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Clients' Expectations of Public Health Nurses' Home Visits

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CLIENTS' EXPECTATIONS OF PUBLIC HEALTH NURSES' HOME VISITS

by

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Abstract

Although there is considerable research on the relationship between client expectations and outcomes of care in acute care settings, less is known about clients' expectations for public health nurses' home visits. The aim of this study was to understand clients' expectations of public health nurses' home visits as a first step in making explicit how expectations affect client responses to, and ultimately, outcomes of public health nurses' care. Interviews were conducted with a convenience sample of 19 primary caretakers of high-risk infants admitted to a Neonatal Intensive Care Unit (NICU) and voluntarily enrolled in a High-Risk Infant (HRI) Program in Southern California. All but one of the participants were the mothers of the high-risk infants.

The findings of this study elucidated a process of *forming expectations,* which consisted of two stages, expectation formation and expectation reformation. Contrary to psychological theories of expectations, participants had not formed expectations of public health nurses' home visits. Most had no knowledge of public health nurses work or their infant's referral to the program. However, with prompts from the researcher, participants used guesswork to predict what the nurse might do or say or to state their ideal expectations. The interaction with the public health nurse was a pivotal influence in confirming positive expectations and disconfirming negative expectations. Participants were surprised when the nurse addressed other health care issues of the family.

Dedication

To the primary caretakers of high-risk infants who so generously shared their stories and themselves. Without them this work would not have come to fruition.

To the public health nurses, who everyday provide nursing care in homes, work places, schools, and communities to promote health and prevent illness. In their competent, population-knowledgeable care, individuals/aggregates/communities are safe and protected.

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*Deceased

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CHAPTER I

INTRODUCTION

Home visits are an important approach to providing public health nursing care (Byrd, 1995). A home visit is "a formal call by a nurse at the client's residence to provide nursing care" (Clark, 2003, p. 498). In all situations, clients have expectations about what is likely to occur. These expectations influence their own behaviors and their reactions to the behaviors of others (Turner, 1999). Consequently, clients' expectations influence acceptance or rejection of public health nurses' services in the home setting and affect the interpersonal interaction between client and nurse.

Discovering clients' expectations of the home visit has potential for uncovering preconceived notions of what may or should happen during the home visit as well as images of clients' anticipated outcomes (Oxler, 1997). The *Scope and Standards of Public Health Nursing Practice* (Quad Council of Public Health Nursing Practice Organizations, 1999) stated that a review of the needs, strengths, and expectations of clients is integral to the assessment process. Although studies are available on patients' expectations and satisfaction with nursing care in hospitals, less is known about clients' perspectives on public health nurses' care in the home. A major shortcoming in studies, reports, and subsequent recommendations is their lack of insight and understanding of

clients' expectations regarding home visits.

The Aim of the Study

The aim of this study was to understand clients' expectations of public health nurses' home visits and to generate a substantive theoretical model of the ways expectations influence nursing interventions for health care outcomes. Identifying clients' expectations was an initial step in making explicit how expectations affect client responses to public health nurses' care, and, consequently, the outcomes of the care provided.

Background and Significance

Because of the constraints of current health care resources, the impact of many societal changes, and related public health problems across the United States, there is concern about increasing the effectiveness of home visits (Deal, 1993; McNaughton, 2000). Interaction research repeatedly demonstrates that clients and nurses do not agree on priorities for discussion during encounters and have differing impressions regarding the success of interactions (Vehvilainen-Julkunen, 1994). These differences need to be made explicit.

In addition, in the United States, visits by public health nurses may be perceived as "stigmatizing markers of poverty or parental skills inadequacy" (Kearney, York, & Deatrick, 2000, p. 369). This is often due to misunderstandings regarding the nature and purpose of the home visit (Kitzman, Cole, Yoos, & Olds, 1997; Olds & Kitzman, 1993). Nurses attempt to inform clients of the purpose for their visits as well as clarify misunderstandings at the outset of home visits. Learning about clients' expectations of

the home visit and what they want the public health nurse to do or say on the home visit will provide a better understanding of their needs and concerns about home visits.

In an era of health care restructuring, the scope of public health nurses' practice has shifted from a biomedical model (with its focus on specific programs or diseases) to a partnership with communities and their residents and members of other disciplines serving the community (Courtney, Ballard, Fauver, Gariota, & Holland, 1996; Dickemper, SmithBattle, & Drake, 1999a; 1999b; McNaughton, 2000). Because of this shift, it is most important that public health nurses identify clients' expectations of the nurse to promote partnership in care giving.

In the past, the public health nurse was a frequent and familiar visitor in low-income neighborhoods, and clients had clear expectations of the nurse's function in the community (Kearny, York, & Deatrick, 2000). More recently, in many areas of the country, client interactions with public health nurses have been limited to a single visit or telephone call. This practice limits the interaction with clients and, therefore, nurses are less visible in the community. Community members are unclear regarding public health nurses' purposes and functions in homes. This challenges nurses' abilities to understand clients' expectations as well as to partner with clients to foster skills and capacity for improving health and well-being.

What clients expect to happen during and after the visit can be ambiguous because neither the expectations of the client nor the public health nurse are articulated in their interaction (Klass, 1997). Since nurses and clients may differ in their expectations of the type of interventions desired or provided and the number of visits to be made (Gomby, Larson, Lewit, & Behrman, 1993), a knowledge of clients' expectations may assist nurses

to meet those expectations or to engage in dialogue to modify unrealistic expectations. Furthermore, client expectations of care might serve as criteria for evaluating the quality and effectiveness of care, while unrealistic expectations could falsely influence evaluation of care.

Although studies have been conducted on patients' expectations and satisfaction with nursing care in hospitals and some ambulatory settings, their findings may not be applicable to the home setting in which public health nurses provide care. Little is known about clients' perspectives of public health nurses' care in the home. While some progress has been made in identifying characteristics of successful home visiting programs (Kearney, York, & Deatrick, 2000; Korfmacher, O'Brien, Hiatt, & Olds, 1999; Olds et al., 1997), there is little knowledge about clients' perceptions and expectations. An understanding of client expectations could assist public health nurses in their work with individuals and families because interactions can have negative consequences if they do not conform to expectations (Klass, 1997). In order for public health nurses to be effective in the environment of the twenty-first century, they must have a better understanding of client expectations.

Scholars recognize a strong relationship between expectations and outcomes. These scholars further support the need for knowledge of clients' expectations for improving outcomes of care (Kravitz, 1996; Oxler, 1997; Staniszewska & Ahmed, 1999). The face-to-face encounter of a home visit initiates a client-nurse relationship. The client and the nurse each bring to this encounter their respective explanatory model shaped by their culture, education, and experience (Byrd, 1997). Because clients control access to their homes as well as the information they are willing to share, an understanding of clients'

expectations of care is prerequisite to co-creating interactive relationships that enhance mutual sharing of professional and experiential knowledge between client and nurse (Wilson, Morse, & Penrod, 1998). This study sought to understand clients' expectations for nursing care in the home setting.

Although public health nurses have a rich tradition of assessing family health status before implementing nursing care, eliciting clients' expectations of care has not been a routine part of the assessment. The goal of family assessment has been to understand the family's background, identify their strengths, their needs, and their goals for health. The typical family database documents sociodemographic characteristics, culture and ethnicity, family history of health problems (Byrd, 1997), and past experiences with health care, the health care system, and health care providers, including public health nurses. More needs to be known about clients' expectations and how to elicit them.

In summary, this study provided useful information about clients' expectations of home visits to high-risk infants and their primary caregivers as a basis for developing a practice model. A model has potential for enhancing public health nursing interventions in the home setting. Identifying clients' expectations of public health nursing care in the home is the first step in theory development.

Research Question

The study was guided by the following primary research question.

What are client's expectations of public health nurses' home visits?

Research Method

A qualitative methodological approach allowed participants to describe their expectations and their experiences with the public health nurse's home visit. The

grounded theory method provided the researcher the opportunity to study expectations from the view of participants receiving public health nursing services. A convenience sample of clients who had enrolled their infants in a high-risk infant program was recruited. Interview sessions were scheduled before and after the public health nurse visited the family. Interviews were audio taped and transcribed verbatim for analysis. All data were analyzed using the constant comparative method to identify clients' expectations of public health nurses' home visits.

Definition of Concepts

Expectation, the major concept of this study, was defined in *Webster's Encyclopedic Unabridged Dictionary of the English Language.* (2001), as: (a) "the act or state of looking forward to; anticipating;" (b) "the act or state of looking forward or anticipating;" (c) "an expectant mental attitude: looking for as due, proper, or necessary;" (d) "a reason or warrant for looking forward to something; prospect for the future, as of advancement or prosperity" (p. 680). These definitions are multidimensional and complex because the concept has different meanings to different individuals.

This definitional complexity is reflected in the psychology, sociology, medical, and health care management literature in which the term patient's expectation was used in widely different ways (Kravitz, 1996; Thompson & Sunol, 1995). Based on a brief literature review of the various disciplines, Thompson and Sunol (1995) proposed working definitions of four types of expectation: (a) ideal expectation, (b) predicted expectation, (c) normative expectation, and (d) unformed expectation.

An ideal expectation is expressed as a desire, a wish, or preferred action or outcome. Ideal expectations reflect the individual's subjective affinities or values. For

example, ideal expectations were prefaced with words such as: "I wish the nurse would"; "I want the nurse to;" " I need the nurse to;" "I would like the nurse to;" or "It is important to me that."

A predicted expectation is realistic, practical, or anticipated and matches what individuals believe will happen based on previous personal experience. Individual judgments lead to conclusions. Predicted expectations were prefaced with: "I guess the nurse will", "I believe the nurse will," or " I think the nurse will."

A normative expectation represents what should or ought to happen and is equated with what individuals are told or led to believe or deduce about what should or ought to happen. A normative expectation is learned and is always based on a story, some prior experience, or media portrayal of what nursing is about.

Unformed expectation occurs when individuals are unable or unwilling to articulate their expectations because they do not have any, they find them too difficult to express, or they do not wish to reify their feelings due to fear, anxiety, or conformity to social norms. Unformed expectations may be temporary until individuals have knowledge or experience (Thompson & Sunol, 1995).

A frequently cited definition of expectations in the literature is cognitive beliefs shaped by client characteristics in interaction with the health care provider's characteristics and behaviors (Westra et al., 1995). These beliefs about services they think they are to receive may be explicit or may not yet be formed.

Expectation in this study was defined as what clients want (or do not want) the public health nurse to do or say when providing nursing care in the home. It was

anticipated that this study would primarily identify predicted and normative expectations, but clients may also articulate that their expectations are unformed.

Client is defined as a person who is the recipient of public health nursing home visits because she/he provides daily care to a high-risk infant; also called a primary caretaker.

A *high-risk infant* is defined as an infant who was admitted to a neonatal intensive care unit (NICU) and whose primary caretaker had voluntarily enrolled the infant in the San Bernardino County Department of Public Health (SBCDPH) High-Risk Infant (HRI) Program.

A *home visit* is the process by which a public health nurse provides nursing care to a client in his or her own home.

A *public health nurse* is an actively licensed registered nurse with a Bachelor of Science (degree) in Nursing (BSN) or its equivalent, who holds a Public Health Nursing Certificate issued by the California Board of Registered Nursing, works in an official public health agency, and makes home visits to clients enrolled in the SBCDPH HRI Program.

Summary

Although there is considerable research on the relationship between client expectations and outcomes of care in acute care settings, less is known about client expectations for public health nurses' home visits. In all situations, clients have expectations about their desires and what is due them. Eliciting and understanding clients' perspectives, priorities, and expectations is key to enhancing the effectiveness of public health nurses' interventions with high-risk infants. With knowledge of clients'

expectations, the nurse will be able to customize interactions to meet clients' unique needs. This, in turn, would lead to client agreement with and participation in the plan of care and, thus, facilitate positive health care outcomes. This study sought to identify and clarify what primary caretakers of high-risk infants expect from public health nurses' home visits as a first step in substantive theory development for improving health outcomes.

CHAPTER II

REVIEW OF THE LITERATURE

This chapter begins with an overview of the research literature related to the concept of expectation as viewed by the disciplines of psychology, sociology, and medicine. Marketing and health care literature join the concepts of expectations and satisfaction with purchase decisions and health care satisfaction and outcomes. The concept of expectation is defined. The relevant literature review for each discipline is presented and then a discussion of research in nursing and public health nursing related to clients' perceptions and expectations is provided. Literature was reviewed not to create hypotheses, but to provide theoretical sensitivity enabling the researcher to understand and derive meaning from the data (Glaser & Strauss, 1967).

Expectation as a Concept

Expectation is a noun derived from the Latin word *expectare,* "to expect." The first syllable of the word, "ex-" means "out" plus *spectare* which means "to look", or *specere, "*to see*"* (*Webster's Encyclopedic Unabridged Dictionary of the English Language,* 2001). Runes (1983) defined expectation as "the act or state of looking forward to an event about to happen; the grounds on which something is believed to happen; a supposition, anticipation, a reasonable hope, a probable occurrence" (p. 118).

Psychologists defined expectation as "conscious anticipation of future events on the basis of prior experience" (Corsini, 1999, p. 351).

Health care literature also reflects these definitional complexities of the concept of expectation. The term patient expectation is used in widely different ways. Over the last three decades numerous studies of patients' expectations failed to document a rigorous definition of the term. Most authors used the term in one of two ways. Studies focusing on patients' predictions about the future examined probability expectations such as patients' judgment about the likelihood that a set of events would occur. Studies focusing on patients' subjective affinities examined value expectations such as patients' hopes, wishes, or desires concerning clinical events including expression of wants, perceived needs, importance, standards, or entitlements (Kravitz, 1996). As noted earlier some scholars have provided definitions of the various types of expectations in an effort to bring clarity and promote theory development (Thompson & Sunol, 1995).

Initial expectations, usually based on prior experiences, may be well formed or amorphous. There is strong evidence that although initial expectations may be formed they are subject to ongoing re-formation in the process of health care experiences (Kravitz, 1996). These expectations may be general or specific, positive or negative, but can undergo modification over time as the relationship with the nurse develops. Since public health nursing is not universally understood, expectations of public health nurses' home visits may be unformed (Kearney, York, & Deatrick, 2000).

Though the disciplines demonstrate an appreciation of clients' expectations in human behavior, little empirical work has addressed them. One reason may be confusion about the definition and measurement of clients' expectations. Another is the lack of a

conceptual model linking clients' expectations to their cultural and social-psychological antecedents and to their cognitive, affective, and behavioral consequences, and addressing their association with satisfaction and outcome (Kravitz, 1996). Health care professions studies take for granted that expectations are a causal factor in the measurement of client satisfaction with health care experiences.

Psychological Perspectives on Expectations

Psychology provides distinctive foundational dimensions for understanding human behavior and, to a minor degree, allows us to theorize about clients' expectations. The conceptualization of expectation as a common cognitive pathway leading to behavior is integral to all psychological explanations. This section of the review of the literature addresses the cognitive dimensions involved in clients' prior and on-going experiences and their implications for expectation formation. A brief review of expectation theories in cognitive, psychoanalytic, and behavioral psychology follows.

Cognitive Psychology

Cognitive psychology emphasizes information processing. People behave in accordance with their expectations. Expectations cannot be inferred from a person's behavior alone. For example, it is premature to conclude that clients who courteously invite nurses into their homes will share their expectations. Expectations are never assumed and must be independently confirmed by the nurse. Since expectations cannot be assumed, this approach supports the importance of dialogue with clients to understand their expectations for the home visit.

