1997-08-01

A Phenomenological Inquiry of Nurse Transition to Family-Centered Perinatal Nursing

Paula Kaye Lilja DNSc, MSN, RN
University of San Diego

A PHENOMENOLOGICAL INQUIRY OF NURSE TRANSITION TO FAMILY-CENTERED PERINATAL NURSING

by

Paula Kaye Lilja, MSN, RN

A dissertation presented to the
FACULTY OF THE PHILIP Y. HAHN SCHOOL OF NURSING
UNIVERSITY OF SAN DIEGO

In partial fulfillment of the
requirements for the degree
DOCTOR OF NURSING SCIENCE

August 1997

Dissertation Committee

Janet Harrison, EdD, RN, Chair
Evelyn Anderson, PhD, RN
Diane Hatton, DNSc, RN

ABSTRACT

A PHENOMENOLOGICAL INQUIRY OF NURSE TRANSITION TO FAMILY-CENTERED PERINATAL NURSING

The purpose of this phenomenological study was to obtain a better understanding of how nurses caring for perinatal patients and their families view their clinical practice role after experiencing the transition from traditional maternity care to family-centered perinatal nursing.

The volunteer participants in the study were 13 female registered nurses employed on a family-centered perinatal unit in one of four hospital settings. The researcher conducted unstructured interviews with the participants and analyzed the qualitative data.

The history of the transition and the context in which the family-centered perinatal nursing model was being practiced are presented. Two major features of the Transitional Model emerged through the process of data analysis: essential characteristics of perinatal nursing and meaning of the transition to perinatal nursing. The first major feature, essential characteristics of perinatal nursing, described the perinatal nurses' new, expanded role and the changes in the interrelationships between the perinatal nurses and the patient and her family that resulted from the transition to perinatal nursing. The second major feature, the meaning of the transition to perinatal nursing, focused on the participants' perception of the experienced change and the evaluation of its effect on the implementation of the new model. It also involved influencing factors that intervened either to promote and facilitate the transition to perinatal nursing or to discourage and hinder the transition to perinatal nursing. The participants viewed these factors as pivotal in that they were interrelated with the other major theme.

The ideal of family-centered perinatal nursing was not achieved, but a compromise model of the current practice did emerge.

The implications for nursing practice, education, and research based on the findings in this study are discussed. Recommendations include further research into the major features of the Transitional Model to determine whether the findings of this study can be generalized to other nurses and thus advance the knowledge of nursing and other disciplines concerning the development of new clinical practice models for nursing and the meaning of transitions.

DEDICATION

This dissertation is dedicated to my dear family, my husband Don, and my children, Mary, Eric, Ken, Anna Mari, Cyndee and Cathy, for the love and support they gave me to pursue my goal.

This dissertation is also dedicated to the memory of my mother, Cecile, for the love and inspiration she gave over my lifetime.

ACKNOWLEDGMENTS

My sincere gratitude goes to my co-researchers, the nurses who shared their personal experiences with me. This study would not have been possible without their participation.

My supportive fellow students and friends at the University of San Diego are sincerely thanked for their caring. I am especially grateful for Marjorie Bendik, Ruth Grendell, and Vicky Schonlau. Then there are my professional colleagues and friends, Bonnie Kellogg, Nel Rogers, and Mary Scharkey. To one and all, my sincere thanks.

I wish to thank my Dissertation Committee, Dr. Janet Harrison, Chair of the Committee, and Drs. Evelyn Anderson and Diane Hatton, for their encouragement, wisdom, and the helpful suggestions offered throughout this dissertation process.

My deepest gratitude is expressed to my husband, Don, who has made many sacrifices for me and who has supported me throughout my education.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF APPENDICES

CHAPTER 1

INTRODUCTION

Family-centered maternity care (FCMC) is a philosophy of care in nursing practice that values the family as the basic unit of society and respects the needs and desires of each of its members, thus optimizing beginnings (Caico & McLean, 1990; McKay & Phillips, 1984; Steensma, 1993). FCMC models have been initiated within a variety of organizational structures. In the national movement for alternative childbirth practices, hospitals and other health care agencies have developed different FCMC facilities ranging from free-standing birth centers to hospital-based programs. What was considered innovative 25 years ago is now routinely practiced in many settings. Such practices include single-room, home-like environments for labor, delivery, and recovery, with father or other support persons available (Schmid & Gerlach, 1986; Young, 1992); sibling visitation and flexible rooming-in (Norr, Roberts, & Freese, 1989; Young, 1992); and combined mother-baby nursing (Caico & McLean, 1990; McKay & Phillips, 1984; Watters & Sparrow, 1990).

As each of these FCMC models was advocated and developed across the United States, the very nature of maternity care practice began to change and with it the traditional role of the staff nurse. Also, the rapid expansion of scientific knowledge and biomedical technology made possible advances in fetal/maternal/neonatal medicine. These advances provided the theoretical basis for a new specialization in nursing practice known as perinatal nursing. This new specialty in nursing developed in response to a need that arose from past successes and failures in the delivery of maternity/newborn care (Butnarescu, 1978; Mandeville & Troiano, 1992; Perez,

1981). In addition, perinatal nursing emerged as the result of a more knowledgeable consumer and this increased professional awareness of gaps and omissions in the delivery of care.

The evolution of perinatal nursing was also rooted in the commonality between maternity nursing and pediatric nursing. In family-centered maternity care, perinatal patients include not only the mother-father unit but also the fetus and, later, the newborn infant. For the perinatal nurse (PN), a thorough understanding of uncomplicated obstetrics and maternity nursing, as well as medical and nursing management of the normal newborn, is basic knowledge (Mandeville & Troiano, 1992; Perez, 1981). Also, in the last decade, changes in the obstetric population have required a thorough understanding of nursing care for at-risk and high-risk critically ill mothers and/or their infants, thus placing new demands on nurses who practice perinatal nursing (Harrigan, 1995).

Perinatal health care is conceptualized as "family-centered" (Betrus, Kane, Malloy, & Boro, 1985) and provided within the context of family relationships (Nichols, 1993). To implement perinatal nursing successfully, a nursing service must design every aspect of the perinatal care carefully (Caico & McLean, 1990).

While the aspects of care in specialty areas such as labor and delivery, postpartum, and newborn nursery were traditionally handled separately, cross-training is now utilized to expand the knowledge and skills of PNs and to enable them to function effectively in more than one specialty area as generalists on family-centered units. This includes the ability of some PNs to care for at-risk and/or high-risk perinatal patients in special care units. In the FCMC movement, the overall goal is for staff nurses to make the transition from their traditional roles to become PNs with more flexibility in providing integrated perinatal services to a more diverse population (Nichols & Palmer, 1994).

Although historically maternity patients have been considered a homogeneous group, a definite dichotomy emerged with the advances in science and technology. Although the strong majority of maternity patients continue to have no identified risk factors, a new "at-risk" population may be readily identified: one that has a greater variety of medical conditions and/or the potential for developing complications. For this at-risk population, the challenge is for PNs to integrate the new scientific knowledge and technological advances and still provide family-centered care. The majority of maternity patients, however, require the provision of family-centered care within a wellness framework (Mandeville & Troiano, 1992).

Statement of the Problem

Family-centered practices have been described as going beyond the routine task orientation of traditional maternity care (TMC) to emphasize the PN's role in working with the family to provide support (McNiven, Hodnett, & O'Brien-Pallas, 1992; Nichols, 1993; Phillips, 1988b; Stainton, 1994), in meeting the individualized needs of the family (Bailey, Maciejewski, & Koren, 1992; Caico & McLean, 1990), in teaching and counseling (Harrison, 1990; McGregor, 1994; Rutledge & Pridham, 1987), and in developing flexible policies and standards of nursing care (Mandeville & Troiano, 1992; McKay & Phillips, 1984; Watters & Sparrow, 1990).

While family-centered practices have been advocated since the 1970s, they are not universally accepted, and many hospitals still provide traditional staffing patterns with nurses assigned to care for either mother or infant in separate labor and delivery, newborn nursery, and postpartum units (Caico & McLean, 1990; Steensma, 1993). Despite the movement toward FCMC, Vezeau and Hallsten (1987) proposed that "the perception that the mother and baby are a natural unit to be cared for by the same nurse

is one of the most striking changes in hospital maternity care in the past decades" (p. 193).

Because transition is one of the concepts central to the discipline of nursing, the nursing profession is concerned about two areas that are worthy of investigation: (a) the meaning of perinatal nursing as viewed by nurses who have experienced the transition from traditional maternity care to family-centered perinatal nursing and (b) meaning of the transition for these nurses in their clinical practice roles and their work settings.

Previous descriptions in literature of perinatal nursing have been theoretical rather than the result of empirical investigation. Equally important, a paucity of literature describes the new speciality of perinatal nursing from the perspective of the nurses. Thus, it is unknown how experienced staff nurses view their work as PNs or the meaning of their experience in the transition to that clinical practice role.

Purpose of the Study

The purpose of this study was to obtain a better understanding of how nurses caring for perinatal patients and their families view their clinical practice role after experiencing the transition from TMC to family-centered perinatal nursing.

Research Questions

The research questions that guided the investigation were as follows.

1. What are the essential characteristics of perinatal nursing as described by the staff nurse working in Labor, Delivery, Recovery (Postpartum) [LDR(P)] and/or combined mother-baby nursing?

2. What is the meaning of the transition to the staff nurse who has made that change from TMC to family-centered perinatal nursing?

Assumptions

To understand the experiences of the participants and avoid imposing any preconceived ideas on the experience, eidetic or descriptive phenomenological analysis requires that researchers state their assumptions regarding the phenomenon that they are studying and then "bracket" or "suspend" them (May, 1991). The following assumptions were made regarding this study and bracketed until the researcher completed the analysis of the data.

1. Nursing roles and speciality areas in nursing practice reflect changes in health care delivery and patient needs and, therefore, are constantly evolving.

2. Perinatal patients include the mother-father unit, the fetus, and, later, the newborn infant. To meet the needs of all of these patients requires expanded knowledge and a variety of skills.

3. Role redefinition or expansion, a major change for professional nursing, has been met with varying attitudes ranging from complete acceptance to overt and covert rejection.

4. Role change brings about a disruption of comfort associated with conformity or consistent, usual activity. Change creates feelings of anxiety and fear and requires people to cope with unknown or uncertain outcomes from change.

5. Individual nurses differ in their capacity for change and role expansion.

6. Acceptance of role change depends on the readiness of the nurse to assume a different role with expanded functions and responsibilities.

7. The PN requires specialized training and must demonstrate competence to function in FCMC health care.

8. Many PNs have the special knowledge and skills to work in more than one specialty area and deal effectively with a variety of complex patient situations (Mandeville & Troiano, 1992; Perez, 1981).

9. Certain aspects of how nurses participate in the transition to family-centered perinatal nursing are rooted in the history of childbirth and maternity care practices; therefore, understanding the antecedents to these practices is essential to understanding contemporary practices (Ham & Chamings, 1983; Melosh, 1982).

Significance of the Study

Extensive efforts have been focused on defining FCMC, identifying the major components of the concept, developing standard policies and procedures that reflect the philosophy of FCMC, establishing implementation principles for changing the traditional roles of maternity nurses, and developing the new role in LDR(P) and combined mother-baby nursing. Nevertheless, from the perspective of staff nurses who have experienced that transition, the essential characteristics of perinatal nursing and the meaning of the transition from TMC to family-centered perinatal nursing have been explored only to a limited degree.

McKay and Phillips (1984) reported that the most difficult aspect of changing to LDR(P) and combined mother-baby nursing is breaking out of the traditional roles of the labor and delivery nurse, the postpartum nurse, or the newborn nursery nurse. According to Watters (1985), the greatest resistance to the perinatal nursing practice of combined mother-baby nursing comes from staff nurses, especially nurses who have traditionally worked in the nursery. She reported that various attempts to "sabotage" the role have occurred, such as leaving infants with mothers who are then given little help with infant care or "trading" mothers for infants (p. 481).

Although Watters's (1985) findings imply that some resistance would be expected from nursing staff who may be threatened by an expanded role, she suggested that this is best overcome by careful, advance planning that involves the nursing staff and provides for staff education and development. Despite using these and other

innovative approaches to implement the new role, many units continue to face the staff's aggression, frustration, anger, and/or passive resistance to change (Cottrell & Grubbs, 1992; Steensma, 1993). Still, no one has adequately explored what makes an expanded role what it is (what it means) to the staff nurse who has had that experience.

The role of the PN is central to the practice of family-centered perinatal nursing. Nevertheless, insufficient attention has been devoted to a description of the actual experience of staff nurses who have transformed their traditionally prescribed roles to practice as PNs. As a result, little is known about the thoughts, feelings, and/or perceptions of nurses who have experienced that transition.

This study provides a description of the experiences of staff nurses who have made the transition into a new speciality known as perinatal nursing and is intended to clarify the meaning that these experiences hold for these nurses. Because transitions may have profound effects on nurses in their clinical practice roles and in their work setting, new strategies designed to prevent negative consequences and promote healthy outcomes are essential. By articulating transition as a central concept and acknowledging its significance in nursing, this study provides an opportunity to develop new knowledge related to the meaning of transitions. Awareness of the meanings of this experience may lead to a better understanding of the factors influencing the transition, the conditions conducive to a smooth and successful transition, and conditions that place the nurse at risk for a difficult and unsuccessful transition (Schumacher & Meleis, 1994).

CHAPTER 2

REVIEW OF THE LITERATURE

The review of the literature addresses the following concerns: (a) an analysis of historical changes and events that have shaped the traditional maternity care practices and the current shift toward Family-centered Maternity Care (FCMC); (b) an analysis of situational and organizational transitions; and (c) an analysis of current perspectives on the development, implementation, and evaluation of FCMC models and the socioeconomic, cultural, and legal/legislative factors influencing this process within the present health care delivery system in this country.

Historical Perspectives

Certain aspects of how nurses participate in the transition to FCMC in contemporary hospital settings are rooted in the history of childbirth and maternity care practices, and understanding the antecedents would be essential to understanding the contemporary phenomenon. The concept of family nursing forms a common strand in nursing. Throughout history the family unit has been viewed as an integral component of society, and women have been traditionally placed in the "healing/nursing role within families" (Ham & Chamings, 1983, p. 41; Melosh, 1982).

Prior to the popular hospitalization of women for maternity care during the last half of the 19th century and early 20th century, women delivered babies at home, surrounded by family, friends, and particularly other women. As part of the general moral order, childbirth was primarily attended by women. A new mother would care for her infant during the postpartum period as much as she was able, feed the infant on demand, and remain in contact with her husband and other children (Leavitt, 1986;

Wertz & Wertz, 1977). Only since the beginning of the 20th century has childbirth been redefined, relocated, and placed within a medical model--a professional paradigm that dictates specific routines and rules for participation for health professionals and patients (Dye, 1986).

As the medical profession was able to solidify its status and authority, women were no longer primarily attended by other women. The newly formed medical profession was able to use its power to exclude other practitioners "by defining the practice of medicine so broadly that it encompassed all forms of health care and by controlling hospitals" (Rooks, 1990, p. 31). The growth of the medical profession resulted in the idea that "childbirth is a dangerous process that mandates technical intervention" (Rooks, 1990, p. 31). By redefining birth as a pathological process (one requiring the intervention of an expert), obstetrics was set apart as a medical profession. According to Arney (1982), all of medicine and the logic of medical inquiry changed as the technology that controlled and dominated the forces of birth replaced midwives' attendance at birth. "Normal" births disappeared with the female midwives, as all births became potentially pathological. To give birth to their babies, women were required to enter a hospital bureaucracy, complete with institutional routines and protocols, and deliver under the management of a medical professional (Rothman, 1982; Sullivan & Weitz, 1988).

In American culture, giving birth became fragmented into medical timetables and routines--a framework that had little to do with a birthing woman's deeper sense of the transformation that she was experiencing. As such, childbirth became the "hospital ritual." A power relationship was inherently present, and health professionals, through ownership and exclusive control of highly valued specialized knowledge, acquired the ability to manipulate the situation. The patient was alienated from her own experience and made to feel like an outsider. The final practice innovation that separated families

once involved during childbirth was the development of centralized nurseries (Eakins, 1986; Rothman, 1982; Sullivan & Weitz, 1988; Tomlinson, Bryan, & Esau, 1996).

Rise of Professional Nursing

The evolution of professional nursing paralleled the rise in popularity and necessity of hospitals for childbirth and maternity care. Obstetrical nursing was considered an important component in professional nurses' preparation for practice. The organization of hospital schools of nursing made available women trained to care for those in the hospital (Dye, 1986).

The emergence of an "efficiency ideal" in industrial management at the turn of the century led to the development of a "task-oriented approach" to work (Taylor, 1967). This has had major effects on nurses, particularly those working within the hospital organization. According to Reverby (1987), nursing tasks were systematically divided into their component parts and analyzed to make them more efficient. Ultimately, efficiency would require managerial control over the planning and execution of all nursing work. Fractionalization of work became idealized. Nurses were thus subscribing to a "morality of efficiency" to validate their claims for "autonomy and power" (p. 144).

Equally influential was the popular development of bureaucratic organizational patterns in which hierarchical patterns of subordinates and superordinates began to compartmentalize patient/family care. With specialization, the family was no longer an entity, and the individual member's care was further reduced into smaller components (e.g., obstetrical care, pediatric care, etc.) (Rosenberg, 1987). As a result, few nurses still focused on the whole family or on the impact that any member had on the whole (Ham & Chamings, 1983).

Arney (1982) described a second transformation in the profession of obstetrics near the end of World War II in which the conceptual basis of obstetrical medicine was changed to a "new logic" and a "new metaphor." Pregnancy was reconceptualized as a process that had a trajectory and a normal course that could be influenced by many systems. Suddenly, all events in a woman's life, before and after the point of birth, were considered important. Technology was changed from a "technology of domineering and control to a technology of monitoring and surveillance, and normalization" (p. 10). As a result, the birth was no longer something to attend to or dominate; it became something to be managed in order to optimize the experience.

According to Arney (1982), every aspect of childbirthing became more carefully controlled as monitoring became the structure of control deployed across the "greatly expanded space of obstetrical involvement" (p. 10). The birth process was reconceptualized as having physiological and psychological components that were intricately related to one another. Not only women and their families but also nursing personnel were subject to this new order of social control. Obstetrical medicine justified detailed surveillance of mother and infant by claiming that it was in the interest of the fetus's/infant's safety.

Post-World War II Developments

In the post-World War II era, nurses were faced with rapid transformations that resulted from developments in health care practices, a rise in birth rates, and dramatic changes in societal expectations for women (Martell, 1995).

Aseptic technique was rigidly adhered to, even after the introduction of antibiotics, because control of infection was still a major concern. This resulted in visitors, including family members, being severely limited for postpartum women; infants were immediately segregated into central nurseries (Martell, 1995).

Instead of the traditional 10-day postpartum hospital stay, early discharge 3-5 days following delivery became routine during this period. The solution for overcrowding of hospitals was the early ambulation of postpartum patients, which not only proved safe but also decreased postpartum recovery time (Martell, 1995).

The early ambulation of women changed traditional postpartum procedures, such as perineal care and breast care that had been routinely carried out by the nurses, to self-care practices by the postpartum women. In addition, teaching about maternal care and infant care seemed to evolve naturally as nursing responsibilities as caregiver shifted to educator. Nurses were concerned about the mother being discharged without adequate knowledge in caring for herself and her infant. As a result, nursery nurses spent time instructing mothers in bottle- or breast-feeding, and postpartum nurses were conducting new mothers' classes for teaching infant care on the maternity units (Martell, 1995).

Rooming-in programs were initiated as maternity nurses began to move away from the former rigid routines to individualized approaches for each new mother. Nurses assisted mothers in the care of themselves and their infants as new mothers became active learners. Health professionals reported the "success" of these programs based on their observations that rooming-in mothers demonstrated more self-confidence in the care of their infants and made better adjustments at home following discharge (Martell, 1995).

Changes in the care of the infant were also taking place. As alternatives to the prevailing rigid and technically oriented approach to infants, some hospitals were introducing rooming-in programs. Nurses assisted mothers in the care of themselves and their infants as new mothers became active learners (Martell, 1995).

Nevertheless, the practice of rooming-in did not become widespread until the 1980s, with the implementation of mother-baby units. There were multiple reasons why

rooming-in failed to become a persistent national trend in maternity care, with the lack of nursing support a major factor.

While the design of the first rooming-in programs attempted to replicate the home environment and make the mother feel comfortable in caring for her infant, the ongoing concern regarding infection created major barriers to modifying the existing physical environment. Concerns regarding returning the infant to the nursery and limiting the number of persons having contact with the infants resulted in the establishment of separate temporary nurseries to deal with visiting hours, housekeeping activities, and nights. The rooming-in policies were rigid and complicated. The only visitors allowed in the rooms were the fathers (Martell, 1995). Changes in routines occurred from day to day over the postpartum hospital stay because, as the amount of time required for instruction and supervision of new mothers increased, the amount of time required for direct caregiving decreased.

Although the intention of rooming-in programs was to be responsive to the needs of the mothers and the infants rather than the nurses' schedules, rooming-in required a great deal of flexibility to be successful, and nurses responded in different ways to the lack of routine in their schedules. Whereas some seemed overly solicitous to their babies, others were annoyed by such factors as the lack of orderliness of rooming-in, the amount of linens used by mothers, and the seemingly endless questions from the mothers. In addition, the rooming-in care of mothers and their infants by the separate nursery and postpartum staff resulted in confusion for both the mothers and the staff. Furthermore, the learning needs of mothers were frequently not accommodated because the separate nursery and postpartum staff failed to modify or coordinate their routines and teaching efforts (Martell, 1995).

Other post-World War II changes such as early ambulation and self-care teaching were accepted by nurses and continued. Nurses developed new procedures and

routines that were consistent with their value of "efficiency through routine" to help them to cope with changes brought about by the nursing shortage, the post-war baby boom, early ambulation, and self-care practices (Martell, 1995).

In order for the nurses to accept rooming-in, however, they had to change dramatically their thinking about "how to best meet the need of mother and babies . . . [and] to give up the control that they had with rigid routines" (Martell, 1995, p. 134). Two major barriers were the difficulty that nurses had in establishing the flexibility necessary for rooming-in and their continued loyalty to their separate nursery and postpartum units. Thus, congruence with what the nurses considered important influenced the acceptance of change in nursing practice. Because nurses would have had to change their thinking radically for rooming-in to be accepted, only those changes that could be incorporated in the existing framework of nursing were accepted (Martell, 1995).

Pressures on the Medicalized Birth

Still in its infancy, the medicalized birth is swayed by external pressures: legal, political, and cultural. Women have fought for reforms ranging from the right to have access to anesthesia in the early 1900s to the right to unmedicated birth in the 1960s. The natural childbirth movement, which emerged in the 1950s, struggled for the right to have a nonroutine, drug-free birth, fathers in the delivery room, and the baby with the mother after birth (Simkin, 1996).

According to Simkin (1996), the natural child birth movement, which grew steadily in the 1960s, began to flourish in the 1970s with the return to home births, breast-feeding, and midwifery care. For the first time, in the 1970s and 1980s researchers began to evaluate the value of such routine obstetrical practices as continuous electronic fetal monitoring (EFM), elective induction of labor, routine

episiotomy, and amniotomy; their clinical efficacy was not confirmed through randomized clinical trials. Other studies criticized the unnecessarily high and increasing Cesarean rate, which led to the vaginal birth after Cesarean (VBAC) movement. In addition, study results indicated that the birth process was influenced by human emotions and that outcomes improved when the emotional needs of laboring women were met.

Meanwhile, in the 1980s, just as the technological imperative to utilize the scientific and technological advancements in the field of obstetrics exerted pressure on the medical professionals to respond, "they began to experience an unprecedented pressure from another source, the legal profession" (Simkin, 1996, p. 250). Medical malpractice and product liability lawsuits increased dramatically in the 1970s and 1980s. According to Simkin, this exemplified society's increasing intolerance of any risk and the increased emphasis on public safety and protection.

When negative and unexpected outcomes occurred, the public was encouraged to find someone to blame, such as obstetricians. Insurance companies were willing to settle out of court rather than face a sympathetic jury moved by a brain-damaged child. To reduce the risk of lawsuit, hospital risk managers began to establish rules of obstetrical management. As a result,

> ruptured membranes, prematurely, post-dated pregnancy, . . . advanced maternal age and long labors became indication for extensive testing, labor induction, constant monitoring, and the ultimate "guarantee" of safety, the Cesarean section. (Simkin, 1996, p. 250)

Eakins (1986) suggested that two distinct and contradictory streams in the culture of American birth have emerged:

> (a) the mechanization of birth by the scientific medical profession, and (b) the consumer movement for the humanization of birth which in practice typically involves low technological approaches as well as greater consumer control. (pp. 213-214)

In the first tradition, families came to believe "that a hospital birth, attended by an obstetrical specialist, surrounded by the latest technology, was the best insurance against having a damaged child" (Dye, 1986, p. 332). Yet those new technologies are rapidly making birth more expensive. In fact, the cost of birth has escalated out of the control of any one group.

In the second tradition, many of today's parents say that they want a humanized birth as well as a safe birth. Families expect compassionate care. They now expect that a certain amount of technology will be part of their care but not the most important aspect (Phillips, 1988a, 1988b). Although for some this may mean that the woman has total control over the entire process, women are forced to conform to the role of "sick patient." When confronted by the roles, rules, and rituals of the medical profession, they surrender their own personal judgment to experts. Upon entering the hospital, authority is transferred, both symbolically and actually (Dye, 1986).

Dye asserted that most families will continue to use hospitals and that a woman's requirements for a humanized birth will probably be satisfied as long as the husband or another person of her choice is present, she is conscious, rooms are nicely decorated, and staff is pleasant. Eakins (1986) proposed that what is needed to solve the incongruities in these apparent divergent trends is a new vision: "a vision that combines excellent outcomes for the infant with a truly family-centered experience" (p. 336).

Transitions as a Concept for Nursing

A comprehensive review of the literature concerning the properties and dimensions of transitions in nursing was conducted by Schumacher and Meleis (1994). They suggested that transition was an important concept to the discipline of nursing and identified four types of transitions: developmental, situational, health and illness, and

organizational. In addition, because transitions are complex processes that are not mutually exclusive, multiple transitions may occur simultaneously during a given time period.

The introduction and implementation of new practice models in nursing exemplified a type of organizational transition that involved the adoption of new policies, procedures, and practices. Organizational transition also included the structural reorganization of institutions that resulted from the development of new programs (Schumacher & Meleis, 1994).

According to Schumacher and Meleis (1994), transitions share certain universal properties across the various categories that help to differentiate them from non-transitional change. First, transitions are defined as processes that occur over time and involve development, flow, or movement from one state to another. The second universal property involves the nature of the change that occurs in the transition. Examples at the organizational level typically included changes in structure, function, or dynamics. In individuals or families, the examples of change included changes in patterns of behavior, ability, identities, roles, and relationships. Consequently, although phenomena may be dynamic in nature, if they do not have a sense of movement or direction, they were not conceptualized as transitions. In general, internal processes were associated with the process of transition, while external processes tended to represent non-transitional change (Schumacher & Meleis, 1994).

Transitional conditions identified as important influencing factors across the four types of transitions included meanings, expectations, level of knowledge and skill, the environment, level of planning, and emotional and physical well-being (Schumacher & Meleis, 1994).

According to Schumacher and Meleis (1994), meanings referred to "the subjective appraisal of an anticipated or experienced transition and the evaluation of its

likely effect on one's life" (p. 121). They suggested that a perception of the meaning of a transition for nurses is essential in order to understand their experience of the transition as well as its consequences for the profession. They also asserted that meanings must also be understood from the perspective of the cultural context of the transition. Since the transition may or may not be the result of personal choice and may or may not be desired by the participants, they proposed that it is possible for the meanings attached to transitions to be positive, negative, or neutral. Thus, they emphasized the importance of understanding a transition from the perspective of those experiencing it.

Expectations were also subjective phenomena that influenced the transition experience. They may or may not be realistic because the person undergoing the transition may or may not know what to expect. Nevertheless, knowing what to expect was associated with sometimes relieving the stress that accompanies a transition (Schumacher & Meleis, 1994).

Another condition that influenced outcomes was the level of knowledge and skill relevant to a transition, which may be insufficient to meet the demands of the new situation. The transition to new professional roles requires new knowledge and skills. A significant aspect found in the literature was the uncertainty associated with the need for new knowledge and skill development (Schumacher & Meleis, 1994).

The importance of resources within the environment during the transition was frequently mentioned. Consideration was given to the helpfulness and supportiveness of support outside the person that may help in the transition. In addition, personal transitions were shaped by the environment when they occurred within the context of the formal organization. During professional transitions, the presence of a supportive preceptor, mentor, or role model was identified as an important resource. Thus, the effective management of the transition resulted from an environment in which

collaboration, team work, effective communication, and support from key persons and groups were evident (Schumacher & Meleis, 1994).

The next condition that influenced the success of a transition was the level of planning that occurred before and during the transition. A smoother transition was facilitated by extensive planning and was concurrent with the ongoing assessment and identification of any problems, issues, and needs that might become evident during the transition. Another important factor in effective planning was communication among the key people involved in the transition, including those in a position to provide support (Schumacher & Meleis, 1994).

Both the emotional and physical well-being of the participants were found to influence the success of the transition. Transitions resulted in a wide range of emotional responses that indicate some of the difficulties found during the transition. Schumacher and Meleis (1994) noted that stress and emotional distress frequently were reported to occur during transition, including "anxiety, insecurity, frustration, apprehension, and ambivalence" (p. 123). They suggested that this may result in the participant's "inability to concentrate, unwillingness to take risks, and avoidance of the unknown" (p. 123).

Physical well-being of the participants included such factors as positive energy and normal physical comfort and functioning. Physical discomfort that accompanies the transition may interfere with the integration of the new knowledge and information (Schumacher & Meleis, 1994).

Schumacher and Meleis (1994) identified three major indicators of healthy transition outcomes: subjective well-being, role mastery, and well-being in relationships. They suggested that these indicators were relevant across all types of transitions. While the term "outcomes" was used by them in describing these indicators of successful transitions, they suggested that these outcomes may occur at any time in

the transition process. For example, role mastery may vary according to individuals. Likewise, it may occur early for some and later for others.

In summary, the review of the literature related to transitions as a concept in nursing provided a holistic perspective of the conditions and indicators that promote a successful transition. The findings included a wide range of subjective, cognitive, behavioral, environmental, emotional, and physical conditions and suggested a holistic experience of transition.

Current Perspectives

When the concept of FCMC was first introduced in the 1970s by Sister Mary Stella, she understood that the practice model must change and adapt to the needs of mothers, infants, and families and must respond to new research findings. From the beginning, flexibility was an essential component of FCMC influencing the acceptance of new practices by the staff. During the past 25 years in many hospitals, changes in clinical practice have evolved to support families and to increase their options and choices. These choices include mother-baby nursing, rooming-in, opportunities for parent-infant bonding, sibling visitation, and partner involvement in Cesarean births. In addition, changes in the physical environment have resulted in the redesign of maternity units with LDR and LDRP "birthing" rooms (Young, 1992).

In traditional maternity care, nurses were subspecialists who were experts in intrapartum, postpartum, or newborn nursing care. When FCMC was introduced in the 1970s, nurses were first cross-trained in postpartum and/or newborn nursery to work in combined mother-baby care (Strohbach, 1992).

McKay and Phillips (1984) popularized single-room maternity centers (SRMC), also known as LDRP. They suggested that patients were attracted to the home-like physical setting and that the changes in the type of delivery environment increased

patient satisfaction. According to Nichols and Palmer (1994), SRMC was thought to decrease the number of staff required and to increase cost effectiveness; however, because the system was primarily designed for low-risk patients, when high-risk and low-risk deliveries were combined, staffing needs did not decrease.

Many maternity units implemented SRMC because of patient demands without adequately cross-training staff. Because many nurses were not cross-trained in all areas of maternity care, the cost of FCMC increased over the years due to increased need for staff. Without a formalized program, most hospital simply required staff from two units to cross-train to the other unit. Some cross-trained a small group of their maternity staff to function as an "internal float pool" to cover multiple areas. To effectively provide FCMC in LDR(P) units required that formalized cross-training programs be developed and that all staff be cross-trained in multiple clinical areas (Arnold & Levy, 1988; Nichols & Palmer, 1994; Strohbach, 1992).

In the 1990s health care economics brought many changes to nursing practice, including the area of perinatal nursing. According to Nichols and Palmer (1994), the role of providing patient focused, cost-effective perinatal care became increasingly more difficult. Length of stay for postpartum women has continued to decrease over the past several years, as hospitals responded to health care costs, patient satisfaction, and reimbursement. Nichols and Palmer suggested that, in order to survive in the next decade, PNs must cross-train in other areas. According to Steensma (1993), mother-baby nursing has become the method of choice for patient satisfaction and staffing productivity as the postpartum length of stay has continued to shorten and staff no longer has the opportunity to provide in-depth teaching and care. Nevertheless, the primary problem that hospitals have had in changing to mother-baby nursing is breaking with the traditional method of postpartum nurses caring for mothers and nursery nurses caring for newborn babies.

Changes in Family Nursing Practice

According to Tomlinson et al. (1996), the roles for PNs were expanded as the development of FCMC was further augmented by utilizing nursing research, which suggested that mothers and infants should not be separated during the first 24 hours because that was a sensitive period for maternal attachment. As a result, intrapartum nursing practices were changed to incorporate family and nursing theories, including the initial assessment of bonding and the promotion of holding, touching, and even nursing immediately after birth. Nursing textbooks and teaching strategies of the 1990s have responded to current and future needs of families by clearly focusing on the involvement of all family members in the birth experience and on the cultural differences in such childbirth preferences as who participates in the birth and the role of siblings and grandparents. Nurses gained a clearer understanding of the fears of fathers for their partners and infants during labor and delivery and developed specific intervention for supporting the fathers. Nurses also recognized the importance of having the fathers and siblings present to support the mothers and to foster the mutual bonding of the family during the intrapartal period. The family-centered focused care, however, was dramatically changed by the need for technological support in medical emergencies associated with high risk infants because of the parents' limited access to infants in NICU.

