously use to make themselves accessible and to ensure referrals. While accessibility is not the primary outcome of health education, public health nurses seem very aware of the implications of visibility and the opportunities for referral that is achieved through participation in these programmes.

Two other study participants talked about their involvement in the new entrant class. One visits the school when she knows there will be children starting and spends time with the mothers while the new entrant teacher settles the children in. Other nurses interviewed described how they do health education in the classroom as well as reading stories to the children. They see this as a way to gain acceptance and referrals. One very experienced nurse described how she eats lunch in the school playground, so building up trust with the children who then felt free to share confidences and problems. This scene is captured in the following interview excerpt:

If you go, if you go into the playground and just sit down, say you decide to have lunch, we do that. Well I do that. Sit down and have a sit in the sun.

In secondary schools public health nurses often run self referral, confidential clinics for the pupils. Nurses also participate in health education and relationship programmes. This is a way in which they can become known and accepted to the pupils. It also enables the nurses to consciously use opportunities for referral.

Their prescribed work of five year old assessments, vision and hearing testing also provide opportunities for vigilance, becoming known and accepted. The five year old assessment is interesting in that the aim of this programme is to detect, monitor and follow up health problems in new entrants. While some participants mentioned problems identified at the five year old assessment, others see its benefit more in making contact and becoming known by the children and their families, particularly mothers who usually attended the assessments with the children. One of the examples

given was:

I would never have picked up this little boy who was being physically abused, if it hadn't been for the five year old assessment.

They see it as a time for mothers to raise issues with them and for the nurse to follow up on these concerns, so creating trust and acceptance. A second example is:

Its main use I think is to get known, to meet people and for them to begin to build up trust. They know you're O.K. and you'll work for them.

A nurse participant who is also responsible for infant welfare as part of her work, related that she picks up additional work because she emphasises that her focus is family health rather than just that of the infant. Nurses also participate in community education programmes, on issues as diverse as weight watching, parenting, women's health and anger management. They see this involvement as creating opportunities for further work.

Being Available

The public health nurses in this study are very available to their clients. They readily respond to need, they do not restrict their client numbers and, unlike most health professionals, are happy to home visit. Home visiting was seen by all the participants as an important way of developing availability. Meeting clients on their own ground is felt to enhance developing relationships. For example:

Where there are concerns you've got to get along side them.... You've got to visit them in their home.

Nurses who work in rural areas identify that being available means clients having access to them beyond the hours for which they are paid. Several participants said that they emphasised, if the need is urgent, the client is welcome to ring them at home at night and even in the weekends. In the words of one nurse:

I say to them ring me if you need me. It doesn't matter what the time is.

Often the nurse's family will relay messages to the nurse and the husband of one nurse is quoted as saying he has to make an appointment to see his wife because she is so busy with her work. It is apparent from statements such as;

Even if I am doing something in my own time, on a garden tour people will ask me about their children....

that nurses in the rural areas or who live and work in small towns, are also likely to be

available outside working hours when they do their shopping, or on some occasions during social activities. Even in urban areas where they are likely to be less visible nurses identify that they receive phone calls after hours. Six of the nurses described how they try to make appointments with the client family at a time all the family members, including the father, could be present, which usually means in the evening or the weekend.

Although *being available* was seen as important by all the nurses some emphasised the negative aspects. One nurse who had been acting for the child in a child abuse situation was verbally abused at her home by a disgruntled father. Another had to remind clients who wished to engage her in long demanding conversations in the weekend that she had her own life to live and needed time away from work.

Summary

In this chapter I have described the concept of being accessible as it is conceptualised by the categories of *getting known*, *becoming accepted*, *using opportunities* and *being available*. Strategies which enabled and increased accessibility are described by the participants. Sometimes accessibility went beyond the extent that the nurse envisaged at the outset of her practice. For instance one nurse was asked how to book a rural hall for a wedding, and the researcher can remember as a public health nurse being rung in the weekend to be asked if certain mushrooms were edible.

These processes do not occur instantaneously, time is a critical element in the development of accessibility. There are also references in the literature to time, research reported by Lukers & Chalmers, 1990; Cowley, 1991; Kristjanson & Chalmers, 1991; focus on the length of the period it takes to develop individual relationships between the public health nurse and their clients. The findings of this study indicate that becoming accessible is much more than the processes that make up the relationship between the public health nurse and an individual client. The encounter is only part of the process, there seems to be important preliminary work that the public health nurse must engage in at a broader level in order to facilitate or enhance their practice.

CHAPTER SIX

FRAMING PRACTICE

As was described in chapter five, public health nurses work in a conscious way to become accessible to their clients. The data identify that they also work hard to make sense of their world, a process which in this chapter is labelled *framing practice*. The discussion in this chapter focuses on the way public health nurses understand and think about their practice. The categories developed from the data, which make up the concept *framing practice* are *building the structure*, *knowing the client*, *discovering the boundaries* and *using metaphors*. One of the subcategories related to discovering the boundaries is *overstepping the mark* which is also described in this chapter along with the consequences of taking such an action.

Although most of the participants in the study were experienced public health nurses they, in common with other nurses, appeared to find it difficult to verbalise concise theoretical descriptions of their work. Instead, the nurses often chose to describe actual situations in order to illustrate their practice. By the use of metaphor nurses were able to describe some of the harsh realities of their world as well as some of their better moments in practice. Through the analysis of these descriptions of the participants' work, categories emerged which indicated that nurses work hard over a period of time to develop frameworks which reflect the meanings and provide a structure for their practice.

Employers of public health nurses have a different perspective. They tend to define nurses' work through broad policies and guidelines. These may endorse a primary health care model, and indicate the geographical area, specific schools and the tasks for which the nurse is responsible. Recent documents prescribing the scope of public health nursing practice in New Zealand focus on broad philosophies as well as specific policies relating to the type of work and the nature of the clientele. (Manawatu-Wanganui Area Health Board, 1992: Otago Area Health Board, 1990: Wellington Area health Board, 1992:).

Analysis of the data demonstrates that for the public health nurses in the study, these

responsibilities translate into practice with individuals, families and groups at a personal level occurring through face to face encounters. Strategies for meeting these responsibilities and managing these encounters are left to individual nurses.

Building the Structure.

In their interviews the participants described how the structure that guides or gives perspective to their practice evolves or is built over a period of time as they gain more experience in public health nursing. Gaining knowledge of their 'patch' - the geographical area within which they work, insight into their own philosophies and increased professional and personal experience contributed to the way they conceptualised their practice experience. Participants recalled beginning practice as very confusing. They told of how they initially depended on the guidelines developed in their area, and on support from more experienced nurses. For nurses who are new to the field of public health nursing or new to a particular geographical area the amount of leeway and lack of clear direction causes uncertainty. An experienced public health nurse describes this in an interview:

There's no structure in the job. I think that's a very important thing, that you actually build that structure in yourself by the way you work. There's actually quite a lot of leeway in the way you can do your job.

For some the experience was quite traumatic. One nurse referring to taking up public health nursing practice in a rural area highlights the difficulties:

I found it really confusing, no support. I wondered if it was worth carrying on. If I hadn't been going to a course I probably would have fled.

Looking back on beginning practice another informant describes her confusion resulting from not having a structure to give meaning and direction to her practice:

I found it very hard to justify, to actually see what I was doing was work....I didn't think I was doing anything. I didn't, you know I could do a five year old assessment. I could do a hearing test, that was something I could measure. That was doing something physical. But these family followups and that. Like I remember I was told to run a health clinic. No one told me what I was supposed to do, no one told me the expectations or anything like that I was just told to be there. And I sat there and thought what am I supposed to do for an hour.

Two participants told how their experience impacted on the way in which they built a structure that gave a framework for their practice. Trust and error played a part:

I guess I don't have the strong public health focus that some public health nurses

have. I've sort of learned by experience what works for me and what works for my clients.

They also drew upon their own personal knowing:

I have a particular interest in the carers of children with special needs, having had a sick child, I just know what it's like.

The contribution of the nurses own experience to the structures that they build to guide practice is also described by Field (1983) in an ethnographic study on the work of four public health nurses. Using information gained from the four public health nurses on their perspectives of nursing Field states that their beliefs and practice appeared to be influenced by *the nurses own life experience and priorities*. (1983:9). Twinn (1991) in her writing suggests that health visitors may conceptualise their practice differently from each other. She believes different conceptualisations result in continuing debate and professional uncertainty, a situation which has the potential to be dysfunctional for nurses seeking a common identity (1991:996). The data from the participants in my study did not always support the findings of Twinn. It indicated that although the public health nurse participants frame their practice in different ways, they commonly share meanings and beliefs about their practice.

From the data it is possible to identify two subcategories in the structures the nurses build to give meaning to their practice. One is a focus on health, the other is a focus on positive outcomes for clients. The two subcategories are not exclusive, both are evident in some interviews, and both are strongly optimistic in nature.

Focusing on health

In the following quotations from four participants one can see a focus on health as a structure that they used to give meaning and direction to their practice:

I believe we have this personal health, personal and individual interest with a public health focus. That make sense? We work on a personal level, one to one with people. But we have an overall public health focus and a community development role.

.....

As nurses we're concerned with health.

.....

We tend to look at the whole picture, everything health and education. That everything is sort of going right for the whole family.

.....

Seeing people holistically, I guess I work from a family base. What affects one member of the family affects them all, and I think as nurses we're looking at wellness and wellbeing.

Kristjanson & Chalmers (1990) and Cowley (1991) also described public health nurses or health visitors holding a *broadly based and longterm view of health* (1991: 652). They see a health focus as influencing both perception, and the way of working for community health nurses.

Focusing on Empowerment

Another way of building structure seemed to be by focusing on the achievement of positive outcomes for clients. The following are examples of this approach:

I'm there to give people options and choices and hopefully empower them to make decisions.

.....

I want to make life easier for them (people). So you can help them access services that are there already in the community that they can use. Help build up their confidence so they can actually deal with things better.

.....

The focus of my work would be improving peoples' quality of life.

.....

I guess I'm a health educator. And whether it's on a one to one level or a group level doesn't make any difference. I think we are educating if we can point out another option exists. Or another way of life exists.

Knowing the Client

In listening to the participants, the interviewer noticed that the nurses found it easier to talk about their practice by grounding it in the realities of remembered situations. The examples of codes and categories related to building a structure are found in the rich descriptions of practice. It is noticeable that the focus of these practice stories is nearly always children, within the context of their family.

This led me to explore with the participants who it is they see as their client base. An exploration which elicited an unequivocal response, as is evidenced in the following excerpts:

I think it's about 84% to 85% of my time is taken up with school age children.

.....

Children. Children and to a lesser extent women.

.....

Children, monitoring childrens health

.....

I feel it's the kids that are the ultimate... and that's where our role comes in the welfare of children.

.....

The child is the centre of our concern. Cause that's where our role is, the child's health and safety.

.....

Child health and safety. It's child health, it has to be doesn't it?

In other interviews, participants stated that although they see children as their clients, they see them within the context of the family. Interview excerpts provide examples:

My work is child and family health.

.....

Well families at risk I think, without a doubt and special needs children.

.....

Children mainly and to a lesser degree families. Mothers in particular, as well as fathers.

The reasons nurses gave for seeing children within a family context are that traditionally public health nursing practice has been concerned with the health of children within the setting of the family. A second reason given was that public health nurses work in close proximity to children and families in the homes, in the schools and in the community. They, of all the health professionals, have many opportunities to know the problems and needs of children and families within the current social context. As one said:

We're seeing more families in chaos, in distress and more children who are emotionally neglected and even physically neglected to a degree.

A third reason the nurses state is the enjoyment they get out of working with children.

For example:

I enjoy contact with the schools, you know, contact with the children contact with the family.

.....
 I enjoy seeing the interaction between the child and their family.

In common with other studies, three participants in the study focussed on the mother when discussing the family. A report of a study carried out by Kristjanson & Chalmers discussed the implications of using 'the family' as a blanket term, without consideration of who was the major caregiver within the family. They believed that women are *most frequently the recipient of public health nursing services* (1991:149) and nurses need to consider this aspect when providing 'family' care.

While many of the public health nurses in the study stated that their main clients are children and families, another informant said her clients came from across the spectrum. In reply to a specific question about her client base, she said:

I would consider it to be across the board. From pre-schoolers teaching them to wash their hands, right through to older people trying to get them to alter their lifestyle.

Working with children in the context of the family, or the school and the community, requires that the public health nurse has well developed expertise in this area. The way in which public health nurses work with children within a family relationship will be discussed further in chapter eight.

Discovering the Boundaries.

As well as *building structure* and *knowing the client*; *discovering the boundaries* has the objective of focusing the public health nurses' work. Discovering the boundaries means that nurses become clear about the nature and the limits of their work. Because of the broad area of public health nursing, participants in the study identified the necessity for them to develop parameters around their practice in order to limit the scope to where they can work the most effectively. Several participants highlighted the uncertainty of knowing their boundaries at the beginning of their public health nursing practice. They described being overwhelmed and worried about their work, which at times seemed limitless and formless, as is illustrated:

And to come into this job where I felt there were no boundaries.

.....
 I didn't know where to start or where to stop either for that matter.

The expectations were never clear, it was nothing like my training.

Discovering the boundaries has also to do with recognition of the scope of practice of the nurse and their working relationships with other health professionals. The work of other groups of professionals who have an interest in the welfare of individuals and families also impacts on the nature and the limits of individual nurses practice. In some areas of their practice public health nurses have developed protocols or guidelines for dealing with specific problems, involving referral of clients to specific agencies or professionals. As one nurse explains:

If a child's at risk we usually take it to social welfare and you usually find with those families there's usually been other people involved.

It may not be a simple issue, personal expertise and experience is judged as well as the service able to be provided by the other professional. If the public health nurse feels the client needs additional or alternative help there may be a problem in matching the needs of the client with the availability of appropriate assistance. In rural areas accessibility of additional professional help may be even more restricted. Boundary issues are further complicated and sometimes blurred because the perceptions of the nature and parameters of public health nurses work may be different for the client, for other professionals and for the public health nurse. One participant graphically describes issues relating to both boundaries and working with other professionals

It's so ill defined, there's never a boundary. It's just sort of like an amoeba, it sticks its feet up everyone's noses. I just have this little vision of an amoeba and rivers in the jungle and it feels its way up that river and withdraws. And every time it sticks up its beak it gets bitten.

Although at times the boundaries appear to be clearly defined and known by the public health nurse, the data in the study indicates that these issues for the public health nurses are not always clear cut or simple. This is apparent in the following interview excerpts:

I think those sort of agencies [social welfare] have aims that are not broad like ours. Usually if social welfare is involved they're involved for specific reasons, for a specific purpose. That's perhaps the difference between other agencies and us, they always have a specific agenda

.....

And I was sort of mulling it around in my mind what should I do whether perhaps I should ring back into the senior nurse or whether to take it to social welfare, whether

it goes to the police. So I rang the principal up [of the school] and he had a yarn to the policeman and he said it's serious it's C.I.B. material. So I left it at that and in the last three months it has resurfaced, it wasn't solved at all.

Boundaries are discovered in several ways, through reflection and experience as well as from the expectations of others such as clients, employers, school teachers and other professionals. Knowledge of policies, protocols and legislation relevant to the work also helps to determine the boundaries of practice. The participants stated that as time in practice increases, observation of the work and the outcomes of other professionals, as well as knowledge of their own developing abilities and skills, helps to develop a sense of the boundaries which impact on and limit practice. Most of these aspects are touched upon in the following interview transcript:

I still visited but I didn't discuss the issue because I'd handed it over you see. When I'd been in meetings with them and the mother's been there she's very happy to talk to me and that sort of thing. But I felt I'd handed it over to another agency so unless she wanted to talk to me about it I shouldn't be interfering in their work. While I don't like partitions, this is yours this is mine type of thing. I don't like to tread in someone else's territory unless I've been approached. Now I have been approached by the psychologist to go back. This child and I have always got on well and she's the sort of kid who looks for you in the school playground. So they've decided that I will be the key worker.

One of the issues identified by this participant is that the boundaries of the public health nurses' work may be based on expediency rather than any clear policy. Boundaries of practice, may be flexible and considered within the context of a particular situation. As one nurse said:

A lot of the bits that no one else wants we pick up, or we tie up the loose ends between a person and a service.

Another described an encounter with a client who is dissatisfied with information and treatment provided by his General Practitioner:

We provide a second opinion for people, if they haven't got what they want in the health service they come to us.

She went on to say that although she knew she would not be having a long term relationship with this client she saw it as legitimate that the client would consult her.

Discovering the boundaries emphasises the open nature of public health nursing work.

It is influenced by special needs of the area in which the nurse works, as well as specific tasks that may be required of that nurse by their employer. In analysing the data from the interviews it appears that the personal characteristics, skills or interests of the nurse also influence the individual nurse's boundary setting. Some of the things they said were:

Myself, some of the extra things that I do above the normal public health are extra things in health education. Smoking cessation, anger management and other things as people ask for them.

.....

I work a lot with children with special needs and their families.

.....

I work with secondary schools but not primary schools.

.....

I think it's about 84% to 85% of time is taken up with school age children. And I only do the primary schools and intermediate. I don't do the high schools. I specialise in two areas I've got health camp, which I'm coordinator for and I'm also coordinator for child protection.