An important example of how expectations can influence outcomes can be seen in placebo effects. Placebo effects are mediated by expectation. Placebos are inert

substances. They can reduce pain, tranquilize, and stimulate moods if one strongly expects such effects. "The proper setting, relationships, clear rationale, and specific therapeutic procedures have been particularly effective in inducing positive outcomes based on clients' strong expectations of hope" (White, Tursky, & Schwartz, 1985, p. 23). Cognitive psychologists accept explanations based on expectations as definitive once the expectation connects observable behavior with an associated psychological state. It is prudent to ask, might the therapeutic relationship with the nurse in the home affirm clients' strengths and expectations of outcomes and motivate or create the placebo phenomenon for clients' goals for health and well being?

Psychoanalytic Theory

The second psychological perspective on expectation addresses the influence of emotional state on expectations. Both cognitive and psychoanalytical fields identify the problem of adaptation to reality as a central psychological question. While psychoanalysis is concerned with id-ego conflicts and ego defense mechanisms, ego psychologists identified perception, intention, thinking, language, memory, and other rational processes, including expectation, as contributing to people's behavior. A list of ego functions and a list of cognitive processes are essentially the same list. Expectation is discussed in the same causative fashion in both fields.

Psychoanalytic theory posits unconscious motives in addition to conscious ones. The ego serves to defend consciousness against unconscious impulses. However, the ego is also hypothesized to distort consciousness, including expectation, as another defense mechanism. For example, an unstable, unhappy individual might marry an undesirable partner *expecting* a bright future. This conscious, positive expectation of having a bright

future may actually result from a secondary unconscious motivation to leave home, thus the primary expectation may be an unrealistic positive expectation of finding future happiness through marriage. The same processes can lead to underestimating the negative consequences of actions. Unconscious motives for using certain behaviors in a given situation may result in the use of defense mechanisms (Frank & Frank, 1991).

Of specific interest to this study is that psychoanalytic theory provides an explanation for why clients' expectations may be unconscious and not be able to be articulated. In addition, clients may use defense mechanisms to avoid relationships with public health nurses or deny the need for any intervention for help or life style behavior change.

Behavioral Psychology

Prior experience is the basis for expectation in the behavioral psychological perspective. When an experiential basis is found to account for the expectation, behavioral psychology explains both the expectation and the consequent behavior in terms of prior experience. Behavioral psychology bases causal factors of expectations on prior experience while cognitive psychology bases expectation on a cognitive rationale. In brief, the differences in causal explanations account for how these two schools of thought view expectations differently.

In the past, behavioral psychology has viewed the mind and body as separate. More recently this view has changed, and the cognitive process of introspection about behavior is acceptable as causal by some behavioral theorists. The behavioral theories that allow cognitive explanation are now identified as social-cognitive theories (Maddux, 1999; Rachlin, 1994).

Early behavioral scholars developed eight theories of expectation, most of which were based on Pavlov's stimulus-response model (1927; 1960). Pavlov, the first neuropsychologist, focused his research on the ability of the cerebral hemisphere to form associations between stimuli and responses. Though the word expectation does not appear in Pavlov's index of his original thesis, it is fundamental to his work. Pavlov (1927; 1960) defined conditional response, known as conditioned response because of an error in translation, as a response that could be predicted based on previous experience.

Stimulus-response theories include: Pavlov's Conditional Response (1927; 1960); Tolman's Expectancy Theory (1932; 1955); Rotter's Social Learning Theory (1966; 1982); Rescorla's Relational Learning Theory (1988); Bandura's Self-Efficacy Theory (1986); Seligman's Theory of Learned Helplessness (1975); Skinner's Selectionism Theory (1971); and, finally, Staats's Theory of Psychological Behaviorism (1968). All but Skinner's Selectionism Theory (1971) were founded in the stimulus-response concepts identified in Pavlov's work. Skinner was a response-stimulus psychologist. The premise of his theory was that new behavior was shaped by old behavior. Complex behavior could be refined from simple behavior by ignoring unwanted behavior and rewarding acceptable behavior.

Expectancies are seen as determinants of behavior in the theories listed above. An exception is Rescorla's Rational Learning Theory (1988). Rescorla viewed expectancy as a mediator of classical and operant conditioning in contemporary learning theory. The more informed and knowledgeable people were about a conditioned stimulus, the less they are affected by the unconditioned response. Thus expectancies become reinforcers for behaviors.

Most of the expected outcomes in behavioral and cognitive theories are the result of stimuli. Stimulus expectancies are responses to external environmental events that influence behaviors. Examples of external environmental events are home visits and recognition by others.

In this study, an example of stimulus expectancy is the client's expectation of increased knowledge and skills in caring for the infant's special needs. This stimulus expectancy motivates the client to interact with the nurse in an open manner based on the desire for greater knowledge and competencies. A collaborative relationship that allows for sharing of professional and experiential knowledge between the client and the nurse, could increase the knowledge and skills of the caretaker, and consequently, result in a good health outcome for the infant. In turn, the affirmation and recognition the nurse gives the caretaker for competent application of knowledge and skills could be perceived by the caretaker as a reward thus bolstering the clients' self confidence and self-worth as a competent caretaker.

Compare the above example with response expectancies. Response expectancies are automatic (Kirsch, 1990). People do not need to think about such expectancies for their effect to be seen. An example of response expectancy is that drinking a cup of coffee will make one more alert. People holding the later expectation reported feelings of enhanced alertness after drinking decaffeinated coffee, but only if they were not aware that the coffee was decaffeinated.

Expectancy-Value Theories

Another category of expectancy theories within the behavioral-cognitive perspective incorporates peoples' value systems as influencing expectations. Expectancy-

value theories propose that expectations are based on an individual's value system and beliefs that specific behaviors will be effective in producing specific outcomes. Theories in the expectancy-value framework include: Tolman's (1932; 1955) Principles of Performance Theory, Rotter's (1966; 1982) Social Learning Theory, The Theory of Reasoned Action and Planned Behavior (Ajzen, 1988; Fishbein & Ajzen, 1975), and Self-Efficacy Theory (Bandura, 1986). At the center of one's ability to plan and self-regulate is the ability to anticipate and develop expectancies, to use past experience and knowledge to form beliefs about and predict future events and states (Olson, Roese, & Zanna, 1996).

The expectancy-value theories reinforce the need for the public health nurse to be alert and sensitive to the value systems of clients' and the influence of clients' values on expectations for autonomy, care, and behavior change. The dynamics of the interactions of human internal cognitive and external sociological experiences are integral to human relationships. A discussion of the commonalities of the social cognitive theories follows.

Social-Cognitive Perspective

Recently psychology has begun to label the broad range of behavioral and cognitive approaches to expectations as social-cognitive theories. The social-cognitive theories have much in common. They share a set of principles and assumptions about basic psychological activities in which people engage. They also share a set of basic conceptual elements and variables from which the principles are developed.

The basic principles and activities common to the social-cognitive perspective include (a) reciprocal causation, (b) centrality of cognitive construals, (c) self-regulation, and (d) social embeddedness of self and personality (Maddux, 1999). A review of the

principles and processes of cognitive-social theories provides greater clarity regarding expectation formation.

The first principle, *reciprocal causation* (Maddux, 1999), defines mutually interacting influences of environmental events, cognition, emotion, and behavior. Bandura (1989) called this process "emergent interactive agency." Although these influences are reciprocal, they are not necessarily simultaneous or of equal strength (Maddux, 1999). Reciprocal causation explains how the public health nurse's appearance, introduction, and mannerisms could influence clients' decisions to interact with the nurse or withdraw from the experience.

The second principle is *centrality of cognitive construals* (Maddux, 1999). People construct their world cognitively. These cognitive constructs greatly influence behavior and emotions. In this way, people understand and give meaning to their world. The recognition of personality formation and the knowledge that prior experiences will influence clients' reaction to the public health nurses' home visit is important when developing relationships.

The capacity for cognition also includes the capacity for consciousness, self-awareness, and self-reflection. People observe their own behaviors, thoughts, and feelings. Simultaneously, they evaluate others' behavior and decide whether their behavior is accomplishing their aims and objectives for the current situation. Expectancies about the effects of certain behaviors under certain conditions and expectancies about the ability to perform those behaviors competently create their cognitive templates for future experiences.

This understanding provides insight that clients' behavior toward public health nurses may be based on prior experiences with other nurses and health professionals and how the provider's behaviors toward them have worked for the client in the past. If the behavior of the client is negative, clarifying the purpose of the home visit and the nurse's expectation for the home visit may allow the client to respond to the public health nurse in a more receptive manner.

The third principle of the social-cognitive perspective is *self-regulation* (Maddux, 1999). Self- regulation is based on the belief that individuals are active designers of their environments and of their own behaviors, thoughts, and emotions, rather than passive responders to external events and internal psychological forces. Their cognitive abilities provide them with the tools for self-regulation. Understanding clients' processes of self-regulation is important for designing appropriate strategies before planning and intervening for behavioral life style change.

The fourth and last principle of the social-cognitive perspective is *social embeddedness* of the self and personality (Maddux, 1999). According to this principle, individuals define themselves largely by what they think about, how they feel about, and how they behave toward other people. An individual's behavior is influenced and shaped by other people and by what the individual expects other people to think, feel, and do in response to his or her behavior. Thus, social-cognitive learning is what individuals learn from other people about how to think, feel, and behave. This learning is most important for relating to other people in society. What other people are thinking, how they explain and predict other people's behaviors, thoughts, and feelings, are also important. Self and personality are perceptions of one's own and others' patterns of social cognition,

emotion, and action as they occur in situations. Thus, self and personality are inextricably embedded in social contexts.

An understanding of an individual's social cognition and behavior in specific social situations, such as the home visit, is important for public health nurses' practice. In addition, the individual's social goals; specific situational expectations; beliefs about social and situational norms; and how individuals select, construe, and organize information about themselves and others must be assessed. Because these traits are socially embedded, personality and self are not simply what people bring to their interactions with others; they are created in these interactions, and change through relationships. Thus, personality and self are not entities; they are processes. An understanding of this dynamic provides support for public health nurses' utilization of communication skills for developing client-nurse interactions. Acknowledgement of needs, strengths, and expectations of clients' in the assessment phase of nursing care given during a home visit supports better understanding which may lead, in turn, to improving health outcomes.

The social-cognitive theories differ in their definitions of expectation, and the labels applied to the variables. Their measurement of expectation and the various variables also differs. Generally, behavioral psychology defines expectations as conscious anticipation of future events on the basis of prior experiences. Using this definition of expectation, each theory focuses on a specific outcome or expectation in the application of the various theories. For example, the expectation of Tolman's (1932; 1955) Expectation Theory was that behavior mediates expectation based on consequences. Rotter's (1966; 1982) Social Learning Theory focused on the individual's "locus of control," and Rescorla's (1988)

Relational Learning Theory proposed that classical conditioning could produce expectations. Bandura's (1986) Self-Efficacy Theory incorporated the expectation of self-efficacy. Seligman's (1975) Learned Helplessness Theory proposed that expectation of uncontrollability is a necessary, but not sufficient condition for depression to handicap an individual, and Skinner's (1971) selectionism incorporated the expectancy that reinforcing good behavior decreased bad behavior.

In contrast, strictly cognitive theories use definitions for expectations that relate to probability and values. Probability expectations focused on patient predictions about the future, while value expectations involved patient's subjective affinities such as hopes, wishes, or desires. These may be expressed as wants, perceived needs, importance, standards, or entitlements. Though the concept of expectation in the behavioral and cognitive perspectives is not clearly defined, the differences between how cognitive and behavioral psychologists use terms like expectation highlight controversial issues associated with expectation within the discipline of psychology (Rachlin, 1994).

The principles shared by the social-cognitive theories depend on a relatively small number of variables. Variables common to the social-cognitive theories include: behavior-outcome expectancy, stimulus-outcome expectancy, self-efficacy expectancy, outcome value, goal, intention, attributions, competencies, and affect (Maddux, 1999). The definitions and labels applied to these variables are inconsistent across the social cognitive theories and across studies examining a specific model. For example, the variations in the ways researchers have measured what Bandura (1986) called "self-efficacy" makes it difficult to compare the findings from one study to another. A close examination of the measures other researchers used to operationally define basic social-

cognitive variables such as expectancies, perceived control, and intentions, also reveal similar inconsistencies.

Response Expectancy Theory

The most recent innovation in theory and research on expectancies is Kirsch's (1985; 1990) response expectancy theory. Kirsch's theory is an extension of Rotter's (1966; 1982) Social Learning Theory that shares the basic principles and processes previously outlined in the social-cognitive perspectives. A response expectancy is an anticipation of automatic reactions to particular situational cues. Response expectancy is the person's perception of stimulus expectancy. The response expectancy is an unintentional response, such as an emotional reaction to a subjective experience and its physiological and psychological concomitants (e.g., emotions, pleasure, pain). Thus, response expectancies are concerned with people's beliefs about their own reactions to events. People actively seek some unintended responses, such as sexual arousal and actively avoid others such as pain.

Kirsch (1985) was able to demonstrate the effects of response expectancies on placebo effects, psychotherapy, and hypnosis. Since that time the theory has been used to guide research in diverse settings extending the understanding of response expectancies across disparate domains. Research has determined that response expectancies are determinants of mood swings (Catanzaro & Mearns, 1999), memory reports (Hirt, Lynn, Payne, Krackow, & McCrea, 1999), fear and anxiety (Schoenberger, 1999), sexual arousal (Palace, 1999), pain perception (Price & Barrell, 1999), asthmatic responses (Sodergren & Hyland, 1999), drug use and abuse (Brandon, Juliano, & Copeland, 1999; Goldman, Darkes, & Del Boca, 1999; Vogel-Sprott & Fillmore, 1999), illness and health

(Hahn, 1999), and responses to psychotherapy and medical intervention (Kirsch. & Sarpirstein, 1999; Walach & Maidhof, 1999; Weinberger & Eig, 1999). The strength of these findings suggests that response expectancies may be more than just another variable, and that causes of certain illnesses, particularly mental illness, may need to be rethought. Indeed these studies support the position that the psychological domain interacts with neurological and immunological body systems to influence health outcomes positively or negatively (Houldin, Lev, Prystowsky, Redel, & Lowery, 1991). These findings legitimize nursing interventions that would affirm clients' expectations for positive behavior and anticipated outcomes through recognition and encouragement in relationships with clients, families, and partners in communities for improved outcomes of care.

One important difference between response expectancy theory and other expectancy theories is its emphasis on unintentional responses rather than intentional behavior. A second important difference is that response expectancies are self-confirming. People tend to experience the unintentional responses that they expect (Kirsch, 1999). They are able to report their beliefs and expectancies when asked to do so, and this enables researchers to assess response expectancies as predictors of experience and behavior. The understandings of these various dimensions will be helpful to the researcher in the collection and interpretation of data. Client-participants should have no difficulty expressing their expectations.

Some scholars within psychology (Rumelhart, 1989; Staats, 1968; Wasserman, 1989) and outside of the discipline have made efforts to construct framework theories of behavior and associated psychological states, including expectation, to promote

unification not only within the discipline but also across disciplines for consolidating knowledge and understanding expectations. An example is Staat's Psychological Behaviorism (1968) combining basic behavioral repertoires of sensorimotor, emotional-motivational, and language-cognitive categories. Other proposed models are the neural network perspective consisting of connectionism and the parallel distributed processing models (Rumelhart, 1989: Wasserman, 1989).

The psychological perspectives on expectation presented here confirm that people are complex. Psychology helps to clarify the internal dynamics of cognition, emotions, and human behavior as they relate to external experiences. This knowledge provides a foundation for developing nurse-client relationships and identifying clients' expectations of public health nurses' home visits. These perspectives further provide insight for public health nurses' understanding of their own humanness. The human experience is unique for each individual based on his or her prior experiences and social-cognitive learning. In addition, these theories clarify how clients' prior experiences inform their expectations of public health nurses' home visits.