Tomlinson et al. (1996) suggested that the family-centered concept continues to expand and should incorporate new knowledge in fields other than nursing, such as the unique roles that families play in society. They also proposed that PNs must be committed to having their work place reflect the values of the concept of family-centeredness by facilitating the birth experience for the family as a whole and by fostering the roles of parents in the work place to approximate their family roles at home. They further asserted that an important emerging concept in family nursing is

the expanding focus on the family as a unit and on the mother and baby as a dyadic unit of care (pp. 333-334).

Despite the strong emphasis on families, most nursing practice has focused on the care of the individual, and most communication skills were learned in one-to-one interaction (Tomlinson et al., 1996). Tomlinson et al. suggested that the skills needed to interact with families are at a higher level of complexity due to such factors as conflicting needs and wants, different background experiences, and the feelings of family members. Many nurses may not have learned these more complex skills. Tomlinson et al. suggested that PNs may be in the position of "taking sides" by being more empathic to one perspective than another and/or by giving one member more information and support. For example, the lack of professional care to fathers or other family members may result in extra demands being placed on the mother's sensitivity, assertiveness. and self-expression skills to provide care to her family when she is most stressed and vulnerable. This may ultimately increase the possibility of family conflict and misunderstanding (Tomlinson et al., 1996, p. 335).

According to Tomlinson et al. (1996), to avoid increasing the stress that the family already experiences, the family assessment must be conducted informally during the process of nursing care and in a noninvasive manner to identify family strengths and needs. It must focus on the dyadic relationships as well as on the individual family members and include such factors as communication patterns, mutual respect, cohesiveness, mutual decision making, and adaptability to change. Moreover, the assessment must identify who provides support and assistance during labor, based on the family's culturally defined roles and expectations. This supports the basic premise of family-centered care, which recognizes that the family and not the nurse is the ongoing provider of care and support for its members.

Tomlinson et al. (1996) suggested that nursing intervention during labor includes "providing support, giving information, modeling coaching strategies, processing feelings and experiences of both partners and providing privacy" (p. 335) to allow them to work out things together. They also suggested that the emotional state of couples may vary so that some couples are able to express their needs and others require the nurses' skilled assessment. Assessment and intervention during labor may be important factors in developing the family system. The experiences of birth can enhance the mother's feeling that she can depend on her partner or it can leave her feeling abandoned. The PN can play an important role in assisting the family unit to have a positive experience of coping by supporting both partners and decreasing their fears and negative feelings. According to Tomlinson et al., this positive experience of working together under stress may become the "prototype" of mutual support after birth and during early parenting. This was considered particularly valuable in families who are at high risk due to medical or social problems. They concluded that, in providing family-centered nursing care, the families who presented the greatest challenge were high-risk families with social problems.

Transition to FCMC

Preplanning the Transition

The need for staff to participate actively in all aspects in the transition process from TMC to FCMC has been repeatedly documented in the literature. According to Nichols and Palmer (1994), nursing management must exercise caution and logic when introducing proposed plans for the transition and must complete a realistic and accurate assessment to determine exactly what should be changed. In addition, management must conduct an assessment of the staff nurses' perspectives regarding whether change is needed, where it is needed, and why it is needed.

Education and Cross-training

In TMC, nurses specialized in one area of clinical practice. An important aspect of the transition process from TMC to FCMC involves redesigning maternity units where perinatal care is delivered to mothers and their infants by PNs who are cross-trained to work in multiple clinical areas. To be successful, cross-training programs require assessment of goals to be achieved, plans to achieve goals, and organized implementation and evaluation of the program. The established goals include the actual skill level wanted for the participants, from complete competence to provide care to competence in some selected skills. According to Nichols and Palmer (1994), planning an effective didactic orientation and cross-training program for the nurses requires that skills and competencies be clearly defined and a method of validation indicated. They reported that, when the staff in their study struggled to acquire new skills and was uncomfortable with the changes, the nurses were frequently tempted to give up. They described the need to be prepared to deal with conflict related to "turf" issues and traditional roles by communication and taking time in implementation. The emotional concerns of staff, such as job loss anxiety and feelings of insecurity, required opportunities for discussion to change the perception of threat. Staff nurses also needed information to be available and easily understood. Timing was viewed as an important factor in decreasing resistance to the program.

Nichols and Palmer (1994) suggested waiting to implement the model until everyone had completed orientation and cross-training and all concerns had been addressed. In order for PNs to continue moving and adapting to the future during the transition, they must be supported by being given the opportunity to mourn their losses. At the same time, these authors indicated that the staff nurses in their study needed to be confronted about resistance to learning new skills and the tendency to resist teaching others their skills because of the assumption that those whom they teach will replace

them. They suggested that staff needed to be reassured that their marketability increased as they acquired new skills. When nurses are competent in more than one area of practice, they are viewed as a valuable commodity for the hospital. The benefits of cross-training were identified as providing an opportunity for nurses to increase their skills, develop multiple areas of clinical expertise, and increase marketability (p. 43). Flexibility and support were identified as keys to successful implementation of cross-training.

Caico and McLean (1990) stressed the importance of cross-training all staff on the postpartum and nursery units when preparing to implement mother-baby nursing; they recommended taking the necessary time to do it. They did not address additional didactic training but mentioned the use of group meetings to orient staff to the new family-centered approach and to solving problems. They indicated that the primary role of the nurses would change from that of a "task master" to that of a well-rounded, skilled professional (p. 59).

Implementation of FCMC

According to Steensma (1993), the implementation of mother-baby nursing in Level I settings with low volume (< 1,000 births/year) and low-risk (primarily vaginal deliveries) was a natural progression, providing improved staffing efficiency. She likewise described implementing mother-baby nursing in a Level II unit, suggesting that it had been much harder to change traditional caregiving in high-risk, high-volume settings that required more PNs. She also asserted that successful implementation of mother-baby nursing required a firm commitment to the concept to make it the only care policy and practice for the perinatal nursing unit. She did not view the traditional hospital routines as supportive of the needs of families. On the other hand, she indicated that in mother-baby type care the patient's needs and interests were

considered first and the nurse was placed in the role of teacher and supporter. She identified the need to evaluate nursing activities, examine unit routine that did not relate to mother-baby nursing, and change the focus to actual patient needs and away from the generalized routines of care (e.g., physical assessments or number of intravenous lines to monitor). She described implementing the FCMC model in incremental steps, beginning on weekdays only on the day shift, with the evening shift 3-4 months later and weekends the last to be included. An implementation calendar with assigned responsibilities helped to keep the process focused and on track.

Steensma (1993) acknowledged that the first 3 months of change was total chaos, and entailed daily confrontations with expressions of dissatisfaction because "a traditional care delivery system cannot be uprooted without it" (p. 153). She identified the crucial aspects of implementation as commitment, planning, and administrative team support. She also discussed staff turnover as a reality and suggested that it was healthy for dissenters to leave the unit and for new personnel who are not relearning to be added. She mentioned the need to keep making changes to make the model work and the importance of listening to the staff nurses who are actually implementing the new delivery system. She also stressed the value of meeting the staff's emotional needs by hearing what each person thinks and by valuing her/his opinion. She indicated that, for successful implementation, every unit must tailor the details to its own care system. She suggested that patients and families should not be expected to recognize that care delivery has changed, in particular the primagravidas who are experiencing childbirth for the first time. In addition, she indicated that not all multigravidas will consider the changes as positive due to the many rough spots encountered during the transition. In fact, patients did not recognize the benefits of having the nurse caring for them and their infants for over a year following implementation. She described the rewards for the nursing staff as a "renewed sense of purpose and pride of accomplishment" (p. 154)

and growth and learning by all. Cross-training resulted in the expanded versatility of staff. The program was viewed as meeting the needs of mothers and families by reducing hospital routines and making the families' choices the priority. It must be acknowledged that implementing mother-baby nursing was difficult and time-consuming.

Caico and McLean (1990) described implementing a FCMC model of mother-baby nursing based on the family's best interest and current obstetrical practice and designed to foster the confidence of the new parents. They stressed the importance of increased flexibility and communication when working with a traditional staff that was unfamiliar with either. Flexibility was required to overcome and remove the past controls of the previously held rigid rules and procedures. They reported that "allowing" fathers on the unit all day caused a major disturbance that required the reassurance of staff that the presence of the fathers and the infants would support the mothers and decrease their anxiety, and that, as a result, the demands on staff would be less and teaching would be enhanced by the "more relaxed atmosphere." In addition, they suggested that the nurses lacked good communication skills because they tended to function independently of their peers when caring for their patients. They proposed that new effective communication patterns, both formal and informal, must be developed for nurses to relate to the family members and to each other. They also proposed improving continuity by having the same nurse teaching the mother/family in order to establish rapport and overcome the former patterns of fragmented teaching and lack of consistent rapport with one nurse. Moreover, they stated that many meetings with staff were necessary to "keep the peace" and overcome the resistance by staff who were hoping that the new approach would go away (p. 59).

Reed and Schmid (1986) discussed the implementation of the SRMC model, in which each room provided not only the technical and emergency support of the

traditional delivery room but also the homelike atmosphere of a birthing room for each mother and family. As a result, instead of being transferred from room to room during labor, delivery, recovery, and postpartum, the mother experiences the entire birthing process and postpartum care in one room. Because the rooms are clustered around a central nursing station with access to each room, this system was referred to as the cluster concept. The equipment was stored and quietly brought into the birthing room when needed by the staff. The new delivery system required changes in the physical environment, including new construction and modification of the unit. This changed the proximity of the nurseries and the mothers' rooms to facilitate the infants being kept with their mothers immediately after delivery and the mother-baby assignment of one nurse caring for three to four couplets. They identified the benefits of eliminating the multiple transfers during the childbirthing period as decreasing anxiety and fragmentation for the mother and the family, individualizing nursing care, and increasing the opportunity for the family being together. According to Reed and Schmid (1986), both low-risk and high-risk patients are accommodated by this method. This includes Cesarean sections that are done in the operating room located on the unit. Following surgery, the mothers recover in the birthing room while the infants are observed and cared for in a central nursery when not at the mother's bedside. They suggested that the staff needs to be prepared to function in each area from labor and delivery through postpartum care. They reported that, because the Level II nursery required specialized skills, it was impractical to train staff in both Level II nursery skills and labor and delivery. As a result, they established two groups of staff, with one group proficient in LDRP and normal newborn and the other group expert in Level II nursery and normal newborn.

Reed and Schmid (1986) discussed preparing for the transition by holding change theory workshops and discussing concerns. From their discussions, they

identified four major concerns: job security, practice questions, safety issues, and physician concerns. They suggested that the underlying theme for their concerns was "fear of the unknown" (p. 388). To promote information sharing, communication, and problem solving among skill areas and management and staff physicians, they established a "communication tree" and a newsletter (p. 388). They encouraged the participation of staff in group meetings in areas that directly affected their daily work such as selecting equipment, revising policies and procedures, and writing philosophy and job descriptions for the new unit. They also reported that they found it sometimes difficult to coordinate the staffing schedule to meet the needed skills level for each shift because minimum numbers of nurses were needed per shift. They reported that staffing needs varied depending on the fluctuating census and acuity level of mothers and infants. Thus, to provide adequate coverage and resource for each skill area required a mix and match of skills. Less-skilled staff also needed the opportunity to upgrade their knowledge and skills.

Evaluation of FCMC

Watters and Kristiansen (1989) compared mother-baby couplet care and traditional care delivery. The findings indicated that maternal competence and maternal satisfaction were significantly higher in mother-baby care and that mothers were more satisfied with the quality of education and nurse-client relationship. Benefits were also more evident for multiparous mothers.

Watters and Sparrow (1990) compared combined mother-baby care while making the transition from traditional care to determine the impact of this change on nursing practice and to evaluate ways to improve the implementation of the model. The results indicated positive differences in maternal perceptions of the nurse-client relationship and overall ratings of postnatal care for combined mother-baby care. In

addition, multiparas benefited from combined mother-baby care more than did primiparas. Multiparas reported feeling more competent and more satisfied with patient education, although no differences were identified in breast-feeding outcomes. Watters and Sparrow indicated that the infants were spending more time at the first-time mother's bedside without the nurses providing adequate support and that a tendency was to complete the infant's bath and exam in the nursery, rather than taking the opportunity to teach these first-time mothers. Staff reported feeling overwhelmed due to heavier patient loads than anticipated, their expectations for their own performance, and concurrent stressors in the work environment. The study results were used to improve the implementation of the model related to patient teaching by incorporating the maternal concerns into the patient education program and using them as the basis for anticipatory guidance by the nurses, such as in the area of problems associated with discontinuing breast-feeding.

According to Cottrell and Grubbs (1992), many FCMC programs have failed despite the many "advantages" of couplet care. They cited the advantages of couplet care for mothers as including increased continuity of care, increased bonding and attachment, and facilitation of breast-feeding. They cited the advantages for the nursing staff as including increased teaching opportunities, decreased staff conflict, less duplication of efforts, decreased patient load, improved communication, and increased job autonomy and accountability that lead to increased job satisfaction. The most frequently reported disadvantages included physical layout of the unit, the patient-staff ratio, the staff nurses' resistance to change, the mothers' need for rest, and the nurses' preference for specializing in nursery or postpartum care.

As a result, Cottrell and Grubbs (1992) studied nursing concerns and attitudes about implementing couplet care before the practice model was implemented. Their findings indicated that the nurses' greatest concerns were related to the nursing couplet

staff-patient ratio being consistently exceeded and increasing their workload from that of traditional care and the nursing care of FCMC. Staff who had worked 6 or more years in TMC were more satisfied with TMC nursing and more resistant to change, and part-time or flex-time nurses were consistently more positive than full-time staff. The findings also indicate that the nurses did not identify any advantages for themselves in terms of working conditions and autonomy; rather, they reported only in terms of how patients would benefit.

Bailey et al. (1992) evaluated the effectiveness of combined mother-baby care in meeting the needs of families. They reported that providing couplet care was considered an effective way to prepare the new family for the changing roles and additional responsibilities involved in the care of a new baby, but few research studies had been completed evaluating this area. During the transition to combined mother-baby care, Bailey et al. conducted a post-test control group study with a self-selected sample of postpartum mothers: 103 mothers who had received traditional care and 102 who had received mother-baby care. They evaluated the mothers' perceptions of their own competence and satisfaction with the care that they had received. The findings indicated no significant differences between the two groups, although multiparous women from both groups scored higher than primiparous women on self-care, infant care, and maternal competence. Bailey et al. identified factors that may have influenced the results, including the short time between implementation of the model and its evaluation. They suggested that, because the nurses had to learn new skills to provide mother-baby care, they may have needed more time to adjust. They also suggested that, because the emotional, social, and educational needs of childbearing women were often underestimated, these needs should be addressed by the combined mother-baby care system.

Cross-training/Clinical Judgment

Strohbach (1992) studied cross-training of PNs in 45 southeastern hospitals. Findings indicated that fewer than half of the hospitals included didactic instruction in their training. Clinical experiences were "task oriented," and participants were expected to complete a checklist of skills. Preceptorships varied in length from 1 to 6 weeks and emphasized beginning competency in intrapartum care. The programs involved a limited time of 1-2 weeks in postpartum or newborn nursery care. Strohbach suggested that the limited mother-baby care was insufficient to develop competency and expressed concern that expert observation and assessment skills required to detect the often-subtle symptoms of illness in the newborn are missing. Furthermore, she suggested that the postpartum period was considered a "period of psychological crisis and adaptation" that required nursing expertise to listen to, support, and teach mothers (p. 65).

Strohbach (1992) asserted that, due to the tremendous expansion of knowledge and advanced technology in the field, it may well be impossible for the PN to develop and maintain clinical excellence in all areas. Nurses face a considerable challenge in just trying to maintain current knowledge in intrapartum, postpartum-newborn care.

Nichols and Palmer (1994) identified several factors that have historically contributed to the resistance by PNs to the concept of cross-training: issues regarding clinical expertise and competency, patient satisfaction, and job security. According to Nichols and Palmer (1994), there has been a lack of consensus regarding the ability of staff nurses to develop expertise in all areas. Both nurses and physicians have continued to argue against cross-training by suggesting that it results in "less-than-expert" nurses caring for patients. Nichols and Palmer suggested that the cross-training process may not result in "a nurse who is an expert in all areas, but one who has clinical expertise in one or two areas and initial clinical competence in others" (p. 35).

Nichols and Palmer (1994) defined expertise and competence as separate issues. For example, "expertise denoted an expert level of knowledge that is attained with an accumulation of experiences overtime [whereas] competence denoted the ability to meet a certain level of practice as defined by specific criteria" (pp. 35-36). While acknowledging that cross-trained nurses may not become "clinical experts," they suggested that a well-defined cross-training program that included didactic and clinical preceptoring provided the necessary requirements to cross-train nurses who are clinically competent and who feel "comfortable" with their skills. They argued that cross-training nurses resulted in such positive outcomes as enhancing their value to the organization and increasing their job security.

Because many risk factors are not evident until labor has begun, it is possible for neonates who are sick and at risk to be born in any hospital. As a result, PNs must know how to stabilize the newborn and to provide the initial care needed until the newborn is transferred to intensive care or to a Level III facility (Harris, Yates, & Crosby, 1995).

Fein (1994) emphasized the need for new strategies that promote safe, individualized care for childbearing women who are low risk in a high-risk environment. She recommended relying on expert nurses who can teach how to protect and support the rights of women for a safe and personalized birth experience.

Strohbach (1992) described the role of intuitive knowledge in making clinical decisions. She defined intuitive knowledge as "the ability to 'know' something without the conscious use of reason" or "the 'sixth sense'" that many expert nurses develop after repeated experiences with a given population (p. 66). According to Benner (1984), nurses frequently referred to intuition as a "gut" feeling that is important in making decisions based on ambiguous or incomplete data. The "intuitive grasp" described by her was the result of the expert's ability to use past experience to take in

cues and analyze them so rapidly that their conclusions appear to be instantaneous. In a study of intuition in clinical decision making, Rew (1988) reported that, based on the strength of the nurses' intuition, they were frequently moved to do something more on behalf of the patient. When their intuition's subjective feelings differ from objective signs and symptoms, however, they may not be taken seriously by physicians.

Factors Influencing FCMC

Responses to Changes in Maternity Care

Early postpartum discharge programs are growing rapidly across the country as length of hospital stay has decreased to between 2 and 24 hours after delivery in response to health care cost containment and consumer demand. Brown, Towne, and York (1996) reviewed the literature from 1960 to the present and identified several controversial issues surrounding early postpartum discharge such as safety, costs, satisfaction with services and care, breast-feeding, and teaching-learning. According to the literature, early discharge was found to be safe in middle-income, low-income, and disadvantaged families with strict selection criteria and adequate follow-up programs in place. From the literature, true cost for early discharge could not be analyzed accurately due to variances among the programs. A lack of standardized tools and reporting of methodology made it difficult to determine satisfaction. Findings indicated difficulty in integrating anticipatory guidance and teaching in prenatal period for problems with breast-feeding prior to the problems developing in the postpartum period.

Brown et al. (1996) reported that early discharge potentially compromised the provision of comprehensive quality care by the PNs "by limiting the amount of time available for providing information and supporting role and physiologic changes" (p. 335). They asserted that most postpartum teaching in the hospital was done at a

superficial level, with little time available for reinforcement and feedback, and that it tended to be focused primarily on the immediate needs of the mother and the infant, with little time given to anticipatory guidance. They noted that reinforcement of teaching and anticipatory guidance can be done during in-home follow-up visits; however, they also reported that "not every mother who is discharged early receives a home visit" (p. 336). Because nearly all reported outcomes for early discharge programs involved those with prenatal and postpartum follow-up programs, they recommended further research to review the effectiveness of early discharge programs with high-risk populations and those without follow-up programs in place.

According to McGregor (1994), many of the recent changes in the health care delivery systems were dictated by insurance companies, including decreased compensation of hospitals, increasingly limited insurance coverage, and decreased length of stay for patients. She suggested rethinking how nurses deliver care in order to work within the imposed constraints to provide optimum care for patients. She expressed her lack of comfort with mothers leaving the hospital before they have learned about infant care, as well as with helping nurses in streamlining their care and teaching by choosing what could be eliminated when postpartum hospital stays were still 3-5 days in length. According to McGregor, the nursing staff had time to observe new mothers in their new roles and had the satisfaction of seeing them as they began to develop comfort in caring for their infants independently. Yet, this changed with the 24-hour-or-less postpartum hospital stay. Rarely are the new mothers observed to be functioning independently with the infants. They are not ready to learn the information that the nurses are trying to give them, and they are exhausted when they are discharged. The nurses expressed feelings of dissatisfaction that they had done a disservice to their patients and that the cycle began again the following day.

McGregor (1994) also argued that the shortened hospital stays were directly connected to the PNs' "losses" and that the symptoms involved feelings of conflict, miscommunication, and negative attitudes among the staff. Nevertheless, as the PNs began to recognize and discuss their feelings of loss, they began to develop a greater sense of community, gained a greater sense of control, and experienced less frustration and more satisfaction in providing patient care (McGregor, 1994).

Harrison (1990) described the advantages of patient education in early discharge home teaching programs as promoting FCMC by decreasing the number of disruptions in family life, providing more opportunities for parent-infant attachment, decreasing exposure to hospital infection, and still meeting the demands for cost containment. She suggested that the critical elements for success were a comprehensive assessment (prenatal and early postpartum), in-home follow-up within 48-72 hours, and individualized teaching that involves the family and is based on the needs identified during the assessment.

Legislative Issues Related to Infant Safety

According to Haller (1996), when the media released the news that Kaiser Permanente (California) planned to reduce postpartum hospital stays to 8 hours, they captured the attention of legislators and interested others. As a result, federal legislation (PL 104-191), passed by Congress and signed by the President, goes into effect in January, 1998. This legislation mandates insurers to cover hospital stays at least 48 hours post vaginal delivery and 96 hours post Cesarean birth. Although insurance mandates have passed in several state legislatures, other state legislatures, such as the California Assembly, failed to pass similar bills that were introduced in the 1995-1996 session.

The federal regulations will allow the decision for shorter hospital stays to be made by the physician and the patient, as most professional organizations have recommended. The American Academy of Pediatrics (AAP), however, has focused on what the minimum criteria for discharge should be rather than when the infant should be discharged. The guidelines of the Committee on Fetus and Newborn (AAP, 1995) are related to the knowledge, confidence, and ability of the mother to care for her newborn in four specific areas that must be documented before discharge: "(a) breastfeeding or bottlefeeding; (b) care of the infant's umbilical cord, skin, and genitals; (c) ability to recognize signs of illness and common problems of infants, particularly jaundice; and (d) proper infant safety" (pp. 788-790).

According to McRae (1993), the nursing profession is "bound by its own standards of care for responsibility to patients" that are separate and distinct from medicine (p. 410). External forces such as the nurses' employers, the nurses' education, professional organizations, physicians, and others exert pressure to enforce the standards of care. Expert testimony is used in litigation cases to define appropriate nursing care.

McRae (1993) also suggested that the consumer needs to understand that not only is it impossible for every infant to be normal, but it is impossible to prevent every negative outcome. Consumer expectations for the best health care using advanced technology have resulted in an increase in medical liability claims and, in certain cases, enormous monetary awards.

In 1988, 52% of all professional liability claims against physicians were against obstetricians, and EFM was involved in 45% of all cases. McRae (1993) suggested that PNs must be familiar with legal terminology and should be prepared to defend their practice. Because EFM becomes a liability in the hands of the inexperienced or uneducated professional, he asserted that a need exists for standards and credentialling

to ensure competency. In his review of case studies involving EFM and untoward patient outcomes, he described how, in each case, the expert witness compared actual practice with practice expectation and illustrated how nursing actions were identified as "proximal cause" separate from medical practice. The presumption made by the nursing profession is that the professional nurse is capable of knowing when it is necessary to intervene immediately and is knowledgeable of the consequences of inaction. Nursing actions were found as proximal cause when the PNs ignored or failed to recognize signs of fetal distress. Thus, in the legal area, nursing practice stands on its own.

Another liability issue involving infant safety in FCMC noted in the literature is related to individual and corporate liability for hospital kidnapings of infants, which have increased in recent years. Fiesta (1990) advised that a security plan specific for the maternity unit should be developed by nursing and risk management in conjunction with security department of the institution. She proposed that the issue of proper identification of all hospital personnel must receive careful attention. For example, identification badges that include photographs must be worn by everyone. She recommended strict enforcement of visitor policies and consideration of badges for visitors. Security must also be in place to prohibit access to the nursery and from the building. Proper instruction must be given to all personnel and to mothers regarding the importance of being alert. Nursing personnel on the mother-baby unit must instruct the mothers to follow the procedures for properly verifying the identity of all persons before giving them the infant. Fiesta noted that staff are frequently concerned regarding the possibility of infant kidnapping, and suggested that management must consider this a priority issue and develop policies that focus on the prevention of such tragedies.

Nurse-Patient Relationships

Numerous aspects of the nurse-patient relationship that were identified by Griffith-Kenney (1986) were related to the nurses' attitudes and behaviors in working with patients as well as other nursing activities directly related to assisting patients and their families. These various aspects involving nurse-patient interaction included values, self-awareness, self-responsibility, caring and communication, and teaching-learning (p. 36).

According to Griffith-Kenney (1986), because values and attitudes strongly influence behaviors, nurses must be aware and sensitive not only to their patient's value system as it relates to health-illness and lifestyle but also to their own value system. She argued that nurses can remain sensitive and avoid imposing their values on patients with differing views when they understand their own values. Nurses can monitor their values only when they acknowledge how their values affect their thoughts, feelings, and behaviors. Otherwise, nurses will simply communicate the discomfort that they feel in working with patients with values different from their own, instead of conveying openness and acceptance of their patients.

Griffith-Kenney (1986) suggested that effective interaction with others requires an awareness of one's own thoughts and feelings. In women's health care this means that the nurses must be aware of their attitudes and thoughts toward women and their health and lifestyle as well as the influence that these attitudes have on themselves, their patients, and nurse-patient interactions.

According to Griffith-Kenney (1986), for the nurse to relinquish control and change his/her attitude of "knowing what is best" for the patient, the nurse must first acknowledge that both self-responsibility (which includes an awareness of one's self and one's values) and accountability for one's own decisions and actions apply to both the nurse and the patient. Only with self-awareness and acceptance of the situation are

the nurse and patient able mutually to "define the patient's needs, establish goals and identify ways to achieve them" during nurse-patient interaction (p. 37). In order for the patient to be truly encouraged to choose from the various options available and to act upon them, the nurse must act to support and nurture the patient by providing sufficient information and assistance.

Griffith-Kenney (1986) asserted that nurses demonstrate caring through the ways in which they communicate with patients, such as "accepting and respecting them, showing positive regard, and expressing warmth and empathy" (p. 37). Effective communication includes "openness, honesty, trust, and genuineness along with congruence of verbal and nonverbal behaviors" (p. 38). When the patient feels understood and accepted, she is more likely to communicate openly and share her true feelings with the nurse and to allow the nurse to assist her with more complex problems (pp. 37-38).

Problem solving and decision making are closely related. The process of problem solving entails gathering information; identifying goals; examining alternatives; weighing the benefits, risks, resources, consequences, and outcome; choosing between alternatives to make the best choice; and testing its effectiveness in achieving the goal. To make effective decisions regarding health concerns requires accurate and complete information from the health care professionals who control this information.

Teaching and learning comprise a common nursing activity and an integral part of the profession. Learning indicates that a change in attitudes or behaviors has occurred as a result of the teaching process. In order to promote learning, nurses must provide an environment that facilitates and supports learning, and they must use methods appropriate to the learner and to the situation. According to Griffith-Kenney (1986), "Teaching and learning are continual and reciprocal processes that occur during

the nurse-patient interaction. [They should be] flexible, stimulating and continuously expanding" (p. 39).

Staff Role Conception

Taunton and Otteman (1986) studied staff nurse role conception in eight Midwestern hospitals. In the area of authority relationship, findings suggested that some nurses constantly "bent the rules" for patients while others rigidly enforced policies to the point that patients and family were unnecessarily inconvenienced. Results indicated that, while certain nurses were willing to call the patient's physician or ask nursing management about situations of concern, others tended to manage the situation first and then reported results of the situation through routine channels of communication; still others delayed calling doctors or supervisors until a situation became chaotic.

Quality of Supportive Behaviors

McNiven et al. (1992) proposed that the role of labor delivery nurses was affected by technological advances of the past 40 years in that technical tasks such as monitoring the physical status of the mother and her fetus have become more important than the supportive functions that enhance the mother's ability to cope. They studied the quantity of supportive activities currently used by 18 labor delivery nurses caring for women in labor. The study obtained observational data to determine the percentage of time that intrapartum nurses spent in four dimensions: emotional support, instructional-informational support, physical comfort support, and advocacy support. The results indicated that the greatest number of supportive activities were in the subcategory of instruction-information. The subcategories of physical comfort and advocacy were virtually absent. The largest proportion of the nurses' time was spent in nonsupportive direct and indirect activities, including many technological tasks. The

findings, however, also indicated that the lack of supportive care could not be entirely explained by the increased amount of technology; even when they were not busy and had quiet periods, the nurses still failed to vary the types and amounts of support that they provided during the periods of observation. The authors suggested that supportive care seemed to be devalued as an aspect of the nurses' work and that "technological tasks minimized the nurse's role as empathetic [sic] supporter" (p. 7).

Nursing Supportive Behaviors

Bryanton, Fraser-Davey, and Sullivan (1994) conducted a retrospective study using qualitative and quantitative approaches to determine which nursing support behaviors new mothers rated as most helpful in assisting them to cope with labor--emotional, tangible, or informational. They suggested that the positive effects of social support given by PNs during labor have been consistent in the literature and that social support appeared to be an influencing factor in women's satisfaction with and coping abilities during labor. The findings indicated that all three categories of nursing support behaviors were perceived as helpful but that the behaviors in the emotional support category were perceived as the most helpful. In addition, the findings supported the significance of individualized care in that "making the woman feel cared about as an individual" was the highest-rated behavior. Bryanton et al. concluded that these findings validated the importance of assessing the needs, desires, and expectations of each woman by the intrapartum nurse in order to formulate individualized plans. Moreover, these findings indicated that competence and physical care were not enough because the perception of the laboring women appeared to be that the nurse's interpersonal skills were more important than the nurse's technical skills.

In their study Evans and Jeffrey (1995) proposed to determine whether expected maternal learning needs were met during labor and delivery. Findings indicated that,

while some teaching in labor was helpful, conflicts in either the information given by nurses or the different expectations of staff were frustrating to the mothers. As a result, some teachings were congruent and some were incongruent with the mothers' expectations. Evans and Jeffrey recommended (a) adequate nurse/patient staffing ratio, (b) consistency in caregivers to provide continuity of care, and (c) sufficient time with mothers for nurses to observe, teach, and support them in labor adequately. This acknowledgment of the value of nurses as teachers was viewed as facilitating their work of delivering effective patient-centered care.

Mackey (1990) explored women's views of the childbirth experience by focusing on the preparation for the childbirth experience. She discovered that, in their descriptions of past and expected experiences in childbirth, women focused on the quality of their own performance and "doing a good job" in managing their own labor and delivery. As a result, she warned that women may be set up for failure by nurses who encourage them to set unrealistic expectations for how they should behave during labor and delivery. Furthermore, she suggested that childbearing women need PNs to be sensitive to their needs and to assist them in meeting their own goals and not the nurse's goals for managing labor and delivery.

In her discussion of nursing support of laboring women, Hodnett (1996) identified the goals of labor support as assisting the woman to achieve her goals during labor by being present, attending to her emotional needs, and actively helping. She argued that the importance of support during labor could not be overemphasized and that the quality of support determined how the experience was remembered "as depersonalizing and degrading or as one that increased self-esteem and self confidence" (p. 257). She described the types of support given as emotional support, comfort measures, information and advice, advocacy, and support of her partner (p. 257). According to Hodnett, supporting her partner including role modeling, encouraging,

and offering times of respite. She proposed that, because of the differences between professional relationships and social relationships, the support that the nurse provides is "complementary to but distinct from" the support that the partner provides (p. 257). In a social relationship both participants are expected to care about each other's needs. As a result, when the laboring woman worries about how her partner is dealing with the stresses of the experience, it is the nurse's role to alleviate those concerns and to support both partners during the childbirth experience. Hodnett suggested that, following delivery, the nurse should meet with the mother and her partner in order to facilitate the integration of their experiences and to put closure on a relationship that was, however brief, also intense and intimate. This also allows time for the nurse to provide comments of praise and accomplishment regarding how well the mother coped with a new, difficult experience.

Hodnett (1996) identified two major barriers to providing labor support: (a) the lack of time due to inadequate staffing patterns in birthing units and (b) the lack of educational preparation of nurses, which tends to focus on the technical aspects of birth rather than on the supportive functions during the childbirth experience.

According to Nichols (1993), the adjustment of mothers and fathers to new parenthood is influenced by their experiences of pregnancy and childbirth. She suggested that the nurse's position of caring for the mother during labor allowed him/her to influence the childbirth experiences of both parents. Nichols studied paternal perspectives of the childbirth experience in a convenience sample of 44 first-time expectant fathers, with 55% having attended childbirth preparation and 45% not having childbirth preparation. The study examined positive and negative responses to labor and delivery and identified four categories depicting what the fathers did to support their wives during the childbirth experience: comfort/physical measures, psychological support, presence, and communication. Findings indicated that the prepared fathers

(45%) experienced more negative responses to labor than did the unprepared fathers (35%) and that, for both groups, the delivery was more positive than labor. Findings indicated that physical comfort measures were described most frequently (40%), followed by psychological support (33%), presence (20%), and communication (8%). Prepared fathers focused more on the physical comfort measures (75%) than did unprepared fathers (25%), and unprepared fathers focused more on presence (54%) than did prepared fathers (46%). Nichols suggested that the prepared fathers' negative response to labor experience challenges the current view that childbirth preparation leads to more positive labor experiences. She suggested that prenatal classes may not have adequately prepared expectant fathers for the realities of labor or that their needs and expectation may not have been addressed adequately. She concluded that support for both the mother and father is essential during labor and must take into account both the needs and expectations of the mother and the father, and that the laboring couple should not be left alone for any prolonged period. Positive birth experiences were viewed as contributing to "a satisfactory adjustment to parenthood and initiation of healthy family relationships" (p. 107).