In summary, discovering the boundaries allows the public health nurse to identify parameters for practice, some of which are more clearly defined than others. Although experienced public health nurses in this study identified that they were aware of the boundaries of their practice, they did not always choose to stay within them. Several nurses described incidents which illustrated the extent to which they were prepared to move outside the recognised boundaries, a point which is taken up in the next section.

Overstepping the Mark

Moving beyond the perceived job boundaries was described as *overstepping the mark for my client* by one participant. Other nurses also narrated incidents where they moved beyond what they perceived to be limits of their practice to help clients. One recounted how she intervened in initiating a custody hearing on behalf of a child who had approached her at school. This nurse, although experienced did not make the decision to become involved lightly. However, in the end she decided to go ahead with what she perceived would be in the best interests of the child even after taking advice that there could be legal implications. In her words:

I did put myself on the line. I decided to go to the father and he asked me if I would

go to family court with them. And the child is now with the father and we've got very much a changed child.

Another participant referred to lending money to her clients to enable them to purchase medication. This same nurse in describing her client group said she 'liked unlikable' people and that many of her clients were people that:

We've inherited, we've gone in where other people have stopped going.

Yet she was always prepared to lend money to help people:

I'd offer, I'd say look I've got ten, twenty dollars here do you want to borrow it to buy medication.....I've lent a lot of money to these people and I've been always given it back.

Another nurse describes *overstepping the mark* as follows:

When I talked to you last time do you remember the little girl who'd been abused?

Well she's been fostered. But I really felt I put my neck out on that one. I had sleepless nights, but I was glad I did what I did.

A common factor seems to be being prepared to go a little bit further for their client. One informant claimed it demonstrates that they are human, another described it as caring for her clients:

Well you wouldn't put yourself on the line if you didn't care. Would you?

In all but one incident of *overstepping the mark* the nurses identified the clients as children, the exception being a young solo mother struggling to look after several children. There are consequences of *overstepping the mark*.

Being in trouble

While the result of overstepping the boundary may be that the outcomes are better for the client, often it has the result of getting the nurse into trouble. This is the case when the nurses' perceptions of the boundaries do not coincide with those of other professionals or family workers. Although prepared to risk getting into trouble for their client often public health nurses may be unaware that they are transgressing until they are actually in trouble. However, overall it seems that while nurses are aware that taking client interests beyond conventional boundaries may land them in trouble, they tend to be undeterred in their pursuit of client interests, as it is indicated in the following interview excerpts:

I'm always saying rude things like I'm never going to send another child to health camp [after a school complained they didn't know a child was there]

.....

And everytime you sort of seem to get into trouble you say, I won't do any thing else to get into trouble again. But you do!

.....

Cause every time you put your head up you get into trouble.

Using Metaphors

Using metaphors is another device the participants employ to frame or give meaning and structure to their practice world. Smith in a article, 'Metaphor in Nursing Theory' defines metaphor as *the product of an intuitive grasp of a unity of meaning; in it a familiar image used in an unfamiliar context fosters a holistic insight in a moment* (1992;48). During the first interview some of the participants used metaphor to describe their practice or practice world. These metaphors added to the richness of the data and captured understandings about the meanings located in their practice. In a subsequent interview I asked all the participants if they could give a metaphor which would describe their practice or aspects of their practice world. Although some of the metaphors refer to different aspects of practice and could have been used to illustrate concepts discussed elsewhere in this thesis the images they capture are more powerful when these metaphors are seen together.

In the following example, (already cited in another context) the participant is describing a way of *enabling accessibility* when she talks about having lunch with and talking to primary school children on a regular basis:

Sit down and have a sit in the sun, the next minute there are little sparrows all up beside you and they're telling you everything. Not that you want to know everything.

The metaphor of sparrows chattering to the nurse and each other, is a wonderful way of describing the interaction of these children and their friend the 'school nurse'.

From the choice of metaphor to describe the realities of their practice, one can see that the world of the public health nurse is not an easy one. The work that they do is not straightforward, nor are the clients they get to see always pleased to see them or seeking change in their life. Sometimes the metaphors are of simple images that only

work embedded in the participants' descriptions of their work, for instance:

I actually said something which sounds rather harsh the other day but, I said that we pick up the garbage. Which is not meaning the clients are the garbage, they are the things that no one else wants to deal with, they're the difficult, the very awkward things, the things other services might not want to touch.

Others presented similar views:

We pick up on a lot of the gaps and overlaps that are missing. The people that fall through the system

.....

People hand onto us what they don't know how to pass onto anyone else.....at least we'll have a go and try something, and then we're kind of expected to work miracles.

.....

Who are we to tell people what to do in their lives? Like you're sort of set up as a sort of police person, like a social policeman putting controls on people, because they're not following falling into line. They're smelling when they shouldn't smell.

Some of the metaphors seem to refer to the backstop nature of public health nurses work. There is a sense of frustration and the almost impossibility of the job running through the metaphors used by the nurses to describe the nature of their work:

We're a safety net.

.....

We work by just putting a finger in the dyke.

.....

What we do is putting the threads together, knitting, sewing, darning the holes basically.

.....

Sometimes it feels like we're rattling around like stones in a tin.

.....

Being there when everyone's left.

.....

That's our job to be the moppers uppers of problems.

Being there without the expectation of a positive outcome illustrates the supportive role that the public health nurse takes at times. There is a sense of resignation but not necessarily of giving up when the nurse says:

I'm not going to be able to change the world.

.....

I learned I couldn't change the world.

Not being able to 'change the world' means the participants sometimes saw themselves as a safety net. This is poignantly illustrated by the following statement and metaphor from a nurse with many years of practice.

Everyone else has had a go or interfered or done their little bit and then left. And we pick up the pieces. We may start it all and we'll go back and be there no matter what.

Another metaphor used by an informant describes the intimacy of some of the public health nurses practice which is also part of *being there*.

You get invited into people's lives.

Throughout the interviews there is a sense that public health nurses often work with people whose progress toward changing their lives or the lives of their children has not met the criteria of other social agencies. These are the people on whom other agencies have given up. Occasionally a nurse reveals that they do not wish to take on all clients who present themselves:

I have a gut feeling and if it's not going to work I try and get them help somewhere else. Which is difficult because often there isn't any where else.

The same public health nurse stated that:

We still get the ones that have been to the service and the service has dropped because they're not getting anywhere.

These quotations and the metaphors capture a stark reality of practice that is in contrast to the optimistic way in which the participants frame the structures of their practice world. Public health nurses seem to live in a practice world of contradictions as has already been highlighted in the discussion on visibility and invisibility in chapter five.

Summary

Building structure, knowing the client and discovering the boundaries all help to give meaning to the public health nurses' practice world. In this chapter the findings are described as the public health nurses related them to the researcher. Consequences and reasons for overstepping the boundaries are identified and discussed and rich description of realities of the practice world are provided through the metaphors of the participants. In the next chapter the themes relevant to the gathering of information needed for client and public health nurse decision making will be described and developed.

CHAPTER SEVEN

SEEING THE WHOLE PICTURE

Whereas chapters five and six dealt with some of the precursors and the context of practice encounters, in this chapter the focus is more directly on the actual work with clients. The public health nurses who were interviewed were convinced that the more complete the picture of the client's situation then the more effective the nursing contribution was likely to be. At the same time they were also clear that *seeing the whole picture* required substantial groundwork. *Legitimizing involvement, glimpsing the pattern, seeing the situation globally, completing the picture and documenting the evidence* are all part of the concept of seeing the whole picture. An important subcategory is *home visiting*, which is discussed within the context of seeing the whole picture, which also contributes to becoming known, already described in chapter five.

As already demonstrated children and families experiencing difficulties constitute a major component of the public health nurse's work. Major and multiple social changes mean that life for families is becoming increasingly complex and this may lead to ongoing problems. At initial referral the difficulties experienced by individuals and families may appear simple or straightforward and easily corrected, yet following investigation the difficulties often turn out to be multifaceted and complex. Although difficulties and problems may directly or indirectly impact upon health, often they are not clearly recognisable as health problems.

Legitimizing Involvement

The public health nurse must first determine the nature of the problem and decide whether she is the appropriate person to work with the client or whether the client could benefit from further or different professional help (see *discovering the boundaries*, chapter six). The participants in the study claim that it is an essential part of their role to develop a relationship within which they can assess the clients needs, then make a decision about appropriate referral based on these needs and the understanding or wishes of the client. Cowley (1991) in a study which analyses interactions between health visitors and their clients describes the process of initial interaction between client and health visitor, as having the goal of legitimating the nurses rationale for

involvement with the client. Her descriptions of this process were corroborated by the participants in my study and illustrated by the following quotations:

Initially when I visit them I introduce myself say why I'm here, perhaps the school has asked me to visit. I sit and listen and I say I can't help you but I know who can, or I can help you but I can't make you do anything you don't want to do

.....

I think a lot of our work is short term contact trying to match people up with a service that will give long term support.

.....

I go to high schools, and I saw two boys. I've never seen such severe scabies, it was right down his back leg. I couldn't get hold of the parents. I rang up the doctor he saw them for nothing. It was the second time but they wanted me to help. They knew you were doing something for them.

.....

It was an urgent referral, we got the children into health camp. The mother was desperate.

For the participants *legitimizing the involvement* meant they had at least the tacit agreement of their clients to proceed with the encounter.

Some of the situations the nurse deals with are uncomplicated, and the outcomes quickly achieved to the satisfaction of both the public health nurse and the client. However, not all of the public health nurses' work is pleasant or of a short term nature, nor does it comfortably fit into the domain of 'public knowledge'. One participant describes how school teachers prefer not to confront situations which are uncomfortable or difficult:

The school want us to refer it [child abuse]. They're happy to tell us, then they want us to do the dirty work.

Public health nurses often have problems or situations revealed to them which are in the 'secret' domain of individual and family life. Uncovering these issues may cause major disruption to the lives of individuals and families. While self help philosophies focus on the positive results of taking responsibility for one's life, they do have a reverse side, they tend to place the blame for problems on the individuals and families experiencing them and to ignore societal contributions such as unemployment and poverty. Increased public recognition and visibility of the nature of public health

nursing work may create tension for some families the nurses visit. These people are likely to be aware of the view that public health nurses deal with difficult and often unpalatable social problems, so are uneasy when the public health nurse initiates contact.

A New Zealand study on client satisfaction with community health nurse interactions (McDrury, 1992) noted that clients were less likely to be satisfied with their interactions with public health nurses and Plunket nurses than they were with their contact with practice nurses. The author noted that contact with the practice nurse is likely to be initiated by the client at a time of need, whereas contact with public health nurses or Plunket nurses is likely to be nurse initiated and in the case of the public health nurse because of a problem identified by someone other than the client or the nurse. In other words public health nurses may work in situations where legitimating involvement may be more problematic than for other nurses. One interviewee describes her belief of how her visits are often perceived:

Because there is a feeling, public health nurses only go to the people who are really bad, and what's wrong with me, why are you here, have I done something wrong?

The public health nurse sometimes faces the challenge of working with a client who may be upset by or resentful of the public health nurse's visit. Other situations the participants describe are working with clients who do not recognise their problems or who do not wish to do anything about them. In this context Zerwekh talks about 'laying the groundwork' (1991b:214). She describes the need to build trust before the public health nurse is able to move on to encouraging self help in their clients. In my study it is termed *legitimizing involvement*.

As one nurse says:

They don't approach us because they don't recognise it themselves. It's very difficult to manage that, because how do you say to a person good-day I'm the public health nurse and we noticed your kids are always late for school and they tend to look as though they haven't been to bed on time and things like that.

Participants recognised that in order to assess, work with or refer clients a relationship based on honesty and trust needs to be developed between the public health nurse and the client. Typical statements were:

They've got to get to trust you, before you get anywhere.

.....
 You've really got to persevere, keep going back and back.

Because the public health nurse has no legal authority, except in very limited situations usually related to contagious diseases, to require that people follow their advice, they are dependent upon obtaining the goodwill of their client and often the client's family.

Persistence is often a strategy which is used by the public health nurse to legitimate involvement, build trust and gather information. Luker & Chalmers (1990) in their study which explored the concepts surrounding the gaining of access to clients, described the strategy health visitors used to deal with a 'difficult' entry was by 'keeping trying'. Persistence and 'keeping trying' were concepts that appeared again and again in the interviews of the participants. One interviewee describes how she perceives her practice to be different from that of other nurses:

We just keep going back and back. We've got no rights to insist on anything. I often keep visiting, and it's awful in the beginning, but we gradually win them around.

Other people give up or refer it to us!

It is within the context of involvement that the nurse begins to uncover the picture.

Glimpsing the Pattern

Many times a child or family may be referred to a public health nurse because of a perceived problem identified by a school teacher. Contact with the family through home visiting may uncover a whole plethora of problems or issues. One participant describes this process as:

...the tip of the iceberg that's what we start off with. Followup reveals what's underneath.

The analogy of an iceberg is apt, although only the tip is visible one is aware that the complete structure exists. Glimpsing the pattern is part of the process of developing a coherent image of the whole.

The initial reason for referral of a client may appear, before investigation to be a straight forward issue amenable to simple advice or intervention by the public health nurse. The reality of the practice world of the public health nurse is that many of the individuals and families they encounter have multiple ongoing problems. One of the participants in Zerwekh's study (1991c:36) also recognised this; '*You get simple referrals and you open Pandora's box*'. The initial reason for referral may be a symptom of the problem

rather than the actual underlying issue. The situations which nurses discover highlight the need for nursing judgement and discretion. Descriptions of situations where the nurses uncovered more than was initially apparent abounded in the interviews:

You come in with a little bit of baggage and go out with a whole lot more.

.....

You know you can come out with a load of other things that wasn't your first referral really.

.....

Sometimes you're terrified, because as I said before often when you go in you find a lot more under the water.

.....

I mean I may have gone in with one issue that perhaps came from the referral, but it may turn out to be quite different so I may have to change the tack.

Two interviewees graphically describe school referrals which illustrate the complexity and the unexpectedness of much of their practice:

You perhaps might go in because a child smells and you find out the washing machines broken down and she can't get it fixed. That's she's [the mother] got no support. She's got no neighbours that can help her do the washing. She's got no friends, she's on her own and struggling.

.....

They keep coming to school without a lunch. And you go to the home and find there's a lot of stress. The finances aren't good, the family's falling apart; those sort of things, then the focus has to change from the child to the family.

Being involved, accepted and trusted seems to be a prerequisite for obtaining 'real' and meaningful assessment information. A participant talks about difficulties in obtaining information in the early stages of her practice as a public health nurse:

Because people only talked up front like they didn't tell you what's behind.

The participants claim intuition and experience contribute to the confirmation of their feelings in knowing that things are 'not always what they seem' and to their recognition of the possibility of larger picture usually with underlying problems. These feelings are illustrated by the following two extracts from the interviews:

But we are sometimes in the situation that you know things are not right but you just can't put your finger on it.

.....

I was really concerned about this little girl. She became more of a concern the more I saw her. I thought any child who wants to spend every lunch time with me there's something wrong really.

Public health nurses on referral of clients were furnished with a *glimpse of the pattern*. Because of experience and reflection they comprehend the glimpse as part of the whole.

Seeing the Situation Globally

Many of the images that the participants use to give meaning to their experience of assessing and identifying clients problems are visual. Zerwekh (1991c) in her article describes 'detecting' as a competency which informs all other public health nursing activities. She claims that nurses often used sensory images to describe detecting. In my study the participants frequently used visual images and talk about 'seeing the whole picture' in relationship to gathering information. The interviewees often described the initial assessment using the metaphor of a picture:

I first of all get a picture of what the problem is before I go in

.....

It's important that you get that picture, that you go directly and get that picture and build up a rapport with the family

.....

Because you actually have a picture, if you do devise a picture. Like you sit in these meetings and then you do the home visit and realise how wrong you were.

Again and again the participants talked about seeing a picture in relationship to identifying issues and problems. It is exciting to speculate that perhaps the process of assessment for the public health nurses is global, experience may enable them to consider the client within the context of both the family, the environment and their problems, simultaneously. Currently the term 'gestalt' is being borrowed from psychology to describe this 'all at once perception'. Rather than a linear process of adding more and more information together until a problem is defined, the public health nurse seems to see the overall situation as a whole. Additional information modifies the picture enabling the public health nurse to see the whole more clearly. Zerwekh (1991c) states that her informants talk about making a picture 'less cloudy' as they collect information, usually through observation gained while home visiting. A participant describes how she assesses her client:

We try and look at the total picture to see... usually the child presents the problem and from there, we look into the school things the home things....but from there we go to the wider community.

Another participant again uses the metaphor of a picture when she is gathering information:

I first of all get a picture of what the problem is before I go in. I sit down and talk to the teacher or the person who's referred the child. [I] look up old notes. I go into the home and get into the picture and build up a rapport with the family.

Completing the Picture

From the data it appears the public health nurses begin their interactions with their client knowing the information they have been presented with is incomplete. They still begin with a picture of the situation, a glimpse of the pattern albeit cloudy or incomplete. The process that the nurses use to complete the picture is described by the concepts of *making the connections*, *replaying the problem* and *home visiting*, recognising that their first picture of the situation is likely to be shadowy or imperfect.

Lapp, Diemert and Enestvedt (1991) in their article on family based practice, describe an assessment tool which merges assessment and intervention. The findings of my study on public health nurses supports this process of a continuous interaction between assessment and intervention but within the context of a relationship, however fleeting. Such a process contrasts with other prescriptive literature for community health nursing practice where a linear model of assessment such as the nursing process is advocated. None of the participants described using a linear assessment tool with discrete steps such as the nursing process.