Sociological Perspective on Expectation

Similar to scholars in psychology, sociologists view the behavior of individuals as shaped by contemporaries in society. In contrast to internal factors of psychology, sociology is concerned with the external factors of the human experience. Sociology shares the principle of social embeddedness used in the social-cognitive theories of expectation discussed above. Further, this discipline provides additional insights about clients' prior experiences and their effect on expectation formation. Clients' prior

experience factors include family, culture, ethnicity, age, gender, education level, and society.

The sociological point of view considers how people construct their realities through the development of causal networks. Expectations serve as the primary formulation of predictions for social interaction. For example, if something is believed to be real, it is real in its consequences. Understanding that members of society base their interactions on symbols, beliefs, sentiments, and rules and standards learned within their families and cultures, social science seeks to understand how individuals think and feel, how they behave toward others, and how they judge the behaviors of others and their interaction.

An understanding of these concepts is particularly helpful to public health nurses working in communities were values, norms, and expectancies vary and may be different from the nurses' own past experience. Attention and sensitivity to the social influencing factors would facilitate gaining entry to homes and developing working relationships with families. Based on the prevalent social norms and culture of the community in which the client lives, the public health nurse must be sensitive to issues clients experience related to culture, intrusion, authority figures, and personal safety.

Expectation-States Theory

A metatheory of expectation-states was found in the sociological literature. Joseph Berger (1958), a sociologist, developed expectation-states theory. Expectation-states theory has provided strong empirical evidence for describing status characteristics, performance expectations, and status validation within groups.

This theory defines expectation-states as theoretical constructs, not observable phenomena. Expectations are seen as reflecting a person's beliefs about the distribution of task competence in a group and society at large. The original focus of theory development was on dyads within small, task-oriented groups using standardized experimental situations. More recently the theory is being applied in real world settings. The theory's central interest is in the processes through which group members assign levels of task competence to each other and in the consequences this assignment has for their interaction.

Originating as a single theory, expectation-states theory has grown to include two branches that share a core of basic concepts and propositions, as well as a set of substantive, methodological, and meta-theoretical assumptions (Berger, 1989). Thus expectation-states theory contains not one theory but several. A meta-theory, expectation-states theory, has two branches: *status characteristics* and *performance expectation.*

A *status characteristic* is any valued attribute implying task competence. For example, status characteristics are viewed as having at least two levels (e.g., being high or low in mechanical ability or being male or female), with one level carrying a more positive evaluation than the other. Status characteristics may also be defined as varying from specific to diffuse, depending on the range of individuals' perceived ability. For instance, mechanical ability is usually considered to be relatively specific and associated with well-defined performance expectations. Gender, however, tends to be treated as diffuse or carrying both limited and general performance expectations. The "diffuseness" refers to the fact that there is no explicitly set limit to the expectations. The characteristic is viewed as relevant to a large, indeterminate number of different tasks. Other attributes

commonly treated as diffuse status characteristics are ethnicity, race, social class, educational level, organizational rank, age, and physical attractiveness (Berger, Cohen, & Zelditch, 1966). An example of a diffuse status characteristic is a belief that Black Americans are less well educated than average White Americans.

The second branch of expectation-states theory, *performance expectations*, links status characteristics to observable behavior, which in turn determines the order of power and prestige within a group. Levels of performance expectation characteristics are associated with degrees of competence and corresponding expectations of *the group* (Berger & Conner, 1969). Performance expectations consist of a set of interrelated behaviors. These behaviors include the unequal distribution in the offer and acceptance of opportunities to perform, the type of evaluations received for each unit of performance, and the rates of influence exerted among group members. Performance expectations are distinguished from evaluation units of performances. While the latter is an evaluation of a single act, the former refers to the level of competence that a person is predicted to exhibit over a number of performances. Once established, expectations tend to be stable, since the behaviors that make up the power and prestige order of a group operate in a way that reinforces the status quo (Berger & Connor, 1969).

Expectation-states mirror the stereotypes of society's beliefs about peoples' abilities. These stereotypes may influence the expectations of both clients and public health nurses. Nurses' first work must be to engage in serious introspection to clarify their personal values and beliefs about the human experience. Introspection assists individuals to recognize their individual bias toward other cultures and socioeconomic and educational disparities, as well as value systems that differ from their own. Akin to

conducting research in similar situations, nurses must come to terms with these issues that could interfere with collaborative relationships and objectivity. Recognizing that social learning is powerful, a person who has no formal education has knowledge. This knowledge can be shared for mutual understanding and collaboration.

Status Validation Theory

Knottnerus and Greenstein's (1981) work added the component of *status validation theory* to expectation-states theory. Status validation theory explains how diffuse status characteristics and the stereotypical beliefs associated with them operate to produce status validation. Their study investigated the processes by which status stereotypes structure social inequality. Inferences based upon diffuse status characteristics such as sex, age, and ethnicity seem to have a ubiquitous effect on human relationships. Using multiple strategies within experimental situations, this theory extended the scope of expectation-states theory by addressing the problem of whether status stereotypes are reinforced by information concerning the competence of participants in the experimental situation. Empirical support for this formulation contributed to expectation-states theory as well as provided insights for practical attempts to remedy status inequities in contemporary society (Blau, 1977).

Research applying expectation-states theory continues to develop in several directions. Refinement, expansion, and integration of various aspects of the metatheory are underway. The research includes the study of the relationship between status and affect (emotions and sentiments) in the assignment of tasks (Ridgeway, 1991; Ridgeway & Johnson, 1990). For example, Ridgeway (1991) combined structural theory with expectation-states theory. Combining structural theory and expectation-states theory

provided the construct which informed the social construction of status value in relation to gender and other nominal characteristics such as race, ethnicity, regional, and religious categories.

In addition, the discipline acknowledged a need for development of a more general sociological theory of emotions in interpersonal encounters (Wagner & Turner, 1998). This general sociological theory is important because it places expectations at its core with a bi-directional influence in face-to-face encounters.

The Sociology of Emotions

The sociology of emotions (Wagner & Turner, 1998) has become one of the leading edges of micro level theorizing in sociology. The bi-directional influence of expectation is manifest in the following manner. Individuals have expectations about what is likely to occur and these expectations influence not only their own behaviors but also their reactions to the behaviors of others. Turner's general sociological theory of emotions included a combination of key ideas from a mix of theories. The theories included: expectation-states theory, symbolic interactionism, dramaturgical analysis, attribution theory, power-status theories, and psychoanalytic theories. The combination of key ideas from these diverse theories delineates the full range of emotional forces operating in interactions during face-to-face encounters. Turner (1999) proposed that overt emotional arousal is a visible state that mutually signals and interprets gestures between individuals, and in so doing determines the flow of an interaction. Emotional displays are only surface manifestations of complicated and covert emotional dynamics, operating through the neurology of the brain.

For every given cycle of emotional arousal, the process begins with expectations from many diverse sources: demographic forces, structural forces, cultural forces, and transaction forces. Those expectations are collated as part of the definition of a situation into a generalized expectation about what will or should occur in the encounter. The person's *self* has a special type of expectation. When the *self's* courage is high before, during, and after an episode of interaction, it exerts a disproportionate influence on emotions. Emotions are aroused by the degree of congruity or incongruity between what is expected and what is experienced in a situation. The process is complicated by the manner in which the neurological processes of the human brain combine emotions during the arousal and by the activation of defense mechanisms.

The level of emotional arousal during an interaction reflects the degree of incongruity between expectations for confirmation of self and actual experiences. Such arousal involves the conversion of primary emotions into first and second-order combinations. Primary emotions included satisfaction-happiness, aversion-fear, assertion-anger, disappointment-sadness, and startlement-surprise with a range of low to high intensity of emotion. First order emotion combinations included two primary emotions such as satisfaction-happiness plus aversion-fear with a range of emotional responses. Second-order combinations included shame and guilt directed at self and includes disappointment-sadness, assertion-anger, and aversion-fear. The nature of emotional arousal is further complicated by the activation of defense mechanisms and attribution processes (Turner, 1999).

Lessons learned from the exploration of expectation-states theory are of special importance for public health nurses' work in communities. Unless the nurse is receptive

and open to the people served and listens to clients' expectations as well as sharing his/her own personal values regarding power/equity at the outset of the encounter, the prevailing stereotype about nurses coming to the home will continue. The prevailing stereotype may create a negative reaction toward the public health nurse. Stereotypical beliefs about public health nurses that may be present in clients' neighborhoods include viewing the nurse as intruder, disciplinarian, and authority figure.

Turner's (1999) discussion of emotional dynamics in face-to-face interactions is fruitful for this study. His ideas bring to light the importance of nurses being alert and sensitive to clients' emotions in their interactions. The meanings of experienced emotions need to be clarified with clients. Because a client's self and personality are inextricably embedded in his or her social contexts, it is important for the public health nurse to be aware of social and emotional influences on the client. Understanding of clients cannot be achieved without assessing their social cognition and behavior expressed in face-to-face encounters as well as understanding their goals and expectations of home visits.

In this study, the researcher was alert to participants' beliefs about social and situational norms and how client-participants make use of them in relation to their identified expectations. Awareness of emotional arousal in the participants' responses to the interview questions in the face-to-face encounter was noted in field notes. The researcher attempted clarification with participants. Their responses were interpreted in data analysis.

Nursing and Expectations

The nursing profession's commitment to caring for the whole person is well documented. A review of nursing literature reveals that the profession has drawn and

benefited from the scholarly work of other disciplines. With the advent of consumerism and quality assurance in health care, considerable attention has been given to learning what consumers want from their health care providers and what quality care means to them. This information helps nurses to understand their clients' expectations. What people expect from their providers influences their satisfaction with care and may affect health care outcomes (Donabedian, 1987; Kravitz, 1996; Oberst, 1984).

Efforts continue in the nursing profession to identify specific attitudes and behaviors of the nurse that meet client expectations of care. Messner & Lewis (1996) noted many factors in clients' past experiences that influenced their expectations. These may include age, gender, health status, socioeconomic factors, educational level, and religious beliefs. Other influences include continuity of care, confidence in the health care agency, level of physical and psychological distress, support systems, and coping mechanisms. Finally, expectation may be affected by perceived empathy, compassion, and friendliness of nurses and influenced by the public media and what others have told clients (Messner & Lewis, 1996).

Kirk's (1993) sample of chronically ill individuals identified the ordinary human virtues of communication, sensitivity, respect, dependability, trust, and personalized service as client expectations of nurses. These attributes of the nurse would assist personal and relational entry into the home with clients who hold these as expectations. When expectations of clients are identified, merging their expectations with state-of-the-art nursing care is more meaningful for clients (Messner & Lewis, 1996).

Role of Expectations in Satisfaction with Nursing Care

Although there is an apparent lack of conceptual agreement and inconsistency in the approaches to understanding expectations, most authors postulate that satisfaction is measured in terms of an individual's expectations (Bader, 1988; Carr-Hill, 1992; Donabedian, 1987; Linder-Pelz, 1982b; Messner & Lewis, 1996; Nelson, Wood, Brown, Bronkesh, & Gerbarg, 1997). There is much diversity in the measures used; however, there is consistency in seeking consumer opinions of what is important to them in their experiences with health care. Are their needs and expectations being met?

The premise that guided nurses and other health professionals in the development of satisfaction surveys was that consumers evaluate their health care experiences based on their expectations of care. The rationale follows. Satisfaction is the client's judgment of health care services and providers. Subjectively, satisfaction captures a personal evaluation of care immeasurable by observing care. Client perceptions provide a unique ingredient in the equation of satisfaction. Their differences in satisfaction mirror the realities of care to a substantial extent. These differences reflect personal preferences as well as expectations. The dimensions of satisfaction include availability of care, continuity of care, provider competence, and personal qualities of the provider, communication with the provider, and general satisfaction. Measures of patient satisfaction are based on short- and long-term processes found in the provider-client relationship.

A common thread among nursing satisfaction survey tools, however, is that patient satisfaction is the degree of congruence between a patient's expectations of ideal care and their perceptions of actual care received (Messner & Lewis, 1996). Thus, this ideology

bases satisfaction on expectations. Therefore, most tools list statements of patient expectation to which the individual responds about their level of satisfaction with nursing care.

The nursing literature addressing quality care and the design of satisfaction survey tools proved productive for identifying what is known about patients' expectations of nurses' services. Drawing on marketing and social psychology, nursing and other health care professions have developed satisfaction surveys. However, Kane (1997) noted that interest in patient satisfaction outpaced advances in concept development and measurement. As noted earlier, this was also true of the concept of expectation in the fields of psychology, sociology, and health care. Therefore, the lack of theoretical models of satisfaction, definition, and methodological consistency cast doubt on the validity of satisfaction studies (Staniszewska & Ahmed, 1999).

Brown's (1986) qualitative study asked 50 hospitalized patients to describe an experience when they felt cared for by a nurse. Eight characteristics of satisfaction based on patients' expectations were identified. Their expectations included recognition of the uniqueness of individuals; reassuring presence; provision of information; demonstration of professional knowledge and skill; assistance with pain management; amount of time spent; promotion of autonomy; and surveillance. Most nursing satisfaction scales itemize these dimensions of expectations for individual response.

Megivern, Halm, and Jones (1992), for example, used qualitative techniques to elicit patients' and family members' perceptions and expectations for nursing care in the critical care setting as a basis for designing a patient satisfaction survey.

Oberst (1984) was the first nurse researcher to propose a framework of clients'

expectations to measure satisfaction with care. No theory was identified. Colleagues continued to work with her over ten years on a valid and reliable measure, the Patient Satisfaction Scale, for the acute care patient's evaluation of nursing behaviors (LaMonica, Oberst, Madea, & Wolf, 1986).

Westra et al. (1995) developed a valid and reliable instrument to measure expectations of home health care, the Home Care Client Satisfaction Instrument (HCCSI). The theoretical framework was a revision of Oberst's (1984) expectation framework and was used as a model to guide the development of the HCCSI for use in home care. Satisfaction was defined as the extent of congruence between client expectations of care and perceptions of care received. "Expectations were conceptualized as cognitive beliefs shaped by client characteristics and experiences in interaction with health care providers' characteristics and behaviors (Westra et al., 1995, p. 394). Client satisfaction was conceptualized as one outcome of care and as a predictor of adherence to treatment, continuing use of health care services (in the absence of financial barriers), and recommending services to others.

Nine domains of expectations were identified in the literature and formed the basis for item development for the HCCSI. These included: (a) art of care, (b) technical competence, (c) financial aspects, (d) access convenience, (e) physical environment, (f) availability of care, (g) interpersonal educational relationship, (h) continuity of care, (I) efficacy, and (j) overall satisfaction (McCusker, 1984; Risser, 1975; Ware, Snyder, Wright, & Davies, 1983). Based on a combination of criteria for each item, the final HCCSI was revised (HCCSI-R). One item from each domain was retained. The financial aspects were omitted because it was most frequently missing in the pilot data.

The scale consisted of twelve items rated on a 5-point Likert scale and 3 overall-satisfaction items rated on a 10-point Likert scale. The remaining 9 items measured expectations of staff performance in relation to safety, health/self-care education, courtesy, dependability, and attention to the client's concern. HCCSI-R was useful for measuring expectations common in both post-acute care and long term-care received at home. The authors suggested that the tool might also be used on admission to evaluate client expectations and provide an opportunity for discussion of realistic expectations regarding home care with clients. Furthermore, the HCCSI-R could be used with new staff at an agency to orient them to client expectations (Westra et al., 1995). This measure fills a void as an important, reliable, and valid measure of satisfaction, one outcome in home health care.