On the other hand, Sandelowski (1984) suggested that the expectations for childbirth have been elevated to unrealistic levels. She argued that women expect either "neurological perfection" of infants, based on the promises of the technological advances in surveillance and intervention or they expect "psychological perfection" of the birth experience through natural means. As the fulfillment of desires for childbirth has become a "virtual right," safety during childbirth is now defined in terms of satisfaction with childbirth experience. She suggested that, when expectations are raised but are incongruent with the experiences, such as in Cesarean sections, they may result in negative outcomes. Two examples of nursing's effort to make experiences conform with expectations, according to Sandelowski, were FCMC and home-like environment

for birth. She concluded, however, that, depending on the success of the caregiver's efforts, women may experience satisfaction or dissatisfaction; she raised the question of just how much human manipulation and control is possible with an unpredictable experience such as childbirth.

According to Stainton (1994), whereas from the medical perspective, during a high-risk pregnancy, the family is considered peripheral and the focus of interventions is on the pathological problems of the mother and the fetus, the nursing perspective views the family as the unit of care, including not only the mother and the unborn infant but also the father, siblings, and grandparents. She suggested that, from the nursing perspective, the goal is to develop a "partnership in caring" in which the caring responses are appropriately matched to the family's needs. She argued that, in order to form a "partnership in caring" that is congruent with the many situations that arise during the pregnancy, the PN must be aware of the family's perspectives and the mother's perceptions of the situation. Caring responses identified by Stainton included cheerleading, advocacy, coaching, and empowering. These caring responses made coping possible for those experiencing the stresses associated with high-risk pregnancies by meeting the specific needs of families. Thus, an important aspect of high-risk nursing care is the acknowledgment of the family as the unit of care that needs support in adjusting to changes that result from the high-risk pregnancy.

Managed Care

The ongoing development of FCMC continues to be affected by the mechanization of birth and the consumer movement. In addition, another new factor--the increased prevalence of managed care plans--is now shaping the conduct of the birth experience by adding cost restrictions to the already tight market. Because cost restrictions placed on service providers by insurance companies actually cut services

through reduced hospital stays, they interfere with consumer demands for service providers to be more sensitive to the changing desires of families. In many cases, the choices and options purported to be available for parents do not really exist (Zwelling, 1996).

In order to deliver cost savings to the purchasers of health care, managed care insurers search for the most cost-effective products. As a result, patient choice may be limited as patients are directed to the least costly provider. This trend is readily apparent in perinatal services when patient volume shifts occur based on the outcome of yearly contract negotiations. In addition, tremendous changes have occurred in many large maternity centers as a result of state efforts to convert Medicaid reimbursement to a system of managed care. As patients are directed to less costly, nonacademic facilities, many of the large maternity centers now face serious reductions in patient volume (Arnold & Kirby, 1996).

Further reductions in lengths of stay and the trend toward substituting lesser-trained and lower-paid unlicensed workers for PNs have increased the need for coordinated community-based programs for perinatal patients and their families. With fewer PNs at the bedside and with the shorter length of stay, PNs are frequently unable to achieve the desired patient outcomes during inpatient hospital stay, which results in patients being discharged with ongoing health care needs (Arnold & Kirby, 1996; Harrigan, 1995).

The role of the PNs has changed significantly as a result of the restructuring of the health care delivery system. In response to fiscal constraints, increased use of technology, worker retraining, and role expansion, the work environment has also been affected by the decreased number of PNs in the work force. For example, a decrease of 20-30% in positions for PNs is expected in institutions. As a result of the need for flexibility in staffing to accommodate the wide swings in census on the perinatal units,

PNs are and will continue to be required to expand their skills and expertise. Perinatal nurses have been cross-training for several years. As the trend continues, PNs with only one set of skills will no longer be employable, as employment criteria will require that PNs be experts in multiple areas of perinatal nursing. Furthermore, increased emphasis on total quality management approaches, the use of external consultants, and cost-containment measures not only have literally erased nurse middle managers but also have significantly reduced the number of clinical nurse specialists (Arnold & Kirby, 1996; Harrigan, 1995).

Many challenges for PNs are created as a result of the current and future health care trends. Within the public and private sectors the incentives for risk reduction are high. As a result, in many communities the economic survival of services for the high-risk family are deemed to be in jeopardy. Health care reform has evolved to the point where the most expert perinatal and neonatal nurses are being eliminated as the number of clinical nurse specialists is reduced (Harrigan, 1995).

Although basic perinatal care is all that is needed for most women, patients at risk require medial and social interventions beyond basic perinatal care. Unfortunately, current managed care models are attempting to reduce costs by decreasing the intensity of services within perinatal care facilities without implementing the community-based portion of models that is essential to reduce risk and minimize mortality and morbidity (Harrigan, 1995).

According to Harrigan (1995), the work of the PN takes on new meaning when productivity is no longer measured by one's "just being busy" but by one's ability to satisfy the patient by efficiently and effectively achieving the desired outcomes (p. 55).

CHAPTER 3

METHODOLOGY

Qualitative research methods and modes of analysis provide the opportunity to gain an in-depth knowledge of human realities and meanings. Because the primary focus of inquiry is on identifying the qualitative aspects or characteristics of the phenomenon itself, qualitative methods allow exploration of experiences, the essence of which is lost in other research methods (Bogdan & Taylor, 1984). The aim of the phenomenological approach is to describe experience as it is lived (Boyd, 1993).

Phenomenology, an inductive method of research, was considered best suited to this study because description of the phenomenon as perceived and experienced by nurses themselves is central to the research. As yet, the essential characteristics or essences of how nurses perceive their work as perinatal nurses (PNs) after having made the transition from traditional maternity nursing has not been studied. The key questions that were posed to PNs were related to (a) the essential characteristics of perinatal nursing and (b) the meaning of transition. Answering these questions may lead to a better understanding of how to support nurses to create conditions conducive to successful transitions.

Research Method

The qualitative research method of phenomenology was used in this study. In phenomenology the researcher investigates specific phenomena by examining the experience described by the participants (Boyd, 1993).

The phenomenological description serves as a reliable guide to the listener's own actual or potential experience of the phenomena. Its essential function is to provide clear and unambiguous guideposts to the phenomena (Boyd, 1993; Spiegelberg, 1982).

Eidetic reduction or analysis aims at seeing through the particulars to discover that which is essential, enabling the researcher to perceive from another vantage point: to seize the experience, and to live it through personally as a part of phenomenological analysis (Boyd, 1993). The researcher searches for relationships or identifying interrelationships, not only looking for essential relationships within an essence but identifying relationships among several essences (Boyd, 1993; Spiegelberg, 1982).

An essential aspect of the phenomenological method is that of clarification of assumptions or presuppositions and the bracketing (holding in abeyance) of those assumptions. This procedure requires the researcher to identify and set clearly in writing, before data collection, all assumptions and preconceptions about the phenomena under study. Only by bracketing out what the researcher has already come to suspect or assume can the phenomena be seen as they are (Boyd, 1993; Cohen & Omery, 1994; Spiegelberg, 1982).

Ethics

All procedures in this study were carried out in accordance with guidelines established by the Committee on the Protection of Human Subjects at the University of San Diego and the participating institutions. The subjects of protection of privacy rights, voluntary and informed participation, and potential risks to participants were discussed first with representatives of the cooperating hospitals and then with the potential participants.

After the study was approved by the University of San Diego's Committee on the Protection of Human Subjects (Appendix A), formal negotiations for permission to

conduct research at the hospitals was conducted through the appropriate administrative offices and the Institutional Review Board (IRB) of one hospital. Prior to requesting access, the researcher prepared a summary of the research methodology and a preliminary interview schedule for review by the hospitals' committees.

Privacy of all participants was ensured by coding all data sources so that personal identification was impossible. To insure confidentiality, all information related to the participants was stored in a locked office file. Findings from the study are reported here and will be reported in the future in such a way as to ensure confidentiality and to protect the privacy of all participants and the institutions at which they worked.

The participants received a cover letter and informed consent form. The cover letter provided an introduction to the study's purpose, an overview of the methodology used, and a summary of the personal background of the researcher. It also included required human subjects information such as anonymity and confidentiality. The participants were told that the interviews were expected to last 1 hour and that more than one meeting might be needed. Reassurance was given that participants could withdraw from the study at any time without penalty. Participants were informed in the letter that all interviews would be audiotaped and that the tapes would be transcribed by a paid transcriptionist; only the researcher and the transcriptionist had access to the tapes. All names, telephones numbers of participants, and the audiotapes were destroyed at the end of the research study.

Setting

The participants in this study were selected from the staff of three moderately-sized private hospitals and one regional medical center located in the southwestern United States. The hospitals had implemented family-centered perinatal nursing by

cross-training nurses to work in these multiple specialty areas, which included labor, delivery, recovery (postpartum) [LDR(P)] and combined mother-baby nursing.

Participants

The participants in this study were registered nurses from the four hospital settings who were employed on a family-centered perinatal unit. The sample size for this study was limited to 13 nurses due to the length of the interview process and the detail of the complete descriptions inherent in the phenomenological approach (Omery, 1983).

Potential participants were screened by (a) Colaizzi's (1978) criteria of having lived the experience of making the transition from traditional maternity nursing to perinatal nursing and being willing to discuss the experience as they lived it in their daily lives, (b) the criterion of having worked 3 years or longer in traditional maternity care (TMC) as a labor and delivery nurse, a postpartum nurse, or a newborn nursery nurse before receiving orientation (cross-training) to work as a PN on a family-centered perinatal unit in LDR(P) and/or combined mother-baby nursing.

Volunteer participants were solicited in the following manner. The researcher made verbal contact with the nurse managers/clinical nurse specialists of the perinatal units at the four hospitals cooperating in this study. The nurses' managers were told that the researcher was interested in studying the staff nurses' perspectives of their role as PNs, and the criteria for participation were presented. Individual meetings were held at each hospital to establish support for the study, to clarify the researcher's position, and to establish boundaries for the researcher's role in relation to various aspects of confidentiality. A letter of explanation was sent to each hospital requesting that the nurse managers/clinical nurse specialists distribute it at their next staff meeting (Appendix B). An introductory letter from the researcher to staff nurses explained the

purpose of the study and the criteria for participation (Appendix C). At three of the hospital sites, arrangements were then made for the researcher to meet with groups of staff nurses at staff meetings or informally on the nursing units to explain the research study further and to answer any questions. Interested nurses were asked to sign their names and write their telephone numbers on a Volunteer Research Interest form (Appendix D) circulated among the staff nurses. At the fourth hospital, the volunteer list was completed and mailed to the researcher. The name and telephone number of the nurse researcher was provided on the introductory letter in order that any staff nurses who did not volunteer at the meeting or who did not attend the staff meeting could initiate contact voluntarily. A consent form (Appendix E) was attached to the introductory letter so that the participant could become familiar with the form before the actual interview was conducted.

Participants were selected from these self-referrals. The first 13 self-referring nurses who met the selection criteria were selected for participation in the study.

To maintain agreement with the phenomenological approach used for the study, demographic data were obtained in two ways. Before the interview actually began, demographic information was collected and recorded on a Demographic Data Sheet (Appendix F). The participants were asked to respond to a series of questions regarding educational preparation and future goals, number of years in nursing, number of years in traditional maternity care and area(s) of speciality, and number of years in perinatal nursing and area(s) of specialty. Occasionally, these questions were also interspersed throughout the interview, specifically when the participants diverted from the topic of the demographic information and began to describe situations that related more to the research question. The researcher then began the interview process and asked the demographic information later on, such as when the interview seemed to be stalled. The demographic information that was interspersed within the interview was recorded

on the audiotape and later transcribed as part of the interview. At the completion of the study the researcher extrapolated the demographic information from the transcribed interview notes and the Demographic Data Sheet. Table 1 summarizes the demographic characteristics and provides a composite picture of the staff nurses who participated in this study.

Table 1

Demographic Characteristics of Perinatal Nurse Participants (N = 13)

Characteristic and Category	n
Gender	
Male	0
Female	13
Age (Years)	
30-35	3
36-45	5
46-55	5
Basic Nursing Preparation	
AA or ADN Degree	6
BSN Degree	5
Diploma	2
Years of Practice as RN in Traditional Maternity Care	
3-5	3
6-10	2
11-15	5
16-20	0
20-25	2
Previous Primary Area of Specialty	
Labor and Delivery	5
Postpartum	4
Newborn Nursing	4
Current Area of Specialty	
Labor, Delivery, Recovery	3
Mother-baby	6
Labor, Delivery, Recovery / Mother-baby	4

Data Collection

The technique of intensive interviewing was used to collect data for qualitative analysis. The interviews were tape recorded and transcribed verbatim. Observations made during the interview, such as nonverbal body language or other contextual information that might add meaning to the verbal discussion, was dictated on the tape by the researcher following the interview and was included in the transcription of the tape.

The interviews were conducted in private in order to facilitate more open communication of information with a minimum of interruptions. The researcher contacted staff nurses who had expressed an interest in participating in the study and reiterated the purpose of the study. Appointments for the interviews were scheduled at a time and place mutually convenient to the researcher and each participant. A variety of settings mutually agreeable to the researcher and the participant was utilized for the interviews: the participant's home, a private room at the hospital, and (on one occasion) the researcher's home. The majority of the participants appeared to be most comfortable in their own homes and away from the hospital setting. The two nurses who felt that there would be too many interruptions at home chose the other two settings.

Lipson (1989) noted advantages in using a peer group to include "easy of entry, avoidance of disruption of normal group processes, prior knowledge of some relevant questions, and enhanced capacity to elicit in-depth data" (p. 349). The researcher was able to make use of prior knowledge in data collection. Nevertheless, unique problems are associated with conducting qualitative research and studying a peer group, including the issues of role conflict and subjectivity. Thus, the researcher had to keep focus on the need for continued clarification of the researcher's role to ensure continuing access

to places and persons, even though specific relationships developed as information was exchanged throughout the study.

Interview Process

At the beginning of each interview, the researcher reviewed the information letter and consent form, which was then signed by both the participant and the researcher. A copy was given to the participant. After answering any questions posed by the interviewee, the researcher discussed the data collection procedure with the participant. The researcher explained that the interview would be tape recorded and that only the researcher and the paid transcriptionist would actually listen to the taped interview. The interviewee was assured that confidentiality would be maintained and that any identifiable reference to person or place that appeared in the first reading of the taped interview would be removed and replaced, if necessary to maintain the flow of the interview, by a fictional name, title, or reference to place.

The researcher described the type of interview to be conducted and how the interview would proceed. The researcher then explained that all interviews would begin at the same point, with an open-ended question in which the participant was asked to describe freely her view of what it means to be a PN. The researcher asked questions or used clarifying words to elicit the essential characteristics of perinatal nursing and how the PN viewed her experiences during the transition from TMC to perinatal nursing working in LDR(P) and/or combined mother-baby units. Participants were asked once more whether they had further questions. After answering these questions, the researcher placed the tape recorder near the participant and told the participant that the interview could be ended by turning off the recorder at any time. The tape recorder was then turned on, and the interview began with the following open-ended theme question:

> I am interested in understanding what it means to be a perinatal nurse from the perspective of the staff nurse who has changed to that role after working 3 or more years in one specialty area, such as labor and delivery, postpartum, or newborn nursery. You have been asked to participate in this study because of your experience in becoming a perinatal nurse and working in the LDR or LDRP and/or combined mother-baby unit. So, the question is: What is it like for you to be a perinatal nurse? Give me as much information as you can, how you feel about it, what you think about it. Please don't stop until you believe you have described all of your thoughts, all of your feelings and perceptions as completely as possible.

During the interview, the researcher maintained an open and attentive attitude. Each participant was allowed to express her thoughts and feelings and was not interrupted except for purpose of clarification or to encourage further description. Any additional questions followed the initial general question and were given in response to the participant's descriptive answers. Examples of such follow-up questions are:

1. What motivates you to continue as a PN?

2. Is there anything that has helped you in your ability to carry out your role in [the participant's specialty area(s) in perinatal nursing]?

3. Is there anything that has hindered you in your ability to carry out your role in [the participant's specialty area(s) in perinatal nursing]?

4. What does it take to be a traditional L & D nurse, a postpartum nurse, and a nursery nurse?

5. What does it take to be a PN working on LDR(P) and/or combined mother-baby nursing units?

6. What has changed about your role and what you do now, compared to what you were doing in traditional maternity care? How is it different from your role before you began to work on LDR(P) and/or combined mother-baby nursing units? Specify the specialty areas in perinatal nursing.

7. Is there anything that we have not discussed that you would like to tell me about your experience as a PN?

While the interviews were anticipated to last 1 hour, the researcher arranged to meet with each participant until the researcher and the participant felt that the total experience had been described. Fourteen interviews were conducted with 13 PNs, each lasting from 1 to 2 hours. All 14 interviews were used in the data analysis. The first interview was reviewed and the technique was discussed with an experienced nurse phenomenologist. Based on this discussion, a second interview was conducted with the first participant to focus on the research question in more depth and to clarify the meaning of several descriptions. Two additional follow-up questions (4 and 5) were developed to gain more in-depth description of the meaning of the experience of perinatal nursing.

Participants were told that the researcher and/or participant might feel that a second interview was necessary. For example, the researcher might wish to clarify a point from the first interview or the participant might have reflected on the information discussed in the first interview and wish to provide additional insight into the experience not recognized during the first interview (May, 1991); however, only one participant was scheduled for a second interview. None of the participants contacted the researcher for a second interview.

After the interview and before the tape recording was given to the transcriptionist, the researcher assigned a code number to the participant. Once the participant's name was assigned that code number, the sheet with the name and other information was placed in a locked file that was accessible only to the researcher.

Within 48 hours after the interview was completed, the tape recording was delivered to the transcriptionist. The interview was transcribed from the tape to a computer diskette; the diskette and one printed copy of the interview transcription were returned to the researcher within 5 days. The researcher then checked the printed copy of the transcription against the taped interview for accuracy. Notes of any pertinent

thoughts concerning the interview were made at that time and included in the interview write-up. The taped interview and printed copy of the transcription were stored in a locked file cabinet. Analysis did not begin until all interviews had been conducted, transcribed, and checked in this manner.

Data Analysis Technique

Phenomenological analysis is a reflective process that involves a sensitive attunement to opening up to the meaning of experience, both as discourse and as text. Thus, following the intensive interviews conducted for this study, the audiotape recordings were transcribed verbatim. The original data were the participants' descriptions of the meaning of their experience in the transition to perinatal nursing. The data were studied following the six-step method of data analysis described by Giorgi (1985).

1. The researcher read the complete description of the participant's experience to gain a sense of the whole.

2. The researcher reread the description more slowly to discriminate "meaning units" of the experience being explored because the whole meaning of the experience is comprised of these units together (Giorgi, 1985). The researcher examined the experience "as meant" by the participants themselves (Ray, 1994). The researcher highlighted descriptive words, traced etymological sources, and identified idiomatic phrases.

3. The researcher eliminated redundant units. The meanings of the remaining units were clarified or elaborated by linking them to each other and to the whole.

4. Each participant's experience was analyzed in isolation from the experiences of the other participants. The researcher completely analyzed the descriptions provided

in each interview before beginning data analysis of subsequent interviews. Significant statements were clustered into themes for each description.

5. When all individual data analysis was completed, the whole was reviewed again. The researcher reflected on the given meaning units, still in the concrete language of the subject, and transformed that concrete language into the language or concepts of science (Giorgi, 1985; Omery, 1983).

6. Patterns of significant statements/meaning units that were common to all descriptions were clustered and reanalyzed for the whole. The transformed meaning units were integrated and synthesized into a descriptive statement of meanings of the participants' experiences (Giorgi, 1985; Omery, 1983).

Further refinement was accomplished by writing or rewriting, which provided the researcher with new insights and moved the descriptions from the particular to a more general reality.

For this study, the descriptive structure of the meaning of the PNs' experiences from their perspectives was deemed to described the essential characteristics of the role of the PN. Further, the results of the study became a comprehensive description of the meaning of perinatal nursing from the perspective of the staff nurse who had made the transition from working in TMC to working in FCMC as perinatal nurses on the LDR(P) and/or combined mother-baby units.

An essential aspect in conducting qualitative research is establishing appropriate criteria for evaluation. The assumptions on which the criteria of validity and reliability were established for quantitative research are inappropriate for the evaluation of qualitative studies (Burns, 1989), and the terms do not fit well when discussing rigor in qualitative research (Lincoln & Guba, 1985). Because the aim of phenomenology is to describe experiences and perceptions rather than to explain them, it relies on its own

rules concerning aims, evidence, inference, and verification (Boyd, 1993; Sandelowski, 1986).

Several methods were utilized to assure methodological rigor in this phenomenological research study. First, before the study began, assumptions and presuppositions were clearly presented to assure that the researcher's biases concerning the questions under study were clearly stated and bracketed before she conducted any interviews. This ensured that the data would accurately reflect the experiences of the participants and not those of the researcher. To prevent the possibility of researcher bias from a previous interview while interviewing another participant, each interview was stored after the researcher read the first transcription of that interview.

The researcher made the assumption that the participants acted as "self-observers and that the data obtained [were] credible because the participants had the experience and were able to adequately communicate their experiences (Colaizzi, 1978, p. 50). During the interview process the participant was observed for nonverbal indications of integrity and credibility of statements was assessed. Because attempting to understand the meaning of the participants' experiences from their perspective is basic to the phenomenological approach, the researcher also requested clarification when deemed appropriate. At the conclusion of each interview, the researcher verified key words and phrases used by the participant to confirm that the meanings were accurately understood.

Methodological rigor was further assured by participation of a qualified expert who assisted through the process of "peer debriefing," described as discussion with and review by a qualified and disinterested person who can validate or refute the interpretations made by the researcher, thus providing an added check on the validity of the study (Lincoln & Guba, 1985).

Peer Debriefing

In order to further ensure methodological rigor, the researcher requested the participation of a peer reviewer. Following completion of the first interview, the researcher discussed the process with the peer reviewer, who recommended additional question to elicit a deeper understanding of the participants' experience. The peer judge who participated in the debriefing holds a doctoral degree and is familiar with qualitative methods of research. The person was neutral in terms of the population and topic under study.

Peer debriefing consisted of two steps. First, the peer judge read two complete interviews and reviewed the researcher's files pertaining to those interviews. The judge's comments were then considered by the researcher, who reviewed the data again in light of the comments. Second, the peer judge read Chapter 5, the report of the findings, to evaluate whether the reported findings reflected the data extracted from the two sample interviews that she had studied. Any discrepancies between the interpretations by the peer judge and the researcher were resolved by consensus.

Conclusion

The researcher's intent was to provide detailed information about the two research questions and a rich description of the findings and the reasoning process though which the data analysis occurred. Evidence is provided regarding the extent to which examples are representative of the phenomena described. The reporting of the information collected in the interviews is intended to be sufficient detail to allow the reader, using the original data and the decision trail, to arrive at conclusions similar to those reached by the researcher (Burns, 1989).

CHAPTER 4

HISTORY AND CONTEXT

This chapter provides extensive description of the history and background setting that constituted the context of the study. History and context depicted the characteristics of the environment in which the transition from traditional maternity care (TMC) to family-centered perinatal nursing was taking place. Relative importance of the history and context emerged because this research required participants to review retrospectively their experiences of transitioning to a family-centered model of perinatal nursing. The participants' perception of FCMC was partially defined by their perception of TMC and the history of the transition. All three aspects provided a backdrop against which the participants viewed their experiences. For example, many participants could not articulate their present experience except in contrast to their prior experience. In order to understand and describe the meaning of the experience they used prior experience and insights for contrast. Therefore, although consideration of the history and context was not the purpose of this inquiry, it emerged as a significant contributing factor to the experience of the participants.

History and Context

Participants' Perception of Traditional Maternity Care

The participants' perception of TMC detailed aspects of the perinatal nurses' (PNs') perception of the traditional practices that were part of TMC. The PNs described their former traditional roles such as the set routines and tasks performed and their interactions with patients. Two aspects--perception of the role and the nurse-

patient relationship-- were viewed as a significant part of the traditional maternity nurse's role.

Perception of the Role

The participants' perception of the role depicted features of the traditional maternity role and their former responsibilities working as nurses in traditional labor and delivery, postpartum, and/or normal newborn nursery. The PNs described features of the traditional maternity role that involved their former job descriptions, expertise, and control.

Job description. The participants discussed job descriptions and mentioned the set routines of the traditional roles as follows:

> It was more of a . . . routine, just the labor and delivery, deliver them and push them out the door situation.

> It seemed so programmed that other way. The babies came out at 9, 1, 5, and 9. The mothers went to sleep. . . . Mothers were staying 3 days.

They also described separation of duties among the traditional labor and delivery, postpartum, and newborn nursery nurses that involved caring for the mother and infant separately during the childbirthing period:

> Babies were delivered, dried off, stabilized and taken directly to the nursery.

> Our teaching role was completely different. . . . We taught the mom. We taught her basically how to take care of herself more and nursery taught her how to take care of the baby more during that time.

Separation of duties also depicted the primary focus of the newborn nursery nurses as protecting babies. According to one participant:

> Before we had it a little bit stricter, . . . visiting hours. Plus . . . when the visitors were there, the babies were not allowed in the room. Where now it's kind of a free-for-all.

Other participants mentioned working more as a team in their traditional roles:

> We used to be really more at the bedside, really helping them, and even though we were doing mother or baby, we still worked as a team.
>
> Before, I think we had a real team. If I was busy and if your patient called. I would run and take care of your patient.

Expertise. Participants also described their traditional role as being an expert, which involved knowing what to do in their specialty area and included special training and practical experience to maintain and further develop their knowledge and technical skills.

> I worked hard to be the best I could. I took classes. I read. I researched. I did everything I could do to try to take care of those babies the best I could.
>
> I've got extensive training in labor and delivery. I had probably 12 weeks of training and then I had an orientation period anywhere from 6 months to a year. . . . We all have things that we are better at doing. Mine happens to be in labor and delivery.

Control. Control described the participants' perception of the traditional role related to manipulating the situation in order to maintain efficiency and order. They perceived the traditional nurse as being in control. Participants discussed being in one area and having everything easily available. This provided the traditional nurse with a sense of control over the whole situation.

> As nursery nurses you were in one area, you were confined. Everything you needed to care for your patient was there. You didn't have to go anyplace. You didn't have to walk down any hallways. You could see your patients, all of the patients at the same time, and you met their needs; they didn't put the call light on. You did it instead on their account . . . nobody can make you leave because you can't leave. You say, I'm in the nursery.

Participants also mentioned making it easy for the doctors as part of their traditional role of rigidly following the hospital routines primarily for the doctor's convenience.

> The doctors had it a lot easier because they came in and all the babies, in fact, the rule said you could not take the babies out until 9 am, so that they could do their assessments and didn't have to go searching.

Thus, participants had definite views involving their role as traditional maternity nurses. They emphasized the set routines established under TMC and the control that it gave them. Even having authority over visiting hours and location of the birthing process gave them a sense of control. Likewise, participants discussed the perceived advantages to separation of duties, stressing that they were experts in their area, whether it was labor, delivery, postpartum, or nursing, and that they were able to give complete care to their patients.

Nurse-Patient Relationship

Participants discussed the nurse-patient relationship that occurred in TMC between the mother and the various maternity nurses who were assigned to work separately with her in labor and delivery and in postpartum and to care separately for her infant in the newborn nursery. The participants discussed the types of interactions that took place between the traditional nurse and the patient. The traditional relationship between the nurse and the patient involved three aspects: supporting the patient, relating to either adult or infant, and confronting the issue of control.

Supporting the patient. Participants described supporting the patient in the traditional nurse-patient relationship in the following manner.

> I started out nursing in labor and delivery when the nurse was the only one in the room with the patient so, . . . the nurse was the main support person for that woman.

This included providing emotional support, which included identifying their support system and available resources.

> There is a lot of emotional stuff that goes on as well as the physical for the new mother. I think you have to realize that and know they are all coming from different situations and see if you can find out what kind of resources they have. Who is there to help them.

Relating to adult or child. Participants described the traditional maternity nurse relating to either adult or infant, depending on the nurse's specialty. Some participants described the traditional nursery nurse as not having experience working with adults and preferring not to relate with them.

> I was a nursery nurse, just give me my babies. I didn't want to have to deal with adults. I hadn't done adults. I had done pediatrics. I had done nursery.

On the other hand, other participants described the traditional postpartum nurse as preferring not to relate with infants due to being uncomfortable with them.

> I hadn't really worked newborn nursery that much either, so I wasn't that comfortable with babies.

They also mentioned relating with the mothers to provide physical care.

> There is a lot beyond just the physical care of the postpartum person. All of this is something that I enjoy. I enjoy listening to them and talking with them and trying to understand what their needs might be.

Support also entailed helping mothers to become comfortable in their new roles.

> I don't think you can really be a good postpartum nurse unless you are really truly interested in helping new mothers become comfortable in their role and caring for them physically at the same time.

So the participants discussed that the patient-nurse relationships was almost exclusively mother-nurse or child-nurse; indeed, several participants expressed reluctance to deal with both, being content to focus either on the mother or on the child. The maternal care nurses emphasized that they cared for the mother both physically and emotionally, while the nursery nurses were able to concentrate on the safety of the infant. To summarize, the nurses' perception of TMC focused primarily on their understanding of their traditional roles and on their relationship with the patient.

Confronting the issue of control. Moreover, the participants described the issue of control as a factor in the traditional relationship with the patient. They also described

the power differences between the traditional nurse, who was viewed as being in control, and the patient, who often had no control of the situation. They further indicated that the issue of control was a factor influencing the transition to family-centered perinatal nursing.

The participants described the traditional nurse as being in control of the whole situation.

> I used to think it was always the nurse [who] was in control of the whole situation and gave directions and you do this and you do that.

They depicted patients as not having control.

> I can remember back when they had Scopolamine and Demerol and I'm not talking small doses, I'm talking big doses and they went totally wild. They really had no control over their own bodies or their actions.

Furthermore, they indicated that PNs missed their traditional role of being in control.

> I think that there are a lot of nurses in labor and delivery who miss that traditional [nursing] where the nurse is the director of everything.

> I see a lot of nurses my age who worked in labor and delivery who were used to the old traditional way. They don't like relinquishing that control.

Participants' Perception of Family-Centered Perinatal Nursing

Another feature of history and context depicted the participants' perception of the characteristics of the new practice model that was being implemented to replace the TMC model formerly practiced. Participants frequently compared and contrasted their new roles with their former roles. In addition, they compared and contrasted variations between roles such as the differences in the levels of responsibility and technical knowledge and skill for LDR(P) nurses and those of the mother-baby nurses. As in the PNs' perception of TMC, the two aspects of perception of the role and the nurse-patient relationship were viewed as a significant part of the new family-centered perinatal nurse role.

Perception of the Role

The participants described the expanded role responsibilities of the PNs. This included the specialized knowledge and skill to work in more than one area of perinatal nursing. Most participants also reported working in either a new or newly remodeled clinical setting, such as SRMC and mother-baby nursing. This new setting accommodated the clinical practice changes that were brought about by the transition from TMC to family-centered perinatal nursing. The PNs who traditionally practiced as labor and delivery nurses began to practice as LDR(P) nurses, which in one setting also included doing routine newborn admissions. The LDR(P) nurses in one setting also described how they were regularly scheduled and "floated" to cover the mother-baby unit. Former postpartum and newborn nursery nurses began to practice as mother-baby nurses. Depending on the setting and training, this included rotating to work as admitting or holding nurses in the newborn nursery or "floating" to assist as back-up in LDR. The participants discussed three aspects of their perception of the role: job description, having marketable skills, and dealing with the unexpected.

Job description. The participants discussed the job description, which included the PN's new position within the setting and further detailed the PN's role and responsibilities in relationship to the needs of the mother and/or the fetus/infant.

> Nursery nurses now are mostly just admissions nurses. They are just with the admissions and then the babies are with their moms. Then on the [mother-baby] unit, former nursery nurses or postpartum nurses, they are mother-baby nurses.

> To provide that total continuity of care and education and self-care and infant care and especially when they go home the follow through care, if the patient calls you back two days later.

They also compared their responsibilities to the different responsibilities of the traditional maternity nurse.

> Now it's more . . . helping moms breast feed, getting the mom and dad and the family bonding with this new baby, helping mothers sometimes or fathers. Whereas before, you just ran the baby up to the nursery.

Depending on their work setting, the PNs' job description involved working in more than one area of responsibility. In fact, perinatal nursing was defined by one participant in terms of the PN's ability to incorporate the skills of all areas to function in LDRP.

> When I think of perinatal nursing, I really think of it as an LDRP. I think of it as a nurse who knows how to utilize her labor, delivery, recovery, postpartum and nursery skills . . . the whole. It encompasses all of this. It doesn't just stop at postpartum. It begins and ends with the mother and baby.

Several PNs reported that, despite their reluctance, they were expected to work in more than one area based on a number of factors:

> When we get floated back there [LDR] to help them, they better let us do something we are comfortable with, so when they come out [to mother-baby], we are fair, we do the same.

Although several participants had worked as LDRP nurses in the past, the actual practice of working in an LDRP by the participants in the study was limited to the rare use of an LDRP room on the mother-baby unit in one practice setting.

Marketable skills. The participants also reported the importance of having marketable skills.

> Basically, I feel that for us to be marketable in this perinatal field, you have to do all three. I don't think that we are very valuable as nurses in the perinatal services if you can't do labor and delivery.

> Eventually, I would assume, if you can't do all three areas, postpartum, labor and delivery, and newborn nursery, you are going to be replaced. That's how we feel.

However, to have marketable skills required that the PNs have learning and cross-training to develop and maintain the specialized knowledge and skills of perinatal nursing in more than one specialty area.

Participants described specialized technical knowledge and skill that was utilized in monitoring and assessing, providing supportive care, and teaching during the childbirthing period. Having specialized knowledge and skills was highly valued and was mentioned by the participants when describing the differences between the LDR nurses' and the mother-baby nurses' level of technical knowledge and skills.

> It's a different role of nursing, I see them [perinatal nurses working on LDR units] as highly technical nurses.

Learning, which included being cross-trained and oriented to work in other areas of perinatal nursing, involved being "buddied up" with somebody from another specialty.

> It's like we all took turns. There were two or three of us who would go into the nursery and the nursery nurses would go out on the floor and learn the postpartum and they were buddied up with somebody.

Several participants also noted that learning and cross-training was required to be qualified to work in the nursery admitting the infants.

> To be a nursery nurse I think is a real skill. They are a skilled nurse and they need education and they need to continue that education.

Participants also discussed the need to be comfortable with the essential skills, especially in potentially high-risk situations.