Making the Connections

The strategies used by the nurses to uncover information or problems tended to be global in nature and more complex using multiple data sources. Information was gleaned from a variety of origins, some of it was already available to the nurses through previous and seemingly unrelated connections. Many of the families with which the public health nurses work may be known to them through previous contact, or through community knowledge, and these sources of information are used to provide background or to set the client within a context.

Although the participants state that they begin an encounter with a picture of the situation, they continue to collect and link information in a meaningful way to refine their initial impression. Sometimes referrals require immediate followup, yet however urgent the situation the nurses still identify the need for a 'complete picture'.

And you think there's something not quite right here. Sometimes you know that everything else is going to have to go by the board. I must go and see this family today. Because that's where you make mistakes if you don't have a complete picture. And if you only get half the story.... because if you don't that's where you put your credibility on the line.

Often the nurse collects information for future reference. This serves a purpose in their child monitoring and surveillance role. As the picture becomes more complete the public health nurse is able to act. More information refines or more sharply defines the picture, often acting as a stimulus for action by the nurse:

Sometimes you know by getting all the information together then you see the real picture.

.....

You are forever connecting and making decisions and that's nursing.

.....

.....and that's when so many things started ringing bells.

.....

We have the ability to connect things then it all comes together and we can do something.

Three participants used the metaphor of a jigsaw when talking about making the connections

I call it a jigsaw, and that's specially important for child protection because nothing's black and white. Sometimes it might be over a long period of time, that's why documentation is so important. You write something that you have a feeling about, you have a lot of gut feelings about that something's not right here.

.....

I suppose its only an active mind, that just shows you there's pieces that don't mix, they don't work together but you have to keep on working to find what the missing link is.

.....

If anything else comes up there's more pieces to the jigsaw.

Networking, experience, intuition, documentation as well as clarifying the situation with the client are some of the strategies the participants use to help in making the connections or finding pieces of the jigsaw. These processes are illustrated by the following quotations from the participants:

Cause often you can know something. And you always find the little bits out don't you. Yes, you are learning little bits all the time.

.....

Public health nurses use networking skills to gather information. Like a teacher referral can be quite difficult because you don't always quite understand what the teacher's reason for referral is. You haven't got the clear picture.

.....

She just said little bits and then I started clicking.

.....

You sort of just keep trying and keep going back and back and as you become visible and little things keep coming up and you start throwing those little things around. People feed on those little things you throw around.... and then you go back to the teacher and say this is what I've found and they give you more information.

Replaying the situation

While public health nurses described seeing their clients and their immediate context as a whole, they also frequently talked about the way they reflect the picture back to the client as a way of clarifying and exploring the situation. They described how they present the reason for coming, then give the client the initiative and sit back and listen. Listening was described by all the informants in the study as being an important part of working with clients. Two participants talk about the development of a relationship and how they listen.

I've got a difficult one at the moment, like you've just got to listen. Just listen and don't even nod your head, because sometimes if you nod your head they think perhaps you're agreeing with what they're doing. Then I'll give them some affirmation.

.....

Actually listening to people to find out. Like, asking them is there anything they don't understand. Just asking that and listening to what they say.

The public health nurses told of how they reflect back to the client their understanding of the situation. This process of listening by the public health nurse then checking their perception and judgement of the situation with the client is termed *replaying the situation*. An illustration of *replaying* is found in the following quotation:

When I go to see someone, I explain to them why I'm there and get them to tell me about what it is, and I say to them, this is the way I see it.

Descriptions by the participants of this process of reflecting and replaying back the information gained from the client occurs again and again in the data. Usually the participants do not stop at simply reflecting back, they engage in a process of reframing the situation. The reframing that the public health nurse does incorporates her own experience and often her own views about the situation. The following is a description of a client interview, it illustrates listening, reflecting back and empathy but it also demonstrates the expertise of the public health nurse, gained from both her own practice and her life experience. It is helpful to recall that this is a condensed version by the public health nurse participant of a lengthy visit and we do not have the mother's perspective:

I said to her do you recognise this child has a behaviour problem? Shoplifting!
You've recognised the fact that you need help. You've been to see your G.P. and you're not satisfied with his explanation. You've been to other people who you have not been happy with and you're still asking for help. Lets look at two years down the track when she will be two years older and may still not be cooperative with you and you are finding the behaviour increasingly more difficult. I sort of tried to point out as I saw the problem now and how I could perhaps see it in the future. I replayed it back to her and we had a few laughs about how kids can drive you up the wall. I just put things in a logical sequence and by the time I was finished with her I had an appointment organised with the psychologist.

Replaying and reframing the situation, by incorporating the client's perspective into the picture, is an important concept which helps public health nurses elucidate the realities of their practice with clients. Kristjansen & Chalmers (1990:215) describe the 'give and take as each participant defined territory and revealed information'. Chalmers (1992) expands on this theme of giving and receiving as a strategy employed by both parties for managing the health visitor client encounter. Replaying the situation, also seems to be used by the public health nurses as a method of involving and recognising the clients

expertise as well as a strategy for enabling the client to retain control in the information seeking-giving situation.

Home Visiting

Home visiting is claimed by the participants in this study as crucial to the process of assessment and *seeing the picture*. Very few writers describe home visiting as an important variable in the practice of either health visiting or public health nursing. In some studies it is taken for granted as a location of practice, others mention it within the context of being accepted as a visitor. Zerwehk (1991abc) however, in the discussion of the findings of her study with public health nurses in the United States, emphasises the importance of home visiting as a prerequisite for coming to know families. *The public health nurse is a detective looking for clues. By observing family living in context, public health nursing experts try to uncover the causes of signs and symptoms that present in isolation in a clinic examining room.* (1991c:30)

When the public health nurse visits people in their own homes she is visiting them on their own territory. The public health nurse enters at the invitation of the person and has no legislated right to be there. Two important points need to be emphasised. One is that the control of the situation is vested in the occupiers of the home. The second point is that the nurse is able to observe people in their own surroundings within the context of their families or significant others. One public health nurse describes how the client manages the situation regarding home visiting:

I've just had two situations where I didn't get past the door step, I discussed quite intimate problems really, out in their back yard.

Observation as part of assessment is critical, especially as it has been demonstrated that public health nurses, even when working with individual clients see them within the context of the family. Participants felt very strongly about the value of home visiting, as the following extracts illustrate:

Families appear to be much more comfortable on their own ground, and more willing to share information.

.....

People in their own territory can express themselves better. Even if they are unwilling to share information it is more difficult to conceal the realities of family life and the interrelationships between its members.

By going into their house you'll often get to meet all the other members of the family to sort of see a bit more of what's going on.

.....

And when I visited her I was able to get her to open up and talk about some of the real problems.

.....

I think by a parent sharing a problem on their home ground lots of other things will come out. By sitting and quietly observing, you know you can pick up very quickly.

.....

They're in charge in their house and they don't put up so many false impressions. They don't pretend so much in their own house, They can see, they know that you can see what's happening there and they can't hide things that are there so much. And for some reason they don't want to.

Public health nurses use information from a variety of sources when they are *completing the picture*. The home visit may be used as a way of validating that information or as a way the nurses can 'see for themselves.' Home visiting seems to be an integral part of public health nurses practice and understandings of clients behaviours or problems may be directly linked to the willingness of the public health nurse to be involved with their clients on their home ground.

I think you need that home contact because you see another side [from the teacher].

.....

Because we get a dimension visiting the homes, that other people don't get. People tend to put on appearances when they go out to see a counsellor.

Documenting the Evidence.

Like much of the public health nurses' work *seeing the whole picture* may take a period of time. Documenting the evidence acts as an aid to the memory in seeing the picture. Several of the participants said that documentation was important in uncovering the problem, making connections and seeing the whole picture. It wasn't until participants sometimes read back over their records, often compiled over a period of time that they made the connections or saw the whole picture clearly. Here two participants describe that process:

We do document, we do, and it's amazing what you flick back and say well it's

happened.

.....

We often gather the information, we document, you write it up and its amazing how it's all connected.

Summary

In a discussion of the data with a colleague who had been a public health nurse for many years I mentioned this ability of public health nurses to be aware of the whole picture and their ability to make connections. Her comment confirmed what had been emerging from the data. *Public health nurses always know what's going on, it's something we need to do our job! Ask a public health nurse anything about her area or place of work and they'll be able to tell you.* Her comments inferred that the ability of public health nurses to *see the whole picture* extended beyond interactions with their clients into the wider context of their practice world.

The way the public health nurses in this study assess and uncover the problems of their clients appears to be very different from the linear models of assessment offered in text books of community health practice. Using the visual image of a picture to create meaning in their practice situations, the participants connect data from various sources, then match it with the overall picture to create a sharper or more reliable image. In this way they can both verify data as it comes to hand and increase the clarity and the refinement of the picture. *Replaying the situation, home visiting and documenting* also seem to be important strategies that the participants use in their practice to ensure quality and accuracy of the assessment information.

In chapter eight the concern will be with the more specific encounters and relationships within the public health nurse's practice. The data will be used to illuminate how these encounters and relationships are used by the public health nurse in their work.

CHAPTER EIGHT

MAKING AND USING THE RELATIONSHIP

The core work of the public health nurse is carried out within the framework of a human relationship. The data shows that the relationship may develop within a brief encounter, or it may continue intermittently for a period of years. Abundant descriptions of these relationships occurred in the data of this study. Critical factors within the context and the public health nurses' practice contribute to the uniqueness of these relationships. These factors are; the public health nurse is often the initiator of the relationship, choices about developing, continuing the relationship or making decisions for change stay with the client, and the clients are visited in their own home. Even when it is the public health nurse who identifies a child at risk the participants still describe the need for a relationship with both the parents and child if satisfactory outcomes are to be achieved.

In this chapter the way in which the informants develop and use their relationships within the context of the family is described and discussed. Important categories which illustrate and explain the practice of public health nurses within the context of the relationship are *beginning the encounter, establishing common ground, being blunt, networking and connecting* and *relating to other professional groups*. Subcategories are *dealing with gatekeepers, working with teachers, social workers and general practitioners* and *needing the support of colleagues*. Other factors such as *involving men, taking time* and *home visiting* are highlighted in the discussion

Working within the context of the family.

In the interviews with the nurses they stated that they considered their primary clients to be children within the context of the family and the social environment. Evidence and examples of this point of view were also given in chapter six in the section working with children. The following extract from an interview illustrates the view of one nurse:

My way of working with kids is to get them to see me as someone who really cares. As somebody who looks to make sure kids are happy and healthy. I like to build that relationship with kids to let them know there are people who are prepared to listen to them, who do care. But you have to involve the family.

Other studies on the work of public health nurses in the USA and health visitors in

England also acknowledge children and families are the focus of the nurse practitioners' work (Abbott & Sapsford 1990: Kristjanson & Chalmers 1990: Chalmers 1992: Zerwekh 1991a: Gillis & Davis 1992). The result of considering children within the context of their families means that the public health nurse works in a relationship with the family rather than with the child on their own, as is expressed in the following interview excerpt:

But if there's something to be done for that child we have to work within the school system and we have to work within the family, we can't work without those supports.

Sometimes the nurses described working with families as an aggregate. Individuals or children are not singled out in their descriptions and each family is seen as an entity with an identity of its own. The following is a description of an outcome which a public health nurse desires for a family. The initial referral was for a child reported as 'behaving badly at school.'

The intervention that I have with them [the family] will mean that life's easier. That you can help them access services that are there already in the community. Help build up their own confidence so they can deal with things better. It may take many years.

Working within the context of the family does not exclude a primary relationship between the nurse and the mother of the child. Usually it appeared that the mother has the pivotal position in the family in relation to public health nurses' work with children. One nurse recognises and describes this aspect:

I work with families but it's usually the mother.

Using the term 'family' but describing interactions with one member has already been touched upon in chapter six. Kristjanson & Chalmers (1991) state that although the literature in public health nursing refers to family nursing, the reality is that the focus of the interventions is the mother. Chalmers postulates that despite the claims that health visitors work with families or provide family focused care, men were often uninvolved in the interaction. *The access to the ...family was usually through the adult female in the household* (1992:7). Abbott & Sapsford (1990) in an analysis of the health visitors role in England, described the family intervention that is the focus of the health visitors' work, but again like the other writers claim that the mothers are often the primary 'target' of the health visitor's intervention.

There are exceptions, for instance if a child self refers to the public health nurse the nurse may keep the work confidential to the child if requested. One nurse described how she gives children the option:

I just say to them if you want to see me, this is at primary school level, just tell Mrs J. that you'd like to have a word. And whatever we talk about is between you and me.

Work with secondary school age children does not involve parents unless the children give permission. Only one participant differed in her belief from the other nurses as to the extent of her involvement with the families of the children she is referred. From her interview:

I don't have any influence on how the family works. I work for the children, and I'll look for the right people to refer to.

An important issue raised by the participants in their interviews was that, although they see children within a family context, occasionally they believe some families are not able or do not know how to meet their children's needs. There are times when the participants claim they do not support a child staying in the family if they perceive the situation to be harmful to the child. For example:

I would look at moving a child out of a situation if it's unable to be changed. I mean I still believe that there are families or situations that are not able to be improved and so the child's better out of it.

In a later section in this chapter a strategy which experienced public health nurses employ to deal with these situations is discussed. The strategy is termed *being blunt*.

Beginning the Encounter

When a child is referred or the nurse initiates a contact with the family, stages in the encounter are identified. Nurses interviewed in the study describe the process as beginning with making an appointment to discuss the problem or the reason for the referral with the family. Prior arrangements are usually made by nurses to visit the client in their own homes. One nurse describes the reason for this:

I used to go in cold but it doesn't really work, now I always try and ring first.

The nurses stated that they like to have a definite reason for going to visit the family. For example:

I like to go in with something real, like the child hasn't had any lunch for a week.

Legitimizing involvement as described in chapter seven is part of this process, but the

expanded description of the ongoing encounter as it is illustrated in chapter eight goes beyond getting permission to begin the encounter.

Involving Men

As stated, the encounter is more often with the mother though some nurses in the study made a special effort to include the father and endeavoured to visit when he was available, as excerpts from several interviews illustrated:

If I'm going with what I would consider a serious problem, I would always go at night and meet both parents.

.....

I get to know the whole family. I have quite a bit to do with fathers because I work with a lot of isolated rural farms.

.....

The rural community up there seems to accept fathers as doing the farming, you know he's out there. He hasn't got anything to do with the inside. I like to include the fathers because it supports the wife.

Chalmers (1992) claims that including work or involvement with men in families is influenced by the health visitor's conceptualization of men within their practice as well the social context.

Taking Time

Some of those interviewed stated that sometimes the encounter is just that, the nurse scarcely gets beyond *beginning the encounter*. The nurse *legitimizes the involvement*, as described in chapter seven, has a fleeting relationship with the client or the family which is terminated rapidly because the purpose has been achieved. Some nurses state that the client may use their services again because they have *become known and accepted* (see chapter three). Several of the participants described encounters where the process and outcomes were unsatisfactory both to the client and the participant and decisions were made by the client or the public health nurse that there would be no point in further contact.

Time is relevant in the development of a relationship from a single encounter. The following descriptions acknowledge the length of time some of the relationships will take to establish and the time some of them will persist, they also introduce the concept of a shared journey:

We've got no power, you just keep going back and back, persisting. First you're on the doorstep, then in the kitchen, then it's a cup of tea, then before you know it you've been around for a year!

.....

You work along side people, you start the journey together to make the change.

.....

Sometimes it takes so long to get anywhere. It can take two years.

.....

Over a period of time you might make a difference. It's only over time, over continual contact.

Christensen (1990) in her concept of lived experience also describes a nurse patient relationship in the terms of a passage over a period of time. The passages she describes are of short duration in contrast to the marathon journeys highlighted by some participants in this study.

Establishing Common Ground

The nurses recounted that in many situations they worked to develop a relationship from a one off encounter. They claimed they do not enter relationships as an 'expert' expounding advice that must be followed. For public health nurses the possibility of using or misusing power in a relationship usually arises from their expertness not from their ability to coerce or require. They stated that they make a conscious effort to work and be in the relationship in a way that will connect with people and will not create a power imbalance. From the data it is apparent that one of the ways public health nurses do this is to use their own experiences and to put themselves in the other person's place imagining how they would feel in a similar situation. An apt, but limited description of this way of working is *creating common ground* a concept described by Kristjanson & Chalmers (1990). They describe this as *the process nurses and clients participate in when they meet and work together in relation to a health/illness focus* (1990:218). In their research it served to integrate a conceptual scheme for capturing the interaction between public health nurses and their clients.

In the description of the encounters between public health nurses and their clients surfaced in the interviews reported in this study, *establishing common ground* has an expanded meaning. It has to do with locating shared experience and using these shared experiences as a basis for an encounter or a developing relationship. Establishing

common ground emphasises similarities rather than differences between public health nurses and their clients. It also has to do with acknowledging power issues in the nurse-client relationship. *Establishing common ground* may be seen as an endeavour which enables nurse and client to interact on equal terms. The nurses asserted that their aim is to share power in order to influence change rather than to use power to compel people to change. They often spoke about their concerns in supporting clients in their efforts to make decisions and retain control of situations.