While progress has been made in designing instruments using expectations as measures of clients' satisfaction with nursing care in home health care delivery, these tools are not necessarily appropriate for measuring public health nurse services in home visits (Lansky, 1998). No measures for evaluating quality care by public health nurses in homes were found. Clients' evaluations of public health nurses' services are needed for professional development and program evaluation of service efficiency both in time and cost. Positive outcomes of nurses' interventions are further indicators of the nurses' accountability and success.

In medicine, some studies have considered satisfaction as a function of differences between expectations and outcome of care (Locker & Dunt, 1978). Woolley, Kane, Hughes, and Wright (1978) not only considered the importance of expectation of outcome as a predictor of satisfaction with primary care, but also addressed the level of

communication about the expected outcome between the patient and the general practitioner. Others, such as Larsen and Rootman (1976), considered expectation as one facet of satisfaction. In a study of satisfaction with hospitalized patients with acute conditions, Thompson (1986) found that expectations were strongly related to satisfaction, explaining 14% of the variation in satisfaction with nursing care, 17% of satisfaction with food and physical facilities, and 6% of satisfaction regarding medical care and information. According to Linder-Pelz (1982a) this might be an artifact of the methodology, because asking patients after their experiences may lead to a *post-hoc* rationalization of their prior beliefs.

An important theoretical and empirical contribution to understanding the way expectations relate to patient satisfaction was reported by Linder-Pelz (1982a; 1982b). Based on Fishbein and Ajzen's (1975) expectancy-value theory, expectations were defined as ". . .beliefs that a given response will be followed by some event; an event has either positive or negative valence or affect" (as cited in Linder-Pelz, 1982b, p. 587). Linder-Pelz (1982a) tested a series of five hypotheses of expectations as determinants of patient satisfaction. These hypotheses stated how particular perception-value interactions might determine satisfaction. Data were gathered from 125 first-time patients at a primary care clinic. Data regarding patients' health care values, expectations, and sense of entitlement to care were collected immediately prior to seeing a physician. After the visit, the individual's post-visit satisfaction with different aspects of care was self-assessed. These were then collated. There was no empirical support for Fishbein and Ajzen's (1975) theory and little for most of the other hypotheses. Linder-Pelz (1982a) concluded that expectations and perceived occurrences make independent contributions

to satisfaction, rather than satisfaction resulting from an interaction between expectations, values, and occurrence. Expectations, while significant, explained only 8% of the variance in satisfaction, and even when values and occurrences are included, the variance explained did not exceed 10%. The overall conclusion is that very little satisfaction has been explained in terms of expectations and values despite there being some correlation. Later work by Linder-Pelz and Struening (1985) also failed to support a relationship between expectations and values and patient satisfaction.

Williams (1994) also found that there was little evidence that satisfaction was the result of fulfilled expectations and values. Furthermore, he questioned whether values and expectations actually exist in all situations. West (as cited in Williams, 1994) suggested expectations might be waiting to be formed when a person comes into contact with the system for the first time. Williams (1994) believed that satisfaction might reflect the passive sick role that patients adopt in relation to professionals, irrespective of the quality of care. "The greater the perceived esoteric or technical nature of treatment the more likely it is that many service users will not believe in the legitimacy of holding their own expectation or of their evaluations" (p. 513). This may explain why studies such as that by Cleary and McNeil (1988) have found that evaluation of technical care explains little of satisfaction, despite technical care being the main determinant of clinical outcome. Williams (1994) interpreted the lack of expectation regarding technical care as an expression of confidence in the professional's skill.

This literature overview highlights the apparent lack of conceptual agreement and the inconsistency in the approach to understanding expectations. Expectation is a multifaceted concept as defined in the dictionary and in the literature. Researchers have

identified both cognitive and affective components of expectations. In most environments expectations and other cognitive processes such as attribution are determinants of satisfaction. The particularities of the health care context may explain why research with clients or health service users does not necessarily replicate what is empirically derived from other environments. The health care environment is often stressful for individuals experiencing health problems. An inclusive theory to guide empirical studies of the concepts of expectation and satisfaction is yet to be developed.

Broadly speaking, however, there is agreement that expectations are beliefs, which implies that they are created and sustained by a cognitive process. Within health services, expectations are: (a) formulated by clients about the services they think they are to receive, (b) may be actively being formed while experiencing the health care system for the first time, and (c) may be actively being re-formed for unfamiliar experiences in different health care settings. Before an inclusive theory can be developed, more needs to be understood about the relationship between expectations and satisfaction in a variety of health care contexts, with different types of patients, and different needs. In-depth interpretive study of how expectations are conceptualized and articulated by clients, using a variety of qualitative techniques and patient narratives is needed to maintain content validity, and accommodate individual satisfaction and health care outcomes (Thompson & Sunol, 1995).

Public Health Nursing and Expectations

Little has been done with respect to the study of expectations and public health nurses' home visits. Of the few studies that exist, one addresses client expectations

(Rover & Isenor, 1988) and one addresses public health nurses' perceptions of client expectations (Fagerskiold, Wahlberg, & Christina, 2000).

While no conceptual framework or method for analyzing the data is described, Rover and Isenor (1988), provided specific knowledge about public health nursing services. They examined the perceptions and use of services provided by public health nurses for two groups of rural mothers sampled one year apart. The stratified samples of 30 primiparas and 20 multiparas in each group consisted of mothers who had vaginally delivered a healthy, full-term infant in a small regional hospital located in a stable, rural community in Nova Scotia, Canada. Clients' extended family networks resided in the same community. A short term, longitudinal design was used.

Interviews were conducted pre-discharge to discuss the need for service as well as their expectations of public health nurses. Two more interviews were conducted at one and six weeks postpartum to verify their expectations and perceptions of public health nursing services and to assess their willingness to seek information from their area nurses. All but two mothers received at least one visit from the nurse by six weeks postpartum.

On the day before discharge from the hospital, the majority of mothers (64% of the first sample group and 70% of the second sample group one year later) in each group stated definitely that they would want a public health nurse to visit soon after they were home with their baby; 26% of each group were uncertain about the need. Comments ranged from wanting to see what evolved to being unsure of the nature of the services provided. A small number (10% of the first sample group and 4% of the second sample group one year later) indicated that they saw no need for a follow-up visit. When the

mothers in the first group were asked more specifically to identify the services they wanted from the public health nurse once they were home, the most frequent responses were "a general checkup of the baby" (26%), to "weigh the baby" (10%), "to answer questions" (14%), to provide "general reassurance" (12%), and some combination of these responses (20%). Two mothers (4%) had requests based on a specific problem, while two others (4%) responded to the question by asking "What does a public health nurse do?"

By the end of the first week at home, just over half of the mothers in each group had received a visit or telephone call from the nurse. The nurse gave priority to the primiparous mothers. Among the 24 mothers participating in group one who received a visit from the nurse during the first week, the service perceived as most helpful reflected their stated expectation before discharge from the hospital. Thirteen identified some aspect of checking the baby such as weighing, general check, and cord care, as the most helpful service, while eight appreciated the guidance/counseling offered by the nurse during the initial session. Itemized responses were providing "a chance to talk," general reassurance, or information. The remaining mothers had no positive comment to offer.

Not all mothers had contact with their public health nurse by one week, but by six weeks all but two in the first group had at least one visit. For 40% and 48% of the mothers in the two groups, respectively, the nurses made more than one visit. Mothers who rated the nurses' visit as not helpful or of limited help offered a variety of reasons for the opinions. Several mothers commented on an apparent difference in the perceived messages given and received by nurse and mother such as nurse talking while the baby was sleeping and the timing of beginning solid foods. Others based their negative

evaluations on the timing of the visits and poor interpersonal fit between themselves and the nurse. The mother's degree of familiarity with the public health nurse was an important variable in initiating contact with the nurse.

By six weeks postpartum, 16 (32%) and 13 (26%) of the mothers in each group respectively, had actually contacted their public health nurse for reassurance about infant weight gain and infant care problems. In most cases, mothers, made contact on their own initiative; a few acknowledged that their physician had advised them to do so because of concern about the baby's weight. Several mothers in each group commented on initial difficulties in establishing contact and hesitancy to respond to answering machines. This study identified clients' expectations and offered insight into their perceptions of the process of public health nurse home visiting. In addition, it identified the importance of the interpersonal interaction between nurse and client.

Although a study by Barkauskas (1983) did not elicit expectations per se, the findings of this study identified valued services that are congruent with the expectations voiced in Rover & Isenor's (1988) study. This study compared the health outcomes of 67 randomly selected mother-infant pairs who had received home visiting services with 43 randomly selected mother-infant pairs who had not received postpartum home visits.

Health outcome variables were the mother's health and health service utilization, the infant's health and health service utilization, and the mother's parenting practices. Data were collected from birth certificates, health service records, and in-home interviews and observations at six months postpartum. Major differential health assets and liabilities between groups of black and white mother-infant pairs were observed. No significant differences in outcomes were revealed between home visited and not-home

visited mother-infant pairs. The interviews with the home visit group revealed a number of helpful insights. At the home interview, mothers were asked, "Were the public health nurse visits helpful to you?" (p. 576). Of the mothers asked, 86% responded that the visits were helpful. Information given by public health nurses was perceived to be the most helpful. Other types of helpful assistance were the baby's check-up, availability of a health care provider, and general support and reassurance. While this study provided data about patient perceptions of public health nursing care activities, it expands the voiced expectations (Rover & Isenor, 1988) related to the nurse's skills for assessing and monitoring, legitimizing and supporting, teaching, and linking to health care.

One study focused on public health nurses' perception of clients' expectations for home visits. Fagerskiold et al. (2000), using grounded theory methods, interviewed 15 nurses working in a child health program in Sweden about what they believed postpartum mothers expected of them. The findings indicated that the nurses thought mothers expected care of the infant and the family, including emotional support, advice and feedback on the infant's development, child health assessments, and vaccinations. Nurses also recalled in their narratives that parents indicated vaccinating, weighing, and measuring the baby as the most important functions of the home visit. The nurses' responses seemed to mirror the goals of the child health program in which they were employed.

While the discipline is in a state of change because of the current social milieu, much is known about public health nurses' work. The missing component is the client's perspective. To be accountable in public health programs today, public health nurses need to understand clients' expectations of nursing care and how this knowledge can influence

nurses' abilities to achieve cost-effective outcomes. Strategies based on clients' expectations of care are needed to improve outcomes at individual, group, and community levels of care.

Summary

This literature review provides a brief overview of the present state of concept definition and issues related to expectation. The interweave of interdisciplinary knowledge complements the tapestry of personal, social, and current environmental dimensions of expectation formation. This review highlights the definitional confusion regarding the concept of expectation within the disciplines of psychology, sociology, medicine, and health care management. No conceptual model of expectation was found that links client expectations to their antecedents and their consequences.

Nursing literature and research that has been attempted using the concept of expectation mirrors the current state of confusion. The two studies that specifically examined client expectations in the public health nursing context have limitations. Both used grounded theory methods that call into question their generalizability. Furthermore, both were conducted in rural settings in countries outside the United States where public health nursing is a routine component of the health care system. Rover and Isenor's (1988) short-term exploratory study lacked specificity for replication with another population. The study findings did suggest that the role of the public health nurse is not understood and that interpersonal relationship skills were essential components for clients to feel comfortable in seeking advice. While a small number of participants in both study groups saw no need for public health nurses' home visits, there was no indication that the authors explored the role of participants' extended family support systems nor, since

reading material was the admitted major source of information for these mothers in the first six weeks postpartum, how the nurse related to this information.

Fagerskiold et al.'s (2000) study interviewed experienced public health nurses in Sweden. The findings reveal public health nurses' ideas of what they believed were expected of them during home visits with the first time or repeat postpartum mothers. Their responses closely mirrored the goals and objectives of the child health program in which they worked. The client's perspective was not explored.

There is a paucity of client-articulated expectations of public health nurses in the home setting. This study was designed to explore clients' articulated expectations of public health nurses' home visits. The methodology for this study is discussed in Chapter III.

CHAPTER III

METHODS

This study used the qualitative research methodology known as grounded theory to identify clients' expectations of public health nurses' home visits because it explains social interactions from the epistemological framework of symbolic interactionism (Glaser & Strauss, 1967). Symbolic interactionism states that the self and world are socially constructed and constantly changing. The qualitative grounded theory methodology, also called the constant comparative method, is one of discovery and explanation. The aim of grounded theory research is to perceive and describe another's world, conceptualize complex interactional processes, and inductively develop theory through interpretation of the data (Glaser & Strauss, 1967). The grounded theory method is especially useful when little is known about a subject (Hutchinson, 2001).

Though this method of qualitative inquiry has been predominantly used in social sciences such as sociology and anthropology, it is currently being utilized by the discipline of nursing. Use of grounded theory has enriched understanding of the nurse-client relationship through description, exploration, and explanation of many phenomena important to current practice, particularly in the areas of caring and cultural sensitivity (Streubert & Carpenter, 1999).

The constant comparative method provides the opportunity to view clients' narratives and processes in a variety of experiences and allows substantive theory to emerge. Glaser (1992) described his philosophy of theory development, stating "it is grounded systematically in the data and it is neither forced or reified" (p. 15). Theory generated from this method is contextually grounded in the experiences of the phenomenon under study. Through observations and interviews, grounded theory provides a systematic way to develop theories about phenomena. It produces "abstract concepts and propositions about the relationships between them" (Chenitz & Swanson, 1986, p. 8).

Theory may be presented in two forms. These forms may be well developed and a "codified set" of propositions, such as in formal theories or a "running theoretical discussion" using categories and detailed properties, as a substantive theory (Glaser, 1992, p. 31). The theory developed in this study was substantive in nature. The aim of this study was to identify and explore clients' expectations of public health nurses' home visits. A resulting substantive theory emerged as a new way of understanding the phenomenon of expectation. This new understanding of clients' expectations may provide insight for public health nurses' interventions in the home and may eventually result in the improvement of patient care or more creative and effective clinical teaching methods.

Sampling and Site Selection

Sample selection was purposive and involved choosing participants who were experiencing the phenomenon under study and who were able to provide rich descriptions of their experiences. Since the purpose of this study was to identify and explore clients'

expectations of public health nurses' home visits, the study population was selected as an exemplar from a program where public health nursing home visits are preplanned. It was anticipated that this program would provide an opportunity to interview clients about their expectations before and after public health nurses made a home visit. Therefore, participants would be able to share initial expectations and how they changed over time.

A convenience sample was recruited from primary caretakers of infants enrolled in the San Bernardino County Department of Public Health (SBCDPH), Community Health Services Family Support Section, High-Risk Infant (HRI) Program. Letters of support for the study are included in Appendix A. The program recruits infants at three local medical centers with neonatal intensive care units (NICUs): Arrowhead Regional Medical Center (ARMC), Colton, California; Loma Linda University Children's Hospital (LLUCH), Loma Linda, California; and St. Bernadine Medical Center (SBMC), San Bernardino, California.

A high-risk infant is any infant who has been admitted into a NICU. These infants are regularly evaluated by a multi-disciplinary team of individuals involved in the infant's current and post-hospitalization care including the hospital case manager, members of community-based programs, Inland Regional Center (IRC), and the local health department's HRI Program. Based on the infant's biological, psychosocial, and environmental risks, each infant is assigned by the team to one of the two programs (IRC or HRI) for post-discharge follow-up. Infants with the greatest risk for poor development are referred to an intensive infant stimulation program with IRC, and those with lesser risks were invited by a mailed invitation to enroll in SBCDPH's HRI Program.