> I think that there [are many] skills . . . about going down for meconium stains or for C-sections . . . that they definitely have to be comfortable with.

Dealing with the unexpected. Dealing with the unexpected was also referred to as an important part of the role and included responding quickly and having good outcomes.

> We can't predict what's going to happen, what things are going to come up. How this baby is going to respond versus another baby.

The participants equated responding quickly with being knowledgeable and knowing exactly what to do.

> Things can change very quickly and you have to be able to respond. You have to be so knowledgeable that you see a strip and you know exactly what to do.

They also mentioned the PN's responsibility for having good outcomes in dealing with the unexpected.

> If you happen to be that RN and there is nobody else around, then you need to be able to know how to do what it takes to have a good outcome for that mother and that baby or the best outcome that can be provided at that time.

The descriptions by the participants provided a clearer picture of the activities performed on a daily basis by the PNs. These activities disclosed how the role of the PN was operationalized in the clinical setting and further depicted the ways in which the PNs viewed those activities. As indicated, the primary concern of the PN was the necessity for a range of skills from labor, delivery, postpartum, and baby in order to be prepared for any contingency and to assist the mother in having a good outcome. Naturally, an important aspect of this role was the relationship of the PN to the mother/child.

The Nurse-Patient Relationship

The nurse-patient relationship was another aspect within the participants' perception of family-centered perinatal nursing. The participants' perception of the relationship between the PN and the patient included relating to the mother and baby as a unit and to the family as a unit. Despite the importance of the family in the family-centered model, not all participants made reference to their relating with the patient's family. The participants described five aspects of the nature of the relationship: personal attributes of the PN, involvement of the family in the relationship, care for mother and baby as a unit, factors influencing the relationship, and issue of control.

Personal attributes. The personal attributes of the PN were the first aspect of the nurse-patient relationship. Characteristics described included being people-oriented, trustworthy, consoling, patient, compassionate, and a good listener.

Most participants indicated that PNs were people-oriented.

> Being that we do a lot with patients and families, we are people oriented.

They also mentioned being trustworthy in relating with the patient and the family.

> Be able to fit in and get the patient's trust. The family's trust . . . but I think that most of all, just be able to relate to them, like to their family.

In addition, they reported using their skills in consoling their patients.

> You have your personal, one-on-one skills with your patients to be able to console and to try to give them reassurance that's needed.

Participants also identified the qualities of being compassionate and a good listener as attributes of the PN.

> You have to be compassionate and have to be able to listen to your patient and work with her.

Involving the family. The majority of participants described the relationship between the patient and the PN as involving the family in the following ways.

> I feel like I'm not there just to be that woman's nurse. I'm there to be the person who gets that little family started together with the husband involved.

> We are kind of integrating this whole new role change that's happening with this family, not just with the mother, but with other kids and with the husbands also.

Mother/baby unit. Likewise, several participants described the importance of caring for mother and baby as a unit. According to one participant, this involved the ability to balance her time and organize her work in order to ensure the needs of the mother were met.

> I think the mother baby nurse needs to be able to balance her time so that she can give the mother the support she needs, but realizes that the mother and the baby are a unit. Just because they are separated back in labor and delivery, they're still a unit.

Factors influencing the relationship. Several participants mentioned specific factors influencing the patient-nurse relationship, including the patient having time together with the same person from the beginning until the end of her care.

> Usually, if you are there from the beginning, taking care of them until the end, then they feel more like a warm family. It's the same person taking care of them.

> You feel a real bond with your patients and the outcomes that you experience with them, new babies, your mothers. The trauma that they may have had during delivery, the ease of it, the difficulty of it.

Issue of control. As in perception of the TMC role, participants described the issue of control in the relationship with the patient. Here, the change in the PN's relationship with the patient-family was considered to be the result of the transition from TMC to family-centered perinatal nursing. Relinquishing control implied a definite change in the traditional role of the nurse.

> . . . kind of be a tour guide or this is what we can do now if you choose or this is what's available. This is what we need to do and why if we need to do something but not total control.

Allowing patients to have control was also viewed by participants as representative of changing from the traditional labor and delivery nurse role to the new PN role.

> I think that this is the biggest change that I've seen in myself in labor and delivery, is allowing the patient control of the labor process and birthing experience rather than the nurse.

> I'm trying to be the person who allows them to do their thing, whatever they want, the type of delivery as long as it is within a safe environment.

In their relationship with their patients, the participants expressed that it takes specific qualities to relate successfully with the mothers and their families. Unlike in

TMC, they saw the mother/family or mother-baby as a unit and were willing to allow the mother more control than in TMC.

History of the Transition

The history of the transition detailed the participants' perception of the experiences of the transition from a traditional model to a family-centered model. They discussed various aspects of preplanning that influenced the transition process in their work settings, such as the introduction to perinatal nursing, the cross-training they received, and the staffing issues. They also described the experiences of implementing the new family-centered model and the various situations that resulted in the PNs compromising the model. Three aspects of the history of the transition were discussed by the participants: preplanning, implementing the model, and compromising the model.

Preplanning

According to the participants, preplanning for the implementation of the family-centered perinatal nursing model varied based upon the organizational and physical structure of each hospital. All participants mentioned preplanning in their descriptions of the transition, which included four aspects: introducing the PN role, changing job descriptions, cross-training, and staffing.

Introducing the PN role. In describing their introduction to the PN role, most of the participants characterized themselves as having no choice in deciding whether or not they wanted to participate in the new model of care.

> Most of us are pretty reluctant. We would not chose to do this if we had a choice.

The only reason that I consented to do this was because it was forced upon us. Even so, some participants described actively participating in the process.

> I was part of the planning committee, I felt that mother-baby was good, but I wanted to make sure the hospital did it right. I felt that I should be part of the leadership going into it.

Several participants described the reasons they were given to support the change.

> It was basically said, this is what we are going to be going to. This is the wave of the future and you are going to be doing it.

> They informed us that the patients wanted it and that was the reason why and possibly there were going to be some savings as far as the money.

As part of their introduction to family-centered perinatal nursing, they also described the preplanning process that occurred in each setting as influencing the ease or difficulty in making the transition.

> The actual start of the mother-baby was something that did not go smoothly at all. I'm not sure that the preplanning was done carefully enough.

> We started in a slow progression. We started leaving the babies in the delivery room, and taking them to the recovery with mom.

> There were orientations, talks and meeting, discussion, and then one shift it happened.

Changing job descriptions. Participants discussed changing job descriptions to alter their traditional roles and responsibilities.

> You either did holding or you did mother-baby coupling, or you did both. You had to have someone doing holding because all the mothers didn't always want them.

Indeed, several participants reported changing job descriptions to what worked best for them.

> If you came on in the morning, you would have your four or five moms [and their babies] and if you got a new one, you were supposed to be responsible for assessing that baby and bathing that baby and everything else. The idea was to do this [baby admission] in the room, in front of the mothers. We found that wasn't working for us.

> So we put the baby in the nursery for their assessment, and it was still going to be that we the nurse [mother-baby] would be responsible for that and that we would go in and do the assessment, Well, were finding that wasn't

> working either. So that what we came to grips with is what we do now [have an admission nurse in the nursery do the admissions], which I think works pretty good for our particular unit. I would say, basically, we adapted to what worked best for us.

Cross-training. An important aspect of preplanning was cross-training, which was to broaden PNs' knowledge and skills and to give them additional experience in working in the other areas of perinatal nursing. Cross-training involved nurses from different specialties such as labor and delivery, postpartum, and/or the nursery working together and orienting each other to their specialty. Participants described taking classes and special training sessions to learn about low-risk and high-risk care and to learn how to do routine and special technical procedures such as monitoring, making assessments, providing technical interventions, supporting, and teaching. All participants described the importance of feeling comfortable with their level of knowledge, skills, and experience.

Some participants described cross-training as having occurred over time, with ample opportunity to learn.

> It like we all took turns. There were two or three of us who would go into the nursery and the nursery nurses would go out on the floor and learn the postpartum and they were buddied up with somebody.

They reported that cross-training and learning occurred until they felt comfortable in their skills as PNs.

> So you did holding and you did mother-baby and then we started doing the admissions . . . but that took additional training to be able to do the assessments.

> We had to take an assessment class and we did a lot of teaching, a lot of classes, a lot of intervention on that, way back then, so that you would be comfortable doing the admissions.

In cross-training situations that occurred without formal didactic training, participants described problems related to the instructions given due to the lack of teaching ability on the part of the staff.

> Some people are teachers and some people are just not teachers. The people who were not teachers were trying to teach other people who were trying to learn. The postpartum were trying to learn and vice-versa, and really messing up . . . were really teaching incorrect things.

Similarly, they indicated receiving limited "supervision" when being cross-trained for special procedures:

> There was nobody there, supervising until somebody was just checked off that they were doing the PKUs and everybody just proficiently doing it. They gave you a sheet that said, these are all the things that you need to do, so there was kind of a check-off, but no one gave anyone guidelines.

Further, some participants described the lack of adequate staffing when they were cross-training prior to and during the implementation of the new model.

> We were told . . . that we were going to be buddies for a month and I had nurses screaming and saying, "I learned nothing." If we were understaffed nursery nurses, I had to take care of babies, so I didn't learn anything with the mother.

> I think staff at that time just wasn't adequate to train the way they wanted us to be trained.

Cross-training was thus an important aspect of the transition to perinatal nursing. Participants described it as an issue that was dealt with effectively in some settings and ineffectively in other settings. The ineffectiveness of the pre-implementation training directly affected the actual implementation of the model.

Implementing the Model

Implementing the family-centered perinatal nursing model involved the participants in the process of expanding their roles and responsibilities in clinical practice to function in more than one area of perinatal nursing, primarily as LDR(P) or mother-baby nurses. Most of the PNs described implementing the model in a new or newly remodeled work setting. Two aspects of implementing the model discussed by the participants involved lacking direction and resisting.

Lacking direction. When the participants discussed implementing the perinatal nursing model, they focused primarily on the problems encountered by the PNs related to what happened when they first started to implement mother-baby nursing.

> It seemed as though none of the staff people really knew what was expected of them in the beginning.

> We really didn't know what we were doing. We had kind of a definition of what it was going to be . . . . We adapted to what worked best for us.

They reported lacking direction on how to restructure their work:

> One of the things I hear everybody say is that there was no direction on how to structure your day because you went from just caring for the mother to caring for the mother and baby.

> How do we start the day? What do we do first? None of that was really addressed and everybody got really panicky. How are we going to handle this day?

They also indicated lacking direction when moving to a remodeled unit and beginning mother-baby nursing on the same day.

> Then we moved back . . . and that was the big fear, at the same time, on the same day when we were moving, they expected us to do this transition to mother-baby and we really didn't know what we were doing.

Resisting. In addition to the lack of direction in knowing what to do, the implementation of the model was hindered by resistance on the part of the nurses.

> I think everybody is afraid of change. When you are told that you are going to do something and then you just think, I don't want to do this. It worked fine before, why should we change things now? Truthfully, I would never go back to the other system, not ever in my entire life. I mean, I suppose that if I was forced to I would have to.

Still other participants described resisting the cross-training to expand their roles, which ultimately influenced how the model was implemented.

> LDRP, we were all going to be LDRP nurses and that's how it was going to be . . . but that really never went over . . . not all the nurses wanted to train in labor and delivery and not all the nurses from labor [LDR] wanted to be postpartum [mother-baby] and they didn't want to do nursery [admissions and holding].

Thus, both lack of direction on the part of nursing management and resistance by the nurses hindered the successful transition from TMC to family-centered perinatal nursing.

Compromising the Model

Another aspect of the history of the transition depicted the PNs modifying their roles and responsibilities to alter their clinical practices in order to revert to the TMC practices and thereby compromising the family-centered model. Although the majority of participants limited their discussion to implementing mother-baby nursing, several participants also described the LDR nurses as compromising the model by having the infant leave the recovery room without staying with the mother. The participants described the difficulties that they perceived associated with implementing mother-baby nursing on the evening and night shifts because the mothers refused to have the infants rooming-in at night. The PNs also reported that the traditional model was more efficient and that former postpartum and nursery nurses preferred to work as teams in which they separately cared for either the mothers or the infants.

Participants described the history of the transition related to how they dealt with problems in implementing the family-centered model, such as compromising the model.

> We used to work 8-hour shifts and the day shift implemented the mother-baby and we tried it on the evenings, some nights we did it, some nights we didn't, and in the beginning, the nights always did the traditional type care because we would find that, between 9 and 10 o'clock, the babies were coming back in to the nursery anyway, so it really was more efficient that way.
>
> Sometimes . . . instead of doing couplet, we would work as teams. The nursery nurses and the postpartum nurses worked together, often the nurse who took care of all the mothers had a nurse who took care of all of those babies . . . and we sort of cheated by doing it the way we liked anyway.
>
> As postpartum nurses, we no longer did the recovery and labor and delivery had to take over the recovery of their own Cesarean sections and it got to the point where they just could not do it [keep the babies at the bedside with the mothers in recovery]. So we kind of switched . . . the baby comes and stays in the

> nursery . . . sometimes, if the mom wants the baby, . . . they let the baby go back to the mom.

Thus, according to the participants, transition to the family-centered perinatal nursing model was difficult. They saw management as dealing inadequately with issues of training and direction and as implementing change too rapidly. Likewise, nursing resistance to transition was not addressed effectively. Such issues as these led to compromise of the model. The influence of history and context on the participants' perception of the transition to a family-centered model is discussed further in Chapter 5, where the interrelationships between the history and context, the essential characteristics of perinatal nursing, and the meaning of the transition to perinatal nursing are presented.

CHAPTER 5

REPORT AND DISCUSSION OF THE FINDINGS

The analysis of the interviews with the 13 participants in this study provided answers to the two research questions. The report of the findings describes the essential characteristics of perinatal nursing and the meaning of the transition to perinatal nursing and includes the major features that outline their characteristics. After this description, the interrelationship of the history and context of this study, the essential characteristics of perinatal nursing, and the meaning of the transition to perinatal nursing are discussed and the Transitional Model of Family-Centered Perinatal Nursing is presented. Following a discussion of the findings, a review of the bracketed assumptions is provided.

Essential Characteristics of Perinatal Nursing

The essential characteristics of perinatal nursing detailed the perceptions of the participants who had experienced the transition from TMC to family-centered perinatal nursing. The participants discussed the perinatal nurses' (PNs') new expanded role and the changes in the interrelationships between the PN and the patient and her family that resulted from the transition. All participants mentioned aspects of the essential characteristics of perinatal nursing. Two themes emerged from the analysis of the interviews with the participants: protective caring and protective managing. The essential characteristics of perinatal nursing are outlined in Table 2.

Table 2

Essential Characteristics of Perinatal Nursing

Major Themes	Minor Themes
Protective Caring	Creating a Connective Link Optimizing Family Beginnings Providing a Continuum of Care Providing Support Providing a Continuum of Education
Protective Managing	Keeping the Customer Happy Protecting and Keeping Safe Relinquishing Control Preserving Order Handling the Unexpected

Protective Caring

The major theme, protective caring, detailed the participants' perception of the PN's new expanded role in perinatal nursing and the interaction between the perinatal patients and their families as they experienced the childbirthing process and the transition to their parenting roles. This major theme also reflected the PN's priorities of balancing the need to create a connective link between the patient-family and other health care providers and provide care, support, and teaching with the need to provide safety and protection to their families. All participants discussed various aspects of this minor theme. Five minor themes emerged from the analysis of the interviews with the participants: creating a connective link, optimizing family beginning, providing a continuum of care, providing support, and providing a continuum of education.

Creating a Connective Link

In this minor theme, creating a connective link, participants depicted the PNs after the transition to perinatal nursing making the connection between the patient-

family and other members of the health care team to ensure that the needs of the perinatal patients and their families were met. In addition, the participants described their connecting with the patient-family in order to understand and to communicate their needs accurately. The four aspects of this theme were connecting with the patient, establishing rapport, acting as liaison, and acting as advocate.

Connecting. According to one participant:

> A lot of times, if you understand their needs, then you can really connect with the patient.

Participants also discussed reassuring the patient to facilitate the connection between patient and physician.

> Sometimes the patients get upset: "Why isn't my doctor here?" Instead of saying, "He's sleeping," I just say, "I will call, we're timing everything, and he will be here."

Establishing rapport. Establishing rapport was another aspect described by the participants as essential to the PN's ability to communicate and meet the patient-family needs.

> I have a very good rapport with physicians. I think that my communication plays a very big role, because that's where the breakdown is. If you can't communicate the patient's needs to the physician, then there is a dead end.

However, the PN's ability to establish rapport with the other health care providers was described as dependent upon the personal and professional attributes and values of the PN, including mutual respect, confidence, and trust.

> I need to have those doctors have confidence in me and my opinion, if I have a concern about my patient.

> I think that you need to have the doctors believe in you and believe in what you are doing for the patients.

Establishing rapport with other health care workers involved being able to work with other nurses and communicate effectively with them.

> Being able to work with other nurses. Being able to communicate, having good communication skills.

According to the participants' descriptions, establishing rapport between staff on both units was important in ensuring the continuity and quality of care for the patient.

> When you transfer your patient, you worry that if you don't have that good rapport with postpartum, [mother-baby] then you think, are they going to offer to take care of my patient the way that I would want them to?

Acting as liaison. Participants also discussed acting as a liaison to serve as a connective link and to exchange messages between the patient-family and the other health care providers, primarily the physician.

> I think we are the life line between the patient and the physician.

Participants described acting as a liaison as an essential part of the PN's role because of the absence of the physician.

> You act as a liaison. . . . The physicians aren't there at your side, so you make that assessment yourself first. When you have done your interventions, then you get on the phone and say, "This is what was done, this is what is going on."

The participants indicated that acting as a liaison required certain personal attributes and abilities to make it possible for the PN to get the physician's attention. The qualities included having confidence and self-assurance in communicating information, being capable of telling a physician to come when he/she was needed, and getting a positive response.

Participants described acting as a liaison in the following manner:

> I feel that when I have a problem with the patient I can get their attention. They have confidence, if I'm in the nursery and I want a doctor to come in to see a baby, they don't hesitate. I know what question to ask and what answers to tell them.

Acting as a liaison also entailed exchanging messages between the patient-family and the other health care professionals.

> I have to have an order from the physician. I'll tell the doctor what this patient wishes. If the doctor doesn't come in and talk to them, then I will tell them what the doctor said.

Acting as advocate. Creating a connective link also involved the PN acting as an advocate for the patient-family and focusing on the patient's wants, as depicted in the following example.

> I feel like I am the patient's advocate rather than the doctor's or the hospital's. I try to give the patients the type of delivery that they want.

Similarly to acting as a liaison, acting as an advocate on behalf of the patient involved personal attributes and abilities of the PN, such as being supportive, self-assured, confident, committed, and able to communicate beliefs.

> . . . being a patient advocate, being out really and truthfully for that patient.

> I think a good nurse will go above and beyond that and do the best she can to try to help that patient.

Participants discussed the PNs acting as an advocate rather than fearful of making mistakes.

> Nurses need to remember that they are patient advocates and . . . not to be fearful of making a mistake on the side of the patient.

Furthermore, an important aspect of acting as an advocate, as described by the participants, was taking action and persevering when, for example, they perceived a problem with an infant.

> Sometimes they [physicians] shrug you off, like you are full of baloney, nothing is wrong with this baby. I have learned to be persistent with these doctors in the nursery. Get on the phone and call him.

> It's a matter of communicating what you are perceiving . . . to call your physician and say, "You know, this is what's happening, . . . there is just something not right."

In summary, participants expressed the importance of their relationship with the patient and her family. They viewed connecting with the patient and establishing

rapport as essential, even before they were able to act on the patient's behalf as a liaison and as an advocate.

Optimizing Family Beginnings

Included in optimizing family beginnings were the new, expanded role activities, performed by the PNs, that focused on providing family-centered care for perinatal patients and their families. Although the majority of the participants described the aspects of this minor theme, two PNs did not refer to the "family" but referred only to the mother and/or her infant, when describing their nursing activities. Two aspects emerged from the analysis of the interviews: caring for and keeping the family together as a unit and preparing the family for new roles.

Keeping family as a unit. Caring for and keeping the family together as a unit involved getting the family started together, balancing time to organize work, addressing individual differences of families, and helping the family unit in difficult situations. Caring for and keeping the family together as a unit included getting the family started as a unit.

> I feel like I'm not there just to be that woman's nurse. I'm there to be the person who gets that little family started together with the husband involved.

Participants also described balancing their time to organize their work and to ensure that the needs of the mother were met.

> I think the mother-baby nurse needs to be able to balance her time so that she can give the mother the support she needs, but realize that the mother and the baby are a unit. Just because they are separated back in labor and delivery, they're still a unit.

> If you realize they are a unit [mother and baby] and you treat them as a unit and do everything at the same time, you can organize it better. . . . don't do all your mothers and come back and do all your babies, that takes more time.

Caring for and keeping the family as a unit also involved addressing individual differences and making each situation unique.

> Every delivery is different, every baby is different. The whole situation is a unique situation and I think that we need to give our care that way. We need to make it a unique situation for each one {family}.

Participants also described helping the family unit in difficult situations, such as those that involved grief or loss and the rewards they experienced.

> To try to help that family unit as much as possible. To get them in the beginning stages of dealing with a loss or a certain grief that they have to go through, . . . Knowing that you have kind of helped that . . . is rewarding.

New roles. Participants discussed preparing families for new roles, which involved integrating the family role change, including the family in the teaching, using supportive listening skills, and receiving professional rewards.

Participants addressed their concern that, in preparing the families for their new role, the whole family should be included in the integration process.

> We are kind of integrating this whole new role change that's happening with this family, not just with the mother, but with other kids and with the husbands also.

They also mentioned including the family in their teaching.

> We include the family as much as we can. We encourage their family. We like to do teaching when both the mother and father are there or the mother and the significant other.

Participants described using supportive listening skills to encourage family participation and to ensure the mother's ability to take care of her baby when they go home.

> They need to verbalize, express their fears and you need to listen to that. You don't just sit there, "This is my sheet of paper I need to check this off by the time that you are discharged."

Preparing the family for their new roles was viewed as professionally rewarding.

> If I can help the initial bonding to therefore improve the level of care that these parents are going to be able to give the baby that I see as a tremendous gift enabling me to be a better nurse. as well as for the patient/family.

Unlike in TMC nurses, PNs view the family as a unit that must be cared for as a whole in order to assist both mother and other family members during the birthing period and to help them to make the transition to their new parenting roles.

Providing a Continuum of Care

The third minor theme, providing a continuum of care, was depicted by the participants as an ongoing flow of care activities performed by PNs for the mother and infant as well as the family throughout the childbirthing period. This minor theme was viewed as an important component of the PNs' new expanded roles working as LDR(P) and mother-baby nurses and included their interactions with patients and their families. The continuum of care included three aspects: providing care, evaluating patient progress, and establishing continuity in the nurse-patient-family relationship.

Providing care. Participants described the nature of the continuum of care as PNs providing care during the entire childbirthing period.

> We can get early labor patients, so basically you are caring for the ones before they deliver all the way through their delivery and their postpartum period.

Part of providing care also involved the professional commitment of the individual PN in caring for the patient during the 12-hour shift.

> I'm going to do the best possible care for my patients in my 12 hours.

Providing care also entailed establishing individualized care plans based on the mother's special requests and tailored to meet each mother's unique needs.

> We specialize our care as far as that goes doing our care planning, depending on the baby and the mother, depending on what the mother has requested.

> Every delivery is different, every baby is different. The whole situation is a unique situation and I think that we need to give our care that way. We need to make it a unique situation for each one [family].

Evaluating progress. Another aspect of the continuum of care involved following through to evaluate the patient's progress.

> I . . . go down and make rounds on my patients I had the day before, just to see how they were doing . . . If mama had some problems, I could say, during delivery, you had this happen, then that made their understanding, and may be their pain and anxiety a little bit less, because they knew why they were feeling that way.

Establishing continuity. Participants detailed providing a continuum of care as establishing continuity in nurse-patient-family relationships:

> Usually, if you are there from the beginning, taking care of them, until the end, then they feel more like a warm family. It's the same person taking care of them.

In reference to working in an LDRP setting, one participant said:

> It was totally the best type of care for the mamas, and babies as well as for myself. Because I felt like having been the labor and delivery nurse, and being the postpartum and nursery nurse, I had a handle on everything that had gone on. So that the care was more compact. Continuity was there. Being able to give reports to the next shift coming on. I could tell them the little things that I had noticed.

Providing Support

Providing support was the fourth minor theme of protective caring. This minor theme involved the PNs in their new expanded role, providing support by performing supportive activities such as providing physical care, providing emotional support, assisting the family, and coaching.

Physical care. The participants described providing support in global terms and indicated the importance of providing physical care to the perinatal patient and being available in order to provide comfort and reassure the patient and her family that her needs will be met.

> You need to go in there. You don't need to buzz and say, "Are you okay?" You need to physically go in there and say, "Do you need another pillow?" or "Oh, your sheet fell on the floor."

> There needs to be more compassion from the postpartum nurses as far as providing the moms with ice packs for their perineum and giving them reassurance that what she is feeling is okay. It's giving reassurance and helping the moms with the baby care.

They indicated that providing physical care also included making themselves available to the patient.

> If there is somebody, just around the corner, that she knows that she can buzz if she is having difficulty, and I am there for her, I think that's good.

Emotional support. Participants also discussed the importance of providing emotional support. By their presence at the bedside, PNs were in the position to provide the emotional support that was necessary to calm and reassure the patient-family who are facing the difficult times of the childbirthing period, including the new responsibilities of parenthood.

> I think that you have to reassure the patient a lot that everything is going to be okay. "You are going to be a good mother." "It's going to fall into place." No matter what.
>
> There is a lot of emotional stuff that goes on . . . for the new mother.

Assisting the family. Assisting the family was another aspect of providing support.

> We encourage them to bring their other children to meet the new baby. Sometimes if they have a 2-year-old, the baby is a threat. Sometimes parents aren't aware of that. You can help them with that.

Coaching. The participants depicted the importance of coaching. They described coaching as helping and reassuring the patient/family that they were doing a good job and getting them through their childbirthing experiences in a positive way.

> It's coaching your patients and working with your moms and dads, to give them the kind of outcome that they want.
>
> When they start to get to the point to where "I can't deal with this," it's like, this is okay. You are all right. This is all right. You are going to experience this. This is okay.

However, according to one participant, in order for the patient-family to accept the PN's coaching, the PN had to demonstrate sensitivity and patience when first interacting with the family.

> You need to be kind of patient, too. A little bit sensitive to the patient, because if you have been sensitive with them, you can coach them later.

To the participants, both the patient and her family were recipients of the PN's support, which included emotional and physical care as well as coaching for the birthing couple.

Providing a Continuum of Education

The last minor theme, providing a continuum of education, detailed the ongoing flow of teaching activities performed by the PNs that occurred from the beginning to the end of the childbirthing period. This minor theme was directed toward preparing the patient-family for the experience of childbirthing, the self-care of the mother, and the care and feeding of the newborn infant, as well as care for the mother and infant at home following discharge. Participants also mentioned conducting prenatal and childbirth preparation and parenting classes. The continuum of education entailed five aspects: teaching, giving information, answering questions, providing explanations and feedback, and validating outcome learning. All participants described these aspects of this minor theme in great detail.

Teaching. Teaching was described as an important part of the PN's professional role. Although the participants indicated that they provided a continuum of education across the childbirthing period (except in settings with LDRP units), PNs provided most patients and their families teaching from two different units (LDR and mother-baby). Even so, the fragmentation in teaching that was evident in the former TMC model is decreased by having the same PN providing the teaching in the combined care

areas of LDR and mother-baby nursing. According to one participant, "Teaching is a major part of our role."

Participants also described the continuum of education in the following ways:

> Teaching is very important. Teaching to me starts from the time they get to labor and delivery.

They mentioned including the family in their teaching.

> We include the family as much as we can. We encourage their family. We like to do teaching when both the mother and father are there or the mother and the significant other.

Demonstrating their commitment to teaching, the participants suggested that they had a moral obligation in teaching the patient-family.

> They have no idea what's going to happen to them when they walk through that door. So, I think that there needs to be some education.

Nevertheless, they mentioned the importance of assessing the mother's readiness to learn before initiating the teaching activities and the importance of prioritizing and streamlining the content.

> You have to assess the mother first and see if she is able, at the stage to get us, to want to hear it. Many times there is just too much going on and you just have to wait.

Participants viewed teaching as essential for supporting the mother in assuming her new role and as including teaching practical skills.

> . . . teaching her all the things she needs to know to feel confident to be that new mother.

Giving information. Giving information and further explanation was also viewed as helping the patient to make informed decisions.

> We admit them and try to explain things to them. Even if the doctor already explained to them, we just make sure they know what's going on and explain to them about epidural.

One participant expressed concern regarding how the information was given to the new mothers.

> Information is thrown at them. Especially for a brand new mom, who is nervous. Information is just thrown at that person.

Answering questions. Answering questions required the PN to have long-term experience in order to develop effective skills of communication.

> I feel that these are skills that you develop over the course of time. Learning to read your patients and to hear what patients are saying or what they are not asking and being open to give them the information that's going to provide them with that knowledge.

They also discussed the importance of encouraging the patient-family to express their needs.

> They need to verbalize, express their fears and you need to listen to that. You don't just sit there, "This is my sheet of paper I need to check this off by the time that you are discharged."

Providing explanations and feedback. Participants discussed providing explanations and feedback to the patient in the limited time available to prepare them for discharge. Participants recognized that many patients and their families had never experienced the childbirthing process or parenting before.

> Give them as much feedback as you can in the short period of time that you have them so that they have more information when they go home

> We're teaching the mother how to take care of herself when she goes home, the reasons that she should notify the doctor for . . . how to take care of the baby, the things to call the baby doctor about.

The positive results or benefits of providing explanations when teaching the patient-family were reported.

> I don't just say, "Turn to your left side." I say, "Turn to your left side because--." And if you say that, the patients understand that there is a reason. They are more willing to do it and they are more willing to be compliant with that.

Validating outcome learning. Participants indicated the importance of validating outcome learning.

> It's all teaching, and then observing and then giving mothers feedback and follow-through as to how she did and what happened.

Participants thus stressed their relationship with their patients and the patients' families, expressing concern that the PNs help and encourage them by providing physical and emotional support and comfort and by preparing them for the childbirthing process and for parenthood through teaching. In all areas, the participants stressed being able to support the patient and family throughout the birthing period.

Protective Managing

This major theme, protective managing, depicted the participants' perception of the essence of perinatal nursing, which involved the PNs' new, expanded roles in perinatal nursing and included the interrelationships with perinatal patients and their families. This major theme primarily focused on safeguarding and clinically managing the care of the patients and their families during the childbirthing period. All participants described various aspects of protective managing. Five minor themes emerged: keeping the customer happy, protecting and keeping safe, relinquishing control, preserving order and handling the unexpected.

Keeping the Customer Happy

The minor theme, keeping the customer happy, was depicted by the participants as primarily focused on safeguarding the satisfaction of perinatal patients and their families. Keeping the customer happy also involved the PNs' expanded role and interaction with patients and occurred as the PNs provided family-centered care to patients while working as LDR(P) and mother-baby nurses. This minor theme involved four aspects: knowing the patient, meeting expectations, achieving professional goals and values, and avoiding negative outcomes.

Knowing the patient. Participants discussed knowing the patient, and described today's customers as more aware, knowing what they want and do not want, and making choices based on the type of experience they want.

> I think our consumer today, the client today, the patient is more aware. There is so much in magazines about labor and delivery and on television.
>
> They come in with their birthing plan. You know, it says, "I want this, this, this and this and I don't want this."
>
> They do a lot of research. They know what they want. . . . They try to go to a physician who will give them the type of delivery they want and they even choose hospitals now according to what type of delivery they want.

Meeting expectations. They also mentioned typical patient expectations.

> Our clientele expect private rooms and they expect their husbands to stay and they expect their meals to be hot and they expect their babies to be in the nursery and they expect them to come out when they want them, but they don't want them when they don't want them.

Participants also described meeting expectations of their patients and their families.

> You are working to give them whatever experiences they expect.

On the other hand, participants also indicated that some patient expectations were unrealistic.

> What people profess or what they think they want, I don't believe they have a realistic out look on what is going to happen during the birth process and the care for this infant.

Meeting expectations also included institutional goals and expectations.

> I think the number one thing that the hospitals are looking for, in my opinion, is trying to make the customer happy.
>
> I think management has said, "We need to give moms what they want and then they'll come to our hospital." And that's really what they are trying to do . . . with mother-baby nursing.

Some participants viewed their institutions' expectations regarding perinatal nursing practices as being forced on the customer.

> They have really pushed this to the customers that this is a better way for us to take care of their babies.

Some participants depicted the institutions as making promises to the community that the PNs were expected to keep.

> In the community, their market[ing] strategy is that . . . the whole family can be involved. This can happen, that can happen, and they promise them everything and then they expect me to deliver.

Achieving professional goals. Even so, the participants described keeping the customer happy as related to achieving professional goals and values in this way.

> We are trying to keep the customer happy so that they have the best experience possible.

> We try to accommodate the patient any way we can. I mean, not necessarily what you as a nurse likes, but . . . we try to do what the patient wants.

Participants also perceived respecting the patient's course of action and allowing her to choose what she desired as achieving professional goals and values.

> If a person desires an epidural, that's fine. If they don't, I respect their ways.

Avoiding negative outcomes. Participants also described keeping the customer happy by avoiding negative outcomes for the perinatal patient and her family.

> You don't want them to have a negative experience. Maternity is the area that most people come into the hospital to have a baby and that might make or break the whole entire life of coming to that particular hospital.

Participants realized that, unfortunately, patients did not always get the experiences they wanted.

> Sometimes, we get these people who bring in their birth plan and it all sounds good on paper, but it just doesn't work that way.

Moreover, participants conceded that when certain patients have a negative outcome, despite the PN's best efforts, the potential exists for the nurse to be blamed.

> Some moms . . . will adapt better; other moms, if things don't go her way, it's like she wants to take it out on us, and we are just trying to do the best we can to make everybody happy.

According to one participant, even though everything went well, the end results may be a negative outcome.

> You aren't guaranteed a good baby even though everything went well; you can't be guaranteed that.

Thus, keeping the customer happy involved meeting the expectations of the patient and her family as well as those of the institution.