Nurses use common sense and experience to *establish common ground*. The public health nurses in this study claimed these attributes are gained on the job or as part of their work and life experience. Being in a public health nurse/client relationship is essentially a commonsense practical experience. One of the categories which contributes toward creating common ground is an ability to be ordinary. The participants do identify that they use specific expert knowledge but they are at pains to emphasise that they do not set themselves up as the expert giving advice. Taylor (1992) describes nurses and patients as sharing a common humanity rather than being dichotomized and different. She quotes Pearson as saying, in an unpublished address *the foundation of genuine helping lies in being ordinary*. (1992:1047). This is illustrated in excerpts from interviews:

You need a little bit of maturity, to give you some understanding. And I think you bring your own experience into this. With the understanding you can relate to what's going on.

.....

I've managed to get alongside people, and work with them, not like control them but work with them.

.....

I use an ordinary commonsense approach and show empathy. I don't rush in and give advice, even when I can see what people should do.

Acting as an Advocate

Public health nurses in the study recounted how they frequently acted as an advocate or mediator for the child with the parents. A strategy of advocating for the child on behalf of or instead of the parents is also described by a number of the participants. For example:

Sometimes I say to the teacher, if you saw where this child comes from, the

conditions....., the stress in the family you should be pleased they're at school at all. The importance the public health nurses in the study place upon meeting the needs or assisting change within a family which will benefit children is supported by many stories in the data. One example follows:

To give the children some chance of improving in the circumstances I work very hard for kids whose parents cannot, for whatever reason, supply them with glasses. I'll negotiate with social welfare on their behalf. Because parents have been ridiculed for asking for special benefits and things. And you know we can get the forms and help them fill them out. It really is over and above what we're supposed to be doing.

Pybus (1993) in her study which looked at the relationships of public health nurses with stressed families also recognises this role. In her study she titles it being an intermediary or a go between but the characteristics she notes are representative of the properties of advocating as described in my study. If the nurse is advocating on behalf of the child, the participants identify that they will often endeavour to make sure the child is absent during the interactions. As one nurse said:

I believe it does them no good to hear it. I will not visit the home if the child who has a problem is there. I don't think it's fair especially if the mother has got to say something that's critical of the child.

However, there are times when the child is present. Vehvilainen-Julkunen (1992) claims there has been little systematic examination of the processes of the relationship between the nurse and the mother particularly when a child is present. Her study looked at the influence of having young children present in the interview, it revealed little except that having a child present provides a verbal and nonverbal focus for the interaction.

Although public health nurses in the study state that they want people to make their own decisions the data revealed that sometimes they enter situations with ideas of where they would like the clients to go and how they would like to see the situation resolved. Experience often teaches them that their expectations are unlikely to be met, or that clients will move at a much slower pace than the public health nurse or the teacher referring would like. This issue of power sharing becomes more difficult when children's needs are not being met. For example:

I want people to make their own decisions, not me going in there and telling them what to do, though I'm strongly tempted sometimes!

Another participant describes her struggles to maintain reciprocity in power sharing:

Sometimes I think I do, sometimes I think they do, I would like it to be a shared thing, an equal. And I try and make it that though I may not always succeed.

In the study the participants often compared their practice with the practice of other professionals who work with families. This comparison often arose when the participants were discussing issues of power. One informant described how she perceived the difference between her practice and that of a social worker.

And they [the social worker] can get in there and say if you don't pull your socks up and get those kids in the bath you'll be in trouble. If we did that we'd be shown the door.

A social worker has the power to require and to initiate the delivery of sanctions. While it is unrealistic to assert that public health nurses have no power, it is perceived by the nurses as being different from that of a social worker.

An experienced public health nurse discusses one of the strategies she uses to develop a relationship that can be used to facilitate change. This nurse's perspective was different from most of the other nurses descriptions in the study who stated that they always worked to facilitate independence. Her comment was:

It's interesting because you might actually do something at the beginning of the relationship which creates a bit of dependency. And then you work through the relationship to independence.

The examples that she gave of creating dependency were that she offered to help someone tidy their house and that she cut someone's hair. Both of these examples could be seen to help *establish common ground* with the client.

From analysis of the data the concept of *establishing common ground* is a way of summarising nurses' descriptions of their endeavours based on common experience to identify and share meanings with clients. They describe how they enter an encounter or a relationship with a commonsense ordinary approach, willing to share their expertise to effect change, sometimes acting as an advocate on behalf of the child or the family.

Home visiting

Visiting at home also seems to be an important variable in establishing a working relationship with the client. Nurses valued the opportunity to work with clients in their own homes. Home visiting helped public health nurses to build an accurate picture of

the situation (see chapter seven) but it also enables the clients to retain the locus of control during the encounter, a situation which is congruent with the public health nurses' stated beliefs about the need of the clients to participate and make their own decisions. For example:

They're in charge in their house.

.....

We've got to fit in, it's their patch.

Home visiting is a subcategory of *establishing common ground*. Several participants stated that they believed home visiting creates a reciprocity in the relationship between the public health nurse and the client family. As described by one nurse:

The actual fact that you go to visit them pays huge dividends. Somebody really cares about me enough to come and see me in my own home.

Being Blunt

Although public health nurses said that they are concerned to leave the power, choice and decision making with the client there are times when they see such freedoms to be dysfunctional. As the public health nurses tell their stories about children who are at risk or neglected (see the section on *landmark cases* in chapter nine), it is clear from their evidence that they endeavour not to leave children unprotected. The way the public health nurses talk about how they use their relationship with the family or individuals in the family on behalf of the child is interesting. A study by Zerwekh identifies that public health nurses working with children actually function on a continuum ranging from advocacy for autonomous choice to persuasion and coercion (1991:103). Public health nurses use coercion with parents when they identify children at risk. Although in the data from my smaller study I have not been able to completely match Zerwekh's (1991) categories it is clear that the nurses are very honest and blunt with their clients. Several participants described the strategy of *being blunt*:

And I said to them you know I can't pull any punches. It's neglect.

.....

I said to her I have some real concerns about how you are looking after her, and I have to be honest with you.

.....

And I said I had some worries, and she used to get angry with me over that. And I said well I have got it at the back of my mind and I need to be truthful about it.

.....

I said I was worried about the behaviour of the child and the way she looked after her. The nurses are not only being honest and blunt with their clients they are using this strategy as a mechanism to protect children. The message to the clients in the family is that the nurses are aware of the issues and will not let them rest if there is not improvement. One of the most experienced participants talked about this aspect of her practice with considerable insight. She claims that she was much more able to use these tactics of bluntness to indicate that she was able and willing to monitor the situation as she became more experienced and sure in her practice. As she sees it:

I think there may be a stage where we have perhaps to be powerful and lay the law down but I don't think we should take that role for too long. I talk to them straight, tell them what's likely to happen if they don't take steps. But if there's an improvement, I back off, tell them everyone's pleased, the child is better at school or whatever. Then I keep an eye out, help the family make some choices.

In a situation where the public health nurse and the principal of the school both identified that the nurse made a positive difference for the children and for the family, the nurse describes one of the early interactions with the father of a the child.

There's a level where we have to be real and point out the effects of what's going on. He was sort of over the barrel really he'd thrown the child down the stairs. And I said I've got two options, I can go to Social Welfare and report it or you can pull your socks up.

Another nurse described to a mother the possible consequences of her actions if she did not move to make her daughter feel safe:

I was very blunt actually. I don't often get that straight. Well I do get straight, and I'm honest with people, but I don't often get that blunt. And I said to her many times, you're going to lose your daughter because you are not protecting her. And she did, her daughter now lives with her grandmother.

Looking at the examples there seems to be more than a blunt statement of facts, often explicit or implicit in the statement is the question 'what are you going to do about it?' The following is a statement which illustrates this aspect:

Say look this is an issue for the family, This's what's come up with your kids, that's affecting you. What are you going to do?

Being blunt captures the meaning of the public health nurses interaction with clients when the public health nurse is aware that children need advocacy or protection within

their family environment. Although public health nurses interviewed in the study told of extended relationships with clients they often related that one focus of the relationship is to identify and initiate other more appropriate help for their clients. The way this help is achieved is through *networking and connecting*.

Networking and Connecting

Public health nurses described situations where they were unable to help an individual or a family because they do not have the skills, the expertise, the resources or the time, or simply the situation was outside their prescribed scope of practice. In these situations the nurses described the processes they use to help the clients seek and attain appropriate help. Descriptions of the processes indicate that the public health nurses do more than link people into an available service.

When referral seemed to be an appropriate strategy, public health nurses described how they worked with the client to prepare them for that referral. Luker & Chalmers (1989) in their study on 'the referral process in health visiting' state that: *Referring clients to other professional services and resources may be considered one of the key functions of health visiting practice* (1989:173). In their report they describe the work that health visitors do, and the processes they go through to ensure that the referral process is successful for their clients. Their findings were similar to the findings in my study.

The nurses in the study claimed that knowledge of what and who is available to clients is an important part of their practice. Just as the public health nurses' practice is judged by others the public health nurses described making judgements about the practice of others. Knowing other workers personally is also stated to influence the choice of an appropriate person or service for referral. The networks that public health nurses develop are important elements in the process of connecting their clients with people or services who may be able to help them.

Participants in the present study used different terms for 'referral' from those in the literature (Hawken & Tolladay, 1985; Luker & Chalmers 1989). In this study several of the participants described the process as networking or connecting. In this context connecting referred to discussing with the clients the options for referral - where the person may go in order to get help. As several participants stated:

I'm not prepared to take on things I can't do, and I tell people that I kind of connect

people into things that might help them.

.....

I use the connections to work out something that might work for a family.

.....

The intervention that I have with them will mean that life's easier. That you can help them access services that are there already in the community.

.....

You help people to look at where their options lie.

Input from the client is also seen to be important. For instance:

It's not a straight referral, I give the person the choice.

.....

I'm a person who likes to give people a choice and let them make their own choice about where to go.

The next quotation illustrates how one participant influences the choices the client makes:

But its more than a list on a bit of paper. I say well there's a number of things you can do. If you do this they usually expect some commitment to it, and if you don't want to do that you could do this and just have the child involved.

At other times the public health nurses will work hard within the context of the relationship to get a client to choose what they consider to be the best possible option.

The following excerpt is an example:

.....I just put things in a logical sequence and by the time I was finished with her I had an appointment organised with the psychologist.

Dealing with gatekeepers

The networks the public health nurses develop seem to be very important in the process of referral. Four of the participants described situations where they identified issues with their clients which necessitated referral to workers such as General Medical Practitioners, some of whom appeared not to be sympathetic with the public health nurses role in referral. General Practitioners often act as gatekeepers for access to other services the public health nurse has identified the client may need. The participants described strategies that they use to enable the client to get what they want. These strategies involve coaching the client in what to say, writing a referral letter which puts the onus of the referral on the public health nurse and stepping outside the boundaries,

see chapter six, by using knowledge to bypass the gatekeeper. For example:

I told her she could go straight to the clinic, she didn't have to through the G. P. and she did and he was furious. But at least she got there, even if I had to live with the consequences.

.....

Just blame me I said, tell him the public health nurse sent you, and he can ring me.

.....

I'll pull strings to get someone in to the best person, I often match them up. These strategies have implications for the public health nurses in terms of their relationships with other professionals.

Relating to Other Professional Groups

In this section public health nurses tell of how they come to know and develop networks with other professional groups. They describe the way they perceive these relationships and how they are developed and used for their clients. The importance of these relationships is illustrated by the following examples:

You've got to learn who's who, that's an important part of your work.

.....

You gradually get to know who can help, who does what. Then you get to know them personally, what they're really like. Its so important, it's not until it happens that you ask yourself how did I manage before?

.....

Other people tell you what they're like, you see the results or lack of results. That helps you in your work.

.....

It helps when you get a group you get on with, they value you and you value them, makes it easier for the client.

.....

I think when you're working with difficult families you're often not the only one that's working with that family and I believe you've got to communicate with those other professionals.

The following are subcategories of working with professional groups. Characteristics of working with each group are described in the sections below.

Working with Social Workers

Because of the unique availability of public health nurses to children and families they are often in the position of identifying children at risk or families in crisis. Social workers complement public health nurses' practice, particularly when children are seen to be at risk. Therefore, problematic relationships between nurses and social workers may be dysfunctional for children and families. Public health nurses seemed to be sure about the role of the social workers however, analysis of the data indicates that the public health nurses feel social workers may not be so sure about the public health nurses role, their knowledge or their expertise.

Some participants talked about good relationships with social workers. One nurse working in a rural area where she is isolated professionally from her nurse colleagues mentioned that she used and valued the support of her social worker colleague:

You know I can act as her support and she acts as mine [Department of Social Welfare Social Worker] We do quite a few things together.

Other participants reported more problematic relationships, sometimes claiming social workers did not recognise or value the expertise that public health nurses felt they contributed to their work. For example:

I have reservations about some social workers, they use us when they want to, but I'm not always sure they respect my judgement.

The way the nurses framed their practice as described in chapter six is different from their perception of the way social workers practice. As told by two participants:

They're trying to provide a safe environment for the child [Department of Social Welfare Social Worker]. We're broader, we look at the family, what will happen in the long term.

.....

They focus on the problem, whereas we're more concerned about the outcome for the child, are they going to be happy in the end?

Although the nurses see their work differently other people may not. An example of this is illustrated in the description which follows:

We've got no clout. We can only suggest. And sometimes you feel very frustrated by that, and you feel you're almost in an untenable position because the teachers are wanting you to make a change and you've got no power. And sometimes you've got

to question the fact that you've got the right to be wanting that change to be made. I think nursing brings to it the availability. That fact that people can get your trust and they do trust you. That's not too different from social work but maybe you won't take it any further without their permission.

Another nurse graphically describes the difference between her practice and that of community social workers:

And they've got smart little attaché bags. They have a meeting one day a week which they devote to planning work, which we think is wonderful. But we wonder how they can justify doing this because when people ring up they're told they have to go on a waiting list even if it's urgent and we've referred them. They have peer reviews all the time and they count the number of cases and they don't allow each other to take cases if they've got too many. Where we just take anything and everything. I wouldn't like to count how many cases we've got at the moment.

Working with teachers

Relationships with teachers are important for the work of public health nurses. School teachers work with public health nurses providing them with their main clientele, they also have the potential to act as gate keepers as was discussed in chapter five. In the subcategory *working with teachers* the participants' information is used to illustrate the critical elements of these relationships.

Often the participants identify that both public health nurses and the teachers have shared goals for the children under their care.

I work with very good supportive teachers, they really care about the kids.

There are some situations however, where public health nurses in the study feel that they do not always share the same expectations and goals for the children. As nurses stated:

We often see things from the family's point of view which may be in conflict with the school

.....

You're trying to meet the needs of the child but you can get into conflict with the school and the parents. So you actually feel sometimes in a situation as powerless as the parents.

.....

Personally I think that the teachers could do a bit more about the other kids and their teasing rather than try and make a child change to try and fit the teacher's expectations, where their own group in society doesn't have those expectations.

.....

Sometimes in this area there are teachers who have taught parents and grandparents, so if someone's done something wrong that label kind of sticks.

Another situation which arose often in the dialogue between participants and the interviewer was the potential for conflict which arises over issues of the childrens' hygiene. The following are statements from interviews:

The teacher says, 'It looks like the jerseys been on five days this week and two days last week'. They can be very judgemental about kids hygiene.

.....

One teacher said to me, there's no need for this child to smell. My mother managed to keep eight children clean.

.....

Well I've actually got to the stage where I've told some teachers at a local school that they're going to have a meeting with me about this. Because I really felt categorised with the family and the child. And I was going to discuss with them what other schools did in similar situations which is to wash the clothes themselves if it's upsetting them that much. And write it into their charter if they want standards of grooming.

Good relationships between public health nurses, school principals and teachers are critical for the public health nurse to work effectively. If the work of the public health nurse is valued children are able to be monitored and receive appropriate help before problems impact negatively on the child.

Working with General Medical Practitioners

As well as teachers, General Practitioners can be important allies to the public health nurses. Relationships however, can be quite problematic. Good relationships with general practitioners are desired yet six of the eight participants volunteered that their relationships with General Practitioners are variable. For example:

I have a very close relationship. We have a meeting once a week. We go to the hospital, me, the district nurse, the O.T. for the elderly in the area. And the G.P. sort of runs the meeting and we all sit there and discuss any problems that we've come across.

.....

You really don't belong to anyone. The doctors certainly don't see you as an asset. You're directing things to them that they would rather just go away.

.....

You soon work out what your G.P.s think is acceptable for you to do. And if I ask someone to go I always send a letter so that the person I'm sending is not disadvantaged. I say I have asked them to come.

Three of the public health nurses describe interactions with general practitioners which were dysfunctional both for the client and the public health nurse. Excerpts follow from the interviews:

And one G.P., I went along and told him that I'd asked this Mum to come along and I didn't think to say I'd sent a urine sample. The mother had said the urine was very smelly. And he'd said what the hell does she think she's up to.

.....

You know the child's failed their hearing test and you know they've been to the doctors and the doctor's told the mother there's nothing to worry about and you think to yourself that really annoys me. I've just had a go on the phone to the doctor not very long ago, but however what can you do.

.....

One of the G.P.s says that no child on his books is allowed to go to health camp³. So we do send them but we just don't tell.

The difficulty in relationships between general practitioners and public health nurses may be related to power and control issues. For example:

I think there is a certain part of doctors that makes them think that they're the ones that have the say so and the right to decide on things. Lots of them still have this health illness focus.