Only the caretakers who volunteered to enroll their infants in the local health department HRI Program were invited to participate in this study. The program protocol required that these infants be assigned a public health nurse who contacts the primary caretaker to facilitate a smooth transition from hospital to home with a pre-discharge home evaluation visit. Once the infant is released from the hospital, the public health nurse makes a post-discharge home visit and continues to visit the infant in the home at least every three months for the first year of the infant's life or discharges the infant based on advanced development and adequate medical supervision. The goal of the HRI program is to assist the family with the problems that the infant's medical care and physical development might cause. The nurse provides direct nursing services to the infant, educates the family, and initiates referrals for other community services as needed (San Bernardino County Department of Public Health, 1996).

While the sample size was anticipated to be twenty to thirty due to the in-depth nature of the interview (Strauss & Corbin, 1998), the final sample for this study was comprised of nineteen participants. The goal was to interview until the data was saturated and no new or relevant data seem to emerge regarding a category. This was accomplished with the nineteen participants and twenty-seven in-depth interviews. The intensive focus and depth of data collected is a more important determinant of study quality than large sample sizes (Allan, 1989).

Sample

The convenience sample for this study was comprised of nineteen primary caretakers of one or more high-risk infants who had required admission to a NICU and

voluntarily enrolled in SBCDPH HRI program. All participants met specific criteria as follows:

All lived within a 30-mile radius of the medical center sites where the infants had been hospitalized. All were English-speaking. None of the primary caretakers had ever had a previous infant enrolled in a HRI Program. However, of those enrolled, three had previous experiences with public health nurses. One was an unannounced visit by the public health nurse who thought the high-risk infant had been discharged, another with a Parenting as Teen Mother program during her first pregnancy and child-rearing experience, and the third had had a student nurse visit in her home three years previously to assess the home for safety and teach infant care.

Initially, study participants were chosen purposefully and systematically to meet the study design to interview clients during three separate occasions: before the public health nurse had made a visit, after the public health nurse had made the home assessment visit, and after the infant's discharge and the public health nurse's second visit. This design would provide the opportunity to uncover as many potentially relevant categories as possible during open coding (Corbin & Strauss, 1998). However, because of the problems in recruiting participants, sampling decisions were based more on participant's willingness to be interviewed than on purposive sampling.

Gaining Entrée

Entrée into the county health department setting and Loma Linda University entities was achieved through a combination of what Chenitz and Swanson (1986) termed "entrée from the outside" and "entrée from the inside" (p. 49-51). As a faculty member for a local baccalaureate nursing program in the area and a previous staff public health

nurse at San Bernardino County Department of Public Health, entrée to the HRI Program was obtained from the Family Support Section Manager and the Director of Public Health Nursing (Appendix A).

This study received approval of the study procedures by the University of San Diego (USD) Institutional Review Board (IRB) (Appendix B). Upon receipt of USD IRB approval, entrée to Arrowhead Regional Medical Center (ARMC) IRB, the IRB for San Bernardino County Department of Public Health, began with a written formal request and application to the IRB Chairman followed by a formal meeting with the Chairman. When ARMC IRB approval was received, a written formal request to work with the Case Manager for the NICU was directed to ARMC Nursing Administration. A meeting was granted with the Nurse Manager for NICU and permission granted to collaborate with the NICU Case Manager. The NICU Case Manager invited the researcher to attend the bimonthly Discharge Planning Committee for the purpose of identifying eligible participants.

Entrée to Loma Linda University Office of Sponsored Research required a number of prerequisite approvals before submitting an application. These included written approvals of the LLUMC Nursing Research Committee, the LLUCH NICU Medical Director, and the LLUCH NICU Head Nurse (Appendix A). In addition, certification of completion of an online research course, "Participant Protections Education for Research Teams" by the National Cancer Institutes, National Institutes of Health and attendance at "Research 101" taught by the Director of the Office of Sponsored Research were required. These documents were submitted with an application and the study proposal addressed to the Director of Office of Sponsored Research was

required. Approval was expedited and granted based on reciprocity with USD IRB (Appendix B). Until the research project was completed the researcher was required to attend annual continuing education conferences related to the protection of human subjects. Following IRB approval the researcher met with the Director of Case Management for LLUCH who identified a NICU nurse manager/discharge planner to assist in the recruitment of primary caretakers to participate in the study (see Appendix C for recruiting instructions and protocol for NICU staff).

Entrée to St. Bernadine's Medical Center was unsuccessful. This site was not used to recruit participants.

Participant Recruitment

Upon gaining entrée following the IRB approvals of the study procedures recruitment was facilitated in two ways. One was a mailed invitation and the second was a verbal invitation by the NICU case managers/discharge planners (Appendix C). The researcher's attendance at the Discharge Planning Committees assisted the case managers/discharge planners to identify eligible participants.

A supply of the mailed invitation packets was provided to the HRI Program supervisor. The packet included a letter of invitation (Appendix D), Information Sheet (Appendix E), *Interest in Taking Part in the Study* form (Appendix F), and a stamped addressed envelope. In addition envelopes and postage to mail the packet with the HRI Program Supervisor's cover letter (Appendix G) was provided. The HRI Program Supervisor addressed and mailed these to enrollees in the program. The researcher then waited for invitees to respond by telephone or mail. Upon receipt of an *Interest in Taking Part in the Study* form (Appendix F), the researcher called the potential participant and

arranged to meet at a convenient time and location to answer questions and verbally invite their participation (see Appendix H).

The second method for recruitment was a verbal invitation by the NICU case manager when the primary caretaker came to visit the infant. A protocol was provided to NICU nurse managers/discharge planners for recruitment (Appendix C). The protocol included the study inclusion criteria, case manager's responsibilities, a suggested script to assist in verbally informing potential participants and seeking their interest in participating in the study. The *Interest in Taking Part in Study* form (Appendix F) was included to assist the nurse manager/discharge planner in obtaining the information the researcher needed to invite participation in the study. In addition, an Information Sheet (Appendix E) describing the study, the research procedures, and the degree of commitment required was provided for the nurse manager/discharge planner to distribute to potential participants who desired more information before speaking with the researcher. When potential participants voiced interest in participating in the study or had questions about the study, the nurse manager/discharge planner contacted the researcher with the potential participant's name and telephone number or faxed the *Interest in Taking Part in the Study* form to the researcher (Appendix F).

When eligible primary caretakers wished to think about participation, the NICU nurse manager/discharge planner gave the individual a packet consisting of an invitation letter (Appendix D), Information Sheet (Appendix E), *Interest in Taking Part in the Study* form (Appendix F), a copy of the cover letter from the HRI Program Supervising Public Health Nurse (Appendix G) and a stamped addressed envelope. It was then the potential participant's responsibility to call, fax or mail the form to the researcher requesting more

information or indicating an interest in participating in the study. The form provided spaces for name, telephone number, days and times of visiting the infant at the hospital, and a contact person who would know the potential participant's location if they should change their telephone number. This information enabled the researcher to contact the individual to discuss the study and solicit participation.

This recruitment plan did not work well for NICU case managers at either medical center. At one site, only one of the five NICU case managers was assigned to identify potential participants for this study. There was a lapse of 30 days between the first two recruits because the designated nurse manager was too busy to check with the other nurse managers for potential participants. Eventually, the researcher was invited to attend the Discharge Planning Conference at this site to assist in identifying eligible potential participants as each of the nurse case managers presented their caseloads.

At the other participating site, there was a delay of three months before nursing administration in that institution gave approval for the researcher to collaborate with the NICU case manager. The NICU case manager at this site invited the researcher to attend the bimonthly Discharge Planning Conferences. Seven (7) participants were identified and recruited based on the discharge plans presented at the conferences. The researcher used the invitation script located in Appendix H to invite participation in the study.

The public health nurse who attended the Discharge Planning Conferences at both sites was not always sure that infants would qualify for the HRI program because the supervising public health nurse made the decisions regarding eligibility. This situation delayed the invitation to participate and complicated the recruitment process. The researcher lacked information regarding the primary caretakers' voluntary enrollment in

the HRI Program. One participant identified at the Discharge Planning conference and invited by the researcher admitted that she had received the researcher's invitation but because her infant was already home she did not respond. She was recruited based on the fact that the public health nurse had not yet made a home visit.

Concurrently, the SBCDPH HRI Program supervisor was mailing her cover letter with the researcher's invitation packet to HRI Program eligible caretakers. Five (5) primary caretakers interested in participating mailed the *Interest in Taking Part in the Study* form (Appendix F) to the researcher in the addressed stamped envelope and two (2) called the researcher indicating their interest. All participants responding by mail had their infants at home when the researcher received their *Interest in Taking Part in the Study* form (Appendix F).

A public health nurse referred three participants whom she had visited who consented to the interview. Of the nineteen participants the public health nurse had

Table 1

Sources of Participant Recruitment

Recruitment Categories	Number	Percentage
NICU Discharge Planner	2	10.5
Mailed "Interest in Taking Part in Study Form"	5	26
Called Researcher with Intent to Participate	2	10.5
Discharge Planning Conference	7	37
Referred by PHN	3	16
TOTAL	19	100%

visited eight (8) before the one and only interview occurred. Table 1 summarizes the sources of participant recruitment.

Upon receipt of the *Interest in Taking Part in the Study* form (Appendix F), the participants were individually contacted by telephone by the researcher. During the telephone contact, the study was fully explained and an appointment date, time, and place were arranged to answer questions. In the face-to-face contact, the researcher assessed further the primary caretaker's interest in participating in the study. The purpose, procedures, and time commitment for the study, including the rights of participants, were explained, and the potential participant was given the opportunity to ask questions.

Human Subjects Considerations

The protection of human subjects was assured through the procedures described here. Every effort was made to keep confidential all data that participants shared. When the analysis was reported, only aggregate results were used.

Consent Procedures

Primary caretakers had adequate opportunity to ask questions about the study and upon their verbal consent, a written informed consent was obtained from each participant (Appendix I). The informed consent incorporated low word difficulty and non-technical language at approximately sixth grade level. Participants also signed the ARMC Experimental Subject Bill of Rights form (Appendix J) and SBCDPH Notice of Privacy Practices, a practice implemented in response to the Health Insurance Portability and Privacy Act (HIPPA) beginning April 14, 2003, as part of the informed consent procedure. LLU IRB requested that primary caretakers interviewed in LLUCH sign an IRB Authorization for Use of Protected Health Information (PHI). Both these forms are

located in Appendix K. Only one participant was interviewed in the NICU at LLUCH.

Confidentiality

Participants were assured that confidentiality would be protected (except when abuse or neglect was suspected); that participation was completely voluntary; and that they could withdraw from the interview or the study at any time without negative consequences to them or their infant. The researcher informed participants that as a mandated reporter, she was required to report any suspicion of child abuse/neglect and that any participant reported would not be included in the study. The researcher had no suspicious experiences, and no participants were reported to Child Protective Services.

Participants were informed that confidentiality was assured through the use of code numbers instead of their names. They were further assured that coded tape recordings and transcriptions would be kept in locked files separate from their consent forms and personal information. Consent also included permission to contact the participants if data were missing or not audible, as well as willingness to participate in a focus group upon completion of the data analysis. At this time the name, address, and telephone number of an acquaintance was obtained for the purpose of locating the participant in the event that their address or telephone number changed during the data collection phase. Participants were further assured that care would be taken that no participant be identifiable in the dissemination of findings.

Audio recordings were clearly understandable, and no participants were contacted to clarify their expressions. The focus group was not held because of the extended time required to collect and analyze the data and the probability that the findings would not be meaningful to the participants due to the lapsed time frame.

Risks to Participants

There were minimal anticipated risks to the participants. Neither fatigue nor emotional upset occurred during the interviews. No participants chose to postpone the interview. One participant did choose not to participate in a second interview but did not withdraw her first interview. Had participants experienced emotional distress, the researcher was prepared to use counseling skills necessary to assist participants.

Potential Benefits to Participants

While there were no direct personal benefits to participation, other parents of high-risk infants may benefit by better home visits. It was anticipated that participants might experience: (a) increased self-esteem based on the assumption that subjects are complimented by being asked to share their experience and their uniqueness; (b) a validation of their experiences, and therefore, their self-worth; and (c) a sense of satisfaction resulting from having shared information that might benefit others. An incentive for participation (e.g., a $20 gift certificate for a local department store) was provided upon completion of the final interview.

The potential benefits were expected to outweigh the anticipated risks. Psychological empowerment (Zimmerman, Israel, Schulz, & Checkoway, 1992) results from the intra-personal (inner thoughts and feelings) and interactional relationships between individuals who listen and provide support. Through dialogue with another there was potential to enhance one's own abilities to assert control over factors that affect one's life (Connelly, Keele, Kleinbeck, Schneider, & Cobb, 1993).

Data Collection

Data were collected by means of semi-structured interviews and observations of the participants and their environments. Prior to the start of the formal interview, participants were given a verbal explanation of the study, and their rights and responsibilities during the interview. Interviews were audio-recorded and transcribed verbatim, and observations were recorded as field notes. Open-ended questions were incorporated into each interview to elicit the richest data possible regarding participants' expectations of public health nurses' home visits (see Appendix L). The Interview Guide consisted of three or four open-ended questions for each of the three interview intervals. Secondary probes were developed and used during the interview if the participant needed additional cues and for theoretical sampling (Appendix M).

Retention of all study materials (such as field notes, coding, and theoretical memos) and documentation of all sampling and analytical decisions established an "audit trail" that allows evaluation of the quality of the work (Glaser & Strauss, 1967).

Interview Procedure

This study employed semi-structured audio taped interviews with each participant. The initial plan for the interviews allowed the researcher to identify initial expectations and their change over time in relation to their experiences with public health nurses. All first interviews took place at the informed consent session. Ideally, the first interview was to occur before the public health nurse's first home visit and before the infant's discharge to capture participant's expectations before meeting the public health nurse. The second interviews were to occur after the public health nurse's home environment assessment visit and before the infant's discharge from the hospital, and the

third, after the infant's discharge and the public health nurse's post discharge home visit. Table 2 (p. 61) outlines the actual timing of the interviews.

While the unique design of this program provided an opportunity for identifying initial expectations and determining how expectations changed overtime, this study was challenged by a number of factors. One factor was discretionary funding of the program. A second factor was the reductions in state funding to local health departments that caused staff shortages. These factors, in turn, had an effect on how the protocol of HRI Program follow-up was implemented; therefore, the study protocol to interview participants in three separate sessions was unsuccessful.

In this study, only one participant was interviewed on three different occasions as the study protocol was designed. One other recalled at the second interview that she had had a home assessment visit by the public health nurse but failed to call the researcher. Three (3) additional participants were interviewed before the infant was discharged, but the public health nurse never conducted home assessment or post-discharge home visits. Two interviews were conducted with seven (7) of the nineteen (19) participants, one after the infant was discharged and before the public health nurses' home visit and the second after the public health nurses' home visit to the discharged infant. Eight (8) participants were interviewed only once as they volunteered after their infants were discharged and public health nurses had made home visits.

First interviews with all participants were conducted immediately following the informed consent process with the participant signing all forms. All first interviews explored the participant's knowledge of the HRI Program and their expectations of the nurse. Interviews varied in length from 30–50 minutes. Because of the difficulty in

Table 2

Actual Timing of Participant Interviews

Participant	Before Home Assessment	After Home Assessment but Before Discharge	After Discharge No PHN* Home Visits	After Discharge and One PHN* Home Visit
1	x			x
2			x	No PHN visit
3				x
4				x
5	x	x		x
6				x
7				x
8			x	x
9			x	x
10			x	x
11	x			x
12	x			
			Refused Second Interview	
13				x
14				x
15			x	x
16				x
17			x	No PHN Visit
18			x	x
19			x	x

*PHN = public health nurse.

recruiting participants before the infant's discharge and the home visit, the protocol for the session one interview was actually only used with four (4) of the nineteen (19) participants. Two interviews were conducted at the hospital and two were conducted in the home before the infant's discharge.