Protecting and Keeping Safe

The second minor theme, protecting and keeping safe, detailed the participants' perception of the essence of the PNs' new, expanded role responsibilities in perinatal nursing that were directed toward safeguarding the well-being of the mothers and their newborn infants. They also expressed the greatest concern for the safety of the mother during labor, delivery, and the immediate recovery period; however, the PNs' concern for the safety of the infant was even greater and included the safety of the infant at the mother's bedside. Several participants viewed the care received by the infant outside the traditional newborn nursery as potentially unsafe. All participants described various aspects of this minor theme: watching for safety of patients, providing a safe environment, being responsible for care (liability), and identifying problems.

Watching safety of patients. Participants characterized PNs as being very protective of both of their patients, which supported their efforts of watching for safety of patients.

> We are very protective over our mothers and our babies.

They also described watching for safety of infants as a routine part of their job description.

> We go to the newborn nursery and do admissions and watch the babies.

Participants justified the importance of watching the safety of patients by portraying the delivery and recovery periods as particularly dangerous.

> I don't think that the consumer realizes how dangerous a delivery and even the recovery period is. . . . We always hear it's such a natural thing to do.

Watching the safety of the patients influenced the PNs to withhold options during the birthing process.

> If a person comes in with a birth plan that says, "I don't want to be monitored unless I need to. . . . Those wishes are respected as long as it was within safe limits.

Participants also described watching the safety of patients as doing what was best for the patients.

> . . . to do what's best for them would be what would be safe. If I think there is a safety problem involved, I'll explain to them.

Safe environment. Another aspect of protecting and keeping safe stressed by the participants was providing a safe environment. When the participants compared the traditional model with the family-centered model, they expressed increased concern for providing a safe environment for the infant at the mother's bedside. Although the family-centered model encourages infants to be rooming-in with their mothers and not in the central nursery, the infants went in and out of their mothers' rooms and back to the nursery at the mothers' request. As a result, providing a safe environment involved knowing where the infants were at all times.

Participants detailed keeping track of the infants on the mother-baby unit and expressed their fears regarding security.

> Back in the traditional, no way. The mothers were in the rooms. The babies were in the nursery. You knew where they were. So what we try to do is, if the baby goes to the nursery, . . . there is this little star that you put on the board where the baby is to keep track, because it gets tough, specially when we get full. Where are they?

Providing a safe environment also involved PNs working to overcome the physical limitations of the environment. While the participants discussed several measures taken, they recognized the limitations of the efforts and continued to express their fears regarding the overall safety of the environment.

> Our layout is very poor for security for babies. Someone could take a baby really easily. It's scary what's going on.

> We have ID band for labor and delivery . . . and mother-baby now, that we change if someone loses their ID band . . . then we all change colors. But what if a mom is sleeping?

Participants described situations in which the safety of the environment for the infant was compromised, such as when parents were distracted by visitors.

> Where the baby is in the room and there are people touching the baby so the baby becomes more stimulated . . . like the dad realized that the baby was blue, it had been choking and they weren't quite sure how long, and then of course, the parents were distracted by the visitors.

Responsibility for care. Therefore, another aspect of protecting and keeping safe reported by the PNs was being responsible for care (liability), as noted in the following example:

> The C-section mothers definitely need more watching and you don't leave the babies in the room. . . . If they demand, they want them to room-in, we let them, but that becomes our responsibility to make sure that we are in there and can take care of that baby, and hand it to her and pick it up and put it back and make sure they are not too medicated.

Several participants discussed their being responsible for care (liability) and thus encouraging the mothers to bring the infants in the nursery.

> In an hour a lot of things can happen, . . . we do encourage the mothers to bring the babies back into the nursery if they are sleeping, because if the baby chokes, and the mother is sleeping, she is not going to pick up on that.

They also mentioned making sure that the infants were safe.

> You have to make sure the baby is not in bed with them. You will tell them no, you can't have the baby in bed. You go back in and they are in the bed.

Consequently, being responsible for care (liability) was mentioned as a factor in wanting the infants back in the nursery.

> It's almost for our safety that we want the baby in the nursery.

Several participants expressed their lack of comfort in being responsible for the care of both the mother and the infant immediately following delivery.

> I feel like . . . I need to focus my attention on one person. So I feel that, for that period, they need to have somebody in there watching the baby or watching the mom.

Participants mentioned their fears of being responsible for learning how to care for infants:

> We were frightened, the postpartum nurses who were going to have to learn how to do something with the baby, . . . but to really know if the baby is sick or not, those were a lot of the fears that we had.

Similarly, participants described the fear of being responsible for care and being held liable for actions taken when they lacked knowledge or background experience required for the situation.

> I thing the biggest anxieties and fear is total responsibility. The liability of doing something and being held liable when you don't have the background knowledge or the years experience to back you up.

Identifying problems. Identifying problems before patient discharge was another aspect of the minor theme, protecting and keeping safe. This meant that identifying problems required that the PNs be able to assess the patient adequately before discharge.

Some participants perceived the assessment of the infant as inadequate when completed in the mother's room rather than in the nursery.

> When you are assessing the baby in a mom's room, and you are fielding all these questions, I just feel like I am not doing as a complete an assessment as I normally would do in the nursery. I am working in a totally different environment.

Several participants mentioned their fears that the infants were being overlooked on the mother-baby unit.

> We are just afraid that a newborn will go home with something undetected . . . . The thing that I am very concerned about is the newborn is the one that is being overlooked.

> I am not as in tune with the baby . . . . I feel like the babies are kind of getting lost in the shuffle.

Participants stressed carefully assessing the patient to identify problems before discharge.

> You just want to make sure you have looked this baby over real carefully before you send it home.

They also expressed concern over the short length of stay for the patients as affecting the PNs' time for identifying problems before discharge.

> It unnerves me to think that I will get some lady who might be in danger somehow and I'm not going to know it and she's going to go home and bleed to death or get a fever, who knows what, because she's got to get out of the hospital in 12 hours.

Participants indicated that the lack of regularly scheduled experience working with newborns made identifying subtle problems more difficult.

> I cannot pick up on the subtle things on a newborn that somebody who works with them 12 hours a day, 3 days a week does. I don't pick up on the subtle things.

Participants thus perceived protecting and keeping safe the mother and infant as a major concern, both in terms of the outcome for the patient and in terms of nurse liability.

Relinquishing Control

The minor theme, relinquishing control, describes the participants' perception of the PNs' new, expanded role in perinatal nursing and the new nursing practices as related to the PNs' "giving up" the traditional manipulation of the situation that had characterized the TMC model of efficiency and order. Relinquishing control involved

the participants' perception of the changes in the nurse-patient relationship, again related to the PNs "giving up" their traditional power relationship with the patients and families during the childbirthing period. The relinquishing of control included the aspects of providing options, allowing choices, supporting decisions, and qualifying relinquishment.

Providing options. As a result of the transition to perinatal nursing, participants described relinquishing control to the patient-family by providing choices over such things as type of delivery, anesthesia and pain medication, rooming-in, and type of infant care and feeding. However, some participants reported qualifying relinquishing of control in situations to meet the expectations of society, the institutions where they worked, and physicians. Participants described PNs relinquishing control by providing options for the patient.

> We have changed a lot, too. When do you want your baby? You want your baby on a 2- or 3-hour schedule? It's totally your decision. You can have the baby as long as you want, as little as you want. It's totally up to you.

This included following the trends in meeting consumer demands by allowing choices regarding the type of delivery wanted.

> I think now the trend is moving toward . . . the consumer, who is directing . . . . They want the type of delivery that they want.

Allowing choices. Participants also described allowing choices by the patient even when the patient's choice conflicted with the needs of the PN.

> I feel like I want to make it better but I can't so I'm going to sit on my hands and not do anything and allow them to have what experience that they want because it's not our place to fix it for them. They don't want it fixed.

Supporting decisions. Another aspect of relinquishing controls mentioned by the participants was supporting the decisions made by the patient-family,

> If the patient wants to try to do this with no IV, no anesthesia, then I will try to support that. I will let them know up front, if you feel like you need medication for pain, you need to tell me. I'm not going to be suggesting to you. If you feel like you need something, then we'll talk about it. I'll give you the options and before you even begin to feel uncomfortable, here are you options. Then if you decide that you want to talk about them more, we can talk about them.

> We have women who have decided to give out their babies for adoption. . . . You have to support them in what they want to do. It's totally up to them to make that decision and whatever they decide we should support them.

Participants also described supporting decisions by advocating the patient's right to make her own decisions.

> You need to try to make your own decisions. Don't let other people make the decision for you. You are the only one who can make your own decision.

Participants personalized the decision-making process when discussing the need for the patient's input into the decision-making process.

> I would not want a nurse, if I were the patient, making all my decisions. I want to be able to have some input into that decision making.

Qualifying relinquishment. On the other hand, several participants reported qualifying relinquishment of control to the patient by the PNs, such as when the patient's choices conflicted with the expectations of society, the institutions, or the physician. First, according to several participants, relinquishment of control was constrained by society's expectations.

> Society has told them that the minute that you have this baby, it should be with you all the time.

> Some mothers do want the baby all the time and they should have it, but there are lots of those [mothers] that really don't. But if you say it in a certain manner, they feel obligated to keep it [the infant].

They also mentioned institutional expectations which conflicted with patient's choices.

> You can't force them to room in . . . they [nursing administration] encourages us to encourage our mothers to room-in. Most of the time [at night] the babies are in the nursery.

Finally, some participants described qualifying the relinquishment of control to the mother as a result of the expectations of the physician.

> The minute the pediatrician walks out the door, the mother says to us, "I don't want any supplements, I don't want anything," which puts us in a bad situation, because if he has written it, then that's what we need to do.

This minor theme was viewed as an important component of perinatal nursing practice and demonstrated a significant change in the PNs' role and interaction with the patient-family. It also marked the significant difference between a traditional model and a family-centered model. In TMC the nurses viewed themselves as being in control, but in their new roles they provide options to the patient, thus relinquishing control. Participants viewed the extent to which control was relinquished as related to the welfare of the mother and infant.

Preserving Order

This minor theme, preserving order, described the participants' perception of the PNs new, expanded role responsibilities and nursing practices. This reflected the concepts of family-centered care while ensuring the orderly management and delivery of care for perinatal patients and families during the childbirthing period. All participants describe various aspects of preserving order. This minor theme involved four aspects: being organized, setting priorities, fitting it all in, and maintaining staffing.

Being organized. Participants described being organized as an important aspect of preserving order. The new expanded role responsibilities of the PN involved reorganizing their former TMC routines and procedures in order to increase flexibility and combine the care of the mother and the infant. The majority of the participants reported that, as a result of the transition, the physical environment of the work place

was also restructured or modified to provide LDR(P) and combined mother-baby nursing.

Participants described being organized as one of the professional characteristic of the PN.

> You have to be organized. Sometimes you have to move very quickly.

They also mentioned that preserving order required the ability to be organized in order to save time.

> You have to be able to organize yourself. It takes more time if you can't get organized.

Being organized also entailed having supplies and equipment available and cleaned up.

> Just getting supplies, having these things accessible to you. Having people prepare areas, stock, keeping things cleaned up.

Participants described SRMC as promoting a sense of being more organized and allowing the nurse to maintain continuity of care for the patient.

> I like LDR(P). I like being in one room . . . and I like staying in one place. I feel more organized. I don't feel as everything's chaotic.

Participants also mentioned that working in SRMC was easier for the PNs. According to one participant:

> It's much easier having it all in one room.

In contrast, several participants described being unorganized when caring for both mothers and babies. They also described combined mother-baby nursing as much harder because the room assignments were often scattered and required the mother-baby nurse to shuttle between the patient's room and the nursery. Some participants indicated that, in some work settings, the LDR, mother-baby, and newborn nursery were all on separate floors.

> When you are doing both [mothers and babies], if your rooms are scattered or separated, you're running a lot. You're doing a lot of running back and forth.

Several participants mentioned caring for the mother and baby as a unit and doing everything at the same time, resulting in the PNs being better organized.

> If you realize they are a unit [mother and baby] and you treat them as a unit and do everything at the same time, you can organize it better . . . don't do all your mothers and come back and do all your babies, that takes more time.

Preserving order on the unit also involved setting priorities in order to deal with the fluctuating census, rapid turnover, and many interruptions that occurred in the work setting. Participants mentioned the effects of the rapidly fluctuating census of the perinatal units, including an influx of patients and additional work.

> Our floor is different than others because the census changes so quickly. We can go from 9 couples to 18 by morning feasibly.

Setting priorities. Participants mentioned that setting priorities allowed PNs to deal more effectively with interruptions such as discharges.

> I can't really tend to them the way I'd like to because of these discharges so it's just a matter of juggling, prioritizing. I try to be as organized as I can, dealing with interruptions.

Fitting it all in. Participants detailed the PNs working to fit it all in when trying to meet the demands of the job. For example, they mentioned working to "fit it all in" when doing extensive discharge teaching, particularly when taking the time to "do it right."

> We do a lot of teaching. It's hard to fit it all in because if you should have four mothers and four babies, all might be going home that day. A discharge is a busy day.

Participants also discussed having difficulty in "fitting it all in" by getting "tied up" by too many demands.

> Sometimes the doctors wants to do the circumcision so, if you are taking care of four couplets and you have a doctor, or two or three doctors want to do the circumcision, you are tied up in the nursery.

The rapid turnover within a shift also made working to fit it all in necessary for the PN.

> A lot of times if you start out with three or four couplets, several or all of them go home, you end up with an entirely new assignment before the end of the day. That's a mountain of paperwork.

Maintaining staffing. Participants described maintaining staffing as important for implementing the family-centered model of perinatal nursing. In some work settings this involved the flexibility of PNs to be assigned to work in all areas. They also reported that maintaining staffing was influenced by the ability to ensure the availability of PNs to provide care and support for perinatal patients and their families, as well as to be ready to deal with the unexpected emergency. They suggested that maintaining staffing interfered with the PN's ability to establish effective communications in the nurse-patient relationship. The majority of participants reported a lack of environmental resources for maintaining staffing, which resulted in the ideals of the family-centered model being compromised.

Several participants indicated that, in their institutions, maintaining staffing required that PNs have the ability to work all areas.

> You really need to be able to do all three areas [LDR(P), mother-baby, and admit nursery] to maintain an adequate working staff at that hospital.

Participants who worked as LDR(P) nurses also discussed maintaining staffing by reassigning other PNs to facilitate one-on-one nursing care.

> I think a lot of times you need to have one-on-one nursing, you can't be scrambling in and out of rooms hearing a little bit of each. They have to assign different assignments to the other nurses.

On the other hand, several PNs who worked as mother-baby nurses, described maintaining staff by routinely returning to the TMC model at night.

> The night nurses, they still divide their patients up, and it's just the mothers, and then there are the nursery nurses because the babies do go back to the nursery at night, so they have a nurse who does admits and then a nurse to hold the babies.

All participants mentioned that maintaining staffing was influenced by a low census. However, they also mentioned the need for staff to be available when labor patients arrive.

> When those labor patients come in, somebody has to attend to them.

They detailed the importance of maintaining staffing in order to be ready to deal with an emergency.

> Things don't change in an hour in labor and delivery, they change in 5 minutes. You get an abruptio in, you get a prolapsed cord in, you have to have three nurses available for the OR suite.

Participants described the staffing limitations enforced by nursing management as influencing the PNs' maintaining staffing.

> They cut us as thin as possible, expect us to do more work. I am a hard worker, but there is no latitude for that emergency when you find it . . . the hospitals are trying to do everything they can to cut down.

They mentioned that nursing management's method of staffing by numbers of patients and stage of labor did not always work out.

> I think that staffing for most nurses is a big issue. They [nursing management will] say, "She is in early labor, she gets half a nurse in labor," . . . it doesn't always work out the way.

For such instances, participants described calling for backup staff when help is needed for maintaining staffing.

> You do need backup, you need to know that you can call someone, another nurse basically, to come and help you out of a situation . . . . That is very difficult in most facilities because you are always staffed according to patient numbers.

Even so, participants detailed the lack of resources for maintaining staffing. According to one participant,

> You can usually call the supervisor, . . . but basically they are not trained in labor and delivery either and there isn't much that they can do, but come up and try to find some help for you.

Several participants discussed problems in maintaining staffing, such as when no one is available to be on call.

> We may have an on-call person that's coming in at 11 PM, so until 11 PM we just have to make do. If there is someone available to be on call. But there are nights when there isn't and then you just have to make do. You deal with it, because most of the time, at night, the babies are not out in the room.

Furthermore, participants described PNs being called off by nursing management as interfering with nurse-patient interaction and with patients getting the time and attention they needed.

> It's one thing to be busy, but to be so busy because they've [nursing management] called off your staff, that you are running in and out of patient's rooms. . . . It's nice to be able to interact with patients, not in a totally harried setting.

> It's one thing if you have five nurses on [in LDR] and you have 16 patients, and there is nothing you can do about it, but when they call everybody off or send them home and then they leave you short and the patients aren't getting the time and attention they need.

Other participants described maintaining staffing by compromising the family-centered model and returning to the TMC model when the PNs were extremely busy.

> Occasionally, when we are extremely busy, we'll go back to a traditional type nursing, where I may be taking care of the mothers and another nurse will be taking care of only the babies.

All participants perceived maintaining order, whether organizing the setting or maintaining adequate staffing, as important in the transition from TMC to family-centered perinatal nursing.

Handling the Unexpected

The minor theme, handling the unexpected, described the participants' perception of the PN's expanded role related to being responsible for successfully dealing with potential/actual events that threatened the life or physical well-being of the

mother and her fetus/infant during the childbirthing period. Participants perceived the childbirthing period as a critical time with potential danger and risk for the mother and the fetus/infant. The PNs viewed both as vulnerable, although the infant was considered to be at greater risk than the mother. This minor theme included five aspects: being prepared with necessary skills, anticipating, monitoring and assessing, being alert (liability), and taking action.

Being prepared. Participants indicated the importance of being prepared with necessary skills. All participants discussed how the lack of regularly scheduled experience in the other areas of perinatal nursing made patient assessment and early diagnosis of a serious, unexpected problem difficult,

> When somebody who comes back to do a recovery in labor and delivery, who doesn't usually work there, might not pick up that this patient is having a problem, that she is starting to have signs of high blood pressure, signs of too much bleeding.

Not having sufficient experience created more stress for the PN.

> But because I do mainly mother/babies, when I have long periods of time when I don't do that [work on LDR unit], it isn't easy. I really have to think, and I feel more stressed. It's not second nature. . . and of course when I go back there it is because it's a crisis.

They indicated that part of the responsibility or obligation of being prepared with the necessary skills for the unexpected included "having what it takes" to handle a variety of situations.

> Many things come in during the shift. You get admits from outside, Emergency Room admits. Babies that deliver on the spot upstairs. We get antepartum moms that have cramping and you just need to be prepared to have what it takes to accept these things.

In addition, the participants indicated that being prepared with the necessary skills included being knowledgeable and knowing what to do. According to one participant, being knowledgeable involved the PN knowing what to do to have a good outcome for the mother and baby.

> If you happen to be that RN and there is nobody else around, then you need to be able to know how to do what it takes to have a good outcome for that mother and that baby or the best outcome that can be provided at that time.

Participants also mentioned being able to respond very quickly.

> Things can change very quickly and you have to be able to respond. You have to be so knowledgeable that you see a strip and you know exactly what to do.

Being prepared with the necessary skills included having the necessary technical knowledge and skills for intervening when unexpected risky situations occurred.

> I think that there is a lot of skills when you are talking about going down for meconium stains or for C-sections . . . there is a lot of skills that they definitely have to be comfortable with.

Having skills that rely on knowing what's going on from experience, a "sixth sense," was mentioned by several participants

> I think it also takes intuition, a lot of intuition . . . . Just knowing what's going on just from experience. Sometimes you just know something is not right, . . . this patient is really moving but she doesn't act like it.

In order to develop the technical knowledge and skills more quickly, the PN must be willing to take risks and not avoid taking care of complicated patients.

> If they are willing to take the chances, in the sense that if you have a complicated or critical OB patient, are you continually going to avoid taking care of those types of patients, it's going to take you longer to become more skilled.

They also mentioned the importance of the PNs being comfortable in their skills and feeling adequately prepared.

> It's good to have that comfort zone within yourself to feel like you can give the best care . . . to be comfortable in your skills for the normal as well as for the emergency.

Despite the importance of the PN feeling comfortable, participants cautioned against getting too comfortable:

> I really believe the nurse that becomes real comfortable and doesn't ever get adrenaline going in L & D is looking for a bad situation to occur. She's got to be missing something.

> If you ever think that you know it all, then you become dangerous, to your patients and to yourself and your fellow workers, because then you've closed yourself up.

For some PNs, the lack of experience in using their skills resulted in discomfort with the responsibilities of their work and limited their ability to function in all areas.

> Nurses don't want to be made to feel like they don't know anything. They don't want to be put into situations that they are not comfortable with. I didn't say to feel expert, but to feel comfortable, and nurses don't want to put their license on the line that way.

Anticipating. Another aspect of handling the unexpected described by the participants involved anticipating the unexpected, particularly in the area of labor and delivery.

> To work in labor and delivery is an anticipation.

> Labor and delivery is one big "what if" waiting to happen.

Anticipating the unexpected was considered important because of the state of uncertainty in the childbirthing process. As a result, the PNs were unable to predict what was going to happen but they were required to be ready to react in an emergency.

> We can't predict what's going to happen. What things are going to come up. How this baby is going to respond versus another baby.

> Things could take place in two minutes, in a minute, in 30 seconds. If a mother codes or if a baby's heart starts to go into distress, you don't wait an hour, you react right then and there.

One participant described the perceived risk to fetus/infant and lack of knowing what to anticipate in the following way.

> I feel safer that it's out, versus being in and watching the monitors and wondering if the baby is going to crunch or whatever.

Monitoring and assessing. Participants discussed monitoring and assessing the patient-family to determine what was going on in a situation. Monitoring and assessing entailed being responsible for watching patients in case they got into trouble or in case

the unexpected occurred. In the LDR, monitoring and assessing included the use of technical monitoring equipment that was centralized. One participant described monitoring in the following manner:

> You have a central monitor. It displays in every room and outside at the nurse's station. . . . You can look up and say, "I know what's going on in every room," because it's right there . . . if I am in one patient's room, I'm looking and going, oh I'd better get out of here, my other patient's heart rate is dumping and I need to go.

Participants also stressed the difficulty of assessing an unseen patient [the fetus].

> You can assess somebody that you've been seeing--it is a lot harder to assess somebody who is just a bleep on a monitor screen . . . because you're working with a patient that you see and your working with a patient you don't see.

Participants reported the risks involved with the technical interventions used in LDR.

> There is risk with any intervention. Perforated uteruses, putting the IUPC incorrectly and damaging the baby's presenting part, there is a lot of risk involved.

Being alert. Similarly, participants described how the possibility of something happening to the mother or the infant made being alert necessary for the PNs to protect against liability, particularly PNs working in the LDR unit.

> And you are constantly on your toes . . . . It's a liability type of game in obstetrics. . . . If something happens to the mother, chances are something is going to happen to the well-being of the baby. If something happens to the well-being of the baby, somehow it is going to affect the well-being of the mother.

Because the legal liability and risk associated with working as an LDR nurse was greater than that associated with working as a mother-baby nurse, and the postpartum period was viewed as a more relaxed period, being alert was not considered as important for the mother-baby nurse.

> It's the liability of it. The liability is so great. I mean any delivery truthfully is a high-risk situation.

Participants stressed being alert during the critical time period immediately following delivery.

> Because all the time, I hear, "She is just a recovery patient." Well, that's where patients get in trouble is in recovery if you don't watch them. That's where the baby can get in trouble too.

According to several participants, being alert involved the PN making the right decisions and doing everything right to avoid litigation. As a result, the PNs, particularly those working in the LDR unit, were viewed as being vulnerable, with the possibility of becoming a victim.

> You're in a more vulnerable position as far as being sued. You have to make split-second decisions and they better be the right ones.

Taking action. Participants described taking action and being persistent when they perceived a problem with the infant. They indicated that physicians sometimes ignored their concerns unless they were persistent and prepared to communicated effectively.

> It's a matter of communicating what you are perceiving . . . to call your physician and say, "You know, this is what's happening, . . . there is just something not right."

Thus, the final minor theme involved in the participants' perception of family-centered perinatal nursing relates to the nurses being prepared to handle the unexpected in terms of having the necessary skills and being alert to all possible situations.

Meaning of the Transition to Perinatal Nursing

The meaning of the transition to perinatal nursing detailed perception of the staff nurses who had experienced that transition. The participants, who had previously specialized as labor and delivery nurses, postpartum, and/or newborn nursery nurses for 3 or more years, described their experiences of the transition to LDR(P) and mother-baby nursing. The meaning of the transition to perinatal nursing primarily focused on the participants' perception of the experienced transition and the evaluation of its effect on the implementation of the new practice model.

The meaning of the transition to perinatal nursing involved the participants' perception of the influencing factors that intervened in such a way as either to promote and facilitate the transition or to discourage and hinder the transition. The occurrence of these factors was viewed by the participants as pivotal in that they interrelated with the other major themes. In turn, these factors ultimately determined the meaning of the transition for the participants. Two major themes emerged: motivating factors and deterring factors. The meaning of the transition to perinatal nursing is outlined in Table 3.

Table 3

Meaning of the Transition to Perinatal Nursing

Major Themes	Minor Themes
Motivating Factors	Experience of Learning Experience of Relationships Experience of the Work Place Experience of PN Practice
Deterring Factors	Experience of Learning Experience of Relationships Experience of the Work Place Experience of PN Practice

Motivating Factors

Motivating factors were viewed by the participants as influencing factors that intervened in such a way as to promote and facilitate the transition to family-centered perinatal nursing. Four aspects emerged as minor themes: experience of learning, experience of relationships, experience of the work setting, and experience of PN practice.

Experience of Learning

The first minor theme detailed the participants' perceptions related to their experience of learning the expanded roles and responsibilities of the PN. They discussed orienting and cross-training to function as LDR(P) and/or mother-baby nurses. All participants described their experience of learning, which encompassed being motivated, personal/professional growth, and being supported.

Being motivated. An essential aspect of learning was the PNs' motivation to learn and meet their professional goals. Participants discussed feelings of being motivated, such as having a desire to be challenged and to expand their knowledge and technical skills, in order to work in the other areas of perinatal nursing.

> It's like I want to be more challenged like that, I want to take on baby stuff. I want to suction. I want to help bag and mask. I want to do that. . . . It makes me want to learn.

Professional goals. Participants characterized their desire to learn and to be knowledgeable in all areas as being motivated by their desire to meet their professional goals.

> I think that's what helps to be a good perinatal nurse, because there is something that you want to learn and you go out and you do it.

> When I went into Obstetrical nursing, I wanted to be the best that I could be, to give the best care possible . . . the only way that I could have accomplished that was to learn all the areas, and to put it all together as a picture, so that I had more [of a] knowledge base.

The participants mentioned keeping up in nursing as another aspect of their desire to learn. Because of the advances in nursing, keeping up in their field was viewed as a motivating factor influencing their desire to learn. As one participant described:

> You do need to try to attend continuing education because the nursing field keeps going. It doesn't stop in one part. You have to keep going.

Participants also indicated that they did not assume that there was nothing more to learn.

> The other thing that I think keeps me doing and learning is the fact I don't assume that I know everything . . . there is always still something new.
>
> I try to keep up with the technology the best I can.

Personal/professional growth. Several participants specifically reported the benefits of learning the PNs' new, expanded role as related to their professional growth and development.

> To provide that totally continuity of care and education, and self care and infant care and especially when they go home, the follow through care, if the patient calls you back 2 days later, ... That has broadened me as a nurse, it has given me the background to be able to provide my patients with the best care possible and that I feel like every patient deserves

They also mentioned the challenges of clinical practice as stimulating the personal and professional growth of the PNs.

> It keeps you on your toes. It makes it challenging, exciting, and stimulating at the same time.

Being supported. Another aspect of the experience of learning, being supported, entailed the participants' perception of being helped, being given back-up support, and being reassured by others during the experience of learning their new role. Three aspects of this minor theme emerged: the environment, cross-training with a buddy, and experts.

Participants expressed the importance of having a supportive learning environment to learn all areas of perinatal nursing.

> For us to build that as nurses, covering all of it, . . . I think that we need to be met half way on that, to make us comfortable in all new learning experiences.

Supportive learning environments were perceived by the participants as leading to their success in learning.

> There was never any "Oh, Don't you know that?" There was never any negatives. Everything was always very positive, very supportive, so it was a good learning environment. I wasn't set up to fail. I was set up to succeed. So I succeeded.

Cross-training typically involved being teamed ("buddied up") with somebody from another specialty and taking turns working in the area opposite of one's specialty. Participants described situations of being helped to feel comfortable (less threatened) and given back-up support while being cross-trained. In addition, situations were mentioned in which other PNs were seen as providing help and reassurance in their role as preceptor/teacher.

> So each one of us had somebody who we were buddied to. We had to go over the assessment ourselves with them until we were comfortable.

> You need someone as a teacher, that sits down and says, "This is the way you do this and this is the way you do that." "Read the policy and now, do you feel comfortable with it?" "Now you can do it."

Participants depicted the availability of experts in the work setting to provide back-up as a means to providing a sense of being supported and as an adjunct to their new knowledge and skills in potentially difficult situations.

> I know if any adult [mother] was in trouble, the advantage here is that there are so many people to ask as well as up in nursery, [with the babies] . . . The fact that we will be continuing to buddy has been helpful.

> Most of the time, I am collaborating with the nursery nurses first. "What do you think he [MD] would do in this aspect of it?" We collaborate on it, they tell me what they think they would do.

These participants thus viewed the experience of learning as positive.

Experience of Relationships

The second minor theme depicted the participants' perceptions related to their experience of relationships in the transition to family-centered perinatal nursing. They detailed situations that involved the interactions and relationships between the PNs and the other health professionals in their work environment. In this minor theme,

experience of relationships, two aspects emerged: receiving rewards and being supported.

Receiving rewards. Participants described receiving rewards as a motivating factor that positively influenced their experience of relationships during the transition to FCMC. Several aspects of receiving rewards were expressed: receiving rewards from patient/family, sense of satisfaction, benefits to patient, and appreciation from patient, doctors, and management.

The participants discussed receiving rewards from the patient/family in terms of appreciation and positive feedback.

> They come back to see me and bring the baby. Come to see me or they write a letter, sometimes they even send me a picture. You just feel good when you are helping people and they appreciate that.

> Positive reinforcement from the patients. I like contact with the patients. "Thank you so much for making theirs a good experience." One of those once a week keeps me personally going.

Participants also expressed receiving rewards that influenced their experience of the transition as a sense of satisfaction.

> It gives me a lot of satisfaction knowing that your are not only bringing life into this world . . . this is their miracle time and to be a part of that.

Several participants described receiving rewards in terms of benefits to patient/family as influencing the acceptance of the transition to FCMC by the patient-family as well as the PN. It was important for the participants to believe that the patients and their families were benefiting from their care.

> You do feel like you are helping people. Helping them to make it through in their life. To have a baby is a very big experience in their life.

> I think that the patients are possibly happier that they have somebody [mother-baby nurse] . . . I feel that everything is more complete . . . less fragmented.

The benefits of the nurse-patient relationship in the new practice model were also considered motivating factor in the transition. Participants mentioned receiving appreciation from the patient:

> It's just a good feeling, because they remember those good times. Sometime you think, it's really nothing I did. It's not what I did, it's what you did, and it's what your husband did--and they say, "No, no, you really helped it."

One PN summarized the patient-family benefit of her being there as a motivating factor in the situation involving a C-section patient whose infant was in the Neonatal Intensive Care Unit.

> And I wanted to be with her, where she was, at that particular time, and I progressed her from doing nothing and feeling crummy and nauseous to getting up and ambulating and taking food. . . . So I helped her to understand the baby's condition that I could empathize with her, encourage her to physically progress with herself so that the goal was to go down to the nursery and see the baby.

Being supported. The second aspect, being supported, described the participants' perception of being helped and given back-up support and encouragement during their experience of working with others in the transition to family-centered perinatal nursing. Participants reported feelings of being supported by peers, managements, and doctors.

Being supported by their peers was viewed by some participants as benefiting the patient, improving work relationships, and making work easier for the PNs. They also mentioned asking for help and back-up support in situations in which they were afraid or uncertain about the well-being of the mother and/or the fetus/infant. In addition, they detailed collaborating with others who were more knowledgeable when working in new areas in which they felt uncomfortable with their own level of expertise. Those participants who described experiences of being supported in turn reported being supportive and collaborating with others. Several participants expressed their feelings of being supported by their peers.

> We're helping one another. I think it's made the nursery and the postpartum staff that much closer.
>
> I go into the nursery, they have two nursery nurses there, if there is a potential problem with the baby, or I think there might be one and I am not sure . . . . in the following examples. I think we collaborate a lot more in things like that.

They mentioned receiving appreciation from their supervisors and what it meant to them:

> Even if you are so tired, you feel great because somebody, your supervisor, appreciates you.
>
> You know that they are appreciating you and your supervisor appreciates your job well done . . . that makes you feel that you are doing things [that are] very important and very good emotionally.

They also mentioned their feelings of being supported by nursing management, such as when they received encouragement.

> I have a very supportive head nurse. I think that you know, when you want to do things, she goes out of her way to try to make certain things happen.

However, participants also reported that getting an "extra hand" frequently depended on the support that they received from nursing management.

> You can usually call the supervisor, . . . but basically they are not trained in labor and delivery either and there isn't much that they can do, but come up and try to find some help for you.

Appreciation from the physicians was also reported by the PNs, as influencing their experience of working with others.

> A lot of the physicians after they deliver, they'll thank you and they'll say you did a good job. They make you feel better. They make you feel you have to keep going on.

Some participants detailed their feelings of being supported by the physicians with whom they worked. They identified certain characteristics of their interactions with physicians as being related to their feelings of being supported. These characteristics included being listened to, showing mutual respect, having confidence, and obtaining trust.

> I feel that when I have a problem with the patient I can get their attention. They have confidence, if I'm in the nursery and I want a doctor to come in to see a baby, they don't hesitate. I know what question to ask and what answers to tell them.

They also described how physicians were being supported by PNs.