Another issue is money:

The big thing is that they see us doing something for nothing that if we kept our sticky beaks out they would get paid for.

³. Health camps were established in 1919 to give disadvantaged New Zealand children an opportunity to experience a healthy life style. In the beginning the focus was on fresh air, diet and exercise for children who were often deprived of adequate physical care. Today the emphasis has changed to accommodate children with emotional and family problems. The public health nurse has a key role in the referral of these children.

Needing the Support of Colleagues

Nursing literature supports the concept of autonomous independent practice and working in the community seems to be a way of achieving this autonomy and independence. While some participants state they enjoy this aspect of their work; for instance;

I like the interaction with people, out in the community. I like constant change, well that's change of which you have a feeling of power over. I like the challenge, I like having the independence and autonomy to be able to make decisions about what I do.

participants also identify public health nursing can be extremely stressful. Relationships with other professional groups seem sometimes to be problematic for nurses. Working with families may also be difficult and depressing. Some participants said how lonely and difficult the job can be especially if interaction with colleagues is limited through distance. Excerpts from interviews describe these feelings:

I've got to have support. You've got to be propped up. I would never walk away from anything even if I know emotionally it'll shatter me.

.....

This is a stressful job. I need to be able to turn off when I go home. In my drive home I just unwind and don't want to talk any more when I get home. I find the week goes better when I do it and it's complete relaxation and time out.

.....

And sometimes I get very angry. If people want you to deal with it they've got to give you all the information. Just for your own safety sometimes. You've got to know what you're dealing with, we're really quite vulnerable. A lot of people have dogs or you walk into a house and it's OK with one person there and suddenly you find six other guys there. I'll stay in the kitchen while the door's open. That's something I'm very wary of now. There are times when I pull up at a house and I just don't go. I'll pull up at their house and it's just felt all wrong. There's extra cars. I'll go in there when the numbers are small, because often you are going in on sensitive issues.

.....

And you don't take things home [nursing in a hospital setting], nearly as much as what you do with public health nursing because you've got nobody.

A way of coping for the participants in the study was by developing relationships with

their colleagues particularly other nurses. If they are isolated in a rural area, they also use other colleagues not necessarily nurses for this support role. There appeared to be few formal mechanisms for support, and the contact public health nurses traditionally have had with each other has been diminished as public health nurse numbers have been reduced. For example:

In theory there's supposed to be support but unless we actually set up the appointments and things it doesn't happen. I don't think women work better on their own. I don't know about men. Most nurses are women. I don't know that anyone works better on their own who's involved with people. People might work well on their own if they're doing something like writing a book, or writing poetry or writing music, but working with people. I think you then need to confirm yourself or affirm yourself with other people. And if you don't you lose something.

.....

You need to talk with each other for support. Often you say look I've got this problem, and they'll say oh I know all about that. I know somebody else that was like that. And you can choose to take their advice or not, its immaterial. But you feel better talking about it. Everyone's got a mine of information that's untapped.

.....

My fellow staff have got me through some very hard times.

.....

You can end up making individual decisions about how you're going to deal with a situation but quite often I will seek the opinions of other people. You'll go back. I regularly go back and check out from some other staff who had dealt with similar problems and check out.

Summary

In this chapter the meanings attached to the encounters and relationships which evolve either through the interactions between public health nurses and their clients or through relationships with their colleagues on behalf of their clients are analysed and interpreted. The categories which reflect these meanings are *beginning the encounter*, *establishing common ground*, *being blunt*, *networking and connecting* and *working with other professional groups*. Subcategories which give substance to these categories are also described in the chapter.

CHAPTER NINE

FROM ENCOUNTER TO CONTEXT

In chapters five to seven the reader was introduced to the activities of public health nurses which facilitated productive encounters with their clients. Following this exploration of the background to the actual encounters with their clients, the data is analysed and in chapters seven and eight the shaping of individual encounters and relationships is outlined. In chapter nine the context of public health nursing practice is described identifying some of the contradictions and constraints of the social structures in which practice is embedded. As well as a critical look at the context of public health nursing practice this chapter addresses some of the most significant encounters the nurses experience in their work. A focus on these important encounters, called *landmark cases*, within the context of practice serves to illuminate the difficulties and complexities inherent in the public health nurses' world.

Context of Contradictions

Public health nursing practice occurs within a context of contradictions shaped by a variety of experiences. Other nurses writing about aspects of nursing, identify that nursing is not carried out in a vacuum. Meleis (1992) referring to nursing moving into the 21st century states that she believes emphatically that the context within which nurses develop relationships and work with their clients is part of the whole experience of nursing.

Nursing as a human science is concerned with the experiences of human beings shaped by history, significant others, politics, social structures, gender, and culture. Meleis (1992:113).

Public health nurses recognise the impact of the context in different ways. One important influence of the context is manifested through the public health nurses' relationships with their client families. Now, in a more difficult environment where many families and children find life harsh and unsupportive, public health nurses are faced with contradictions and constraints which impact upon their ability to practice with their clients. It is becoming critical to recognise and expose these constraints and contradictions for scrutiny and analysis. Public health nurses have demonstrated that

they are amenable to changed patterns of practice to allow more effective response to client need. It is becoming increasingly evident that difficulties which public health nurses identify as affecting their ability to practice effectively, occur not only because they find it difficult to articulate and document the reality and the vision of their practice; but also, because the contradictions and the way these constrain practice have gone largely unrecognised and certainly unchallenged. In the following section some of these contradictions which create barriers to practice will be uncovered and discussed.

In the current complex political environment public health nurses are struggling to survive. Abbott & Sapsford (1990) surmise in their work on the health visitors' role in England, that health visitors work within a *set of contradictions* which makes their work difficult to justify in an environment which demands practitioners prove they supply value for money. Public health nurses in New Zealand are now working with managers and management systems that require the nurses to elucidate exactly what it is they do, demanding that public health nurses begin to identify the outcomes of their practice. These outcomes will be scrutinised and matched to the health goals and priorities, developed as policy designed to meet the health needs of the community. In a less regulated age, public health nurses responded to need as they recognised it and worked to the best of their ability to meet their client's particularly children's, needs. The ability of public health nurses to direct their own practice, to work with, or refer on clients, depending on time and expertise and to move at the client's pace is under threat.

Being a nurse

Participants in the study identified that the experience of being a nurse equipped them with skills which help them in their practice as a public health nurse. Accepting people, no matter how 'unlikeable', being connected rather than being separate and being trusted are qualities they named as contributing to developing and maintaining a public health nursing relationship.

Participants claimed that these abilities arose from the experience of being a nurse rather than from educational preparation. Most believed that their initial preparation as a nurse did not prepare them for public health nursing practice, because of the institutional, illness focus of their training programme. Abbott & Sapsford (1990) stated in their research that they found that some health visitors did not see their nursing training as being particularly helpful in the home visiting role. In contrast others said they used

their nursing skills and knowledge constantly, though had difficulty articulating how these were used (1990:124).

However, it was implicit in the contributions of participants in this study that the knowledge base of nursing influences their work as a public health nurse.

Contradictions arise when public health nurses believe their ability to carry out their work in the community arises only from experience. As more nurses are recruited into public health nursing from more recent nursing registration programmes with a strong community focus and as public health nurses have greater opportunities to study community health nursing at post basic or post graduate levels the links between practice and education become more explicit. If public health nurses remain isolated from continuing and advanced nursing education there is a danger that the belief public health nurses do not require a nursing preparation will continue to be perpetuated.

Visibility and Invisibility

The contradiction of visibility and invisibility has been identified in chapter five as influencing the ability of nurses to be known and accessible in their working communities. The paradox between the necessity of working hard to increase visibility in order to enhance access and availability to their client group contrasts with the secrecy and confidentiality required for much of their work. Public health nurses note that aspects of their work are unpalatable and difficult for society to contemplate. Work with children who are neglected and abused, or families disrupted by violence are not issues that public health nurses commonly choose to discuss in the wider community. Impersonal statistics related to numbers of cases do little to convey the reality of the public health nurses work with disadvantaged children and dysfunctional families. The metaphors and descriptions of *landmark cases* are not usually available for public scrutiny, people may be recognised and client nurse relationships jeopardised. The personal work of the public health nurse thus may be much less visible than is their participation in health promotion and health education programmes.

Many of the metaphors the participants used to describe their practice identify the 'backstop nature' or 'safety net aspect' of their work. One participant stated that; 'If everyone else did their work properly there would be no need for public health nurses.' While this statement is debatable there is certainly a feeling that comes across in the data that some of their work with children and families develops because there is no one else

who works in the unique way of public health nurses, or strategies are not in place for people, particularly children, to access appropriate help. Involvement in these areas may not be recognised, planned or adequately resourced. The unique access arrangements the public health nurse develops with children and families are not recognised as such. While some nurses question the importance of the five year old checks as a screening mechanism their value as a way of becoming known and accepted is acknowledged by public health nurses, although this aspect is probably unrecognised by managers.

Simplicity versus complexity

Pragmatic management philosophies have a major impact on the delivery of public health nursing practice. Outcomes of services are paramount. These outcomes are required to be measurable and achievable. Management has not been alone in adopting this pragmatic approach. The nursing process, commonly advocated as a framework for practice is based on the model of collecting data, identifying problems then defining simple outcomes, usually one to each problem. Public health nurses work with people who have multidimensional complex problems, often of a long standing nature and influenced by social and economic factors beyond their control or that of public health nurses.

Today the issues New Zealand society and public health nurses must deal with are problems of modern living, family breakdown, addictive conditions and poverty. The contradiction is between a world view which attempts to define complex contextually situated issues as simple compartmentalised problems with measurable, quickly achieved outcomes, and the public health nurses' perspective. The frame of reference for the public health nurse focuses on people inseparable from their context of significant others and the community, recognising the whole as being greater than and different from the parts. Definition and judgement of public health nursing practice based on the use of short term outcomes, the attainment of which are dependent upon factors or structures likely to be beyond the control of both the public health nurse and the client has grave implications for the continuing viability of the personal work of public health nursing.

Public health nursing is vulnerable because of the nebulous and complex nature of much of its practice. Although the work of district nurses and Plunket nurses may have

similar characteristics to that of public health nurses, the nature of the tasks that are part of Plunket and district nursing personal practice with their clients allows for quantification of that practice. Arguably, the essence of district nursing and Plunket nursing maybe just as difficult to detect as that of public health nursing. Their future may be less uncertain simply because it is easier to measure tasks and count visits. It is interesting to note the advertisement in the newspaper (Evening Post, 1993⁴) which asked interested applicants to apply for the position of a Specialist Ear Nurse. Here is an example of looking at the reductionist, task focused approach applied to health care. It is reassuring that at least, employers are looking for a nurse rather than a technician, presumably acknowledging qualities that nurses bring to the situation that technicians do not.

Continuity and Availability

Public health nurses visit people in their own homes. They are part of a minority group of professionals who continue to provide this service. They identify that they are able to 'get a better grasp of the picture' or assess the situation more effectively when they are able to view families on their home ground. Home visiting has been discussed within the assessment framework in chapter seven, and in chapter eight. Working with families, or acting as an advocate for children, is identified by the participants as having more productive results when the public health nurse is prepared to spend time in the clients's home. Because public health nurses are concerned with issues of power and maintaining the locus of control with the client, working in the client's home is seen as a way of achieving this. Indeed the public health nurses reiterate how they visit again and again, persevering in making slow progress into being accepted into the client's home environment. They measure ways of assessing the potential for facilitating positive change in their client's lives in terms of their acceptability in their client's homes. As identified in earlier chapters, acceptance and availability contribute to continuity of the service provided by public health nurses. Whereas public health nurses view home visiting as a critical adjunct to their practice, this belief is not so evident with other health professionals who practice in clinic situations and therefore only know their clients in artificial settings.

⁴ The Evening Post is a daily New Zealand (Wellington) newspaper. The edition containing the advertisement was January 16, 1993.

Home visiting, as a critical element of the public health nurses practice is not well described, neither may it be recognised by management as necessary in order to carry out effective practice of public health nursing. Plunket nurses who provide the majority of well baby services in urban New Zealand have had the allowed number of home visits to their families reduced considerably. It is not improbable that public health nurses may face similar restrictions. Although public health nurses identify that having rooms in a place where the public has access is important and may attract new clients, they believe strongly that home visiting provides a unique perspective on children and families. Policies which concentrate on efficiency, throughput and cost effectiveness by bringing clients to the public health nurse rather than public health nurses visiting clients may impact negatively on some of the most important work of the public health nurse.

Constraints and contradictions related to the impact of the context become obvious after analysis and critique. They are much more visible in the stories public health nurses tell about significant encounters and relationships with their clients.

Landmark Cases

Significant encounters and relationships stand out in the data. They stand out because they deal with difficult, unpalatable and sometimes shocking aspects of people's, particularly children's lives. They also stand out in the data of this study because public health nurses frequently chose these significant and disturbing scenarios as exemplars when asked to describe aspects of their practice.

The participants were asked by the interviewer to identify situations where they felt they made a difference. Of the eight participants seven responded by describing incidents of child abuse or neglect and their subsequent involvement. When asked to describe situations where the public health nurses felt they had not made any impact or difference to the situation the same seven participants described another situation involving children at risk. Family violence and dissent also featured in their stories.

Because these situations appeared to make such an impact on the nurses and on the researcher in the study I have called them *landmark cases*. In a way they appear to be similar to paradigm cases as described by Benner (1984). Benner & Wrubel (1982) state that some experiences *may be powerful enough to stand out as paradigm cases*.

Landmark cases describe circumstances which impact critically upon the consciousness of the public health nurse. They also impact critically upon the listener to the 'story'. Listening to the public health nurses telling about children suffering from deprivation and neglect within a context of family life makes these stories real. The researcher in her work as nurse educator also listens to student nurses telling of their clinical experiences of working with public health nurses. There is the same predominance of incidents relating to situations where children are deprived, neglected and abused. These *landmark cases* are powerful and disturbing.

The following quotations from the nurses' accounts are examples of some of the situations which they deal with in the course of their work, and that I have designated *landmark cases*:

.... and this child's mother kept saying she hated her. She was only five. Could I get her into health camp? I'm not keen on sending little children to health camps. The school referred her again. 'Would I go and see this mother because she didn't appear to be relating to her daughter.' This child came to my notice again. And it was through acting out apparently what a group of them had seen on a pornographic video.

.....

The teachers come and tell you that the child was quite badly beaten across the arms with a broom.

.....

I had a young girl come to me at the Intermediate who sort of said fairly bluntly to me. I'm frightened my dad's going to molest me again.

.....

It was a little boy who was two, who is badly bruised on the cheek and something that sort of looked like a burn. And the mother says the five year old's abusing the child doing it at night when she was asleep.

In other interviews the participants describe lives grounded in deprivation and neglect:

It's hard to say the degree of neglect. Things like children coming, (and people move around a lot now), people coming from away.[sic] Every winter and even locals, the kids'll go off to school and they'll have a jacket on but it's not a heavy enough one, and they haven't got anything woollen on. By the time they get to school they're absolutely frozen particularly the little ones. And I really think the parents don't

know how cold it is and you just have to tell them. I suppose that's neglect, it's not intentional neglect.

.....

This young woman, I think she was about 21 or 22 and she had 6 children. 5 or 6 children I couldn't believe it. And her eldest little boy his hygiene used to be phenomenal. He was a bedwetter and there were other things too. I tried to visit her and get along side her 5 year old and ask how he was getting on. She wouldn't let me see the other children, she used to hide them away and all sorts of things. One day I went up there and she had two black eyes, she'd been beaten up.... but I wasn't able to get past the barrier.

.....

She had two children different fathers. She was a young Maori woman who had been a drug addict, she kept terrible health. It's a pretty sad story actually. She also played a victim. She was a victim and she lived like a victim. She was very asthmatic. She smoked heavily, she was only in her 20's. Her brother had been in jail, had come out and beaten her up several times. It was quite sad really. She had two girls and because of asthma also had trouble coping with them.

.....

Sometimes you go to the home and it would be dreadful. You wonder on earth how they get on, just by the lack of facilities in the house. Like no carpet, no curtains, mattresses on the floor.

Although these descriptions are grim and often shocking they reflect realities of the public health nurses' work. Some of this work arises because of the accessibility children have to public health nurses through the way nurses have become known and trusted through school visiting. For the public health nurse initial access to these families often comes about through the referral of children by school teachers. These exemplars emphasise the importance of the unique accessibility arrangements public health nurses develop in their practice, particularly in relationship to their access to children.

Nurses participating in this study describe how they are often the first person to suspect and identify issues of child abuse. Through family visiting and advocacy for the child the public health nurse works to change the situation. Currently in New Zealand there is no mandatory reporting of suspected child abuse, although there are strong suggestions

that the law will change at least to require mandatory reporting for health professionals. Public health nurses in conjunction with other interested professionals have developed protocols which provide guidance in the areas of child abuse, but often cases are not clear cut or resolution achieved and the public health nurse continues to work with the family when other interventions fail.

Complex and difficult though the situations may be, the participants identify that they often are able to make a difference. One of the ways that they use to work with clients who are putting children at risk is, by *being blunt* (chapter eight). *Being blunt* describes how public health nurses are honest with their clients about the consequences of the client's actions. One participant described a situation where she learnt afterwards that a family where she had spelt out the repercussions of the parent behaviour is doing really well:

I happened to be talking to a school principal who said, you know that family in the next street. They're doing really well. The wee boy's doing well at school and the mother coming into help every week. And I said that's not possible, and he said it was you that made the difference.