Interview session two was conducted in the hospital (1) or participants' homes (7). This consisted of a second semi-structured interview with the primary caretaker after the home assessment visit (the public health nurse's first home visit) or after discharge but before the public health nurse's first post-discharge home visit. This interview took 30-40 minutes, and focused on participants' perceptions of the home

The third interview session took place in the home after the infant's discharge and after public health nurses' first or second home visit. This interview averaged 40 minutes and explored participants' perceptions of the experience with the public health nurse and whether primary caretakers' expectations of the nurse were met or not met. In reality, this interview was third for only one (1) participant, second for six (6) and first and only interview for seven (7) participants.

In summary, the study protocol for interviewing participants was not realistic for the current state of public health nursing practice. However, a positive outcome of this recruitment process was the facilitation of selective and theoretical sampling in the data collection and analysis because of the variety of participant experiences and reactions and their ability to articulate them.

Interview Questions

Interview questions were designed to solicit participants' thoughts and feelings about their expectations and experiences with public health nurses' home visits

(Appendix L). In addition, demographic information was obtained. Questions asked of participants included the following:

First client interview (prior to public health nurses' home assessment visit before infant discharge).

- Why do you think the nurse is coming to see you?
- What do you expect to gain from the visit?
- Has anyone talked with you about the nurse's visits? If so, what did they say?

Second client interview (after public health nurses' home assessment visit).

- Tell me about the home visit. What did the nurse do?
- Was the visit similar to what you expected?
- What do you expect of the next home visit?

Third client interview (following public health nurses' visit after the-infant's discharge).

- Did the nurse do what you expected him or her to do?
- What didn't he or she do that you expected?
- What did he or she do that you didn't expect?
- Is there anything else about the nurse's visit that you would like to tell me?

The focus of the interviews was on expectations that primary caretakers had of public health nurses before and after being visited in their homes. Secondary cues (Appendix M) were utilized when participants were vague or too brief in their voiced expectations. As the interview data was coded and analyzed, the interview questions were modified so that emerging categories and hypothesized relationships could be clarified,

validated, and made more dense (Strauss & Corbin, 1994). This process continued until all categories were *saturated* (Strauss & Corbin, 1994), and no new information emerged.

Field notes included the date and length of the observation, with beginning and ending times noted. Additional content included the pre-interview goal for the session, location of interview, and persons present. Observations of the environment and non-verbal behaviors of the participant were noted. Key words, topics, focus, and exact words or phrases used by the participants were also noted. In addition, the researcher documented impressions of interviewees' comfort or discomfort with certain topics, and emotional responses to people, events, and objects. A summary of the researcher's analysis including questions; tentative hunches, trends in data, and emerging patterns; and technical problems with the tape recorder completed the field notes.

Field notes provided a reference for the interview sessions (Wolcott, 1995), and were analyzed along with the interview data using the coding processes described below. The primary caretaker's code number identified the entry. Field notes were cross-referenced to the interview schedule to aid in keeping track of the data and locating related observations and interviews.

Theoretical memos were written for each analytic session. These memos incorporated and elaborated the coding sessions by keeping track of all the categories, properties, hypotheses, and generative questions which evolved from the sessions. This system provided a firm base for keeping track of theory development as well as writing a report of the research process and its findings (Strauss, 1992).

Data Analysis

The transcriptions of audiotapes were analyzed using Strauss and Corbin's (1998) methods for identifying emerging themes through content analysis and coding to identify participants' expectations of public health nurses' home visits. Data analysis used the constant comparative method in which data collection, coding and analysis, hypothesis generation and verification, and literature review were conducted simultaneously with each step informing and being informed by the others (Glaser & Strauss, 1967). The aim of this "constant comparison" (Strauss & Corbin, 1994) was to construct a consistent, credible theory, well grounded in the data. Analysis continued through the final description of the emergent substantive theory.

The QRS N6 Student, the latest enhancement of the QSR NUD*IST software program, was used to assist the researcher in textual analysis of the data. The program allowed for entry of the transcribed interviews, field notes, and theoretical memos. This tool helped to maintain the rigor of grounded theory in the analysis process and the generation of hypotheses. A strength of the program is the ability to create and maintain an "audit trail" (Glaser & Strauss, 1967) of all study materials including the transcriptions, field notes, coding, and theoretical memos and documentation of all sampling and analytical decisions (Gahan & Hannibal, 1998). This program facilitated evaluation of the quality of the work and assisted the researcher to demonstrate theoretical rigor.

Data analysis through open, axial, and selective coding was guided by the method described by Strauss and Corbin (1998) and by committee members with expertise in grounded theory methodology. Coding is the fundamental analytic process used by the

researcher. A discussion of the three basic types of coding in the order of application used in the analytic process follows.

Data analysis began with o*pen coding,* which is the initial stage of constant comparative analysis. At this stage, it was imperative that the researcher avoided preconceived ideas about the issue or the data. This was achieved throughout the interview and data analysis process in several ways. First, participants were allowed to complete their thoughts and sentences without interruption or suppositions by the researcher. Second, the interview questions were asked in a similar manner to each participant. Third, the data analysis followed the grounded theory methodology and new codes and categories emerged throughout the data analysis process. This ability to remain neutral and available to new discoveries was the first step in maintaining theoretical sensitivity

The purpose of open coding was to give the analyst new insights by breaking through standard ways of thinking about or interpreting phenomena reflected in the data. The interview data were examined line by line. Each sentence was coded in order to discover as many substantive codes as possible. Open coding led to the emergence of data categories and their properties and continued with each subsequent transcript until the core categories emerged. At the end of open coding, there were forty-one (41) initial codes identified. Open coded data were then broken down into incidents of interactions and analyzed for similarities and differences. The fundamental processes for the constant comparative method were carried out through comparison of interactions with interactions, interactions to concepts, and concepts to concepts. The concept is a label to create a category. Properties of each category were generated using this process. (Kools,

McCarthy, Durham, & Robrecht, 1996; Strauss & Corbin, 1998). Categories that lacked foundation, when compared to subsequent data, were eliminated (Streubert & Carpenter, 1999). Open coding ended when the core categories were identified (Strauss & Corbin, 1998)

As data were coded, they were compared with other data. As this second level of coding progressed, the data were assigned to categories of "obvious fit." Comparison of these categories continued until they were mutually exclusive. Early analysis determined the lower level categories, but constant comparison permitted the emergence of the overriding concepts and interpretation.

Simultaneous data collection, coding, and data analysis began with the first interview and continued drawing on the *coding paradigm* of conditions, context, strategies (action/interaction), and consequences which continued until the conclusion of the study (Glaser, 1992). Data were continually compared with additional data generated in each subsequent interview. Interviews with primary caretakers who had already experienced public health nurses' home visits with their high-risk infants provided the opportunity for discriminate sampling. These interviews were directed and deliberate to maximize opportunities for verifying the data and relationships between categories and filling in poorly developed categories (Strauss & Corbin, 1998). Observational and theoretical memos were an integral part of the coding process (Glaser & Strauss, 1967). As constant comparative analysis progressed, the researcher integrated the categories and properties, delimited the theory, and finally refined the theory.

During the analytic process, the researcher drew upon previous experience to think through the conditions that might lead a client to express expectations, and what the

consequences for the client might be. All hypothetical relationships proposed deductively during this second level of coding, axial coding, were considered provisional until verified repeatedly in incoming data. Deductively arrived at hypotheses (i. e., initial hunches about how concepts relate) that did not hold up when compared with actual data were revised or discarded (Strauss & Corbin, 1998). Constantly comparing one piece of data to another prevented distortion of interpretation.

The goal of grounded theory is the discovery of the core phenomenon. The third level of coding "describes the basic social psychological process" (Streubert & Carpenter, 1999, p. 110), which essentially comprises the title given the central themes, that emerge from the data. The basic social process identified in this study was *forming expectations*. *Selective coding* leads to the identification of this basic social process and was based on the microanalysis of open and axial coding. This process brought unity to all categories around this *core* category. The following questions were asked of the data: "What is the main analytic idea contained in the data?" "If my findings were to be conceptualized into a few sentences, what would I say?" "What does all the action/interaction seem to be about?" " How can the variation seen between and among the categories be explained? " The other categories stood in relationship to the core category as conditions, action/interact ional strategies, or consequences thus creating conceptual density. Diagramming assisted in integration of categories (Strauss & Corbin, 1998), as did sorting code notes, theoretical memos, and several analytical schemes that linked the theory together. General reading and re-reading of the data to understand the organizing themes aided in composing a description of how the categories support or enlarge the core category and achieved identification of this basic social process. Identification of the

lower level categories resulted in a good description of the findings but did not yield a basic social process. Emergence of the basic social process of *forming* expectations was ultimately achieved by reanalyzing the data and reviewing the eighteen theoretical family codes or "coding families" described by Glaser (1978, p. 73). These codes helped this researcher to conceptualize how the substantive codes related to each other and led to the development of a substantive theory. A defining model was evaluated by public health nursing colleagues.

Credibility and Rigor

Issues of credibility and rigor were considered important elements of this study. Glaser and Strauss (1967) found that the use of comparative analysis and inclusion of different aspects of data corrected data inaccuracies. However, grounded theory cannot be deemed accurate until one has established its creditability and rigor (Krefting, 1991).

Credibility refers to the believability of the theory. Judgment of credibility is twofold, in that the reader must be "sufficiently caught up in the description so that he feels vicariously that he was also in the field" (Glaser & Strauss, 1967, p. 230). Second, the reader must be convinced as to how the researcher arrived at the conclusions. Thorough theoretical sampling of participant experiences at different stages of public health nursing interventions was included in the study to increase the credibility of the substantive theory. Several of the techniques suggested by Lincoln and Guba (1985) for improving credibility were applied to this study, such as prolonged engagement, persistent observation, and peer debriefing.

Steps were taken in this study to include participants with different experiences and who were informed or familiar with the phenomenon being studied and to assure that

data analysis, theoretical sampling, and development of theory would have sufficient credibility. Interviews were 30–60 minutes in length and were conducted on two to three different occasions with the majority of participants to provide ample opportunity for persistent observation.

In addition, two dissertation committee members for this study have completed research using qualitative methodologies. The dissertation chair and one committee member are experts in community health nursing and the issues involved in current practice. Also, a peer who has completed qualitative research has reviewed the data and subsequent analysis for this study.

For the theory developed to be applied to daily practice it must have the following requisite properties: (a) fit, (b) understanding, (c) generality, and (d) control. These four requisites are necessary for either substantive or formal theory to be applicable in settings similar to those originally studied (Glaser & Strauss, 1967)

Fitness infers that the substantive theory must fit or correspond closely to the data in order for it to be useful in everyday realities. This study was faithful to these realities, as the findings are entirely based on interview data, which is grounded in the experiences of clients of public health nurses. When substantive theories have fitness, they can then be understandable to those working within the substantive area.

Understanding is considered essential for application of the developed theory. In this study, the substantive theory, *forming expectations,* is understandable because it is grounded and faithful to everyday realities of primary caretakers of high-risk infants

Generality is achieved when the theory is "general enough to be applicable to the whole picture" (Glaser & Strauss, 1967, p. 242). Abstraction is viewed in a balance, in

that the researcher must not be so abstract that the theory loses sensitivity and sufficiently abstract to allow for changes over time and from situation to situation. The use of *QSR N6 Student* insured that all data were reviewed for fitness and understanding and provided audit trails that could be scrutinized. This program allowed the researcher to view and organize the data with multiple perspectives. All data was immediately available for analysis and similarly coded data could be compared with minimal effort. No data was lost or misplaced. If the data did not belong it was returned without losing the original content flow.

Grounded theory includes both prediction and control. When utilizing substantive theory, one must be able to predict and control the consequences of changes that may occur. In order for control to be recognized in a theory, adequate concepts and interrelationships need to be determined and explained. This study provides a framework for the process of *forming expectations*. It explicates the interactive nature of expectation formation and reformation in face-to-face interaction with public health nurses in the home visit. The concepts and interrelationship of the process of *forming expectations* for public health nurses' home visits will be described and discussed.

Summary

Grounded theory allowed sensitivity to the nuances in the words of participants, tolerance for ambiguity, flexibility in design, and creativity. Participants' thoughts and experiences were accepted as stated. No data were ignored. The approaches to data analysis included comparing and contrasting participants' words in order to characterize and describe the phenomena, identify central characteristics, and place them within substantive theory. It further included prediction and control. When utilizing substantive

theory, one must be able to predict and control the consequences of changes that may occur. In order for control to be recognized in a theory, adequate concepts and interrelationships need to be determined and explained. This study provides a framework for the process of *forming expectations* for public health nurses' home visits to high-risk infants. It describes the phases of expectation formation and reformation participants experienced when informed that they had been referred to a HRI Program and how their anxieties were disconfirmed by the public health nurse's skills and personal qualities. In the following chapter, the concepts and interrelationships of the concepts of *forming and reforming expectations* are described and explained.

CHAPTER IV

FINDINGS

This chapter identifies and explores client's expectations of public health nurses' home visits as described by primary caretakers of high-risk infants. Using the qualitative methodology described in Chapter III, a total of nineteen (19) participants were interviewed. Twenty-seven (27) individual interviews were transcribed, coded, and analyzed.

The participants ranged from 18 to 60 years of age with a median age of 27.7 years. All were female and spoke and understood English adequately enough to participate in the study. Fifty-three percent were married, 21% were divorced, 21% were single, and one (5 %) was engaged to the infant's father. Of the nineteen primary caretaker participants, 18 were mothers of their high-risk infants and one was a maternal grandmother. Forty-four percent of participants were first time mothers, while 55% of them were mothers of two or more children. Thirteen participants experienced singleton births and six participants had multiple births. Four ethnic groups were represented, 53% White/Hispanic, 21% White/Non-Hispanic, 21% African American/Black, and 5% Indonesian. None reported communication problems with public health nurses, although translators accompanied the nurses on some home visits, the participants confided that

Table 3

Demographic Description of Primary Caretaker Participants

Sex		N	%
	Female	19	100
Age			
	18-19	4	21
	20-29	10	53
	30-39	3	16
	40-49	1	5
	50-59	0	0
	60-69	1	5
Ethnicity			
	White, Hispanic	10	53
	White, Non-Hispanic	4	21
	African American/Black	4	21
	Indonesian	1	5
Primary Caretaker Status			
	Mother	18	95
	Grandmother	1	5
Marital Status			
	Married	10	53
	Divorced	4	21
	Single	4	21
	Engaged	1	5
Primary Caretaker Maternal Status			
	First Child	8	42
	2-3 children	10	53
	Grandmother	1	5
Birth Types			
	Singleton birth	13	68
	Multiple births (Twins, triplets)	6	32

the translator had not been needed. Table 3 presents the demographic characteristics of the participants.

The Process of Forming Expectations

The core category identified in this study was the process of *forming expectations* Primary caretakers had not developed expectations of public health nurses' home visits over time. Most participants' initial responses when asked about their expectations were "I don't know what a public health nurse does", "I have no idea", indicating that their expectations were not formed. Since actual knowledge of public health nurses' work was absent, secondary probes assisted participants to form judgments of what the nurse would do. These *expectations* were prefaced with "I guess." Participants continued with: "Check on the baby," "Check the environment," and "Check how I am caring for the baby."

Conversely, only five participants had information about public health nurses' work. Four participants recalled information shared by health professionals or lay-people they had met in a local department store, and one participant had experience with a public health nurse as a teen mother with her first baby. These five participants' expectations reflected what they had been told by their informants or had experienced.