> To be honest, they [physicians] could not function without nurses . . . especially in labor and delivery because doctors really have to be dependent upon the nurses to have that nurse call them over there in time to deliver their patients, or not come over and sit two hours waiting when they've got busy office hours.

Relationships were thus viewed by these participants as positive, giving them a sense of being rewarded in terms of support from patients, peers, and management.

Experience of the Work Place

The third minor theme described the participants' perceptions related to their experience of working in the setting where the transition from TMC to family-centered perinatal nursing occurred. All participants described their experience of working in the setting and expressed the feelings that those experiences involved. In this minor theme one aspect emerged: feelings of satisfaction.

Feelings of satisfaction. Feelings of satisfaction described the positive feelings of enjoyment and comfort that the PNs experienced in the work place. Participants discussed various situations related to the work environment, type of work, and job responsibilities that resulted in their enjoyment. They also detailed their enjoyment of various alterations in the work environment as part of the transition to perinatal nursing that produced their feelings of comfort.

> It's a fun environment [in which] to work.

> I would be bored working in a medical/surgical area where there wasn't the hustle and bustle of a labor and delivery unit.

> You do have to do your things quickly and I like that part of it. They are in and out. . . . It's fast moving and it's interesting.

They also mentioned enjoyment of the type of patients for whom they cared.

> You do get a high-risk sick patient, but they are not really . . . we are not sending anybody home usually with a serious disease . . . but in the long run, it's just a happy place to be.

One participant attributed her feelings of enjoyment to her colleagues.

> Most of the people I work with are dedicated and really try to go above and beyond, and that's why I love where I work because I know that.

Participants described their comfort as a result of changes in the physical environment that also benefited the mother and the baby.

> You move a few more things in and quietly. It's not disrupting the patient so much if she is trying to stay in control. If she doesn't have anesthesia.

> I like not having to move a patient. There were many times when you would be moving a patient ready to deliver, so there was a lot of stress to me. This is calmer, less stress, you gradually change from a labor room to a delivery room as they get closer to delivery.

Thus, the setting was discussed by the participants in terms of comfort and satisfaction for the patient and the nurse.

Experience of PN Practice

This minor theme depicted the participants' perceptions of their experience of practice related to the transition from TMC to family-centered perinatal nursing. The participants described their progression from their former traditional roles to their new, expanded roles as LDR(P) and mother-baby nurses. In this minor theme, two aspects emerged: desire to succeed and feelings of accomplishment.

Desire to succeed. This first aspect involved the participants' desire to succeed as PNs practicing perinatal nursing. Several participants described the difference in the sense of satisfaction in being a PN versus being a traditional nurse:

> You are putting more of yourself into it than you did before. Before it was just okay work, it's not really work any more. It's not a job. It's the satisfaction of seeing everything working out well versus we had 10 deliveries today. Now it's

> more this patient and her husband and the baby, and the family, the whole process, rather than the number of babies delivered.

Feelings of accomplishment. The participants also expressed their feelings of accomplishment when they described the sense of achievement that they experienced in fulfilling their roles as PNs in clinical practice. The participants described situations related to their success in expanding their level of knowledge, technical skills, and practical experience to function in their clinical area as leading to their feelings of achievement.

Participants described their feelings of fulfillment related to their practice of perinatal nursing in the following manner:

> It's just the whole picture to me. It's just what I pictured nursing to be for myself and it's fulfilled every time I go to work.

> I get more fulfillment out of it for myself as a labor and delivery nurse. As a nurse, period, as to what I can provide and what I can do to help assist.

Participants also described their feelings of accomplishment that resulted from successfully using their interpersonal skills in relating to the patient-family.

> I enjoy the closeness to the patient, if you're the only one there, but I also get that comforting feeling by allowing that person, those persons to have the type of delivery that they want, knowing how much to stand back, how much support to give, when to insert guidance, I guess or support into that family situation.

The transition to perinatal nursing was facilitated by the participants' ability to expand the three aspects of knowledge, technical skills, and practical experience in order to function successfully in their practice areas. Participants described their feelings of achievement in the above three aspects:

> I feel that when I have a problem with the patient I can get their attention. They have confidence, if I'm in the nursery and I want a doctor to come in to see a baby, they don't hesitate. I know what question to ask and what answers to tell them.

> It's good to have that comfort zone within yourself to feel like you can give the best care . . . to be comfortable in your skills for the normal as well as for the emergency.

Another aspect related to the experience of the PN practice related to the participants' perception of their achievement of skilled role performance that included a feeling of mastery with the responsibilities required of the PNs in a new family-centered setting. These feelings of mastery were reflected in their positive state of being.

> I really like the work. I really feel I am good at it. I feel my skills are excellent. It is easy for me. I don't know if I have a sixth sense about it or not. It seems that it comes easy to me.

In summary, motivating factors that the participants perceived as influencing a good transition included their experiences of education, relationships, work place, and their practice. It is interesting that these same themes were presented as deterring factors to implementing family-centered perinatal nursing.

Deterring Factors

Deterring factors were viewed by the participants as influencing factors that intervened in such a way as to discourage or hinder the transition to family-centered perinatal nursing. Four aspects emerged as minor themes: experience of learning, experience of relationships, experience of the work place, and experience of PN practice.

Experience of Learning

The first minor theme of the meaning of the transition detailed the participants' perceptions related to their experience of learning the expanded roles and responsibilities of the PN. They discussed orienting and cross-training to function as LDR(P) and/or mother-baby nurses. The participants described both the intellectual and emotional experiences. Feelings of threat to self detailed the participants' perception

regarding the PNs' negative emotions toward the experience of learning, which included feeling fearful. Although situations that evoked fear varied, frequently they involved orienting and cross-training in areas that the participants considered threatening.

Threat to self. The participants expressed fear of forgetting something or not doing something right. Participants described situations in which they expressed fear.

> We had the opportunity . . . whoever wanted to do this [train in LDR], I didn't even sign up because I was afraid. So, it's my internal fear.

> I would have been more comfortable that first year of training had there been a doctor in the house. That was one of my fears, that the doctor wouldn't get there in time.

> If I screwed up down there [LDR], I don't know that I could ever forgive myself and that's the fear I have.

The participants described numerous situations that triggered feelings of discomfort. For one participant, being uncomfortable was defined as "a fear of inadequacy, that I don't know, that I haven't performed those procedures." Participants detailed the importance of being comfortable with the essential skills used in potentially high-risk situations.

> We were all required to take the class so that you could become more comfortable with infant care and most postpartum nurse weren't that comfortable with the babies and the nursery nurses certainly were not comfortable with the mothers.

Some participants described situations in which their feelings of discomfort improved as they gained more knowledge and experience.

> I hadn't really worked newborn nursery that much either, so I wasn't that comfortable with babies, . . . I remember working there the first couple of time really uncomfortable with that situation. So we took a lot of classes.

On the other hand, other participants described threat to self in situations in which they continued to feel discomfort as a result of their lack of routine or practical

hands-on experience. This in turn interfered with their ability to carry out the responsibilities of their work and limited their ability to function in all areas.

> Some of our nurses now have been doing more mother-baby and not so much the admission [of infants], and even though they were doing that in the past, they no longer feel comfortable to go down at times for C-sections.

> I don't go down for the meconium stains at all. I am very uncomfortable with that, probably because I just never really have done that. I have gone down and buddied with somebody, but I just basically observed.

In addition, the participants described the perceived threat to self related to being held liable for their lack of experience and background knowledge in new areas of responsibility. They especially mentioned the risk involved in being responsible for the life of the baby.

> I thing the biggest anxieties and fear is total responsibility. The liability of doing something and being held liable when you don't have the background knowledge or the years experience to back you up.

> I was scared to death of the responsibility of having to make judgment calls where I didn't really have any experience doing that on a baby.

Participants thus were concerned about the additional responsibilities of their new roles. They described wanting to avoid unpleasant situations in which they felt uncomfortable or threatened.

> Nurses don't want to be made to feel like they don't know anything. They don't want to be put into situations that they are not comfortable with. I didn't say to feel expert, but to feel comfortable, and nurses don't want to put their license on the line that way.

Participants thus viewed learning as a threat to their self-esteem.

Participants discussed threat to self in situations that resulted in feeling that they did not know what to do. They mentioned the initial difficulty, when cross-training for mother-baby nursing, of getting other nurses just to agree, "Yes, we can do this and you can learn this one and we can learn yours." Participants reported cross-training and orienting to work in new areas of responsibility, such as LDR(P) and or mother-baby nursing, as particularly stressful situations.

> That would be the basis for why I didn't like LDR because I wasn't sure if I knew what to do. I don't like that feeling. That's the stress part of it, not knowing inside of me that I know where everything is and that I know that I can do it myself.

Experience of Relationships

The second minor theme of the meaning of the transition depicted the participants' perceptions related to their experience of relationships in the transition to family-centered perinatal nursing. They detailed situations that involved the interactions and relationships between the PNs and the other health professionals in their work environment. In this minor theme, the participants described the experience of relationships in working with others and the feelings that the experience evoked. The two aspects of this minor theme are feelings of conflict and threat to self.

Feelings of conflict. The first aspect, involving feelings of conflict, described the participants' perception related to the negative emotions evoked by the experience of working with others, including disagreements and lack of rapport with peers, management, and doctors.

The participants described their feelings of conflict in working with their peers. These included peers who worked on the same unit as well as on different units in the other areas of perinatal nursing.

Several participants described their feelings of conflict when working with their peers.

> There are some that it is like their goal and motive to find all the wrongs, not "let's work and see what needs to be done this morning," but what wasn't done yet.

> Nurses with lots of experience forget that one day they were new, too. And now, they're very critical of everything that goes on.

Likewise, participants reported feelings of conflict between PNs on different units related to the lack of rapport.

> When you transfer your patient, you worry that, if you don't have that good rapport with postpartum [mother-baby], then you think, are they going to offer to take care of my patient the way that I would want them to?

Participants discussed feelings of conflict with management in disagreements. The level of support given to PNs by nursing management and nursing management's' expectations regarding the PN's level of participation were both issues in contention.

> I would like to be supported more in my efforts and have my upper management ask for more feedback because they aren't as connected to the reality of it on a day-to-day basis as I am.

They also reported a lack of rapport with management in situations involving the participation of PNs.

> I think sometime we feel that we are no longer collaborating, but just doing what administration likes us to do whether we like it or not.

Participants described feelings of conflict with doctors in disagreements, such as those regarding patient care and the doctors expectations regarding the responsibilities of the PN.

> Some doctors are very difficult . . . . Some of the doctors are very demanding.

Several participants indicated a significant difference in the rapport between physicians and the PNs working on the LDR unit versus their rapport with the PNs working on the mother-baby unit. Several participants reported that the PNs' ability to establish rapport was dependent on the opportunity for PNs to engage in activities with physicians that promoted attitudes of mutual respect, confidence, and trust.

According to one participant, difficulty in building rapport was related to the degree to which the physician depended on the PN:

> In LDR, physicians depend on you to be their eyes and ears at that time. The postpartum period, they don't really depend upon you so much. So it's hard for that [mother-baby] nurse to build up that rapport.

Participants also discussed the lack of opportunity to build rapport related to the lack of acuity of interaction with physicians.

> Most mother-baby nurse have not had the opportunity to build a good rapport with many of the physicians because they haven't been challenged . . . . Your interaction, your contact with the physician is not acute. They come in, they come out. They very seldom ever need you or your opinion.

This included one-on-one relationships in high-risk situations.

> Their [LDR nurses'] rapport with doctors is a little different than our [mother-baby nurses'] rapport. I think basically it is because they are working one-on-one with those doctors in a high-risk situation.

Threat to self. The second aspect, involving feelings of threat to self, depicted the participants' perception related to negative emotions evoked by the experience of relationships, which included threat of disapproval and lack of respect for opinions.

Participants described the threat of disapproval from the physicians related to the PNs not supporting physicians who are resisting the transition.

> I think that they are so angry with the whole setup . . . . They want to come in and they want their three babies and leave. Well, management says they have to check their babies in the rooms, so we are constantly having to struggle . . . and you want to be nice to them.

Participants described their feelings of threat to self in situations in which the opinions of PNs were accorded little or no respect.

> It doesn't matter what you say, they're going to do it their way, and the fact that they don't listen to you makes it degrading.

Participants also depicted the lack of respect for the ideas and expressed needs of PNs in situations in which nursing management made the decision without using the PNs' input.

> I see people go to meeting, but when they voice their opinions and express themselves and say what they need, I don't see upper management taking that in. It's as though they've already made their decision before they got out input.

Several participants indicated the significant differences in the level of respect given by peers, physicians, and nursing management to the PNs working in LDR versus to the PNs working in mother-baby nursing. This resulted in situations in which

the comparisons made between the two groups of nurses were perceived as a threat to the self-esteem of the mother-baby nurses.

For example, LDR nurses were depicted as having a lack of respect for the mother-baby nurses when making comparisons based on differences in their level of skills and job responsibilities.

> They [LDR nurses] feel they are highly important and far more important and that their job is far more important than any of our jobs on the mother-baby unit.

> In LDR, physicians depend on you to be their eyes and ears at that time. The postpartum period, they don't really depend upon you [mother-baby nurses] so much.

In the area of relationships, participants expressed feelings of conflict and threat rather than rapport and teamwork.

Experience of the Work Place

This minor theme involved the participants' perceptions of the experience of the work place where the PNs' practiced. They considered these experiences to be significant hindrances to the transition from TMC to family-centered perinatal nursing. All participants described the experience of the work place and the feelings of frustration that the experience evoked.

The PNs' experience of the work place involved feelings of frustration related to eight aspects of the work place: preplanning, demands of the job, situations that thwart ability to function, limitations of setting, division of units, staffing, economics, and risks to PN and patient.

Preplanning. The participants expressed feelings of frustration resulting from the lack of preplanning and reorganization of their work setting by their nursing management prior to the implementation of the mother-baby nursing model in their facility.

> Things such as phone numbers for the staff: I said to them, "We need phone numbers on both floors of all staff." No one ordered any books. It just didn't seem to matter. We needed nursery supplies on the postpartum floor.

They also expressed feelings of frustration related to the preplanning done by nursing management prior to the implementation of perinatal nursing that resulted in the PNs' lack of clear expectations, direction, and structure.

> What came first? How to structure your day so that you wouldn't feel so lost. . . . That was really never gone over or explained. . . . That was the beginning of a lot of insecurity.

Demands of the job. Participants also described feelings of frustration related to the demands of the job that hindered the PNs' ability to meet the needs of the patients and their families. Participants reported feelings of frustration related to being overwhelmed and "getting tied up" by too many demands of the job.

> It seemed as though the very first thing in the morning there were 300 things you had to get done before the doctors came in, before the examinations of the mothers and babies, and not enough time to do it.

> I take the baby to her beside, give her some basic instructions and tell her that, "I'll be right back." . . . Sometimes I don't get back. It's not that I do it purposely, but that I have so many other things I need to be doing.

Interfering situations. Participants expressed their feelings of frustration in situations such as dealing with the fluctuating census, rapid turnover and the many interruptions that occurred in the work setting. They described the PN's personal limitations and the difficulty in always being there for everyone.

> Our floor is different than others because the census changes so quickly. We can go from 9 couples to 18 by morning feasibly.

> I can't really tend to them the way I'd like to because of these discharges so it's just a matter of juggling, prioritizing. I try to be as organized as I can.

> I can only be so many places at one time. The one great thing about working in labor and delivery, and I tell patients this, whoever needs us the most gets us.

The feeling of frustration described by the participants related to the situations that thwart the PNs' ability to function in family-centered perinatal nursing. Participants described feelings of frustration regarding the full integration of the perinatal nursing roles on the mother-baby units.

> Even though we went through this integration [of roles], there are still the nursery nurses and there are still the postpartum nurses. . . . I think we are always going to have postpartum and nursery nurses.

The participants indicated feelings of frustration regarding other PNs' nonsupportive behavior to patients and their families during labor.

> They chart outside. They just look at the monitor and they only come in when the patient buzzes or if they find that the alarms are going off. . . . I think their patients will sense that the nurse hasn't really been in here. Even if it's just, "How are you doing?"

Participants expressed feelings of frustration regarding having more distractions when making a complete assessment of the infant in the mother's room rather than in the nursery and when providing discharge teaching.

> When you are assessing the baby in a mom's room, and you are fielding all these questions, I just feel like I am not doing as complete an assessment as I normally would do in the nursery. I am working in a totally different environment.

> You have so little time to do it, and the time that you do have to do it you have so many family members in there

Furthermore, early discharge of the patient resulted in the PNs not being there when complications developed.

> We are sending them home so soon, we are not there when they have their postpartum blues. We are not there when they have their engorgement.

Limitations of the setting. Likewise, the participants discussed feelings of frustration related to the limitations of the setting that hindered the transition to family-centered perinatal nursing. The participants described the limitations of the setting related to the physical layout of the work place. Although all of the facilities

restructured the former labor and delivery units into LDR units, the participants reported that the postpartum and newborn nursery units were not always modified to facilitate mother-baby nursing. Several participants indicated that the LDR unit, the mother-baby unit, and the newborn nursery were on separate floors. In one facility the NICU and the newborn nursery were also on separate floors. Participants further indicated limitations of the setting related to the physical layout and the ability of the PN to maintain the security of the infant.

> The lay out of our unit is wrong. . . . When they designed it, the nursery was there, postpartum was close, and now, it's way down in the other end. Labor and deliver is way far from the nursery. There is no way to change that, but that makes for a lot of running.
>
> It's a major problem. And of course, the hospital is not going to rebuild us a whole OB unit, so we have to work around that.

They also mentioned the limitations of the setting related to maintaining infant security.

> Our layout is very poor for security for babies. Someone could take a baby really easily. It's scary.

Division of units. In addition to issues regarding the setting, participants discussed their feelings of frustration regarding the division between the two units, LDR(P) and mother-baby nursing. The participants reported that this situation was further complicated at some of their work settings by having the LDR and mother-baby units located not only on separate floors but also managed by different nursing managers.

> Since they are in two different areas, . . . the nurses become separate. You are postpartum, you are labor and delivery.

They also mentioned division of units related to problems in communication between the PNs' on both units.

> Communication between units, it seems like it's always a problem. We shouldn't be a separate unit, meaning labor delivery and postpartum [mother-baby]. We should all flow.

Staffing. Closely related to the division of units were issues related to staffing that engendered feelings of frustration and hindered the PNs' ability to deliver care to their patients effectively.

Participants expressed feelings of frustration regarding decisions made by nursing management for staffing the units.

> I think that staffing for most nurses is a big issue. They [nursing management will] say, "She is in early labor, she gets half a nurse in labor" . . . it doesn't always work out that way.

> It's one thing if you have five nurses on [in LDR] and you have 16 patients, and there is nothing you can do about it, but when they call everybody off or send them home and then they leave you short and the patients aren't getting the time and attention they need.

They also mentioned feelings of frustration related to having staff available for patients when they arrive, including situations involving an emergency.

> When those labor patients come in, somebody has to attend to them.

> Things don't change in an hour in labor and delivery, they change in 5 minutes. You get an abruptio in, you get a prolapsed cord in, you have to have three nurses available for the OR suite.

Participants described feelings of frustration regarding the difficulty of having backup staff when help is needed.

> You do need back-up, you need to know that you can call someone, another nurse basically, to come and help you out of a situation. . . . that is very difficult in most facilities because you are always staffed according to patient numbers.

They identified the difficulty when no one is available for being on call.

> We may have an on-call person that's coming in at 11 PM, so until 11 PM we just have to make do. If there is someone available to be on call. But there are nights when there isn't and then you just have to make do.

Furthermore, staffing restrictions enforced by nursing management influenced the availability of staff for an emergency:

> They cut us as thin as possible, expect us to do more work. I am a hard worker, but there is no latitude for that emergency when you find it. . . . the hospitals, they are trying to do everything they can to cut down.

Economics. Another factor influencing of the participants' experience of the work setting that evoked the PNs' feelings of frustration related to the economics of health care.

> Economics has played a role in what I am able to do as a nurse. The time that I am allowed to do what I do.
>
> With the insurance situation the way it is today, we don't have a lot of time for teaching because in most instances they have to go home within 24 hours.

They also described feelings of frustration regarding the marketing strategies used by their institutions in competing for health care consumers.

> In the community, their market[ing] strategy is that . . . the whole family can be involved. This can happen, that can happen, and they promise them everything and then they expect me to deliver.

Risk to PN and patient. Most important, participants expressed feelings of frustration related to the risks to the PN and patient that were part of the experience of the work place and hindered the transition to family-centered perinatal nursing. Participants described the risks to patients, both the mother and the infant, and the related risks to the PNs involving their liability for negative patient outcomes. The PNs' new expanded roles in family-centered perinatal nursing resulted in their being responsible for the well-being of both the mother and her fetus/infant.

Several participants reported feelings of frustration related to the risks to the patient:

> There is risk with any intervention. Perforated uteruses, putting the IUPC incorrectly and damaging the baby's presenting part, there is a lot of risk involved.
>
> I don't thing that the consumer realizes how dangerous a delivery and even the recovery period. . . . We always hear it's such a natural thing to do.

Several participants also described feelings of frustration related to the risks to the PN.

> It's the liability of it. The liability is so great. I mean any delivery truthfully is a high-risk situation.
>
> We could become the victim. We are the ones taking care of them. We have to do every right move.

Participants spent much time in discussing how the limitations of the work place actually hindered implementation of the new model of family-centered perinatal nursing.

Experience of PN Practice

This minor theme depicted the participants' perceptions of the experience of practice related to their transition to family-centered perinatal nursing. The participants described their experience of practice that involved progressing from the former traditional roles to the expanded roles as LDR(P) or mother-baby nurses. In this minor theme, three aspects emerged: feelings of resistance, feelings of frustration, and threat to self.

Feelings of resistance. As an aspect of the experience of PN practice, the participants described feelings of resistance that involved the negative emotional feelings directed toward the transition from the TMC model to the family-centered perinatal nursing model. Participants described situations that evoked feelings of resistance and resulted in compromising the model. Their feelings of resistance related directly to the introduction of the model.

> It was met with a lot of negativity initially by the staff who were very comfortable in their role and wanted things to always be as they were.

Participants mentioned compromising the model by displaying feelings of resistance toward actual implementation of the new model. For example, one participant described the PNs' active resistance before the model was introduced:

> . . . so we tried our darnedest to put our feet in and say, "No, we like it the way it is," including myself.

Participants also described their resistance to working as LDR(P) and mother-baby nurses.

> I really enjoy the LDR concept. I don't like the LDRP concept at all.
>
> I make no bones about it, I do not like to work the nursery [admissions], I do not like to work the postpartum floor (mother-baby nursing).

In addition, the participants discussed compromising the model related to the PNs' lack of integration of the roles of postpartum and newborn nursery nurses of traditional nursing into the role of mother-baby nurse in perinatal nursing.

> I think that even after all of these years, and even though I have had some training, . . . I still feel like a mother nurse. I really do. In the same token, the nursery nurses prefer not to take care of the mothers.

Finally, participants described compromising the model by altering the PNs' couplet assignment in order to work as teams instead of doing combined mother-baby care.

> Sometimes, instead of doing couplet, we would work as teams. The nursery nurses and the postpartum nurses worked together, often time the nurse who took care of all the mothers had a nurse who took care of all of those babies . . . and we sort of cheated by doing it the way we liked anyway.

Feelings of frustration. The second aspect of the participants' experience of PN practice encompassed the feelings of frustration regarding the sense of interference that some participants encountered in their new clinical practice. They described situations that seemed to thwart the PNs' ability to fulfill successfully their expectations for clinical practice by triggering feelings of frustration. They also expressed feelings of frustration in situations in which they were unable to fulfill expectations.

Several participants described their feelings of frustration related to changes in practice that resulted from the transition from TMC to family-centered perinatal nursing and involved the PNs' roles and responsibilities.

> I feel with perinatal nursing, when they expect you to spread yourself so thin, to be able to do mother-baby coupling and then to expect you to do labor and delivery, that you are making mediocre nurses.

The participants' feelings of frustration also involved the differences between the expectations of the PNs regarding their practice and the demands of the patient-family in situations such as patient care, teaching, and the safety of the mother and the infant.

> I feel like I want to make it better but I can't so I'm going to sit on my hands and not do anything and allow them to have what experience that they want because it's not our place to fix it for them. They don't want it fixed.
>
> But, I get frustrated with them too, because I am trying to teach them from my experience and they are looking at me like as if I have no experience. I have no education. As if I am just there to wheel their baby back and forth.
>
> The C-section mothers definitely need more watching and you don't leave the babies in the room. . . . If they demand, they want them to room-in, we let them, but that becomes our responsibility to make sure that we are in there and can take care of that baby, and hand it to her and pick it up and put it back and make sure they are not too medicated.

The participants conveyed feelings of frustration over not effectively accomplishing their responsibilities of caring for the patient-family. They detailed situations related to various limitations that interfered with what they were able to do in their clinical practice. This included the added demands that resulted from their expanded roles and from decisions made by nursing management.

For example, several PNs mentioned the difficulty of always being physically available to the patient-family to meet their needs.

> You feel like you are being pulled too far apart and you can not leave a baby in the middle of a bath and parents really, unless they have several other kids, don't know what to do.

Participants also expressed feelings of frustration with being too busy with other priorities to care for the patients adequately.

> I take the baby to her beside, give her some basic instructions and tell her that "I'll be right back." . . . Sometimes I don't get back. It's not that I do it purposely, but that I have so many other things I need to be doing.

They expressed feelings of frustration over situations involving decisions that they felt were arbitrarily made by nursing management.

> It's one thing if you have five nurses on [in LDR] and you have 16 patients, and there is nothing you can do about it, but when they call everybody off or send them home and then they leave you short and the patients aren't getting the time and attention they need.

Finally, several participants conveyed their feelings of frustration over the limited time that they had in clinical practice for meeting their obligations to their patients and their families.

> I feel we are very rushed with doing what we need to do, and I feel that we are sending people home now, who aren't ready to go home yet. We don't have two or three days with them, We have one day with the patient and that's kind of hard.

Threat to self. The third aspect of the experience of PN practice described by the participants involved feelings of threat to self related to interpersonal losses. The loss of approval, loss of self-esteem, being blamed unfairly, personal safety, and discomfort encountered in their clinical practice were all described by the PNs.

Some participants discussed feelings of loss related to the potential loss of approval by someone whom they regarded highly, such as an expert in the field.

> I feel very clumsy . . . part of it is that there is a doctor there, so clumsy in his eyes when he says "I want this" and not knowing where this is in that drawer.

Several participants also reported that the PNs who were able to work in all three areas of practice were viewed as more highly valued and marketable. This situation resulted in the loss of self-esteem for some PNs.

> Basically, I feel that for us to be marketable in this perinatal field, you have to do all three. I don't think that we are very valuable as nurses in the perinatal services if you can't do labor and delivery.

> Eventually, I would assume, if you can't do all three areas, postpartum, labor and delivery and newborn nursery, you are going to be replaced. That's how we feel.

They also expressed their feelings of loss related to changes in the PNs' level of knowledge and skills and level of expertise in the new area(s) in the following manner.

> You have nurses that are not experts in their area fumbling through. I think it'll be a long time before they become experts.

> Why take the people who are proficient and force them to do other things at which they are not proficient and it's going to take quite a while for them to become proficient?

In addition, the participants discussed feelings of loss for the traditional role of the labor and delivery nurse.

> I think that there are a lot of nurses in labor and delivery who miss that traditional [nursing] where the nurse is the director of everything.

Participants also described losing confidence and skills following cross-training to new areas when the PNs lacked practical experience to maintain those skills and were utilized only infrequently in the new areas for back-up or relief staffing.

> Like with anything, if you are not doing it, you don't have hands on, you lose your confidence and lose you skill.

Several participants reporting having experienced situations in which they felt that they were blamed unfairly. These situations usually involved interactions between the PN and the patient-family or other health professionals in which the PN felt that she was blamed for whatever went wrong.

> When it does not go like that, it's usually the nurse's fault. I usually get the blame because something didn't happened the way they wanted it to.

Situations related to the actual or potential risks to the well-being of the mother and the baby posed threats to personal safety because of the liability of the participants to be alert and know what to do.

> And you are constantly on your toes. . . . It's a liability type of game in obstetrics. . . . If something happens to the mother, chances are something is going to happen to the well-being of the baby. If something happens to the well-being of the baby, somehow it is going to affect the well-being of the mother.

> You're in a more vulnerable position as far as being sued. You have to make split-second decisions and they better be the right ones.

The feelings of resistance to change, the frustration with the methods of change, and the threat to self related to interpersonal losses experienced by these PNs impacted their experience of their practice and thus implementation of the family-centered perinatal nursing model.

Interrelationship of the Major Features of the Transitional Model of Family-Centered Perinatal Nursing

Two major features--the essential characteristics of perinatal nursing and the meaning of the transition to perinatal nursing--emerged from an analysis of the interviews with the 13 participants in this study. The description of the interrelationship between these two major features and the history and context of this study resulted in the Transitional Model of Family-Centered Perinatal Nursing (see Figure 1).

History and context formed the backdrop and framework for the transition from TMC to family-centered perinatal nursing. The ideal of family-centered perinatal nursing was not achieved but a model of the current practice emerged. The investigator assumed that changes will continue because the situation is dynamic.

History and Context

The three major aspects that framed the context for the situation in which the perinatal nursing was being practiced were (a) the participants' perception of TMC, (b) the participants' perception of family-centered perinatal nursing, and (c) the history of the transition. These major aspects described the backdrop of the clinical practice environment in which the transition was taking place.

The participants' perception of TMC served to define their former roles and focused on their understanding of their relationship with the patient in that particular setting. The participants' perception of family-centered perinatal nursing served to define the new PN role and the new nurse-patient relationship. Together, they formed

the basis for understanding the meaning of the changes that occurred in the PN's role as a result of the transition from TMC to family-centered perinatal nursing. The history of the transition served to provide the participants' perception of the experience of the transition and the various aspects of the preplanning, orientation, cross-training, and staffing that occurred in the setting. The history of the transition also included the participants' perception of the experience of implementing the new practice model and the issues that led to compromising the model. These three major aspects were obviously essential to each other; one did not exist without the other two because they were all interrelated.

Essential Characteristics of Perinatal Nursing

The essential characteristics of perinatal nursing were the major feature of the Transitional Model of Family-Centered Perinatal Nursing that described the essence of perinatal nursing for nurses who had made the transition to family-centered perinatal nursing. The essential characteristics were described in terms that linked them to the participants' perception of the traditional role and the family-centered role. As such, the participants perceived the essential characteristics of the PN's new expanded role and interrelationship with perinatal patients and their families during the childbirthing process as protective caring and protective managing.

In the interviews, the participants described the transition from the traditional model to the family-centered model. They discussed the PNs' new expanded role and interaction with perinatal patients and their families as protective caring. Protective caring involved the PNs' priority of balancing the need to create a connective link between the patient-family and other health care providers and to provide care, support, and teaching with the need to provide safety and protection to their families. They also discussed the PNs' new expanded role and interaction with perinatal patients and their

families as protective managing. On the other hand, they also discussed the PNs' new expanded role and interaction with perinatal patients and their families as protective managing. Protective managing reflected the PNs' priority of safeguarding and clinically managing the care of the patients and their families during the childbirthing period. These two themes are obviously interrelated and, together, comprise the essential characteristics of perinatal nursing for nurses who have experienced the transition from.

In addition, because the essential characteristics were from the perspective of nurses who had made the transition from TMC to perinatal nursing, they were interrelated with the history of the transition. Hence, the relationship between the three major themes of history and context and the two major themes of the essential characteristics of perinatal nursing were interrelated.

Meaning of the Transition to Perinatal Nursing

The meaning of the transition to perinatal nursing was primarily focused on the participants' perception of the experienced transition and the evaluation of its effect on the implementation of the practice new model. The meaning of the transition involved the influencing factors that intervened either to promote and facilitate the transition or to discourage and hinder the transition. These factors were cited by the PNs as intervening in PNs' learning the new, expanded roles and responsibilities of perinatal nursing or with PNs relating with others in the transition to family-centered perinatal nursing. There were also the factors cited by the PNs as intervening in the work place where the transition occurred or with the PNs' clinical practice and the progression from the former roles and responsibilities to the new expanded roles and responsibilities that influenced the participants in making the transition.

Motivating Factors

The motivating factors directly influenced PNs' perception of protective caring and protective managing by intervening to facilitate the transition from the former TMC roles to the family-centered role of the PNs. In turn, the participants' perception of their new, expanded roles determined the meaning of the transition so that the influence was again interrelated.

Deterring Factors

The deterring factors directly influenced the PNs' perception of protective caring and protective managing, which were the participants' perception of the PNs' new, expanded role and the interaction between the perinatal patients and their families. Deterring factors intervened to discourage and hinder the transition from the former TMC roles to the family-centered roles of the PNs. In turn, the participants' perception of their new expanded role determined the meaning of the transition, so the influence was again interrelated.

The conceptual framework of the Transitional Model of Family-Centered Perinatal Nursing and the interrelationships among the major features of the model are diagrammed in Figure 1.

Discussion

In this study the PNs described their practice as reflecting both the humanization of birth (protective caring) and the mechanization of birth (protective managing) suggested by Eakins (1983). The PNs also discussed blending certain traditional practices from the former model into the framework of the new family-centered model, which was reflected in the strong threads of protection, concern for safety, and control that were found running throughout both themes.