Another nurse discussed her involvement with a family who were experiencing multiple problems. This nurse identifies that she *overstepped the mark* (see chapter six) for the children in the family, forcing intervention from other professionals. She identified the results as being positive for the family:

It probably is an enormous ego trip, but I would like to think I was responsible for those kids having a better quality of life.

Sometimes the participants identify that the reason their relationship went wrong and they were unable to make a difference in the family is because of the involvement of another professional. One nurse describes a situation where she intervened with a family in which the children were coming to school inadequately clothed and fed during winter. The consequences of her actions are graphically described in her story:

I went into the school and the teacher said; 'Do you know your name is black again? That lady was in here saying that public health nurses, they're all an interfering lot. She'd had trouble with them before.....' I don't know what went wrong. I think that the teacher didn't support my point of view.

Another participant describes how her work with a client who physically abused and

neglected her children fell flat because of a disagreement with another professional involved with the family:

The psychologist said I can't see her. I've worked before with professional disagreement and it never works for the client. I thought everyone would pat me on the back for getting this lady along. I wasn't patted on the back, I fell flat on my face. The woman turned up much to my consternation and she was turned away because of this professional disagreement.

Another issue for the public health nurse participants is that other professionals may 'rush in' to the family before proper consultation with the public health nurse. The consequences of other professionals taking over without allowing the public health nurse time to explain or support their client through the referral process may result in difficulties for the client in their new encounter or with the public health nurse. Both results may be dysfunctional for the client and the professionals. One participant describes the consequences of hasty decision making:

If you've got to take it from being confidential, out to bringing in other agencies. Then on one or two occasions Social Welfare have bowled in holus bolus instead of taking it quietly and going in with you. All they've gone in and done is distanced the person from you.

The data identifies that the quality of the relationships that public health nurses have with their clients impacts upon the outcomes of their work. Likewise the quality of their relationships with the other professionals with whom they confer or make referrals to, impacts on the outcomes for the client.

New Zealand health professionals, social workers and the public are becoming aware of the extent of the problem of child abuse and family violence (Ritchie 1988: Department of Health 1989: Max 1990:), The media also reports many situations of child abuse and neglect and family violence and deprivation. For the public, reports of court cases and television programmes may raise awareness of the issues. Public health nurses do not learn of the issues from media accounts. They learn through first hand experience, and see the *landmark cases* within a framework of individual, family, societal relationships and the social context in a way neither statistical information nor the media reports are able to convey. Max (1990) associates child abuse with particular government policies, unemployment, poverty, inadequate housing and social isolation. Just as Max identifies the impact of the social context on families and children, the

participants in this study identify the impact of the social context upon their practice world. It is at best, supportive to public health nursing and is at worst constraining and contradictory.

Summary

The difficulty of the work of the public health nurse arises in part because of its embeddedness within the constraints and contradictions of the current social context. This is a critical factor in the shaping of public health nursing practice.

Landmark cases are significant encounters in the practice world of the public health nurse. Clients whose problems are shaped by the complexities of dysfunctional family life and a harsh social and economic environment may need considerable input and support from public health nurses who work within a complex context. Finally in chapter ten the interrelationships between the categories are discussed and their fit within the emerging theory is addressed.

CHAPTER TEN

ENABLING CHOICE: A FRAMEWORK FOR NURSING PRACTICE

This chapter is used to present the theoretical framework developed from integration and interpretation of the data of the study. The descriptive categories with their concepts and subconcepts are presented and compared in order to identify a core category. Chenitz & Swanson (1986:116) advise the researcher to ask questions which will enable identification of a category which explains the *major action in the phenomena*. Hutchinson (1986:118) states that a core category *recurs frequently*, that it *links and explains variation* in the data. With these criteria in mind the four categories of *being accessible, framing practice, seeing the whole picture and making and using relationships* were examined and compared. *Enabling choice* seemed to be the core category, as a theme it recurred frequently in the data, it made a link between the categories and it could be used to explain variation between the four categories.

Public health nurses do not enter the lives of their clients with clearly defined motives or specific goals. The data in the study reveal that the nurse participants make judgements relating to their practice with their clients based on a global category of enabling choice. To enable choice is to allow possibilities for the client, that before the encounter or relationship with the public health nurse either did not exist, were invisible or were seen as unattainable.

Dixon (1991) in the preamble to a curriculum provides a perspective of *enabling* when she writes: *Sharing knowledge and providing opportunities for increased awareness to enable others to take control of their health and their lives.* (1991:xii). The Ottawa charter (1986) also discusses the process of enabling within the context of health promotion: *Health promotion action aims at reducing differences in current health status and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential..... People cannot achieve their fullest health potential unless they are able to take control of those things which determine their health.*

Christensen (1990) in her study identifies *enabling* as part of the work of the nurse in the partnership relationship with the client. She defines *enabling as the empowering*

dimension of the nurse's work which assists the client to attain the means, opportunity and ability to act within the present circumstances (1990:197). Enabling choice requires the sharing of knowledge between the nurse and the client. It encourages the development of increased awareness by the client with the goal of moving decision making and control into the hands of the client.

All the conceptual categories and subcategories are listed in Table 1 (p.120). Enabling choice is a core category and a basic social process, which evolves from these categories. The categories, as they emerge from the data, reveal that all aspects of the public health nurses' practice are underpinned by the desire of the public health nurses to enable choice for their clients. Enabling choice develops and evolves over time just as the other categories develop and evolve over time. The way in which the public health nurse practises transmits to the client the awareness of the possibility of acting on choice. One participant describes her beliefs about the clients' rights to act on choice. She is also showing us how these beliefs colour her whole perception of her practice:

We are privileged to have such a intimate view of our clients. However, I never forget that the client has the right to say no, I don't want any involvement with you. And this is what we want, we don't force people, unless we are looking after the children's interests.

Enabling choice is constantly modified as it is influenced by the developing relationship between the public health nurses and their clients. Chalmers (1992) in a study on health visiting practice describes the unifying theme of her study as being *the mutual interaction between health visitors and clients in which both parties control the interactions by regulating what they offer and accept from each other* (1992:1319). The data obtained in this study of New Zealand public health nurses did not focus on the 'giving' behaviours of clients, although it was clear *enabling choice* occurred through, and was influenced by the interrelationship between the public health nurse and the client. Enabling choice may be identified in the way public health nurses frame and describe their practice world. It may be the small possibilities that the participants describe as occurring when the public health nurse embarks upon an encounter with a client or it may be the large possibilities that are realised during an ongoing relationship with a client.

Table One: Categories and subcategories

1. BEING ACCESSIBLE

- Getting known
- Becoming accepted
- Using opportunities
- Being available

2. FRAMING PRACTICE

- Building the structure
- Knowing the client
- Discovering boundaries
- Focusing practice
- Using metaphors

3. SEEING THE WHOLE PICTURE

- Legitimizing involvement
- Glimpsing the pattern
- Seeing the situation globally
- Completing the picture
- Making the connections
- Replaying the problem
- Documenting the evidence

4. MAKING AND USING THE RELATIONSHIP

- Working within the context of the family
- Beginning the encounter
- Establishing common ground
- Being blunt
- Networking and connecting
- Relating to other professional groups

The first phase of the enabling process has been conceptualised from the data as *being accessible* which was described in chapter five. *Being accessible* involves the processes or actions which the public health nurse undertakes in order to develop visibility and acceptability in her areas of practice. *Being accessible* is also dependent upon the recognition and positive interpretation of successful interactions with clients. Except in rare situations clients have the choice as to whether they will accept involvement with the public health nurse. Accessibility and acceptability are the first steps the public health nurse takes towards enabling choice for the client.

Enabling choice signifies a whole range of actions or approaches. Although the public health nurse may appear to be less constrained in her scope of practice than other registered nurses who work in a more prescribed situation, it is necessary for the public health nurse to have some focus to her activities. In chapter six the structure, the boundaries and the metaphors that public health nurses use to describe their practice were elucidated. The meanings public health nurses attach to these processes focus and help to determine the choices that the clients have.

In order to offer or enable choice the public health nurse needs to have a clear picture of the client's problems or needs. The way in which the public health nurse gathers information was discussed in chapter seven. The 'picture' that the public health nurse discovers involves a joint process of sharing and validating knowledge with the client. Information sharing helps to clarify the picture for both. This process acts to enable choice by clarifying, the situation which has necessitated the involvement of the public health nurse, and by outlining possible choices available to the clients.

Chapters eight and nine are concerned with descriptions by the public health nurses of encounters or relationships with their clients. The information in these chapters focuses on the processes that occur in interactions with specific clients. Rather than a generalised perspective of practice these chapters deal with categories arising from actual encounters between public health nurses and their clients.

Added meaning to the way public health nurses work within their relationships is provided by inclusion of contextual factors. These are identified in all chapters but more specifically in chapter nine, where the way in which the immediate context of the

nurses' practice world acts to constrain or reduce choice is discussed. Enabling choice is the possibility at all stages and levels of the public health nurses' work. The outcome that these nurses claim they desire for their clients is that the latter will have access to, and be able use fully the available range of services and knowledge so enabling choices which ultimately will enhance and improve lives.

Being Accessible: Enabling Choice.

Analysis and reflection on the data identified the significance of the processes of becoming accessible in the practice of the beginning, or relocating, public health nurse. *Being accessible* is also a key category which explains some of the uniqueness of public health nursing practice. Public health nurses are accessible to clients in a way very few other health professionals are able to be. They have an intimate and realistic view of the client or family through home visiting. Clients are able to refer themselves at no cost. Being accessible means that children (through the public health nurses' work in schools) are able to have unusual and exceptional access to a health professional, known to them, concerned about them and willing to act on their behalf.

The data reveal that the practice of public health nurses is judged by both clients and the people who refer clients to the public health nurse. Positive outcomes of these judgements result in the public health nurse becoming credible and acceptable to their client group. Poor results for the client impact negatively on the ability of public health nurses to attract work. Being acceptable is a necessary component of being accessible, just as being accessible is a necessary prerequisite in order to have one's work judged.

Using opportunities is a way public health nurses identify that they make themselves accessible to their clients. They creatively use opportunities in their working context to become known, accepted and available. Being available implies a willingness to interact and work with clients on the clients' terms. After the initial encounter continuance of the relationship is dependent upon client wishes, usually because they can see some benefit. The public health nurse does work hard to convince and demonstrate the benefits of continuing the relationship but the actual decision to do this rests in the client's hands.

Enabling choice operates as a basic social process throughout the interactions which make up the processes of becoming accessible. At every interaction the public health

nurse is concerned with enabling choice. They may be small choices associated with the client's right to choose the health professional they know and with whom they feel comfortable. There may be choices associated with the right to judge the practice of the public health nurse and make decisions about whether this practice meets their needs and whether they will continue to use the service the public health nurse provides.

Enabling choice is a possibility because the public health nurse may be there when other help or professionals are not. By being there for children and adolescents the public health nurse enables choice where choice may not otherwise have been available. Throughout their interactions the control of the situation is vested in the client. Even in the descriptions of their interactions with very young children it is often the children who determine the pace and who decide what they would like to happen. Enabling choice is a process which influences and determines the type of interaction the public nurse has in the domain of being accessible.

Framing practice: Enabling choice

Like being accessible, *framing practice* is a global concept. It is concerned with the realm of public health nursing practice rather than specifically with a narrower focus of a client nurse relationship. It is the background or an antecedent condition to the more personal practice of public health nurses with clients and families.

When the participants reflect on their practice world they identify how they work to become accessible. They also identify what they do to integrate their experience and knowledge in order to put some structure and boundaries on their practice. Length of time in practice is identified by the participants as a variable that influences the way in which public health nurses frame their practice in order to create meaning and develop understanding.

The structure that the public health nurses build gives a focus to their work. Beginning public health nurses often see public health nursing as huge in scope and boundaryless. Although there are specific tasks that the nurses are expected to perform in the course of their work much of their practice is concerned with children and family problems. Framing their practice within a health and empowering model allows the public health nurses to enable positive choice even when the situation seems overwhelmingly focussed on difficulty. The following participant quotation captures the beliefs of many

of the public health nurse participants about health as an intrinsic part of their practice:

My work involves seeing people holistically, I guess I work from a family base.....

I think as nurses we're looking at wellness and wellbeing.

When discussing their practice in a global sense the public health nurses articulate the hopes they have for all their clients. Here is an example of a participant articulating her belief about the framework of her practice:

I'm there to give people options and choices and hopefully for them to make reasonable decisions.

In the way they frame their practice public health nurses identify the outcomes and possibilities they wish for their clients. Many of their descriptions highlight the possibility of enabling choice through removing some of the constraints that disempower people. Other possibilities are illustrated through illuminating and supporting the decisions people make to change and improve their lives. This framing of practice, no matter how philosophical and abstract, acts in a real way to focus and direct the nurse's practice toward enabling choice for their clients.

There is an interesting contrast between the way nurses frame their practice and the metaphors which the nurses use to describe what they do. The structures they build, when described have an optimistic air; 'making life easier', 'seeing people holistically,' 'improving peoples quality of life.' The metaphors the participants used often painted a grim reality for both people's lives and their practice world.

We pick up the pieces.

.....

Being there when everyone's left.

.....

Darning the holes.

Even when the participants use these images emphasising inadequacy and the backstop nature of their work, the positive qualities that they use to frame their practice in the context of contradiction, enables them to find constructive ways of working with their clients.

The category, *knowing the client*, highlights the implications of identifying children as the primary concern of public health nurses. Guidelines and prescriptions for practice

emphasise the health needs of children. However, the data reveal that the public health nurses' concern for children arises both from their knowledge and involvement with families, the schools and the community as well as from prescriptions for practice. The participants explain that they believe of all their client groups, children, have the most need for advocacy and support because of their vulnerable position within families and society. The public health nurses, through various strategies, organise themselves in their practice to be accessible and to act as an advocate for children.

Children are always considered within the context of their families by the public health nurses. Enabling choice for children, of necessity, involves interaction with the family. Work with a family can have the positive effect of enabling choice for both the family and the child. The categories, *identifying the boundaries*, *overstepping the mark* and *being in trouble*, identify the extent to which the public health nurses are prepared to personally become accountable to enable choice for their clients.

Seeing the Whole Picture: Enabling Choice

The data in chapter eight illustrate the way in which public health nurses assess and evaluate the problems of their clients. In their descriptions the participants reveal that they do not approach their clients without already having an overview of the problem or the issues for that person or family. The individual person is seen by the participants within the context of their family or social grouping and although the information may be sparse upon the initial referral the participants highlight the process that they use to uncover information. Uncovering information is not only functional for the public health nurse, it reveals and clarifies issues for the client as well. The participants identify that they do not see the client as a passive informant, there is a two way dialogue between the client and the nurse.

The concepts identified by the participants which make up the category, *seeing the whole picture* are *legitimizing involvement*, *glimpsing the pattern*, *making the connections* and *documenting the evidence*. These concepts are developed through interaction between the client and the public health nurse. Although the public health nurses identify that they often obtain referrals and information from other sources the primary source of their data is the client within their social networks. Secondary sources of data are important however, and the public health nurses reveal that they often develop a 'sixth sense', noticing and storing away pieces of information which

may seem insignificant at the time but eventually help the nurses 'to complete the jigsaw' or to 'make the picture more clear'.

Public health nurses in the study, reflected back to the client the interpretation they put upon collated and synthesised information. Because very little of public health nursing practice revolves around the delivery of care involving tasks or technical skills the communication processes involved in the information gathering or *seeing the whole picture* is also part of the intervention process with the client.

Validating and replaying the situation back to the client acts to enable choice. Clarifying the situation may give the client increased awareness of their problems, which in turn may increase their chances for realising possibilities or enabling choice. Making the connections or seeing the picture also suggests the possibilities to the public health nurse of enabling choice for the client. As well as giving information about problems it uncovers knowledge of the client, providing information on client experiences and the resources that they bring to the situation. The public health nurse is able to use this knowledge to build on strengths, to enhance the client's control of the situation in order that the client is enabled to choose strategies for health.

Having a clear and realistic picture of the realities of children's lives, documented and validated, helps to enable choice for children at risk. Accurate depiction of their situation is empowering for abused children

Making and Using relationships: Enabling choice

Here the focus is the public health nurses' interaction with the client within their social context. When the public health nurses work with clients within the framework of an encounter or a more enduring relationship, it is usually within the context of the family.

Occasionally the participants articulated specific goals relating to individual encounters or relationships. Usually however, the situation that presents itself to the public health nurse is multidimensional and complex. Resolution is not achievable through the attainment of simple goals. Examples of these complex situations are discussed as landmark cases. The philosophy of public health nursing practice is to empower the client to act. The public health nurse does not make decisions for the client, rather she works within a relationship to enable people to make functional decisions for

themselves and their families. Many of the clients lack confidence or the self esteem to make decisions. Taking time, creating common ground, and home visiting are ways that the public health nurse uses a relationship to augment the possibilities for the client through enhancing their client's self esteem and ability to take control of their own lives.

Increased awareness for the possibilities of choice and change are realised through the constant clarification and validation of the situation with the client. The purpose of the relationship with the client, either an individual or a family is to enable choice. The data reveals that the public health nurse aims for 'enlightened choice.' The use of health as a structure or framework for practice enables a positive focus within the possibilities of choice.