The process of fo*rming expectations* was dynamic and most expectations were developed during the unstructured interviews for this study. While the majority of participants' initial responses to the research question indicated that their expectations were not formed, expectations were inferred or predicted as a guess with the researcher's secondary probes.

Before the home visit, participants cognitively used their embedded prior life experiences, their experience of birthing a high-risk infant as well as their anxiety about

their infants' survival to articulate expectations of the home visit. Expectations were general and became specific based on their concerns for their infant's special needs. In addition, articulated expectations included expectations for nurses' behaviors. This phase was *forming expectation.*

The process of *forming expectations* continued in the face-to-face interaction with public health nurses during the home visit and retrospectively after the visit. This latter phase of the process was *expectation reformation.* During this phase, the actual interaction during the home visit, participants stated that expectations were met (confirmed), not met (disconfirmed) or exceeded. Actions of the public health nurse that exceeded expectations were articulated as surprises. Thus, the interaction with public health nurses lead to new or revised expectations, and/or a melding of previously articulated expectations. This melding experience, in turn, informed the participants' responses to public health nurses' home visits to their high-risk infants, *reforming expectations,* and in turn holds the possibility for influencing interactions with public health nurses. Figure 1 illustrates the dynamic process of *forming expectations.*

In the second interview as participants discussed their interactions with public health nurses' home visits, they were mindful of the phase of *expectation reformation.* All participants unanimously confirmed that home visit interactions met or exceeded their expectations. Their negative expectations or anxieties of public health nurses' behaviors were not validated in their experiences with public health nurses. Participants further identified surprises or unexpected behaviors of public health nurses' interactions in the home. These interaction experiences *reformed expectations* and have the potential to

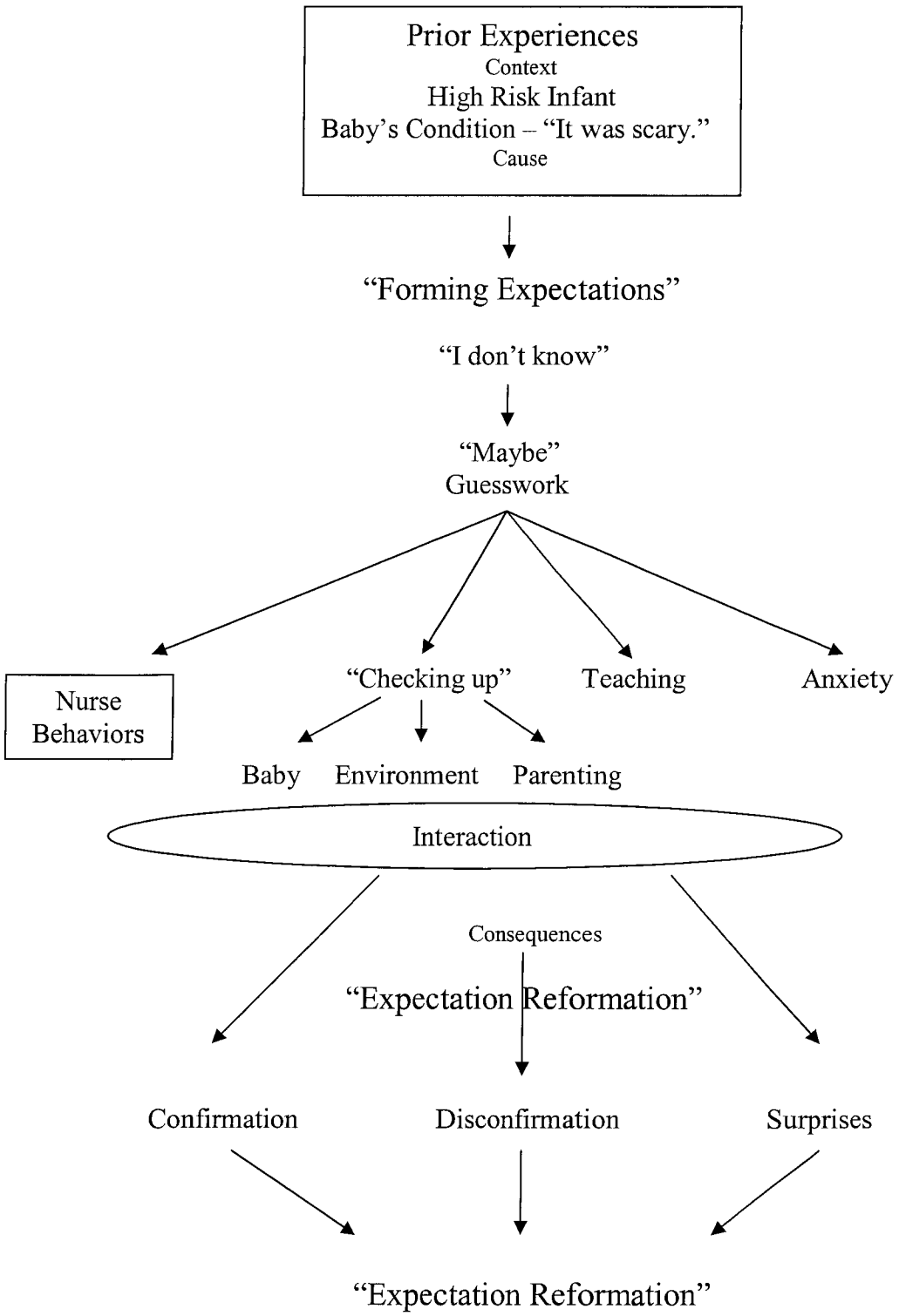

Figure 1: The process: Forming Expectations.

influence future interactions with public health nurses and what they share with others about public health nurses' work.

The process of *forming expectations* will be presented in this chapter. It was constantly influenced by context, conditions, and interactions and resulted in participants' evaluation of the outcomes or consequences of the interaction with public health nurses' during home visits, and thus, reformation of expectations. *Forming expectations* was an interactive process occurring before, during, and after the home visit.

Phases of the Process

High-risk infants' condition along with primary caretakers' prior life experiences were conceptualized as the context for creating primary caretakers' expectations of public health nurses' home visits. The cause or reason for home visits was high-risk infants' enrollment in the HRI Program because of their conditions.

Two phases emerged within the interactive process of *forming expectations*. The first phase, *expectation formation,* included two stages. The first stage was unformed expectations, and the second stage was a guess or predicted expectation. In the first stage of unformed expectations, participants admitted that they were not knowledgeable about public health nurses' work in homes and did not know what to expect. This indicated that expectations were unformed. Secondary probes assisted participants to move to the second stage to guess or predict expectations of public health nurses' home visits to high-risk infants.

Articulated expectations of home visits ranged from general to specific. Conjectured general expectations, most often were introduced with "I guess the nurse will," and included checking on the baby, environment, and parenting. Specific

expectations most often related an expectation of teaching to the individualized special needs of their infant, such as "How to prevent aspiration" or "Check that his incision is healing." Negative expectations or anxieties were also expressed during this phase, as were expectations of public health nurses' behaviors.

The second phase of the process, *expectation reformation* occurred during the actual face-to-face interactions with public health nurses during home visits and retrospectively as the participant reflected on the home visit experience. During this phase participants re-formed their stated expectation based on their interactive experience with the public health nurse leading participants to respond that *expectations were met, exceeded* or disconfirmed. In addition, they further identified nurse actions that were a surprise, a fourth category. However, negative expectations or anxieties about the home visit experience were not validated by the home visit experience. The reformation of expectations was predicated on interaction during the face-to-face meeting with the public health nurse during the home visit. This process allowed participants to evaluate outcomes or consequences of the home visit interactions in light of their own articulated expectations.

Prior life experiences were a continuing influence for participants' expectations or lack thereof. Infants' conditions were conceptualized as the context for *expectation formation* and their enrollment in the HRI Program, the cause for public health nurses' home visits. A description of participants' prior experiences as well as their experiences and dilemmas with birthing a high-risk infant, the context for *forming expectations* follows.

Prior Experience

Socio-demographic characteristics as summarized in Table 3 were contributing factors to participants' prior experience. Participants' age, culture, family situations, life experiences as well as experiences with health care providers, including their most recent experiences with the NICU staff, contributed to the participants' prior experience.

An important added component of prior experience was the primary caretakers' experiences and dilemmas with the birth of a high-risk infant. This experience was most often described, as "It was scary." While the high-risk infant's condition was the cause for public health nurses' home visits, the baby's condition was the context for the articulated expectations for this study.

The HRI Program was designed to use home visits by public health nurses to facilitate the high-risk infant's transition from hospital to home and to monitor their health and developmental needs. This protocol was the cause for public health nurses' home visits to voluntarily enrolled high-risk infants. None had been previously enrolled in a HRI Program and no one recalled having had a public health nurse in their homes as children.

Unaware of the High Risk Infant Program

Only five participants recalled having been informed about the HRI Program at the time of their infant's discharge. Their informants included nurses or social workers in the NICU. Another reported that a public health nurse while making an unannounced visit, thinking the infant had been discharged, informed her about the HRI Program. Most did not recall having been told about the HRI Program.

Only a handful recalled getting an invitation from SBCDPH in the mail informing them about the HRI Program and seeking their voluntary enrollment. One participant said, "They just put me in. I really didn't find out anything to even ask."

Another participant stated that the public health nurse had called her: "She said that she was with the public health of San Bernardino, and asked if she can come. And I said sure. And she told me if I want a nurse to come to my house. And I told her, 'Yeah'."

Another responding to a public health nurse's call seeking permission to make a home visit was grateful that she did not have to take her infant to the doctor and expose the infant to illnesses in the waiting room of the doctor's office.

Home Health Nurse Versus Public Health Nurse

When designing this study the researcher did not anticipate that home health nurses also visited high-risk infants upon discharge. This practice confused participants, as they did not understand the difference between the two nursing specialties. This situation required the researcher to clarify with participants the agency the visiting nurse represented.

Five participants had visits by home health nurses the day following the infant's discharge. They further recalled being told by the doctor that a home health nurse would be making a home visit 2, 3, or 4 times following the infant's discharge. A participant recalled that she was told while the infant was in the NICU, "...since he is so little, you know a nurse will stop by and weigh him, see his heart rate, take his temperature." All participants' descriptions of the home health nurse' visits portrayed the nurse assessing the infant's physical status, weighing the infant, and answering caretakers' questions.

Participants likened these procedures to those performed in the health care provider's office. They further commented that the visits were brief.

Since these five participants were unaware of the HRI Program and uninformed about public health nurses' services, the experience with the home health nurse confounded their understanding of public health nurses' services. During the screening process for participation in the study, participants' confusion became evident as these five participants reported that a public health nurse had visited them. Participants were unaware of the differences between home health nurses and public health nurses.

The only participant who had had experience with both types of nurses described the difference, as she understood it,

> They (home health nurse) come and she weighs the babies, and ah, she sees their breathing, and listens to the heart and stuff, more like a nurse at the hospital would do. And that's about it. And the other one (public health nurse) would just ask questions and see.

Another participant admitted that she did not know the difference between the two nursing specialties. The difference she expected was related to the public health nurse being "concerned about the environment and the infant's safety."

Two participants reported that they knew of home health visits for elders, but only one was aware of services in the home for babies. One participant reported,

> Nobody told me. That's why I didn't knew (client's wording) that program for babies, you know, preemie babies. I only knew that there were nurses that could go to home with elders, you know, that have disabilities. That is the only thing I knew. But not for babies!

Knowledge of Public Health Nursing

Five participants related normative expectations. Four participants were informed by their public health nurses' introduction of themselves and the HRI Program. Their responses mimicked the information shared by their informants. Responses included very general expectations of assessing the babies, weighing them, measuring growth, helping with breastfeeding concerns, discussing sleeping patterns, developmental screening, teaching stimulation activities, and answering the mother's questions. An example of a participant's response follows,

> I was just under the impression that they would be coming to check on the baby, to make sure that she was doing well after her discharge from the hospital. You know that, that the house was safe for her to be in, and that they were just going to keep up on that for the first year. That is what I was told by the public health nurse who made an unannounced visit before my baby was discharged.

Another based her expectations on an experience she had had with a student public health nurse three years previously,

> I did have one student (nurse) come out for one of my toddlers. It was part of a paper she was doing, from one of the local universities. She just came out to check the baby. She (the baby) was a month old and to check for safety in the home. She was very nice and someone came with her to oversee. So that was nice:
>
> I think the usual. I believe they check the head circumference. And I know they check the length, and I am not sure she is going to weigh Him. If she is going to bring a scale? She might. And I'm sure she will give him a thorough check.

Another participant recalled the NICU nurse stating, "... They would be coming by and checking her weight and see how she was doing and that's what the doctors' want. I don't know anything else about a public nursing or any thing about that."

The same participant further recalled that a clerk at a department store shared her experience with a public health nurse when she had a high-risk infant,

> Before the baby came, I actually was in a department store; one lady helped us, with some baby things. She said that when she had her baby, she was in the NICU and a nurse came by and told her that if she put the new diaper under the other diaper, if she peed it would save the sheet. And she checked out the house and stuff, and taught her how to breast-feed. And stuff like that. I don't know. That's all she said.

Another participant recalled that the public health nurse upon introducing herself over the telephone provided the following explanation:

> She told me that she would come and just assess the babies, weigh them, see their length. Just kind of answer any questions that I had. If I was breastfeeding, she would help me with that or sleeping patterns, any thing that I had any questions about she said she would help me, you know. So yeah, basically, yeah, just to check the babies out, whether they are progressing, because she said that with twins they have their adjusted age. Make sure that when people say they should be sitting up that you understand they were born prematurely.

The only participant who had had experience with a public health nurse with her first baby had just given birth for the third time. At the time of the interview for this study, her recollection of her experience with the public health nurse was,

> They (public health nurses) came to my house and they would just see on his growth and how he was growing. And they also offered little things to us for being in the program. And they just kept records of his weight and what he was eating and stuff.

Upon prompting whether she recalled whether the public health nurse did anything else, the response was, "Ah, yes. She would, they gave me a little bit of information on, ah, just about how, about babies as infants, and stuff." This participant admitted volunteering for the HRI Program reporting, "I was interested just because myself, I want to learn more too about my babies. And ah, just on being premature and stuff and wanting to find out more, more about things also. To help them (babies)." This clarification of her reason for enrolling acknowledges the participant's understanding of the teaching role of the public health nurse in the home.

Context: "It was scary"

All participants experienced dilemmas with their infants' conditions often beginning before their births and through the birthing process and the infants' admissions to and complex treatments in the NICU. A sketch of these experiences and dilemmas portrays the context for participants' articulated expectations of public health nurses' home visits. For all participants, complications in the last trimester of pregnancy resulted in premature delivery, either vaginally or by Cesarean Section (C-Section), of very low or low birth weight infants. One participant described her experience,

> And they were telling me that was happening, and her (baby's) heart rate had dropped so they were going to give me a C-Section, but since I had dilated, just to have it. I'm sorry. It was sad. Ahh, it was scary because I didn't know what was

going to happen to her. I didn't know. It was scary because I didn't know, if, like she was going to be OK, if she was going to make it. She couldn't breathe by herself. She couldn't eat. They had to feed her through tubes, and she couldn't keep her body temperature. And it was like hard, like wondering, but after she started getting better, and stuff, like I was happy and stuff. She had to have a blood transfusion; she got really better, like fast. I was really happy when she got to come home.

Another participant knew she was at high risk during her pregnancy.