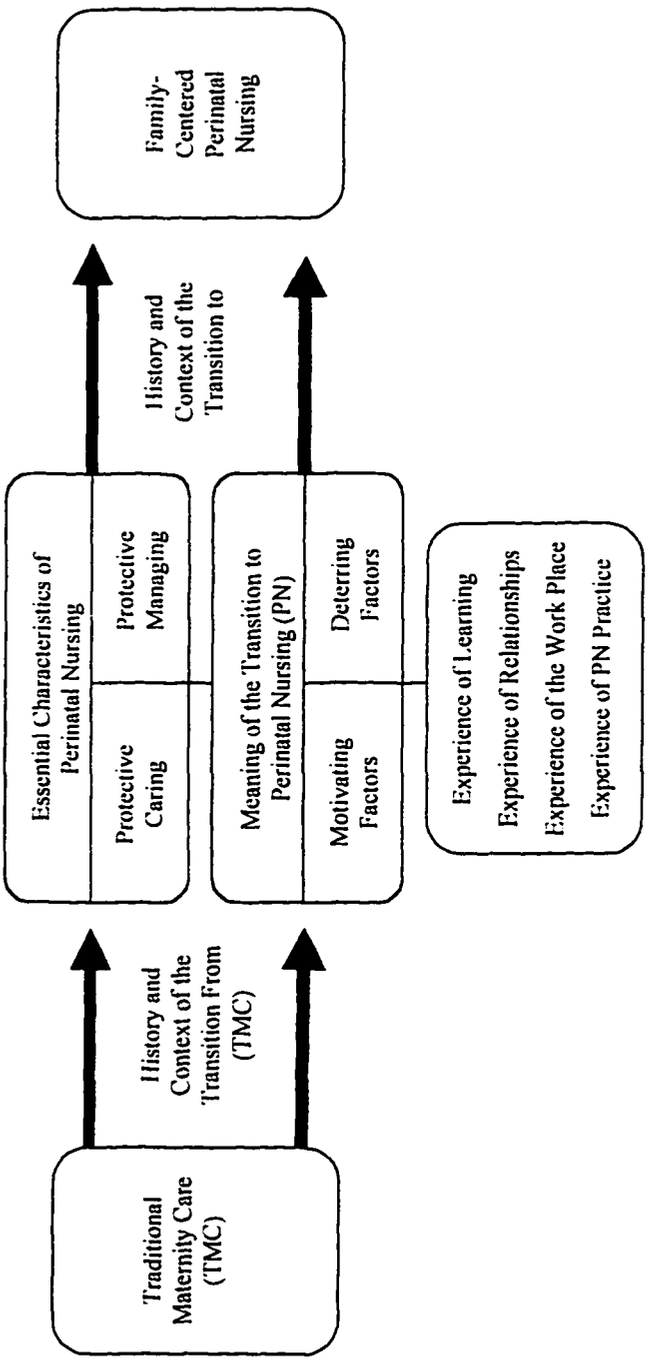

Figure 1. Transitional Model of Family-Centered Perinatal Nursing

For the participants in this study, the meaning of the transition to perinatal nursing involved the participants' perception of the influencing factors that intervened in such a way as either to promote and facilitate the transition or to discourage and hinder the transition. The occurrence of these factors was viewed as pivotal in determining the PNs' experiences of learning their new, expanded roles and responsibilities, establishing relationships, working in their setting, and practicing perinatal nursing.

This discussion includes a presentation of the major themes in this study and describes the relationships between the essential characteristics of perinatal nursing and the meaning of the transition to perinatal nursing in relationship to the literature. In the first section, protective caring and protective managing are discussed, followed by a related discussion of the motivating and deterring factors influencing the transition to perinatal nursing and the implementation of the family-centered model. A review of the bracketed assumptions is discussed in the concluding section.

Protective Caring

In order to care and provide adequately for their patients, the participants regarded establishing a personal relationship with their patients as integral to their ability to do their job. Because they are at the bedside with the laboring woman, the new mother and baby, and the extended family unit, the PNs viewed themselves as the ones to develop the connective link that enables the patient to have an optimal experience, both physically and emotionally. This connection is important not only important to the welfare of the patients but to the self-esteem of the PN.

At its most basic level, in order to provide appropriate care, the PN needs to know and understand what the patient wants and needs. Thus, the PN must establish a connective link. Such a link gives the patient a sense of trust that the nurse is there for

her. This feeling may be engendered by simply holding the patient's hand, being at the bedside, and listening to her. The importance of maintaining a connective link through meeting the emotional, social, and educational needs of the childbearing women is discussed by Simkin (1996) and Bailey et al. (1992). These participants viewed such a connective link, including emotional and physical support, as an essential aspect of protective caring, which tends to refute the findings by McNiven et al. (1992) that supportive care seems to be devalued.

Because protective caring also requires the nurse to serve as liaison and advocate for the patient, part of this connective link entails establishing rapport with physicians and other health care workers. Getting the best care for the patient means making sure that other health professionals and physicians know what is going on with the patient. The PN is responsible for ensuring that information is communicated adequately and quickly. Part of protective caring is focusing on what the patient wants, not what the doctor or hospital or even the nurse wants. Thus, when the nurse understands the personal needs of the patient, the PN should be an advocate for the patient. Such action involves answering questions and encouraging the patient/family to express their needs. Acting as a liaison is supported by Schwab (1996). Likewise, Griffith-Kenney (1986) and Stainton (1994) identified advocacy as meeting the needs of patients/families.

The findings suggest that the participants realized that the patient/family must clearly understand to be properly informed and that the PNs saw this aspect of their role, informing and explaining, as essential to ensuring the patient's/family's right to make decisions regarding care. It is thus evident that the PNs saw establishing a connective link with the patient/family unit as well as other health professionals as an essential aspect of their nursing practice.

The participants also considered caring for and keeping the family together as a unit and preparing the family for its new role as essential to their ability to optimize family beginnings. Because some PNs viewed themselves not just as the woman's nurse but as the nurse who gets the family started together, they recognized the need to incorporate the concepts of family-centered care into their role as PNs. In order to care for and keep the family together as a unit, the PNs must balance their time to organize their work and make sure that the mothers receive the support that they need. They also must organize and restructure their former "routine" practices in order to "efficiently" combine the care of both mother and infant. Optimizing family beginnings by caring for and keeping the family together as a unit is important because the care is fragmented when the PNs do not efficiently care for the mother and baby together. This supports the findings of Tomlinson et al. (1996) when they asserted the importance of focusing on the family as a unit and on the mother-baby as a dyadic unit of care.

Protective caring involves addressing the individual needs of the family and helping the family to deal with difficult situations, including grief and loss. Because the whole childbirthing situation is unique for each family, the care given to each family by the PN should be individualized. Caring for the family requires that the PNs respect the unique differences of families in their experience of pregnancy and childbirth and recognize that the needs, wants, and desires of families vary according to their past experiences, their culture, and the uniqueness of individual family members, a concern addressed by Tomlinson et al. (1996) and Strohbach (1992).

Protective caring allows the PNs to address the fragmentation that occurs in traditional nursing when different nurses are assigned to care for the mother and infant. Indeed, the participants considered providing a continuum of care, support, and education for the patient/family as vital to their ability to fulfill their responsibilities.

The PN establishes a special rapport with the patient/family as a result of having taking care of the family consistently throughout the childbirthing process. As a part of protective caring, the PNs viewed, as essential, following through in order to evaluate the patients' progress and see whether they are having any problems, even though they transfer the patient to another area of perinatal nursing. This supports the findings of Caico and McLean (1990) and Reed and Schmid (1986), when they asserted the importance of eliminating the fragmentation for the mother and infant, individualizing nursing care, and increasing the opportunities for the family to be together.

Protective caring requires the PN to prepare the families for their new roles by working with the whole family. Because the new role changes are not just happening with the mother or the father, the PNs frequently must involve the siblings and extended family. As a part of the continuum of care the same nurse teaches the mother and family in both the mother's self-care and the care and feeding of the infant and the preparation for care at home. This promotes congruence in the information that the family receives prior to discharge. This entails setting priorities and assessing the mother's readiness to learn before initiating the teaching activities--something the PNs acknowledged as very difficult, considering the shortened length of stay that limited the time available to prepare the family for discharge. This supports the finding of Brown et al. (1996) and McGregor (1994).

Teaching the mother the practical skills of caring for her baby is essential in developing the mother's confidence in her own abilities and in supporting her as she assumes her new parenting role. The PNs realized their unique position for getting the whole family together and helping them to learn how to carry out their responsibilities, consistent with the findings reported by Nichols (1994). The participants considered themselves responsible and were particularly concerned to ensure that parents are adequately prepared to care for the infant. In teaching, the PN must be sensitive to the

parents' need to verbalize and express their fears and not rely on a "routine" check-off list. Thus, the PNs found that they were able to optimize family beginnings by including the family in their teaching and assisting the family to feel as comfortable as possible in caring for the infant so they are prepared to go home. The centrality of educating, explaining, and giving advice is supported by the research findings of Cottrell and Grubbs (1992), who cited the advantages of FCMC as including increased teaching opportunities.

An important aspect of providing explanation and feedback involves observing and reinforcing previous teaching and validating outcome learning to see that the patient/family has actually gained the knowledge or developed the skill that was taught by the PN. When the PNs were unable to validate outcome learning for the patient/family, these families were frequently referred for telephone or in-home follow-up and/or social services to ensure that the patient/family was adequately prepared to provide the care safely.

It is evident the PNs are truly concerned that the family's fears were alleviated or resolved prior to discharge, so they are ready to assume their new parenting roles and care for their infant safely. Thus, it is evident that protective caring has the potential of enabling the PN to enhance the family's positive perception of their experiences of childbirthing and their new parent roles. It enables them to address the fragmentation that occurs in traditional nursing by providing a continuum of care.

In conclusion, an important aspect of the participants' perception of perinatal nursing was helping the family to have an optimal beginning. For some, the family unit included only the mother and baby, but others included the father and siblings. Optimizing beginnings included physical activities such as teaching as well as emotional support, which sometimes meant helping families deal with loss.

Protective Managing

Protective managing focuses on the PNs' goal of keeping the customer happy, which entails meeting the expectations of the patients and their families and avoiding negative outcomes. Today, the trend is for consumers to direct the type of birth experience they want. The participants viewed implementing mother-baby nursing as an attempt by the hospitals to keep the customers happy by giving them what they want, and described trying to accommodate the patient in any way possible and respecting the patient's right to choose what she desires.

Although the PNs viewed today's perinatal "customers" as more aware of what they want and do not want, they also indicated that some patients have unrealistic expectations, which supports the finding of Schumacher and Meleis (1994) and Sandelowski (1984). Hence, part of protective managing is recognizing that the potential exists for something to go wrong. Even though everything may seem to have gone well, the result may be a negative outcome. Because of unavoidable circumstances, nothing is guaranteed. This means that patients do not always get the experiences they want, a concern addressed by McRae (1993). Because the potential also exists for the nurse to be blamed when certain patients have negative outcomes, the PNs viewed protective managing as giving their best effort to do whatever it takes to make sure that something good comes out of the experience.

Keeping the customer happy requires the PN to give the mother choices that meet her expectations. Conflict may arise, however, when the expectations of society and the institutions where the PNs work are different from those of the patient/family. For example, because some hospitals contend that mother-baby nursing is the best way for the PNs to care for their babies, they expect the mother-baby staff to encourage all mothers to have their infants rooming-in with them. Nevertheless, the participants indicated that most mothers prefer not to have the infants in their rooms at night,

except for feeding, and mothers who have Cesarean sections are frequently unable to care for their infants during the first 24 hours or longer.

It is evident that the PNs felt pressured by the patient/family expectations and demands as well as by the managed competition that exists in today's health care market, with physicians and hospitals competing for customers in women's health.

Perinatal nursing requires the PN to implement changes that are congruent with the family-centered concepts, which include the PNs relinquishing control of the patient/family experience that characterized the former TMC model of efficiency and control. Because the PN gives up the traditional power relationship with the patient/family, a new nurse-patient relationship is established that empowers the patient/family to manage and control their experience. For example, the PNs discussed relinquishing control by providing options to the perinatal patients and their families regarding such things as type of delivery, anesthesia, pain medication, rooming-in, and type of infant care and feeding. The participants discussed relinquishing control and allowing the patients/families to makes choices even when the patients' choices conflict with the PNs' own values and needs. Allowing the patient to make choices also implies that the PNs must have the knowledge and experience to provide the patients and their families with sufficient information regarding options and choices. The importance of relinquishing control to the patient/family by reducing hospital routines and making the families' choices the priority is supported by Steensma (1993).

The participants viewed supporting the decisions made by the patient family as an essential aspect of protective managing. Supporting patient decisions requires the PN to relinquish control in order to encourage patients and advocate for the patient's right to make her own decisions. Because the PNs recognized the importance of not creating conflict between the patient and her partners, they also indicated the need for involving the family in the decisions, respecting the differences in cultural values, and

acknowledging how they felt about having input into decisions that affect themselves and their own experiences. These findings also supported by those of Tomlinson et al. (1996).

These findings suggest that the PNs supported the family-centered concept of providing options to patients and their families, although keeping the customer happy and relinquishing control by allowing the patient/family options and choices sometimes meant compromising the model and hospital expectations. Nevertheless, the participants discussed how it may not always be possible for patients to be given the options that they want. This may also become more difficult as the current cost restrictions placed on service providers by insurance companies limit the options available to families, a concern addressed by Zwelling (1996).

The participants regarded being responsible for the care and safety of the patient/family as an essential part of their ability to do their job. Because the PNs viewed themselves as very protective of their mothers and babies., protective managing also means that PNs must sometimes qualify the relinquishment of control to the patient. As a result, the PNs must withhold patient/family options when there is a concern for the safety of either the mother or the infant. Participants justified the importance of watching for the safety of patients by portraying the delivery and recovery periods as particularly dangerous. Hence, an integral aspect of protective managing is knowing when not to relinquish control.

Another part of protective managing, which is discussed by Reed and Schmid (1986), is making sure that the mother and infant have a safe environment. Although the participants considered the childbirthing period as a critical time, with potential danger for both the mother and fetus/infant, they felt that the infants were at greatest risk. Although the family-centered model encourages infants to be rooming-in with their mothers and not in the central nursery, the infants routinely went in and out of

their mothers' rooms and back to the nursery at the mothers' requests. Because some participants viewed the care received by the infant outside of the traditional newborn nursery as potentially unsafe, protective managing requires the PNs to watch the infants carefully and be sure that they are safe at the bedside. Because of the PNs' fears and concerns regarding infant security in the work setting, protective managing requires the PNs to keep track and be sure that they know where the infants are at all times.

These findings suggest that nursing management should address the fears and concerns of the PNs and provide additional supportive resources to ensure the safety of the infant, a finding supported by Fiesta (1990).

An important aspect of protective managing is the PNs' responsibility/liability for the care of both the mother and the infant. Because of the legal liability and risk associated with working in the LDR, the participants viewed the LDR nurse as being in a more vulnerable position than the mother-baby nurse. The PNs, particularly those working in the LDR unit, described themselves as being in a vulnerable position, with the possibility of being a victim, a concern addressed by Simkin (1996) and McRae (1993). When the infant is left at the bedside with the mother, it is the mother-baby nurse's responsibility to be sure that the infant is safe. Because of the concern for being responsible for the infant's care, some mother-baby nurses encourage mothers to bring the infants into the nursery.

These findings suggest that PNs may have difficulty in implementing family-centered concepts related to giving the patients and their family choices when they perceive that a risk for the safety of either the mother or the infant is involved. Whether the safety factor is part of the risk management approach to avoid lawsuits or a true emergency cannot be determined from the data. However, these findings demonstrate that safety of the infant is a major concern that impacted the PNs' level of

comfort in providing mother-baby nursing and rooming-in and, therefore, it influenced the implementation of family-centered nursing practices.

Another aspect of protective managing, which relates to the issue of liability, is the need for PNs to be prepared with necessary skills to handle the unexpected events that may occur while caring for the perinatal patient and her infant, which supports the findings of Harris, Yates, and Crosby (1995) and Stronbach (1992). Also, the PNs must have the knowledge and skills to identify problems before the mother is discharged with the infant. The participants were thus concerned over the short length of stay for patients, which affected their time to identify problems before discharge, a concern addressed by Brown et al. (1996).

These findings reveal that some of the participants who traditionally worked as labor and delivery or postpartum nurses did not consider themselves sufficiently competent or sufficiently expert to detect the subtle deviations that might make a difference in the infant going home. Although the participants were cross-trained and oriented to work in the new area(s), they lacked the expertise of the more experienced nurses who routinely worked there. The lack of regularly scheduled experience in the other areas of perinatal nursing made patient assessment and early diagnosis of a serious, unexpected problem difficult. These findings were supported by Strohbach (1992).

Findings indicate that, in order for the PNs to be prepared with the skills that are associated with having intuitive knowledge, they must have expert knowledge that is derived only through experience. Cross-training and orientation with limited experience does not further develop the PN's intuitive knowledge, which supports the findings of Benner (1984). When uncomfortable with their skill level, the PNs were reluctant to implement the family-centered model, reverting instead to their traditional roles.

The PNs were also concerned that they may be blamed for negative outcomes because of the expectation that technology can "guarantee" positive outcome for the fetus/infant. Because of expansion in the use of advanced technology and medical intervention in obstetrics, the PNs must be comfortable in their skills in using this technology. They do not want to be held responsible and unfairly blamed for outcomes that were beyond their control. In addition to necessary skills, participants viewed being organized and having sufficient staffing as essential to effective protective managing.

Being organized was viewed by the participants as a professional characteristic that enabled them to get the job done efficiently. They indicated that, in order to meet their expanded responsibilities for providing family-centered care to their patients as LDR(P) and mother-baby nurses, they had to be able to move quickly. Being organized allowed them to do that and helped them to save time. Being organized also entailed having supplies and equipment available and clean. Because of the current cost restrictions in hospitals, availability of ancillary personnel to ensure clean supplies and equipment was described by the participants as limited. The responsibility for making sure that the unit is adequately stock became the PN's responsibility.

The participants who worked as LDR nurses described how SRMC (birthing rooms) were much easier for them because everything was in one room. They indicated that it promoted a sense of being more organized and allowed the PN to maintain continuity of care for the patient because the PN did not have to move the patient to the delivery room in the middle of labor. This finding is supported by Reed and Schmid (1996). In contrast, several participants who worked as mother-baby nurses described being disorganized when caring for both mothers and babies. They also described combined mother-baby nursing as much harder because the room assignments were often scattered, which required the mother-baby nurse to move between the patient's

room and the nursery. These finding were supported by Cottrell and Grubbs (1992) and Steensma (1993).

Preserving order on the unit also involved setting priorities in order to deal with fluctuating census, rapid turnover, and the many interruptions in the work setting. Lack of adequate staffing impacted the readiness to deal with the unexpected. Participants reported that staffing limitations enforced by nursing management prescribed their ability to maintain adequate staffing levels. This impacted the PN's ability to provide care and support for perinatal patients and their families. Other PNs who worked as mother-baby nurses described maintaining staff by returning to the TMC model routinely at night and assigning different nurses to care for the mothers and infants separately. The importance of maintaining adequate staffing to implement the model is supported by Cottrell and Grubbs (1992), Caico and McLean (1990), and Steensma (1993). It is evident from these findings that maintaining adequate levels of staffing impacted the PNs' ability to manage and deliver care to their patients in an orderly manner, which in turn influenced the consistency of the PNs providing family-centered care to the patients and their families.

In conclusion, although an important aspect of the family-centered model is the patient's right to choose and although the PNs supported the patient's right to be given options and be allowed to make choices and decisions, these findings indicate that the patient is never in total control. These findings also suggest that the expectations of society, the institutions, and physicians impacted the PNs' ability to relinquish control to the patient, which in turn influenced the PNs in qualifying relinquishment of control to the patient. Nevertheless, the main issue in whether or not the model is compromised centers on the safety of the mother, or infant, both for the sake of the patient/family and for the PN's concern with liability. Findings thus suggest that nursing management must adequately prepare the PNs for perinatal nursing with skills and experiences in

order to increase their confidence, provide a safe environment for the mother and baby, provide adequate staffing, and ensure that the perinatal unit is appropriately organized.

Motivating and Deterring Factors

Experience of Learning

Being able to work in more than one area of perinatal nursing means expanding the PNs' level of knowledge and technical skills and ensuring that they have a sufficient level of competence to safely provide care for the mother, the fetus, and the infant. Hence, being motivated to learn and grow both personally and professionally is integral to facilitating the PNs' experience of developing their skills and having what it takes to work as LDR(P) and/or mother-baby nurses.

The participants' view of their experience of learning focused primarily on the initial period of orientation and cross-training during the transition to the new roles. Because of the PNs' commitment to excellence in clinical practice and their choice to stay abreast in their field, they eagerly faced the necessary training. Some PNs were also motivated by the rewards of working with challenging patients/families, which they viewed as exciting and stimulating, both personally and professionally. These findings are supported by Nichols and Palmer (1994) and Steensma (1993) as they described the benefits and rewards for the staff.

It was thus evident that the participants' view of their experience of learning was facilitated by factors which motivated the PNs' desire to learn and challenged them both personally and professionally.

Participants perceived a supportive learning environment as critical to their ability to learn the expanded knowledge and skills necessary to do their jobs. Being supported and reassured by others during the experience of learning these new skills is viewed as essential to the promotion of a smooth transition. For example, success in

learning is facilitated significantly by providing a supportive preceptor/mentor to address the PNs' specific learning needs and extending the training period and having experts available to provide back-up support, which supports the findings of Schumacher and Meleis (1994). However, Strohbach (1992) argued that preceptorships that were too limited in time were insufficient to develop more than a beginning level of competency. She also argued that the development of sound clinical judgment is threatened by the development and implementation of cross-training programs that fail to provide appropriate experiences and fail to support the training with an adequate knowledge base.

It was thus evident that how the participants view the challenge of cross-training and of being supported by having sufficient environmental resources to support learning is a key factor that facilitates and promotes the experience of learning.

On the other hand, it was found that some PNs' experience of learning was hindered by their fears and disinclination to be cross-trained. Fears related to their concern with the risk of liability, especially in the LDR or admissions nursery. They feared being blamed and held accountable for not being adequately prepared with the expertise based on years of experience and background knowledge. Because of their fears, they avoided learning the new area(s) if possible, and instead, remained in the areas where they felt most comfortable. This supports the findings of Reed and Schmid (1986), who asserted that the underlying theme for the nurses concerns was "fear of the unknown."

Because of the threat of liability based on the PNs not knowing what to do, the PNs avoided such situations, being unwilling to take the risk of caring for the more challenging patient instead of viewing such situations as learning opportunities. As a result, some PNs felt an ongoing discomfort due to their lack of hands-on experiences in areas where they lack expertise, hindering their ability to carry out the expanded

responsibilities of their work and limiting their ability to function in all areas. These findings are supported by Strohbach (1992).

Experience of Relationships

The participants experienced a more positive acceptance of the transition to perinatal nursing when they perceived that the transition provided for a closer relationship with the patient/family--one that not only benefits the patient/family but also rewards the nurse. Some PNs felt that caring for both the mother and the infant enabled them to establish a more trusting relationship with the whole family. The PNs felt rewarded by the appreciation and positive feedback that they received from the patient/family. They also experienced a greater sense of satisfaction with their jobs and increased morale. In addition, the PNs viewed appreciation and support from other health care providers facilitating collaboration, effective communication, and team work, which supports the finding of Cottrell and Grubbs (1992) and Schumacher and Meleis (1994).

In order to effectively meet the needs of the patient/family, the PNs must have good working relationships with the physicians who care for both the mother and the infant. Effective communication and collaboration between PNs and physicians means that they must show mutual respect and trust and have confidence in each other's knowledge and skills. An important part of the PNs' experience of relating with physicians involved their ability to communicate effectively the patient's needs to the physician. Being supported by other health professionals facilitates the PNs' ability to work collaboratively with others in order to meet the needs of the patient/family and is thus a motivating factor that ultimately influences the success of the transition. These findings are supported by Schumacher and Meleis (1994) when they identified one of the major indicators of healthy transition outcomes as the well-being of relationships.

In contrast, the participants may have experienced disagreements when relating with their peers, managers, and physicians, which hindered their ability to establish positive working relationships. Peers, who focus more on what is wrong rather than on how teams work, influenced the PNs' ability to be cross-trained in new areas and successfully implement the model. Because the PNs regarded some of their colleagues as highly critical and nonsupportive, they found it difficult to establish rapport. When these feelings of conflict occurred between staff on different units, the PNs felt that the continuity and quality of care to the patient/family suffered when the patient was transferred.

The participants viewed managers as less connected to the reality of the problems and concerns that affect the PNs' clinical practice, failing to give them adequate resources to implement the new model successfully. The PNs also felt that they were not respected for their opinions when management made the decision without nursing input. The PNs considered collaborating with managers regarding decisions that affect the day-to-day reality of their practice as essential to the successful transition to perinatal nursing, which supports the findings by Nichols and Palmer (1994) and Steensma (1993).

Similarly, the PNs often worked with MDs who were very difficult and demanding and refused to listen the PNs' suggestions regarding possible interventions for the patients. The PNs disagreed with the physicians regarding patient care and some of the PNs' roles and responsibilities. Some physicians may have difficulty in collaborating with the PNs because they still consider themselves to be completely in control of managing the patients' care. The PNs' ability to establish rapport was dependent on the opportunity for PNs to engage in activities with physicians that promoted attitudes of mutual respect, confidence, and trust. These findings are supported by Schumacher and Melies (1994) and Schwab (1996).

It is evident from these findings that the feelings of conflict with peers, management, and physicians impact the PNs' experience of working with others and, in turn, hinder the PNs' ability to transition to family-centered perinatal nursing. The negative emotional feelings of threat to self, including the threat of liability and lack of professional respect, hinders the PNs' ability to work with other health care professionals, which in turn hinders their ability to make the transition to family-centered perinatal nursing.

Experience of the Work Place

Part of the participants' satisfaction related to their place of work is based on the kind of work the PNs did, the type of patients/families for whom they cared, and the commitment of their colleagues. Although it was difficult to generalize because this varied according to personal preferences of PNs, the PNs experienced an overall sense of satisfaction because they worked primarily with young perinatal patients who are not sick or chronically ill. The importance of the participants' satisfaction was identified by Schumacher and Meleis (1994) when they identified a sense of well-being as one of the indicators of healthy transition outcomes.

In order to implement LDR(P) and mother-baby nursing, certain structural changes were necessary in the work place. Structural changes that added to the PNs' comfort and made their job easier resulted in the PNs experiencing more satisfaction with the work setting. With the implementation of the LDR(P) units, the majority of the patients remained in one room for childbirth and the equipment was stored in the room or was readily available and brought in for the delivery. Thus, because the PNs were not required to transfer the patients multiple times during an uncomplicated delivery, they felt more comfortable in giving care and felt that the job was easier, which is supported by Reed and Schmid (1986).

On the other hand, when the institution failed to make the necessary changes or when the changes were viewed by the PNs as adding to their discomfort by making their job more difficult, the PNs were less satisfied and frequently became frustrated with the work place. The PNs identified a number of limitations to the physical setting in which they worked. Combining the care of the mother and infant entailed "running a lot" between the mother's bedside and the newborn nursery, particularly at night, when most mothers did not keep the infant for rooming-in. The PNs also experienced fear for the security of the infant at the mother's bedside. Thus, concern about the limitations of the setting impacted the PNs and influenced their ability to implement family-centered perinatal nursing, a concern addressed by Cottrell and Grubbs (1992).

Participants experienced frustration in the work place because they failed to fully integrate the perinatal nursing roles and the perinatal units remain divided. Despite the implementation of mother-baby nursing, some PNs still considered themselves either postpartum or nursery nurses. Because the LDR and mother-baby nursing units were located in separate areas, the PNs were also separated, creating competition between the PNs on the two units. When the two units are located on separate floors and managed by different managers, the division of units is even greater. This has resulted in ongoing communication problems between the LDR and mother-baby nursing units, which acts to further separate and divide the nurses.

Because the transition to perinatal nursing takes place in the midst of rapid changes in health care, multiple deterring factors intervene to hinder the PNs' ability to do their job effectively and to make a smooth transition to the new model of care. For example, the PNs viewed the economics of health care as playing a key role in what the PN is able to do in the time available. Insurance mandates have required that most patients be discharged within 24 hours or less. In addition, in order to compete for consumers, the institutions have resorted to marketing strategies that promise the

families everything and then expect the PN to deliver without the adequate resources to back them up. These findings are supported by Arnold and Kirby (1996) and Harrigan (1995), who discussed the significant changes in the role of the PN as a result of the restructuring of the health care delivery system.

In this study it was found that, prior to and during the implementation of perinatal nursing, part of the participants' experience of the work place depends on the level of preplanning that is done by management as well as the PNs' level of participation in the preplanning process. Feelings of frustration were also experienced when PNs did not have clear expectations, direction, or structure for reorganizing their work. The lack of preplanning by management was the beginning of insecurity on the part of some PNs. It was evident that, if the PNs failed to get involved in determining which changes were needed, where they were needed, and why, their ability to make a smooth transition to mother-baby nursing and care effectively for the mother and infant together was hindered. The importance of preplanning was supported by Nichols and Palmer (1994), Schumacher and Meleis (1994), and Steensma (1993).

Experience of PN Practice

Because some of the participants were committed in their desire to succeed, they were putting more of themselves into their practice than ever before. As a result of their involvement with the entire family rather than just being focused on the number of tasks accomplished, the PNs indicated they had more of a sense of satisfaction and accomplishment as a PN rather than as a traditional nurse. Knowing how to intervene effectively and providing individualized patient/family care, support, and teaching added to the PNs' sense of accomplishment in fulfilling their roles as LDR(P) and/or mother-baby nurses, which supports the finding of Steensma (1993).

Feeling comfortable with their knowledge and skills for the normal as well as for the emergency promoted the PNs' sense of confidence in their overall achievement of skilled role performance. When the PNs experienced feelings of mastery, they had self-confidence in their clinical decision-making ability as well as their knowledge and technical skills for PN practice. As a result, they were confident of their ability to give the highest quality of care and experienced a sense of empowerment over the situation that is reflected in their positive state of well-being and sense of role mastery. Role mastery was identified by Schumacher and Meleis (1994) as one the three indicators of healthy transition outcomes.

On the other hand, when the model was first introduced. because most participants felt comfortable in the traditional roles, they saw no reason to change and they experienced feelings of resistance toward implementing the model. They also indicated that they would not have been motivated to be perinatal nurses except that they had no other option, and they compromised the model by altering their assignments to work as teams instead of doing combined mother-baby care.

Some of the participants felt frustrated about the changes in their clinical practice that resulted in "making mediocre nurses." Because of the transition, the participants who had expertise primarily in one specialty area were now expected to learn to care for both mother and infants and practice in more than one area. These findings are supported by Strohbach (1992). The transition also led to some basic differences between the expectations of the PNs regarding their practice and the demands of the patient/family, such as providing patient care, teaching, and the safety of mother and the infant. These changes were frustrating to the PNs who were used to being in charge and who were unable to fulfill their responsibilities of caring for the patients in situations that created conflicting demands, a concern addressed by Evans and Jeffrey (1995) and Mackey (1990).

The participants' feeling of threat to self related to the interpersonal losses that they encountered as part of their PN practice. Working with skilled professionals, whom they highly regarded, resulted in feelings of potential loss of approval when the PNs did not feel adequately prepared to perform their new role. That PNs felt that they were giving up their level of expertise in order to branch out into other areas of perinatal nursing. Because the PNs, who were able to work in all three areas of practice, were viewed as more highly valued and marketable, the participants experienced a loss of self-esteem when they were unable to work in all areas.

Because not all PNs felt prepared to handle the risks involved in their expanded roles, they were uncomfortable in situations that they viewed as risky for the mother and fetus/infant. They were uncomfortable when they worked in an area outside their routine assignment or outside their traditional role because of the issue of liability. This finding is supported by Schumacher and Meleis (1994), who asserted that the participants' emotional distress may result in the inability to concentrate, unwillingness to take risks, and the avoidance of the unknown. Thus, the resistance on the part of the PNs, their frustration over new role expectations, and their feeling of threat to self impacted their willingness and ability to implement the transition. Indeed, these issues led to compromise of the model.

To conclude, one of the primary issues relating to the transition involves the attitudes of the PNs themselves. If they were enthusiastic, motivated, and confident, and if they felt supported, they adjusted to the transition; if they lacked confidence and knowledge or if they felt lessened professionally by the role change, they resisted. The attitudes of other health professionals and nursing management as well as the amount of preplanning, preparation, and cross-training directly influenced the PNs' feeling, thereby influencing the implementation of the family-centered model.

Review of Bracketed Assumptions

It was clear from the results of this study that family-centered perinatal nursing and the PN's role reflect changes in health care delivery systems and in patient needs. Nurses' roles are therefore dynamic and constantly evolving. The transition was contextual in that it was greatly influenced by factors in the health care environment in which the PNs practiced. Part of this environment stems from the historical practices of childbirth and maternity care, including medical control of the patient. The perceptions of the participants in this study regarding these historical practices impacted their view of the new practice model and thus their willingness to take part in the transition from TMC to perinatal nursing.

The care of perinatal patients included the mother-father/family unit and the mother-fetus/infant unit. Protective caring evolved from the need to develop a connective link among the patients, their families, and health care providers and to provide physical and emotional care, support, and education. The expressed goal of the PNs was to provide the mothers and their families an optimal birthing experience. Protective managing involved keeping their patients safe while clinically managing them during the birthing process. The PNs discussed avoiding negative outcomes and keeping the mother and her family secure by providing a safe environment and by being prepared for the unexpected. They also discussed the issue of providing options for the patient and supporting her choices while keeping both the mother and the infant safe. Meeting the needs of all perinatal patients and their families required that PNs expand their knowledge and have a variety of specialized skills and abilities.

The analysis of the meaning of the transition demonstrated that the actual experience of role redefinition or expansion is a major change for the PNs who experience the transition from the TMC model to the family-centered model of perinatal nursing. This was evident in the examination of the various influencing factors

that the PNs discussed that either promoted and facilitated or discouraged and hindered the transitional process. The PNs' attitudes ranged from complete acceptance to overt or covert rejection that led to compromise of the new practice model. Likewise, the deterring factors that the PNs discussed, involving the role changes that brought about a disruption of comfort, were associated with conformity or consistent, usual activity. These changes also created feelings of anxiety and fear and required the PNs to cope with unknown or uncertain outcomes stemming from the change.

It was evident from the results of this study that individual PNs differ in their capacity for change and role expansion. Acceptance of role change depended on motivating factors, which included the readiness of the PN to assume a different role with expanded functions and responsibilities. It also required specialized training and demonstration of competence by the PN to function in family-centered perinatal health care.

The results of the study demonstrate that many PNs have the special knowledge and skills to work in more than one specialty area and deal effectively with a variety of complex patient situations.

Whether the perceptions of the study participants regarding the Transitional Model of Family-Centered Perinatal Nursing discussed here are reflective of the perceptions experienced by PNs in general remains to be determined through further research. Also, whether the perceptions of the study participants regarding the essential characteristics of perinatal nursing and the meaning of the transition to perinatal nursing discussed here are reflective of the perceptions experienced by PNs in general remains to be determined through further research.