If a child is disadvantaged or at risk within the family situation the public health nurse is particularly concerned with enabling choice for the child. They state that if the family seem unable or unwilling to grant choice, choice that will enable the child to grow up well and whole, then they will intervene on the child's behalf. Before instigating more extreme measures the nurse proceeds through a process of *being blunt* that spells out to the family the implications of their actions on the child. Being blunt acts as a warning to the parents, it still enables choice but only within certain parameters. If the child's choices continue to be restricted by the family then, for the nurse, enabling choice for the child will take precedence over the choices for the family.

Complex multidimensional problems require skilled and specialist help. Nurses use the resources of other professionals to enable choice for the family if they are unable to meet all the client needs. The participants suggest they connect specific services or help provided by other professionals to people in need. These connections are facilitated if the public health nurse has the ability to interpret the practice of appropriate professionals in a way that will encourage support by the family. Good relationships between other professionals and public health nurses impact positively toward enabling choice for their clients.

Enabling choice means that public health nurses work in collaborative creative partnerships with their clients to facilitate people to take charge of their own health and act as their own advocates within the context of their own lives (Meleis 1992:113). In a

less than ideal world public health nurses fulfil a unique function in their ability to achieve a close and watchful relationship with children. Enabling choice for children requires ongoing contact, access to families on their home ground, good relationships with other professionals and a philosophy that embodies the value of caring for the vulnerable in our society.

Enabling choice as an emerging theory empowers clients to act in ways that promote health, both for individuals and for families as a whole. It links the personal aspects of the public health nurses practice with children and families, to the concept of health promotion. Thus, *enabling choice* as a theory has the ability to link interventions at a personal level with a global view of health.

The relationships between the core category, *enabling choice*, and the emerging concepts of being accessible, framing practice, seeing the picture and using relationships can be represented diagrammatically, see Diagram one (p.129)

Context of Contradiction: Enabling choice

Throughout the analysis and collection of the data, it became apparent that the nurses in the study practised in a difficult and often contradictory environment. Not only were the messages they receive about their practice likely to be contradictory, often aspects of their work were in direct opposition to each other. For example the requirement to provide privacy for their clients constrains the development of a higher public profile. There were no clear guidelines or failproof strategies which public health nurses could use to determine or verify their practice. The participants in this study believed that much of what they know about their practice they had learnt through experience. It also took a considerable period of time, which surprised them at the beginning of their community health practice lives. That no one else seemed to understand or particularly value their practice was also not surprising to the participants. They realised that much of their practice was invisible, and that they often worked with intractable clients where the gains were small and slow to come.

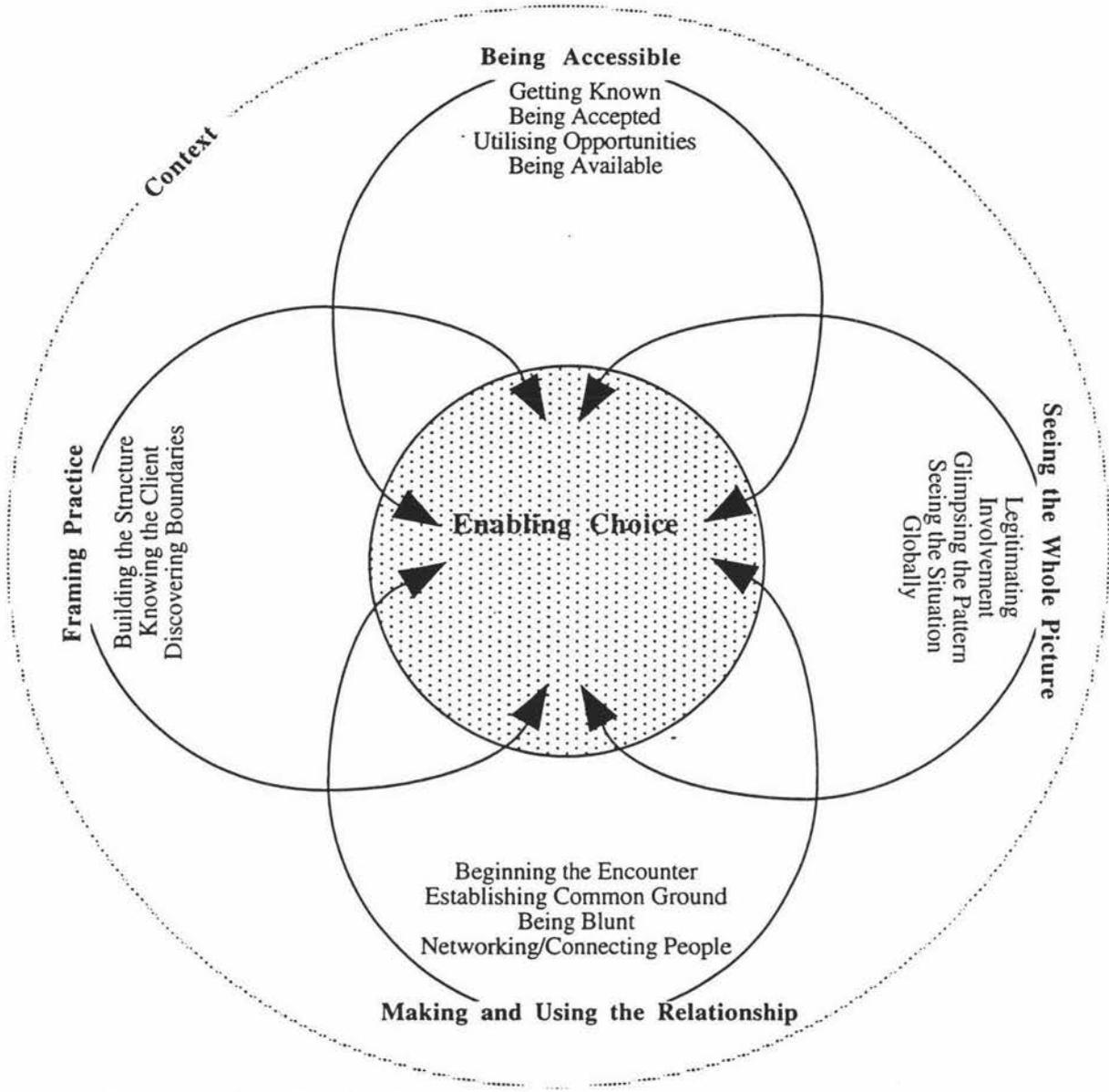


Diagram 1: Enabling Choice

The diagram illustrates the variety of elements which contribute to the outcome of enabling choice, although it is difficult to convey interaction and sequence in a two dimensional representation. Enabling choice is the integrating concept which arises from the interaction of all the categories and concepts perceived by the public health nurses to be part of the nurse-client relationship.

Summary

In this chapter the emerging theory is described as it arises from the concepts uncovered in the data. In effect the data has highlighted the flexible, intuitive and often unstructured value of public health nursing practice. Yet despite these ambiguities the public health nurses were very clear about the outcome they desired for their clients, that of enabling choice.

CHAPTER ELEVEN

DISCUSSION AND RECOMMENDATIONS

Introduction

The theoretical description and explanation of the work of public health nurses as it has been presented through the conceptual categories emerging from the data, frames their practice within a model of enabling choice for their clients. The possibilities of enabling choice are situated in the context of a complex and often contradictory environment. In this final chapter implications for public health nursing practice and for nursing education arising from the model presented in the previous chapter are identified and discussed.

The findings of the study identify that families, and in particular children, through public health nursing enjoy a unique service, within a relationship unreplicated by any other health professional group. The model of enabling choice contributes to this uniqueness of the service and the relationship. In this chapter comments and recommendations regarding the contribution of public health nursing practice to healthy children and families will be made. Limitations of the study are identified, and the efforts made to ensure rigor in both the findings and the conclusions of the study are discussed. Finally suggestions for future studies are made.

The Practice of Public Health Nurses

The study has focussed on the personal practice of public health nurses. The findings have provided insight into some of the meanings of their practice world. Specifically the data have shown that much of the meaning relates to work with children in the context of their families. Public health nurses are also involved in screening programmes, immunisation, health promotion and health education work in the community; but these aspects of their practice have not been explored in this study. The interviews were unstructured and the focus of the interviews tended to be on their work with children, in schools and families. This can be taken as an indication of where their priorities lie.

Although practice is framed from the public health nurse participants' perspective, a

clear and realistic picture of their work with clients, particularly children and families is portrayed. Another New Zealand study on public health nurses work with stressed families (Pybus, 1993) reported very similar findings.

Conceptual categories were identified from the data, these begin with the way public health nurses develop necessary relationships in the wider community, followed by an analysis of the way they frame their practice. Next the thesis considers how they interact with their identified clients to gather information and to validate this information to gain a meaningful picture of the situation. Encounters with their clients and with other key professionals are described and analysed in the light of their contribution to the shaping of public health nursing practice.

Framing Practice

Public health nurses develop an overall view of their practice. To a certain extent the data identifies that the way participants shape their practice is dependent upon previous work related and personal experiences. There is a sense from the data that public health nurses also are familiar and supportive of the Primary Health Care philosophies embodied in the Alma Ata Declaration (1978) and the Ottawa Charter (1986), in particular the notion of empowering individuals to make choices and take action in addressing health needs.

Assessment

Registered nurse assessment of clients in order to make informed decisions regarding appropriate outcomes and nursing intervention has been a major preoccupation of nursing practice since the 1970s. In spite of systematic work on both the theory of assessment and ways of documenting the client assessment it has been recognised that nurses have difficulty recording meaningful assessment data. Christensen (1990:81) identifies that the lack of a meaningful appraisal protocol consistent with a theoretical understanding of practice may contribute to the difficulty of achieving a useful and documented data base.

The information gained from the participants in the study indicate that the way they assess clients is very different from assessment models commonly prescribed for community health nursing practice (see chapter seven). The nurses in the study seemed to develop a holistic, global perspective of the total client situation, where people

remain unseparated from the relationships with meaningful others and the social context. The perspective of assessment described by the participants may be indicative of 'expert' practice or it may indicate dissonance between current assessment models promoted for use in public health nursing and the reality of both the practice situation and the way in which public health nurses work. Development of appropriate documentation of the assessment processes described by public health nurses in the study, is a challenge for resourceful practitioners working in the area and an issue suitable for further study.

Enabling choice

Enabling choice as a theoretical model links all the conceptual concepts describing aspects of the public health nursing practice. Enabling choice as an emerging theory provides understanding and explanation as to both the interpretation and meaning public health nurses attach to their work, and to the direction they hope to move with their clients. However, the outcome of enabling choice that they desired for their clients is an abstract rather than a concrete concept. Evaluation of improvement or positive change that may occur slowly, and the part the public health nurse plays in this improvement or change may be invisible or very difficult to demonstrate, at least within a short time frame.

Public health nurses, through their practice experience come to know their practice and their clients in a different way from the perspectives propounded in prescriptive models grounded in the science of public health (see chapter one for a discussion on models for practice). That is not to deny that public health models, knowledge and skills have a place in their practice. However, it is within the scope of personal practice where their efforts go largely unrecognised, undescribed and unvalued that public health nurses' care may be the most effective in improving health status.

As pointed out in the literature survey there are relatively few studies of public health nursing practice, either in New Zealand or overseas. New Zealand studies to date (MacInnes et al, 1985; Kinross et al, 1987; Lungley & Barnett 1991) have focussed on the tasks and the way these have been carried out by public health nurses. They have not addressed the meaning of public health nursing nor have they contributed to the development of a theoretical basis for practice. It is encouraging, however, to read Pybus's (1993) study which offers insight into the meaning of the work of public

health nurses with stressed families in complex situations in a New Zealand context.

There are a few researchers in England who have carried out studies, several of the recent ones being grounded research studies in the area of home visiting, which have relevance to public health nursing in New Zealand. Zerwekh (1991abc; 1992) in the United States has reported her study, the findings of which seem to indicate that concerns regarding clients and practice may be shared by public health nurses in New Zealand and the United States. In Zerwekh's study the meanings and realities of the personal practice world of public health nurses when they work with children and families would be recognisable to public health nurses in New Zealand. Although the practice world of public health nursing practice in the United States of America appears to be embedded in an especially harsh environment, some of the situations New Zealand nurses face are also extremely challenging.

Both the overseas studies and the findings from my study emphasise the impact the context has on public health nursing practice. Highlighting the nature of the context reveals that public health practice is affected by the economic and political decisions of others as these dictate the prevailing social policy. Identified in the study is the extent to which public health nursing practice is constrained through the context in which it is practiced. The current health environment in New Zealand may not just constrain through economic restrictions and resource implications. The goals of public health nursing with its emphasis on choice and empowerment may be very different from those currently in vogue in the New Zealand health care context. The contradictions within what is becoming an increasingly alien context may be just as constraining as some of the financial and resource limitations.

Implications of the Study for Practice

The findings of the study with the development and explanation of the theoretical model go some way to providing a framework for public health nursing practice in the area of personal practice where the public health nurse is working with children and families. The emerging model is one which it is anticipated that practitioners will experience as affirming. There are few extant theories developed from public health nurses practice. The findings of this study complement that carried out and reported by Zerwekh (1991, 1992) in the United States, so expanding understanding about the nature of public health nursing, generically, as well as in the individual countries of the studies. The

theoretical constructs of both studies appear to be compatible, it is apparent that community health nursing practitioners share common experiences and meanings related to their practice.

Equally valuable are the understandings that have arisen through the analysis and reflection on the descriptions of practice as they have been articulated by the participants. Public health nurses were willing and able to describe their practice world to the researcher. They frequently used stories embedded in the real life situations of their practice which included reference to the impact of the social context, to illustrate how and why they worked in a certain way. The influence of the social context, in terms of its constraints and contradictions were uncovered in these descriptions of practice, and provide valuable understanding as to some of the difficulties public health nurses experience in articulating their practice.

The way in which health care is to be managed in New Zealand in the near future, where funding will be separated from the operational organisations or services which are to provide health services (Health and Disability Act 1993) may make it even more difficult for public health nurses to continue their work in their care of children within the context of the family unless they are able to communicate the nature of their work to funding providers. Nurses may have difficulty in identifying tasks which are quantifiable. In an area of practice where technical skills and specific tasks may be less important than communication skills and therapeutic use of self, misunderstandings and difficulties arise from the differences between the interpretations and values public health nurses and decision makers hold about health. Dunlop, cited in the New Zealand Nurses Organization Social Policy document (1993) provides support for this view in the following quotation *we need also to direct our attention to the social and political structures within which people care* (1988:21). Measuring results of interventions is critical in providing evidence about the effectiveness and hence the long term viability of public health nursing. Public health nurses may be prepared to support and intervene because of their awareness of the long term results of lack of knowledge, deprivation or neglect. There would seem to be a place for longitudinal studies despite the fact these are notoriously difficult to get funded and to carry through. Decision makers, whilst subscribing to the rhetoric of health promotion may be less willing to commit resources to intangible long term outcomes. Criteria for measuring the impact of care that are consistent with the values of the consumer, the funding provider and the public health

nurse need to be developed by public health nurses.

There has been little reference to the consumer in planning and evaluation of nursing services (McDrury 1992: Barraball & Mackenzie 1993), and it may be timely for public health nurses to consider how they can demonstrate the effects of their work, as well as identifying the impact of structure and process on the outcomes. Through the stories told by the participants, their work with children and families becomes real, the consequences of parenting or being a child in a hostile environment without social support become meaningfully illustrated. Aspects of our society become visible and warrant inclusion in the planning for the health structures that are to become mandatory in the new environment. The report of the Core Health Services Committee (1992) states that a priority must be given to the health of children. The Tamariki Ora report (1993) gives substance to this statement calling for children's health to become a priority.

I believe that the study also describes aspects of 'expert practice.' Benner's (1984) work *From Novice to Expert* uses exemplars to illustrate the development and the practice of 'expert nurses'. Her study focussed on nurses working in acute practice areas. Paterson (1989) used a New Zealand setting to study expert practice, although again her setting is acute practice areas. Zerwekh (1991, 1992) describes public health nurse expert practice in her study in the United States but until the recent publication of Pybus's 1993 report there have been no studies in New Zealand that looked at expert nursing practice in community areas. The research on public health nursing reported here provides public health nurses with a voice, and in doing so gives examples of expert public health nursing practice.

The study highlights ways public health nurses skilfully utilise opportunities for referral and develop their acceptability and accessibility to their clients. It identifies how they assess their clients, utilising their expertise and the expertise of other professionals to complete a picture of the client's needs, whilst recognising and acknowledging the client's networks and significant relationships. Finally, it describes how public health nurses knowingly use these encounters and relationships to move their clients toward a state of enablement, where they are able to take responsibility for their own decisions and ultimately their own health.

Throughout these descriptions there is a sense of proficient judgement arrived at through thoughtful reflection and integration of previous experience. These qualities are illustrated in the participants' scenarios by their awareness of timing, pacing, knowing when to persevere, when to refer and identification of the energy put into the development of useful networks. Recognition and acknowledgement of expertise arising out of particular interests or attributes and integration of their own life experiences seems to be an important component of expert nursing practice for public health nurses.