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

The purpose of this study was to obtain a better understanding of how nurses caring for perinatal patients and their families view their clinical practice role after experiencing the transition from traditional maternity care (TMC) to family-centered perinatal nursing. This was accomplished by describing the two major features of the Transitional Model of Family-Centered Perinatal Nursing and their interrelationships: Essential Characteristics of Perinatal Nursing and Meaning of the Transition to Perinatal Nursing.

Limitations of the Study

Due to the limited number of participants in the study, it is not feasible to generalize the findings or to develop precise implications for a theory of clinical practice. This was an in-depth study of these 13 participants and their reaction to the transition. In addition, because all the participants volunteered and were self-selected for the study, it is impossible to know whether their motivations for participating in the study in some way affected the data collected on the transition. Furthermore, because the work settings were not representative of all FCMC models in which perinatal nurses (PNs) work and a single-room LDRP unit was not included, work settings different from those in which the participants practice might have yielded different findings.

Because of the subjective nature of phenomenology, relevant data may have been overlooked because of the researcher's personal bias or technique. For example, the researcher's personal history of previous participation in and bias for family-

centered nursing in community health may have hindered the ability to perceive broadly and to focus accurately. Furthermore, because of the researcher's personal history of working as a postpartum nurse in a traditional maternity setting that was in the early preplanning stages of introducing mother-baby nursing, the researcher may have identified more with the mother-baby nurses than with the LDR(P) nurses during the interviews and with their perceptions of the essential characteristics and meaning of the transition to perinatal nursing. Despite these limitations, the study findings support research by other nurse investigators as demonstrated previously.

Conclusions

The most striking findings of this research related to the interaction of multiple factors that led the participants to compromise the new practice model. First, the participants' descriptions of the essence of perinatal nursing reflected certain aspects of the two distinct and contradictory streams in the culture of American birth suggested by Eakins (1986) as the humanization of birth (protective caring) and the mechanization of birth (protective managing). They also blended certain traditional practices from the former TMC model into the new framework of the family-centered perinatal nursing model, as reflected in the strong threads of protection, concern for safety, and control that run throughout both themes. As a result, the participants modified their practice by adapting the FCMC model to "what worked best for them" in their particular settings, rather than radically changing their thinking and completely eliminating their former traditional model.

Together, protective caring and protective managing also reflected the PNs' priorities of balancing the need to provide family-centered care and support for the perinatal patients and their families with the need for clinically managing the care of the patients during the childbirthing period. In addition, protective caring and

protective managing reflected the PNs' more traditional priorities to continue to protect and safeguard the mother and her infant, which resulted in the PNs continuing to control the situation and qualifying the relinquishment of control. This, however, seems reasonable, considering the current risk management approach that is part of obstetrical practice and the desire to avoid the risk of litigation. It is best explained by exploring the meaning of the transition to perinatal nursing and examining the participants' experience of learning, experience of relationships, experience of the work place, and the experience of the PN practice.

The transition from TMC to perinatal nursing represented not only a situational transition in the clinical practice roles for the participants, including changes in practice setting, function, and scope of practice; it also exemplified a type of organizational transition that involved the adoption of new policies, procedures, and practices. As a result, it required the PNs to change the patterns of their behavior, ability, identity, roles, and relationships in an environment that was at the same time changing its organizational structure, function, and dynamics. These particular findings are synonymous with what Schumacher and Meleis (1994) referred to in their review of the literature of transitions in nursing as the multiple transitions that may occur simultaneously during a given time period. The organizational transition was precipitated by external changes in the wider socioeconomic and political environment of the health care delivery system as well as by the internal changes within the organizations' structural dynamics. These external changes were primarily brought about as a result of the managed care movement and the cost control measures that were enforced on the hospitals by the insurers, resulting in the trends toward reduced hospital length of stay, earlier discharge of patients with ongoing health problems, and substitution of lesser-trained and lower-paid unlicensed workers for PNs. With fewer PNs at the bedside and with the shorter length of stay, the PNs in this study were

frequently unable to achieve desired patient outcomes during inpatient hospital stay. It was evident from these findings that the organizational transition from to family-centered perinatal nursing influenced the lives of the participants as well as the patients whom they served.

The meaning of the transition to perinatal nursing focused on the participants' perception of the experienced transition to perinatal nursing involved the issue of control when implementing the new family-centered model. The findings indicated that the influencing factors described by the participants intervened in such a way as either to promote and facilitate the transition or to discourage and hinder the transition. Ultimately, this resulted in the compromised model of perinatal nursing that is currently practiced by the participants, rather than the ideal of a family-centered model. Nevertheless, because the issues that influence (either promote and facilitate or discourage and hinder) the implementation of the model are ongoing and dynamic, the model is still evolving. Although the ideal of family-centered perinatal nursing had not been achieved by the PNs in this study, the current compromised model represented the "way it works best for the PNs" in their particular settings. It was their attempt to fulfill their role responsibilities by coping effectively within an increasingly complex health care system in which they have "maximum accountability with minimal control and continuous changes of [patients], technology, and role expectations" (Schwab, 1996, p. 171).

Implications for Interventions

Nursing Practice and Education

The results of this study validate the significance of transitions as an important concept to the discipline of nursing. It is essential to understand the conditions and influencing factors that affect transitions in nursing practice. The influencing factors

identified in this study impacted the participants' perception of the essential characteristics of perinatal nursing and, in turn, influenced the participants' perception of the meaning of the experienced transition. Because the transition may or may not be the result of personal choice and may or may not be desired by the participants, it is possible for the meanings attached to transitions to be positive, negative, or neutral (Schumacher & Meleis, 1994). It is important to the success of a transition that, prior to implementing the new practice model, nursing management develop a mechanism for interacting with the staff who will be putting the model into practice. Management and staff should discuss any issues and concerns that they may have and thus, gain a clearer understanding of transitions, which involves expanding the PNs' clinical roles to work in more than one area of perinatal nursing, and its meaning to them.

Likewise, the findings demonstrate that the level of planning that occurred before and during the transition was an influencing factor. Planning should occur over time and be concurrent with the ongoing assessment and identification of problems, issues, and needs that might become evident during the transition. Effective planning requires communication among the key people involved in the transition, including those in a position to provide support (Schumacher & Meleis, 1994). One method that might be helpful is for nursing management to establish a series of roundtable discussions comprised of the management and staff personnel who are involved in the transition. This would provide the opportunity for them to study what a family-centered model is and how it is needed to benefit the perinatal patient and her family, as compared to the current TMC model. Moreover, advantages for the staff as well as the issues and concerns of the PNs can be identified and discussed.

Another influencing factor identified was the PNs' expectations regarding the transition. According to the findings, knowing what to expected sometimes relieved the stress that frequently accompanies a transition, as noted by Schumacher and Meleis

(1994). Nursing management has a responsibility for providing the staff a clear picture of what to expect as well as making the expectations realistic, based on the current resources available within the environment of the work place where the transition is occurring. Serious consideration must be given to identifying ways of providing a supportive environment to the staff. For example, preceptors were identified in this study as an important environmental resource that facilitated the success of the PNs' role transitions. Management should ensure the availability of a qualified, experienced teacher/mentor to serve "as a guide, role model and sounding board" (Schumacher & Meleis, 1994, p. 123).

Participants in the study indicated that motivating and deterring factors influenced the PNs' experience of relationships, which in turn influenced the implementation of the new model. Similarly, well-being in one's relationships, which was described in terms of "meaningful interaction" and included integration with broader social support systems, was identified by Schumacher and Meleis (1994) as an indicator of a successful transition. Difficulties in transition outcomes involved such factors as lack of cohesiveness, increased absenteeism, turnover, increased conflict, and decreased cooperation. Management should endeavor to promote well-being in relationships at the individual level by mitigating disruption in relationships and fostering the development of new relationships. In order to promote a successful transition at the organizational level, management should take steps to facilitate the interaction among persons and subsystems with the organization to ensure that an environment in which collaboration, team work, effective communication, and support from key persons and groups are evident (Schumacher & Meleis, 1994).

One of the most important factors influencing the outcome of the transition was the level of specialized knowledge and skill relevant to the PN's new, expanded roles and responsibilities in perinatal nursing. A significant finding in this study involved the

orientation and cross-training to new areas of perinatal nursing that included the need for the PNs to demonstrate competency in using the new knowledge and skills. Participants indicated that motivating and deterring factors influenced the PNs' experience of learning and ultimately influenced the implementation of the model. Role mastery, which indicates the achievement of skilled role performance, was identified by Schumacher and Meleis (1994) as an indicator of a healthy transition in the individual. At the organizational level, mastery included high quality of care and efficient work performance. Management must ensure that sufficient time and supervised experience is given for the PNs to develop knowledge, decision making, psychomotor skills, and self-confidence in the new areas. In addition, serious consideration must be given to such issues as the ability of PNs to develop and maintain clinical excellence in all areas due to the tremendous expansion of knowledge and advanced technology in the field (Stronbach, 1992). On the other hand, management should confront staff regarding the issue of resistance to learning new skills so that this resistance is dealt with openly.

It was evident that the emotional and physical well-being of the participants in this study influenced the success of the transition. A wide range of emotional and some accompanying physical responses were reported, including anxiety, insecurity, frustration, anger, fear, discomfort, and loss. These responses resulted in the PNs' inability to concentrate, unwillingness to take risks, and avoidance of the unknown. Similar findings were reported by Schumacher and Meleis (1994). Management must acknowledge the disruptive nature of a transition and work to understand and meet the staff's emotional needs by hearing what each person thinks and by valuing each person's opinion (Steensma, 1993). The realization by staff and management that such negative emotions frequently occur in a transition has the potential for developing positive ways to assist staff such as counseling and/or individual and group support sessions.

According to Schumacher and Meleis (1994), in a successful transition the participants experience their feelings of distress evolving into a sense of well-being. The participants in this study described numerous factors indicating subjective well-being, motivation, a desire to learn, personal and professional growth, and job and role satisfaction. An awareness of these indicators would provide staff and management a basis for establishing personal goals and objectives as well as outcome measures for program evaluation.

Awareness of the significance of transitions as an important concept to the discipline of nursing and of influencing factors that affect transitions in nursing practice has implications for nurse educators in the classroom and for clinical nursing instructors in the hospital setting. Issues relating to the essential characteristics of perinatal nursing and the meaning of the transition to perinatal nursing could be appropriately included in courses on implementing a new practice model, role development, and professional issues. A sensitivity to and an awareness of the experiences of learning, relationships, work place, and PN practice would benefit the clinical instructor whose students may encounter similar situations in their clinical experience. Also, these factors might be addressed by hospital-based inservice instructors and perinatal clinical specialists in the development of orientation and cross-training programs for the new, expanded roles of the LDR(P) and mother/baby nurses.

Nursing Research

Research in this area of the understanding of how PNs view their clinical practice role after experiencing the transition from TMC to perinatal nursing is very limited. All aspects of the phenomenon are open for inquiry. Continued research on the essential characteristics and meaning of the transition to perinatal nursing is necessary for understanding the phenomenon. Continued efforts are needed to consider how to

avoid compromising the model such as exploring perinatal units which made the transition successfully to describe what as the difference, examining issues of control for nurses to determine what this means to them, and maybe even determining whether the family-centered model or the compromised model is "better." Continued efforts through qualitative investigations are also needed to confirm this study and to identify additional influencing factors that intervene either to promote and facilitate the transition or to discourage and hinder the transition among similar and dissimilar populations.

Additional research efforts are necessary to validate the participants' descriptions of the essential characteristics of perinatal nursing using participant observation methodology to observe PNs in their new, expanded roles and their interaction with patients and their families. Through program evaluation studies the transitional outcomes as well as specific areas of concern such as preplanning, being oriented and cross-trained, and implementing the model can be further explored.

The studies proposed here would further develop an understanding of the essential structure of the role of the perinatal nurse and the nature of the transition from family-centered perinatal nursing, including the participants' experiences of learning, relationships, work place, and PN practice. Through continued research efforts, educational strategies, and specific interventions that further promote and facilitate the implementation of the family-centered concepts may be developed and tested, as well as those that overcome the factors that discourage and hinder the transition to a FCMC model.

Most important, many challenges and difficult barriers lie ahead for the nurses who specialize in perinatal nursing, as in-depth decisions must be made about the future of health care. Ultimately, the issue will be who is going to be in charge of nursing practices--nurses, physicians, hospitals, or technology? According to Mullaly (1991, p.

21), "If [perinatal] nurses are not leaders, decisions may be made that are not in the best interest of either patients or nurses."

APPENDICES

APPENDIX B

LETTER TO PARTICIPATING HOSPITALS

PAULA K. LILJA
419 Rosarita Drive
Fullerton, CA 92635
(714) 526-4478

(Date)

(Name and Title)
(Agency and Address)

Dear _____:

This letter is in follow-up to our verbal discussion of the study pertaining to my doctoral dissertation. The purpose of my study is to describe the essential characteristics and meaning of the role of the perinatal nurse from the perspective of staff nurses.

The role of the perinatal nurse is central to the practice of family-centered maternity care. This study will lead to a better understanding of the experiences of staff nurses who work as perinatal nurses in LDR (P) and/or combined mother-baby nursing.

With the nurses' permission, I would like to tape the interviews for later transcription so that I may listen more intently during the interview and not write extensively. Interviews would be conducted at a time and place mutually agreed upon by the participant and myself. The estimated length of the interview is expected to be 1 hour. There is the possibility that I may wish a second interview some time after the first interview, or the participant may also request a second interview if there is anything she wishes to add to the first interview.

There is no special payment for participation. All interviews will be kept strictly confidential. Anonymity will be protected throughout the entire project, and participants may withdraw at any time if they feel uncomfortable.

The criteria for inclusion in the study are that volunteer participants be willing and able to verbalize past and present experiences and feelings and be committed to seeing the project through to the end. Also, participants must have worked 3 years or more in a traditional maternity care setting as a labor and delivery nurse, a postpartum nurse, or a newborn nursery nurse before receiving orientation (cross-training) to work as a perinatal nurse on a family-centered perinatal unit in LDR (P) and/or combined mother-baby nursing. All participants must be registered nurses currently employed on a perinatal unit.

Would you please share the enclosed letter of information and sample consent form with your staff and have any staff who express an interest and willingness to participate sign their names, addresses, and phone numbers on the enclosed volunteer forms. Enclosed for your convenience is a self-addressed, stamped envelope to return the volunteer listing. Upon receipt of the volunteer forms, I will be contacting the individual volunteers to set up appointments for the interviews and answer any questions they may have. If staff prefer to contact me directly, they have my name and phone number on the information letter.

This is a wonderful opportunity for staff nurses to describe their experiences in becoming perinatal nurses. But more importantly, it is an opportunity to help the nursing profession understand what the role of the perinatal nurse means to the nurse who has transitioned into that role. Perhaps this understanding can help other nurses in their transition to new or evolving roles.

I am very excited about the opportunity to learn from staff. I very much appreciate your sharing this information with them. Each participant and the participating hospitals will receive a summary letter of the study results on completion of the research.

I would be delighted to answer any questions that you, the nurse managers, or potential participants may have. Please call me at (xxx) xxx-xxxx. Thank you for your attention to this matter.

Sincerely,

Paula K. Lilja

Encl.

APPENDIX C

INFORMATION LETTER

April 25, 1994

Dear Nursing Staff:

My name is Paula Lilja. I am a doctoral student in nursing at the University of San Diego. Although I am currently employed in public health, my interest in perinatal nursing began several years ago when I worked as a staff nurse on a postpartum unit. The focus of my doctoral dissertation evolved as a result of that work experience. As part of my doctoral work, I am currently doing a study, the purpose is to describe the essential characteristics and meaning of the role of the perinatal nurse as seen from the perspective of staff nurses.

The role of the perinatal nurse is central to the practice of family-centered maternity care. Unfortunately, we really don't know very much about the experience of staff nurses who have transitioned to the role of the perinatal nurse in LDR (P) and/or combined mother-baby nursing. To date, no one has approached staff nurses to find out their perspective. As a result, I am interested in learning what it's like to be a perinatal nurse from the viewpoint of staff nurses who have transitioned to that role after working 3 or more years in traditional maternity care (in one speciality area such as labor and delivery, postpartum, or newborn nursery).

The interview would be scheduled at your convenience. The estimated length of the interview is expected to be 1 hour. The interview will be tape recorded for later transcription. There is the possibility that I may wish a second interview some time after the first interview. You may also request a second interview if there is anything you wish to add to the first interview.

Your participation is voluntary and will not be connected to your employment in any way. There is no special payment for participation. All interviews will be kept strictly confidential. Anonymity will be protected throughout the entire project, and participants may withdraw at any time if they feel uncomfortable.

The criteria for inclusion in the study are that volunteer participants be willing and able to verbalize past and present experiences and feelings and be committed to seeing the project through to the end. Additionally, participants will have worked 3 years or more in a traditional maternity care setting as a labor and delivery nurse, a postpartum nurse, or a newborn nursery nurse before receiving orientation (cross-training) to work as a perinatal nurse on a family-centered perinatal unit in LDR (P) and/or combined mother-baby nursing. All participants must be registered nurses currently employed on a perinatal unit.

If you are willing to participate, please sign the sheet that is being circulated by your nurse manager or call me at the phone number listed and I will call you to discuss your participation and to answer any questions you may have.

This is an opportunity for staff nurses to describe the essential characteristics of the role of the perinatal nurse. But more importantly, it is an opportunity to help the nursing profession understand what the role of the perinatal nurse means to the nurse who has been required to transition into that role. Perhaps this understanding can help other nurses in their transition to new or evolving roles.

I thank you for your time and consideration in this matter. I look forward to talking with you very soon. I would greatly appreciate your participation in this study. Each participant will receive a summary letter of the study results on completion of the research.

Sincerely,

Paula Lilja

APPENDIX D

VOLUNTEER RESEARCH INTEREST FORM

Nurse Researcher: Paula K. Lilja, RN MSN
Doctoral Candidate
University of San Diego
Philip Y. Hahn School of Nursing
Doctorate of Nursing Science Program

Nursing Research Study: To describe the essential characteristics and the meaning of the role of the perinatal nurse from the perspective of staff nurses.

Criteria of Participation:

* Registered Nurse currently employed as a staff nurse on the LDR Unit and/or the Mother-baby Unit.

* Three years or more experience in traditional maternity care as a labor and delivery nurse, a postpartum nurse, and/or a newborn nursery nurse

* Willing and able to verbalize past and present experiences and feelings of working in maternity nursing and the transition to perinatal nursing

Instructions:

After reading the information letter and sample informed consent if you are interested in volunteering to participate in this research study, please sign your name, address, phone number, and indicate the best time for you to be called on the attached sign-up sheet. Indicate which unit you work on and your shift. This information will be mailed to me by the nurse manager on your unit.

VOLUNTEER Research Interest Form

Upon receipt of this form, I will contact the individual volunteers to set up appointments for the interviews. If you prefer, you may call me directly to volunteer to participate. Interviews will begin May 18, 1994.

Thank you for your willingness to participate. If you have any questions, please call Paula Lilja at xxx xxx-xxxx.

NAME	ADDRESSS	PHONE/TIME	SHIFT	UNIT
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

APPENDIX E

STATEMENT OF INFORMED CONSENT

STATEMENT OF CONSENT

You are being invited to participate in a study to describe the role of the perinatal nurse from the perspective of staff nurses who have transitioned into that role. In order to do the study, the researcher, Paula K. Lilja, doctoral candidate at the University of San Diego, will conduct interviews with staff nurses who work in LDR/(P) and/or combined mother-baby nursing. It is expected that a clearer understanding of the essential characteristics and the meaning of the role of the perinatal nurse from the nurses' perspective will expand nursing's knowledge base and provide guidelines for education and practice.

The participants in this study will be volunteers selected from the perinatal nursing staff of four private hospitals who have implemented family-centered maternity care (FCMC). If you agree to be involved, you will be asked questions about your experience in becoming a perinatal nurse and working in the LDR (P) and/or combined mother-baby units.

The interview will be tape recorded, and written notes will also be taken at the time of the interview. The taped interview will last about 2 hours. There is a possibility that a second interview may be scheduled in a week or two after the first, either at the request of the researcher or by the participant. All interviews will occur at mutually convenient times and will be conducted so that you may talk freely or may decline to comment as you choose.

To preserve anonymity, all names or other identifying information will be coded in the research materials. The coding will be known only to the researcher. The tape recordings from the interviews will be transcribed by the researcher or a paid transcriptionist. The coding will be used throughout the typed manuscript of the interview so that no individual can be identified. All tapes and information containing identifying information will be kept in a locked file cabinet accessible only to the researcher. All tapes will be destroyed after the study is completed. The data on the study will be held in strict confidence. Answers to questions will be analyzed in group form which will further maintain anonymity. The demographic data questions will not contain your name, will also become part of the group data. If any excerpts from individual interviews are used in subsequent publication in professional journals, all personal identifying information will be changed so as to make the identification of any one participant impossible.

No discomfort is expected to ensue from this study. Your participation is voluntary. You may refuse to participate or may withdraw from the study at any time without penalty. While there is no immediate benefit to you for participating in this study, you will be afforded an opportunity to review the findings at the completion of the study. There is no agreement, written or verbal, beyond that expressed on this consent form.

I have read the above, and questions regarding this study have been answered to my satisfaction. On that basis, I agree to participate in this study to describe the role of the perinatal nurse from the perspective of staff nurses who have transitioned into that role.

_____

Signature of Subject Date

_____

Location (e.g., Fullerton, CA)

_____

Signature of Researcher Date

_____

Signature of Witness Date

NOTE: If you have questions about the research, do not hesitate to ask the researcher, whose phone number is (xxx) xxx-xxxx. If you have questions about your rights as a participant, please contact the chairwoman of the Dissertation Committee for this study at the University of San Diego, Philip Hahn School of Nursing: Dr. Janet Harrison, (xxx) xxx-xxxx.

Researcher:
Paula K. Lilja, DNSc Candidate

APPENDIX F

DEMOGRAPHIC DATA SHEET

DATE OF INTERVIEW _____ CODE NO. _____

PLACE OF INTERVIEW _____ AGE _____

PHONE _____ (WORK) _____ (HOME)

ETHNICITY _____

EDUCATIONAL PREPARATION:

BASIC _____

ADVANCED _____

FUTURE EDUCATIONAL GOALS _____

NUMBER OF TOTAL YEARS IN NURSING _____

AREA OF SPECIALTY: _____ L & D

_____ POSTPARTUM

_____ NEWBORN NURSERY

NUMBER OF YEARS IN PERINATAL NURSING _____

AREA OF SPECIALTY:

_____ LDR

_____ LDRP

_____ COMBINED MOTHER-BABY

_____ OTHER _____

REFERENCES

REFERENCES

American Academy of Pediatrics Committee on Fetus and Newborn. (1995). Hospital stay for health term newborns. Pediatrics, 96, 788-790.

Arney, W. (1982). Power and the profession of obstetrics. Chicago: University of Chicago Press.

Arnold, L., & Kirby, A. (1996). The evolving nature of perinatal nursing. Nursing Clinics of North America, 31, 259-267.

Arnold, T., & Levy, K. (1988). Cross training without cross fire. Managed Care Nursing, 13, 269-272.

Bailey, P. H., Maciejewski, J., & Koren, I. (1992). Combined mother and baby care: Does it meet the needs of families? Canadian Journal of Nursing Research, 25(3), 29-39.

Benner, P. (1984). From novice to expert: Excellence and power in clinical practice. Menlo, CA: Addison-Wesley.

Betrus, A., Kane, E., Malloy, C., & Boro, L. (1985). Organizing for primary care in obstetrics. Nursing Management, 16(11), 31-33.

Blais, R., Lambert, J., Maheux, B., Luiselle, J., Gauthier, N., & Framarin, A. (1994). Controversies in maternity care: Where do physicians, nurses, and midwives stand? Birth, 21(2), 63-69.

Bogdan, R., & Taylor, S. J. (1984). Introduction to qualitative research methods: A phenomenological approach to the social sciences. New York: John Wiley & Sons.

Boyd, C. O. (1993). Phenomenology: The method. In P. L. Munhall & C. J. Oiler (Eds.), Nursing research: A qualitative perspective (2nd ed.) (pp. 66-93). Norwalk, CT: Appleton-Century-Crofts.

Brown, L., Towne, S., & York, R. (1996). Controversial issues surrounding early postpartum discharge. Nursing Clinics of North America, 31, 333-339.

Bryanton, J., Fraser-Davey, H., & Sullivan, P. (1994). Women's perceptions of nursing support during labor. Journal of Obstetric, Gynecologic, and Neonatal Nursing, 23, 638-643.

Burns, N. (1989). Standards for qualitative research. Nursing Science Quarterly, 2(1), 44-52.

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

Caico, C., & McLean, M. (1990). Making mother-baby coupling work well. Nursing Management, 21(5), 58-59.

Cohen, M. Z., & Omery, A. (1994). Schools of phenomenology: Implications for research. In J. M. Morse (Ed.), Critical issues in qualitative research methods (pp. 136-156). Thousand Oaks, CA: Sage Publications.

Colaizzi, P. F. (1978). Psychological research as the phenomenologist views it. In R. S. Valle & M. King (Eds.), Existential-phenomenological alternatives for psychology (pp. 48-71). New York: Oxford University Press.

Cottrell, B., & Grubbs, L. (1992). Nurses' attitudes and concerns about implementing complete care. Journal of Nursing Administration, 22(6), 5-6.

Dye, N. (1986). The medicalization of birth. In P. S. Eakins (Ed.), The American way of birth (pp. 21-46). Philadelphia: Temple University Press.

Eakins, P. S. (1986). The American way of birth. Philadelphia: Temple University Press.

Enkin, M. W. (1994). Risk in pregnancy: The reality, the perception, and the concept. Birth, 21(3), 131-134.

Evans, S., & Jeffrey, J. (1995). Maternal learning needs during labor and delivery. Journal of Obstetric, Gynecologic and Neonatal Nursing, 24, 235-240.

Fein, E. (1994). Keeping expert nurses expert. Managed Care Nursing, 19, 305-300.

Fiesta, J. (1990). Security: Whose liability, infant kidnapping? Nursing Management, 21(5), 16-17.

Giorgi, A. (1985). Phenomenology and psychological research. Pittsburgh: Duquesne University Press.

Griffith-Kenney, J. (1986). Contemporary women's health: A nursing advocacy approach. Menlo Park, CA: Addison-Wesley.

Haller, K. (1996). Drive-through deliveries. Journal of Obstetric, Gynecologic, and Neonatal Nursing, 25, 9.

Ham, L., & Chamings, P. (1983). Family nursing: Historical perspectives. In I. Clements & F. Roberts (Eds.), Family health: A theoretical approach to nursing care (pp. 33-43). New York: John Wiley & Sons.

Harrigan, R. (1995). Health care reform: Impact of managed care on perinatal and neonatal care delivery and education. Journal of Perinatal Neonatal Nursing, 8(40), 47-58.

Harris, J., Yates, B., & Crosby, W. (1995). A perinatal continuing education program: Its effects on the knowledge and practices of health professionals. Journal of Obstetric, Gynecologic, and Neonatal Nursing, 24, 829-835.

Harrison, L. L. (1990). Patient education in early postpartum discharge programs. Managed Care Nursing, 15(1), 39.

Hodnett, E. (1996). Nursing support of the laboring woman. Journal of Obstetric, Gynecologic, and Neonatal Nursing, 25, 257-264.

Leavitt, J. (1986). Brought to bed: Childbearing in America, 1750-1950. New York: Oxford University Press.

Lincoln, Y., & Guba, E. (1985). Naturalistic inquiry. Newbury Park, CA: Sage.

Lipson, J. (1989). The use of self in ethnographic research. In J. M. Morse (Ed.), Qualitative nursing research (pp. 6-76). Rockville, MD: Aspen.

Mackey, M. (1990). Women's preparation for the childbirth experience. Maternal-Child Nursing Journal, 19(2), 143-173.

Mandeville, L., & Troiano, N. (Eds.). (1992). High-risk intrapartum nursing. New York: J. B. Lippincott.

Martell, L. (1995). Response to change: Maternity nursing after World War II. Managed Care Nursing, 20, 131-134.

May, K. A. (1991). Interviewing techniques in qualitative research. In J. M. Morse (Ed.), Qualitative nursing research: A contemporary dialogue (pp. 188-201). Newbury Park, CA: Sage.

McGregor, L. A. (1994). Short, shorter, shortest: Improving the hospital stay for mothers and newborns. Managed Care Nursing, 19, 91-96.

McKay, S., & Phillips, C. (1984). Family-centered maternity care. Rockville, MD: Aspen.

McNiven, P., Hodnett, E., & O'Brien-Pallas, L. L. (1992). Supporting women in labor: A work sampling study of the activities of labor and delivery nurses. Birth, 19(1), 3-8.

McRae, M. (1993). Litigation, electronic fetal monitoring, and the obstetric nurse. Journal of Obstetric, Gynecologic, and Neonatal Nursing, 22, 410-419.

Melosh, B. (1982). The physician's hand. Philadelphia: Temple University Press.

Minard, F. (1988). Competition vs. cooperation among nurses. Nursing Management, 19(3), 28-32.

Mullaly, L. (1991). Choosing to make a difference. Managed Care in Nursing, 16(1), 21-23.

Norr, K., Roberts, J., & Freese, U. (1989). Early postpartum rooming-in and maternal attachment behaviors in a group of medically indigent primiparas. Journal of Nurse Midwifery, 34(2), 85-91.

Nichols, A. A., & Palmer, D. G. (1994). Cross-training in perinatal units. Journal of Perinatal Neonatal Nursing, 8(3), 33-45.

Nichols, M. R. (1993). Paternal perspectives of the childbirth experience. Maternal-Child Nursing Journal, 21(3), 99-108.

Omery, A. (1983). Phenomenology: A method for nursing research. Advances in Nursing Science, 5(2), 49-63.

Perez, R. (1981). Protocols for perinatal nursing practice. St. Louis: C. V. Mosby.

Phillips, C. (1988a). Productivity and maternity care. Nursing Management, 19(10), 54-56, 58-59.

Phillips, C. (1988b). Rehumanizing maternal-child nursing. Managed Care Nursing, 13, 313-318.

Pierce, L., Hazel, C. M., & Mion, L. C. (1996). Effect of a professional practice model on autonomy, job satisfaction, and turnover. Nursing Management, 27(2), 48.

Ray, M. A. (1994). The richness of phenomenology: Philosophic, theoretic, and methodologic concerns. In J. M. Morse (Ed.), Critical issues in qualitative research methods (pp. 117-133). Thousand Oaks, CA: Sage Publications.

Reed, G., & Schmid, M. (1986). Nursing implementation of single-room maternity care. Journal of Obstetric, Gynecologic and Neonatal Nursing, 15, 386-389.

Reverby, S. (1987). Ordered to care: The dilemma of American nursing, 1850-1945. New York: Cambridge University Press.

Rew, L. (1988). Intuition in decision making. Image: Journal of Nursing Scholarship, 20(3), 150-153.

Rooks, J. (1990). Nurse-midwifery: The window wide open. American Journal of Nursing, 90(12), 30-36.

Rosenberg, C (1987). The care of strangers: The rise of the American hospital system. New York: Basic Books.

Rothman, B. (1982). In labor: Women and power in the birthplace. New York: W. W. Norton.

Rothman, B. K. (1996). Women, providers and control. Journal of Obstetric, Gynecologic, and Neonatal Nursing, 25, 253-256.

Rutledge, D., & Pridham, K. (1987). Postpartum mothers' perceptions of competence for infant care. Journal of Obstetric, Gynecologic and Neonatal Nursing, 16(3), 185-194.

Sandelowski, M. (1984). Expectations for childbirth versus actual experiences: The gap. Managed Care in Nursing, 9(4), 237-239.

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

Schmid, M., & Gerlach, C. (1986). LDRP: Staffing a single care maternity system. Nursing Management, 17(8), 36-40.

Schumacher, K., & Meleis, A. I. (1994). Transitions: A central concept in nursing. Image: Journal of Nursing Scholarship, 26(2), 119-127.

Schwab, L. (1996). Individual hardiness and staff satisfaction. Nursing Economics, 14(3), 171-173.

Simkin, P. (1996). The experience of maternity in a woman's life. Journal of Obstetric, Gynecologic, and Neonatal Nursing, 25, 247-252.

Spiegelberg, H. (1982). The phenomenological movement: A historical introduction (3rd ed.). The Hague: Martinus Nijhoff Publishers.

Stainton, M. C. (1994). Supporting family functioning during a high-risk pregnancy. Managed Care Nursing, 19(1), 24-28.

Steensma, J. (1993). A plan for implementing mother-baby nursing. Birth, 20(3), 148-154.

Stolte, K., & Meyers, S. T. (1988). Nurses' response to changes in maternity care: Family-centered changes and short hospitalization. Birth, 14(2), 82-85.

Strohbach, M. E. (1992). Clinical excellence and cross-training. Managed Care Nursing, 17(2), 65-66.

Sullivan, D., & Weitz, R. (1988). Labor pains: Modern midwives and home birth. New Haven, CT: Yale University Press.

Taunton, R. L., & Otteman, D. (1986). The multiple dimensions of staff nurse role conception. Journal of Nursing Administration, 16(10), 31-37.

Taylor, F. W. (1967). The principles of scientific management. New York: Norton. (Originally published 1911)

Tomlinson, P., Bryan, A., & Esau, A. (1996). Family-centered intrapartum care: Revisiting an old concept. Journal of Obstetric, Gynecologic, and Neonatal Nursing, 25, 331-337.

Vezeau, T., & Hallsten, D. (1987). Making the transition to mother-baby care. Managed Care Nursing, 12, 193-198.

Watters, N., & Kristiansen, C. (1989). Evaluating hospital postnatal nursing care: Development of the instrument. Research in Nursing and Health, 12, 299-305.

Watters, N., & Sparrow, B. (1990). Combined care: As good as they say? The Canadian Nurse, 86(2), 29-32.

Watters, N. F. (1985). Combined mother-infant nursing care. Journal of Obstetric, Gynecologic and Neonatal Nursing, 14, 478-483.

Wertz, R., & Wertz, E. (1977). Lying-in: A history of childbirth in America. New York: Free Press.

Young, D. (1992). Family-centered maternity care: Is the central nursery obsolete? Birth, 19(4), 183-184.

Zwelling, E. (1996). Childbirth education in the 1990s and beyond. Journal of Obstetric, Gynecologic, and Neonatal Nursing, 25, 425-432.