In summary the study has implications for public health nursing practice because it both describes the realities of practice in New Zealand and elicits meanings public health nurses hold about their practice. It describes and explains a theoretical model for practice based on a grounded view of public health nursing practice. It seems to complement the few other studies on similar areas of practice that have been completed in other countries. It also attempts a beginning analysis of the impact of the social context on practice. This aids understanding of the difficulties experienced by public health nurses in articulating and describing their practice in the changing health environment. Finally it describes aspects of 'expert practice' that are unique to the area of public health nursing which may help others to recognise and value the expertise implicit in public health nursing practice.

Implications for nursing education

Currently New Zealand nursing education programmes place considerable emphasis on community nursing practice. Large amounts of the student's clinical experience may be carried out in community health settings. Often this clinical experience is observation of registered nurse practice in various settings, including public health nursing. Public health nursing is valued by both students and lecturers as a placement for student clinical experience (Tully & Bennett 1992).

The structures practising public health nurses use to frame their practice are positive, enabling and strongly health related. The influence of the primary health care model and the Ottawa charter (1986) can be detected as an influence in their practice. In New Zealand public health nurses through their continuing education programmes have had high exposure to these models and their underlying philosophies.

The study has identified that public health nursing practice has a unique perspective, different from other nursing practice that is carried out in the community and certainly different from nursing carried out in acute care settings. The focus of the study has been the personal practice of public health nursing, predominantly with children within the context of their families. In both educational and practice settings primary health care is the model which provides the underlying philosophy for practice. Often other frameworks or models are introduced to nursing students as an adjunct to the primary health care model to enable more specific prescriptions for understanding and organising what is perceived to be the personal practice of public health nurses. Usually these other frameworks or models have been developed in or for acute care settings. There is a presumption that these models will transfer readily into the public health nursing setting, indeed community health text books usually recommend the use of the nursing process; a problem solving approach used extensively in institutional settings with individual clients.

At least two of the fourteen nursing education registration programmes in New Zealand use the 'Partnership Model' developed by Christensen (1990) as a framework for students involved in community health nursing practice. The Partnership Model focuses on nurse client interactions which are specifically organised around a 'passage' or change in the clients life, the 'passage' is usually associated with a significant change in health status for the individual and the expertise of both the nurse and the client is utilised in moving the client through the 'nursed passage' in a relationship mutually defined as a partnership.

While the use of these frameworks are not inconsistent with public health nursing practice the findings of the study indicate that aspects of practice are different from other models or are unaccounted for in the nursing process. For example the study identifies that certain antecedent conditions must have taken place before the public health nurse becomes an accepted and successful practitioner, these conditions are specific to the practice of public health nursing. Public health nurses in their interactions with clients appear to be very conscious of allowing clients choice in their decision making. From descriptions of client-nurse interaction, awareness of power and control issues seem important. Public health nurses are more likely to talk about perseverance than compliance.

It seems timely that the curriculum relating to community health nursing begins to use or at least examine and critique models developed in areas of community health nursing practice. The findings of the study provide one model that can be used or at least examined within the context of public health nursing in New Zealand and may be more appropriate for inclusion in nursing curriculum than models derived from other areas of nursing practice. Emerging out of practice the model has immediacy and authenticity which is likely to appeal to student and novice nurses, as well as to more experienced practitioners.

As will be discussed in the section 'possibilities for research', the study on public health nurses is a beginning attempt to understand and explain public health nursing practice. It is also specific to the personal aspect of public health nursing practice. Public health nursing is a specialised area of nursing practice, although in New Zealand basic preparation for entering this area of practice as a beginning practitioner is included in educational programmes designed to meet the requirements for nursing registration. It is encompassed in the meaning of Comprehensive Registration. Educational preparation for advanced practice will need to include theoretical models that explain and can be used to provide a framework for practice as well as pointing to opportunities for enhancing and extending practice. The findings of the study, in particular those that relate to assessment and the ways public health nurses work provide insight and guidelines for practitioners who wish to develop more advanced practice in the area of personal care within public health. The theoretical model arising from the conceptual categories identified in this study fills a gap by providing a theory which explains the personal care in public health nursing practice, but which also is consistent with the theories and models which globally define public health nursing practice.

Increasingly, nurse educators are focusing on families and aggregates as the client group of nurses. Much family theory has been developed by other disciplines and is borrowed by nurses to provide theoretical understanding as a basis for practice. The findings of this study particularly as they are related to working with children within the context of the family provide a complementary view and one that has been developed in a nursing context. It would be appropriate for nurse educators to incorporate theoretical understandings from the discipline of nursing as well as other disciplines as an aid to understanding and working with families.

Finally I would issue a challenge to nurse educators. The teaching of assessment of clients has been a critical part of teaching nursing skills. Christensen (1990) states that it is an area that is often not systematically carried out by nurses. My study identifies that the linear model of assessment that the nursing process espouses is not the model or the way public health nurses assess. They seem to use a much more global process, identifying a complete view of the situation which they modify or change as they obtain additional information, they do not build their assessment piece by piece. Nor do they seem to rely on predetermined outcomes, instead assessment and intervention seem to occur simultaneously with the outcomes being a guide to the direction of intervention rather than specifically directed toward individual problems. Educators often are responsible for the development and introduction of a model for practice, perhaps the time has come for educators to think more creatively about developing a framework that allows for global and holistic assessment within community health nursing practice rather than supporting only a problem solving approach. Evidence of a changing focus is found in the revised New Zealand Nurses Organisation standards (1993) for practice, where there has been a move away from using a framework based on the nursing process to a broader approach.

Limitations of the study

The researcher began this study with some preconceptions about public health nursing practice. Unlike a quantitative study where strenuous efforts are made to control for these preconceptions or to eliminate them, qualitative researchers acknowledge and document their preconceptions and either attempt to set them aside by a process of bracketing or attempt to identify the effects of these preconceptions on the study findings.

A predominant belief of the researcher was the centrality of the client-public health nurse relationship to public health nursing practice. Coupled with this belief about the centrality of the encounter or the relationship was the feeling that the quality of public health nursing practice is determined by the quality of the relationship. These beliefs were only partially upheld in the findings. Relationships are important, but in a more complex way than was envisaged. Public health nursing practice was seen by the participants to encompass aspects of practice beyond those which simply subscribed to developing and maintaining relationships with individuals or families. Indeed critical aspects of public health nursing practice illuminated by the participants were to do with

the antecedent conditions for practice with individuals and families. These conditions were the considerable lengths to which public health nurses go to become accessible to their client group, and the frameworks and boundaries for practice that they develop. The findings of the study identify that these conditions contribute as much to the outcome - *enabling choice* as does the client nurse relationship.

Because the researcher teaches in the area of community health nursing, it has been impossible to avoid familiarity with the realm of public health nursing practice and with some of the literature. Nurses unlike other grounded theorists do not enter the arena of their research in a naive fashion. Being aware of the literature may be considered to contribute to preconceptions about the area of the study. However, much of the literature on public health nursing originates in the United States and is concerned predominantly with the problems of aligning the science of public health with the practice of community health nursing. This focus leads to prescriptive theory for practice with an emphasis on groups and aggregates. The literature, with a few notable exceptions, tends to be sparse in actual descriptions of public health nursing practice, and certainly in theory generation for personal practice. Christensen states that the dual role the nurse finds herself in;

'is a viable one that can be exercised in a study using the grounded theory approach. Therefore the researcher who is a nurse, while always remaining 'grounded' in the field data and using this as the primary source for the emergent theory, will also acknowledge that the theory is 'grounded' within current theory and knowledge' (1990:234).

Although the researcher's preconceptions in some instances were sustained and in others overturned, the researcher believes they did not bias the outcomes of the study.

Limitations in time may act as a constraint to the development of grounded theory in the study. Eight public health nurses provided the data for the study. Five of them worked from rural towns with their practice areas extending into the surrounding rural areas and three worked in an urban area. Analysis of the data did not differentiate significantly between the practice experiences of rural and urban public health nurses except perhaps to the extent rural public health nurses appear to have a more intimate knowledge of their 'patch'. Limits on time constrained increasing the number of participants from both urban and rural areas and therefore the scope of the study. In the grounded theory methodology chosen for the study time limits may also result in premature closure,

before the data are saturated, impacting negatively on the adequacy of the data to generate theory. Sixteen indepth interviews were conducted with the participants and new categories did not emerge in the final interviews, therefore it was assumed by the researcher that the categories were saturated. Whilst increased numbers of participants may have led to increasing the scope of the study, grounded theory is generated from the data, acknowledging commonalities and exceptions in the data. Increasing the scope of the study is an issue that is discussed in the recommendations for further research.

The researcher believes the study meets the criteria outlined by Sandelowski (1986) and Burns (1989) to ensure rigor in qualitative research. Credibility is achieved when the description and interpretations are recognised and confirmed by the participants and by audiences with similar practice experiences. Throughout the duration of the study, findings were shared with both the participants and with other critical colleagues who have worked in similar practice situations, both rural and urban. There has been recognition and support of the theoretical concepts as they have arisen. In a seminar session public health nurses from a completely different geographical location indicated that they connected emotionally and intellectually with both the data and the emerging theoretical concepts. Other members of the seminar audience, although not public health nurses, clearly identified with concepts arising from the data related to 'expert practice' and 'landmark' or 'paradigm cases.' Because the study question was concerned with the perceptions of public health nurses the data were not collected from multiple sources, there was however, planned ongoing discussion with a variety of nurses from different geographical locations and from different clinical settings. Recognition of meaning by these registered nurse audiences outside the study situation meets the criteria of 'fittingness' as described by Sandelowski (1986).

'Audibility' is achieved when the reader or another researcher can follow the research process and arrive at a theory which would support the researcher's findings. In grounded research it is highly unlikely that different researchers would come up with precisely the same theory. In the writing up of this study the steps in analysing the data, the development of categories then the theoretical concepts and finally the emerging theory have been carefully documented and represented diagrammatically as well as in a written form, hereby providing a 'decision trail' for the reader to follow. The researcher believes the theoretical concepts and the emerging theory demonstrate a good 'fit' with the data.

In reviewing the above descriptions the criteria of descriptive vividness, methodological congruence, analytical preciseness, theoretical connectedness and heuristic relevance described by Burns (1989) and discussed in chapter three, appear to have been met along with Sandelowski's (1986) criteria of credibility, audibility, fittingness and confirmability.

Possibilities for further research

My study was carried out with a very small number of participants, and because of the research question which focussed on the perceptions of the public health nurses regarding their practice, it did not explore the perceptions of the clients and their encounters and relationships with public health nurses. Neither did the researcher observe public health nursing practice. The practice situations described in the study were used as they were recounted to the researcher. A further research study incorporating the perceptions and meanings of the public health nurse client encounter from both the perspective of the client as well as the public health nurse would complement the scope of the original study, enhancing the knowledge base of public health nursing practice as well as widening the focus. Field observations (although difficult, for ethical as well as practical reasons) would add another dimension to the study.

Public health nurses in the study identified what they perceived to be the aims and the outcomes of their practice. There is scope for an evaluative study that identifies whether the perceptions of the public health nurses about the outcomes of their practice are substantiated by their clients. Public health nurses also identify in the data that they value their ability to foster client autonomy and choice. Whether the client values these attributes in the same way may be a area for exploration and study.

The Tamariki Ora Report (1993) has identified the health of New Zealand children as causing concern. Public health nurses are able to provide a perspective on this issue which has largely gone untapped. Causes of child accidents and illness rarely can be attributed to simple cause and effect models. It is now recognised that illness and accidents are often events in multiple complex chains of events. The study has identified that public health nurses, through their intimate knowledge of children observed in their home and educational settings are able to 'know' and document from

personal experience the impact of economic and social factors such as unemployment, parenting, family violence and separation. The commissioner for children (Morning Report, 1993⁵) suggests that the public respond to the information contained in the report by calling for and voting in a referendum.

Although my study focused on the perspectives of public health nurses, the stories of the participants surfaced realities of life and related health issues for children and their families. I would suggest that further research be undertaken from the unique perspective of public health nurses, with the aim of increasing understanding and knowledge of children and families and patterns of health and illness.

The proposed changes in the New Zealand health care system (for earlier discussion see chapter two) strongly suggest that the practice of all practitioners will need to be visible and subject to scrutiny in order to ensure accountability for the resources used. The findings of the study identified that public health nurses work with families to promote the health of children. The study also suggested that much of their work goes unrecognised, undocumented and unvalued. Certainly this is the view held by the nurse. If public health nurses are to utilise opportunities for future practice in the areas of child health, there needs to be initiation of research studies that identify and match their skills and competencies with identified child health needs. Research on public health nursing practice will enable public health nurses to scrutinise aspects of their practice, to uncover what often seems to be kept invisible and to speak with a collective voice on issues. There is also a need for research studies that have as their aim the development of new and innovative patterns of practice which will make a measurable impact on indices of child health.

The findings of the study identified that public health nurses appear to assess clients in a holistic manner using visual imagery. Assessment of clients has been a vexed issue for nurses, Christensen (1990) identifies the difficulty registered nurses have in documenting and using a coherent assessment of the client for informed decision making. There is room for further study on assessment and decision making, it would be interesting to explore how registered nurses in other areas of clinical practice assess

⁵ Morning report is a current affairs programme, on the National programme of Radio New Zealand. The programme referred to was July 3, 1993.

their clients. Would the process be similar to that described by the public health nurse participants in this study? How do nurses incorporate the findings into functional models promoting excellence in nursing care delivery? These and other questions are waiting to be researched. The suggestions for future research are not intended to be definitive. Any research that has nursing practice as its focus surfaces more questions generating exciting possibilities for research.

Concluding Statement

Grounded theory strategy has been used as a research method to generate explanation and theoretical understanding of the work of public health nurses. The study has uncovered previously little recognised conceptual meanings and understandings related to the practice of public health nurses in New Zealand. Comparison with relevant literature reveals that the findings are supported by studies carried out in other countries, although the latter are not numerous.

The study shows that public health nursing is not generic nursing practice, it is a specialised area of nursing with a unique contribution to make to the health of New Zealanders, particularly children. The Tamariki Ora Report (1993) reveals that child mortality in New Zealand ranks 16th in the world, there is no basis for complacency regarding our child morbidity and accident rate.

One of the criticisms that has been levelled at public health nursing is that it is backward looking and insular, and that it has been resistant to proposed changes which often involved suggestions for the development of a generic community based nurse. Unless public health nurses are able to describe and quantify the outcomes of their practice they risk possible extinction, or curtailment of services in the new environment. With further developments planned in the New Zealand health care environment, (Health and Disability Services Act 1993) which include nursing services having to contract for the delivery of core health services, it becomes imperative that the scope and expertise that public health nursing encompasses is identified, clearly articulated and given public recognition. Equally, public health nurses will need to value research and develop further strategies for innovative practice. As a contribution to these goals this thesis exposes some of the possibilities arising from the recognition and valuing of the work of public health nurses.

APPENDICES

Appendix 1

Information Sheet for Potential Participants in Research Study.

My name is Barbara Robertson Green. I am a Registered Nurse working towards a Master of Arts degree with a major in nursing, at Massey University. My research study is concerned with the perceptions nurses have about their client and the importance of this relationship (in the nurse's perception) to their practice.

I am interested in exploring with you (a Public Health Nurse) your perceptions of the encounter you have with your clients, and the contribution the kind of relationship you have makes to your practice. I will not be interviewing clients.

Participation in the study will be in your own time and would probably involve three interviews that will take between an hour and an hour and a half with me (the researcher) in the location of your choice. With your consent these will be audiotaped and transcribed by a typist who will not have access to any information that would enable identification of you as a participant. The transcript of your audiotape recording will be discussed with you by the researcher.

You may ask to have the tape recorder turned off at any time. If you wish to discontinue the study you are free to do so without any adverse effects and may request that material relating to you be destroyed. You will not be identified by name on the audiotape or in any written documentation.

No personal evaluation of performance is involved and I am completely independent of Otago Area Health Board management who will not be notified of your involvement in the study.

In the final writing up of the study no one will be identifiable by name or in any other way, neither will the geographic location be identified. A copy of the thesis will be in the Otago Polytechnic library and this will be available for you to borrow.

Although this study will be of no direct benefit to you, it is important that research is carried out in the area of community nursing to endeavour to identify factors that influence the quality of nursing practice.

If you would like to volunteer to be part of this study or to discuss it further I would be pleased to be contacted at (03)4775 238 (home) or (03)4773 014 (work).

Thanking you in anticipation of your assistance.

Barbara Robertson Green

Appendix 2.

CONSENT FORM

Participation in this research which is being undertaken as part of masterate studies in nursing at Massey University will involve individual interviews (of probably not more than three) with the researcher. With your consent these will be audiotaped. You will not be identified by name on the audiotapes or any any written documentation. You will be free to withdraw from the study at any time and you may request that all material relating to you be destroyed.

The researcher's name is Barbara Robertson Green and may be contacted on (03) 4775-235 to discuss any questions or problems.

Declaration

I have had the nature of the proposed research fully explained to me. I understand as a participant in this research I have given permission to be audiotaped. I will not be identified by name in any typed or written material. Access to material relating to me will be restricted to myself, the reader, a transcription typist and the supervisor.

My right to privacy will be respected such that I can divulge as much or as little information as I myself decide. I also understand that I can ask to have the tape recorder turned off at any time, and or can discontinue my participation in the research at any time without adverse effects to me.

I therefore give my consent to participate in this research.

Date.....

Signed.....

(Participant)

Date.....

Signed.....

(Researcher)

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