And I have risk and I have to take the baby out. 'Cause then they went and consulted the doctors and said the baby has to come out right now or my kidneys could fail and something could happen to me. That's what happened to me. I was 32 weeks when I went in. And they took her out (C-Section). And she came and she was supposed to be a boy. ... And it was a girl. And I was like, 'What?' That's what happened and she was in NICU a month. And I just got her out. Yeah, I was scared. Yeah, I was scared. I thought something would happen.

My husband was there and he was like, 'Is it OK if she gets taken C-Section and the baby gets taken out and stuff? It was like yeah, as long as everything goes OK. And at first I was kinda scared, but I thought if my kidneys fail and my liver goes down, then what? They did take her out and she turned out to be OK. She only took a month. Other kids in NICU took a lot longer.

A number of these infants had underdeveloped lungs or congenital malformations requiring surgery and prolonged in-hospital treatment. Multiple births had their own set

of challenges with low birth weight and congenital anomalies. A young mother of twin boys shared the following experience,

> My pregnancy was all right until the labor came on. They were too early. They tried to make 'em stop so I could have them until the date that they wanted to come. They were 28 weeks. The first twin came vaginally but the second was up side down, the butt was on the bottom. So that is why I had to have him C-Section. He is still in the hospital waiting to get his shunt done. His operation was postponed because he had an infection. So we are waiting.

Most participants visited their infants' daily while they were in the NICU, some traveling 30 miles or more one way to bond with their infants. In addition to meeting their own post-partum healing needs, participants had to plan for meeting their families' daily needs, and for time to return to the hospital. Those having had Cesarean Sections had the added challenge of arranging for their transportation until they could drive themselves. These factors, combined with the infants' extended hospitalizations, were sources of stress for these primary caretakers. One participant expressed her fears as follows,

> It's scary. There is a lot of scary moments especially when I first had her. Ahh. She was only two pounds six ounces when she was born. She was very tiny and fragile. She stayed in an incubator for a month and a half and she was strong enough to be in a regular bed. And that was when I had the chance to start touching her and holding her and ahh, changing her and she still had a lot of instability, scary moments. She is much better now. She still has a lot of breathing

problems. She has respiratory distress syndrome. Ahh, she's ahh, she actually has been, she, she is my miracle child.

She is my blessing and something I have to deal with now. It's hard. It is different raising her from my other ones. I have to watch what I do around her. I have to watch how I lay her. And I just have to keep a close eye on her. It is different. But it is not as difficult as I thought it was going to be. I thought I would have these different machines or all these different clothing and it's not like that. She is just a normal baby and just extra care is needed.

They couldn't stop the bleeding. I almost lost my life and hers. And being that they couldn't stop the bleeding and I was contracting and then started dilating, that is when they decided to go ahead and induce me. It was meant for her to be early. So they rushed me in and did an emergency C-Section.

All participants, including the grandmother, recalled their anxiety and moments of high stress related to their fragile infants' status. The grandmother described her anxiety,

And I'm so scared because some people told me that premature, all the time sick. But no! Thank God he is no. He's OK, now. For me I am so scared the first time, because he was so little, so tiny and ah, my nervousness I feel shame. Now I'm relaxed and I change and everything. And this is my baby. Butta, I look at everyday. He grow-up and grow-up and the things I don't keep here. My daughter (auntie of the baby) she say, 'Mommy, he here? ' I say, 'Yes.' She says, 'Baby, baby, the baby's don't move.' She closed the door. And the baby says, and she says, 'Yah, he's here. The baby moved.'

This description indicates that primary caretakers' anxiety continues after discharge in regards to high-risk infants' survival. Some participants described experiences with aspiration and stoppage of breathing. For example, one woman said,

> Well, it was kinda scary at first because that was my first experience, but it went well. She was only in there for about a month so she didn't have any complications, she was on the ventilator or something like that. She was just low birth weight. And the reason I had her low birth weight was because I had toxemia, which is high blood pressure. And she did really well.
>
> I was kinda scared when she came home because she had relapse. You know she couldn't breathe. So I just kinda picked her up and tapped her on the back. She done that twice, you know. So after she was fine.

Another participant spoke of her days after the baby's birth.

> Yeah, I knew all the nurses. I was there a lot, a lot of hours, and I was there all the time. I didn't get much sleep and I didn't eat. I was just there. I just wanted to be there. I felt so bad.

In summary, prior life experiences influenced participants' expectations or lack thereof. High-risk infants' conditions that participants described as being "scary" were conceptualized as the context for *forming expectations* and the cause for public health nurses' home visits. Articulated expectations were formed through guesswork within this context.

Forming Expectations

Expectation formation was the first phase of the process of *forming expectations.* Two stages were identified within this phase. The first stage was "I don't know."

Expectations were not formed. Participants denied knowledge of public health nurses' work and the majority had not been informed about the HRI Program. The following description provides insight into participants' responses to the research question: What do you expect the nurse to do during the visit?

"I don't know" or Unformed Expectations

When queried about their expectations for public health nurses' home visits, 63% of the respondents responded, "I really didn't have too many expectations. I really didn't know" or "I don't know what kind of service they provide." "I honestly don't know what to expect." "I wasn't sure whether or not she was gonna draw his blood or anything like that." "I don't really know." "I don't know how the public health nurse can help me."

Another participant, a Certified Nurse's Assistant (CNA), had worked in a medical clinic but was unfamiliar with public health nursing. She was reluctant to articulate her expectations for the public health nurses' home visit, even to say that she would like the baby weighed, because "It is not my lead. She (public health nurse) has protocol she must follow." She did not know what to expect or she was too stifled by submission to authority and her respect for the hierarchies within the health care delivery system to express her expectations.

These responses indicate a lack of knowledge about public health nurses and their practice in the home setting. This was true of eighteen of the participants. Only one participant had a public health nurse visit her with her first baby. Because of the lack of knowledge of public health nursing practice, expectations were unformed. These unformed expectations were non-perceived and usually were participants' first responses when queried during the first interviews about their expectations.

"Maybe" or Guessed Expectations

Following the first stage of unformed expectations or not knowing what public health nurses' do, the second stage of e*xpectation formation* was a conjecture or *guessed expectation.* Secondary probes were necessary to encourage expression of what participants thought the nurse would do or say during the home visit (Appendix M). Three categories of voiced expectations emerged. These categories included: Checking up, Teaching, and Anxieties. These categories contained general and specific expectations. In addition there were expectations of nurses' behaviors.

"Checking Up"

General expectations included "checking up," the first category of guessed expectations. There were three components of "checking up." The three components included "checking up" on the baby, the environment, and parenting skills.

"Checking the baby." All participants' expected that public health nurses would "Check up on the baby" or "Maybe check her and look if she is OK." Participants understood that public health nurses had skills and knowledge about babies that they did not have. They said that checking the baby was "something I can't do myself." The public health nurse would do this with physical assessment, developmental assessment, monitoring nutrition, elimination, and medication regimes. Not all participants' responses enumerated all of these nursing skills. A few stated that they would expect the nurse to visit for the first year.

Physical assessment expectations included weight, length, and head circumference measurements. "Just to see how the babies are doing and let me know." "Well, if she is a nurse, then I think she is going to check, ah, how she is doing. You

know probably take her temperature maybe, ah, all the routine procedures that they do." Another participant stated,

> I think the usual. I believe they check the head circumference, and I know they check the length, and I am not sure she is going to weigh him. If she is going to bring a scale. She might. And I'm sure she will give him a thorough check.

Another voiced similar expectations,

"So I assumed that they would come check her breathing, check her vitals, make sure her lungs were clear, that her vitals were within normal limits." Examination would include "listening to the heart." "She would remove the clothing and just basically look to see everything like when she goes for a check-up at the doctor's. She would just do something like that. Check-up."

Other comments in this area included the following:

> I would just expect her, you know; to make sure that everything was fine, check up on the baby, to see that she was still doing well after since she has had surgeries, to make sure that all was well with her incisions and things of that nature.

One participant described her experience with the nurse "checking up,"

> One day she did hear crackles in my baby's lungs. We were concerned and she told me to go to the emergency room, to get it checked and get some x-rays, to be safe, you know. So any questions or concerns that I had, you know, she would give me advice. Not advice, but she would give me a plan to deal with the situation, you know. So she would come and she would check the baby and check her vitals to see her well being, an overall assessment of her, you know.

Developmental assessment included measurements of length and weight as well as measurement of the head circumference. One woman said, "Yeah, I appreciate that they take time to come to my house to see how my baby is doing. How is his development himself." She further stated,

> Basically, yeah, just to check the babies out. Weighing him and she told me that she would assess them and see if their movements are good. And see if, just the little things, check on their vision and if they respond to her and see if the pace they should be at.

Another participant thought the nurse would,

> Check the babies out, whether they are progressing, because twins have their adjusted age because of being preemies. The public health nurse can help you understand that when people say they should be sitting up that you don't get your feelings hurt because they are a month behind. They were a month early. There are a lot of physical therapies that we can do.

This participant also noted that nutrition of the baby as well as medication administration, and other needs are important when *checking* on the baby. For example, one participant expected,

> Checking to see that they are getting the right formula, the right amount of food, that I am giving the right medicine at the right time, the right doses. As far as if we need a new thing, you know. They have helped out with diapers. Just things like that.

Another participant stated the nutritional concerns in the following words, "See how I

am doing and see how the baby is doing. You know, probably about the breastfeeding and about how my breastfeeding is going. OK! And about things like that."

When asked to clarify what was expected of the nurse, one participant stated, "I just wanted to make sure that she was all right." These responses seem to acknowledge that nurses use their knowledge of high-risk infants, assessment, and communication skills to check infant's status and progress.

"Checking if the house is safe." Checking the house had three aspects, safety of the infant, health risks, and necessary furniture and supplies. The term "public health" seemed to conjure anxieties. "Public health! Probably inspect the house. I guess to see if it is suitable for the baby." Another participant noted, "That's what you hear from some people, like, yeah, they (public health nurses) come in and search your house and stuff and look and see if your baby is safe and all right." Still another woman voiced her expectation as

> "I would expect that she would check out my house and see that he was in a good environment. I would imagine that just being a public health nurse, that is nature of her job. I would think that she would be interested to know that he was in a good environment."

An environmental assessment was expected to determine safety hazards for the infant. Comments by participants included the following: "Maybe to check every thing here, house and family members, are fine." "That the house was safe for her and that of the baby. And probably the environment of the house, you know. Just to see if the baby is in a safe environment also. So her health and welfare issues." "They come by, and see if

your house is safe enough. I guess to see if it is up to standards for a baby. See if it is clean. I guess."

Primary caregivers of very sick babies guessed that the public health nurse would be concerned about the environment. Twin boys had severe lung problems requiring medication, oxygen, and positive pressure treatments. Their oxygen saturation was constantly being monitored and they were sensitive to the chemicals of ordinary household cleaners as well as household dust. Their mother stated her expectation as "I guess to make sure we had an environment for the boys that was not harmful."

Another participant commented

> Especially with her immune system, you know, probably, they want to see if it is going to be a health risk for her. I expected this nurse to come and check over my home, make sure it was child safe(ty), and make sure that it was good enough for her, and the air condition. And being that she was a high-risk baby, I wanted to be sure that the temperature was correct.

Participants guessed that the public health nurse would be interested in the baby's own bed. For example, one participant stated, "She would want to know where he slept and she would want to make sure he was in his own bed. That would be a good thing." Another woman expected the nurse

> To make sure she was OK. Maybe to check to see if it was OK were she was? Yeah, I thought like 'cause in the hospital they asked me a lot of questions and stuff, like if I had things for her, a crib and stuff and look at the house and stuff, and make sure that all was OK."

"Checking how I am doing." Some participants thought the public health nurse would be concerned about parenting skills with a high-risk infant. This was apparent in such responses as,

> That I was doing what I needed. That I was using the equipment right. And I guess, just to see that I was taking care of them like the way they are supposed to be. You know, just little things - like am I using the equipment the right way, you know. Obviously attending to them, not leaving them unsupervised, you know; they are getting the right formula; the right amount of food, that I am giving them the right medicine at the right time, the right dose.

Only one woman suggested that public health nurses are concerned about child neglect and abuse in relation to their mandated reporter status, while another saw the public health nurse as a helper who would assist her in the proper care of her infant, "That if I am doing everything OK. If I am not, they have to teach me the correct way."

Teaching

The second category of guessed expectations was *teaching*. As one woman stated, "Teaching is highly expected." Participants' expressed expectations became specific in their quest for knowledge and skills. Specific teaching expectations related to the special care needs of participants' high-risk infants, such as "Teach me the correct way if I am not doing the care correctly;" "Teach me how to take care of my baby;" "Talk to me about the baby and see if I have any questions;" "Tell me if something is wrong and teach me what to do or help my baby be more comfortable;" "My first baby! And I really don't know much about babies;" or "Information that I don't know."

High-risk infants' special care needs of concern to primary caretakers in this study were aspiration, colic, colostomy care, care of circumcision, gastro-intestinal problems due to shortened bowel syndromes, inguinal and/or umbilical hernia, and ventricle shunt. Participants voiced expectations of teaching specialized care techniques.

One participant was particularly concerned about gastric-reflux and aspiration. She said, "I did have concerns about her spitting up her food. I was concerned that she would aspirate because the milk would come into her nose. And I just didn't want her to get it in her lungs, the fluid." Her special need for more knowledge about preventing gastric reflux and consequently preventing aspiration is evident in the following statement that also presents a broad view of topics for further teaching that primary caretakers needed.

> Expect? Ah, about the formula, as far as how to prepare the formula, or how to feed the baby or how to feed a baby with a gastric reflux. Keep the food from coming back up her nose. You know, ways of how to keep the food down or. I think that she would probably be concerned with safety issues, like if the baby, like sleeping issues, like how she should sleep in the crib and stuff like that. Ah, hand washing, because of the baby's immune system. Burping the baby, I know they were talking about not to pat too hard because it could cause the food to come back up. That was one of the issues, then milestones to see if she is at development or if there is some development. Because though she is a preemie, every preemie develops different. Some areas she may catch up and other areas she may be right on target even though she is a preemie. Some areas like that. You know!

Another participant was most concerned about her infant who had gastro-intestinal shortening due to a congenital defect. The infant cried after each breastfeeding as though she was uncomfortable. In addition she was concerned about the foul smell of her daughter's flatulence, going 2-3 days without a bowel movement followed by a watery stool. Her pediatrician had recommended placing the infant on her stomach across her knees and patting her bottom. The health maintenance organization's nurse on call, who had no idea of the infant's history, had told her that every three days for a bowel movement was normal. She had tried a medication that had been recommended but it did not relieve her daughter's discomfort. In addition, she had tried being selective with her own diet. She was most distressed about how to best comfort her baby. She wanted the nurse "maybe to teach me how can I do, for how I can take care of my baby better? Ummm. Ummm. To check my daughter. Yeah. I think she can help me or give me any thing better to help."

Another participant had concerns about the care of a circumcision because the doctor was giving different information than her mother, mother-in-law, grandmother, and others in her family. She said,

> I asked her about the circumcision because he had just had that and whether I should be doing things. And ahh, the nurse, I mean the doctor who did it said that I shouldn't do anything. And then when I had his check-up, they still said I shouldn't do anything. And everybody, like my mother, and his grandmother, my boyfriend's mother's mom, you know they are old fashion, they thought that I should pull it back. Like clean it. Or I should tie a little something around it to

keep his head (of the penis) out. And because it was kinda like the skin was growing over again. Ahh, it looked like it was hurting him, you know.

So she (public health nurse) said that every person she visits, some of the mothers have said, "How come I don't do anything to his pee pee?" She says, "I don't know. Now the doctors say not to do anything to it. She said, "I still think that you should push it back."

You know, because I hadn't done anything for 5 days. It was already healing and stuff and she's like, and she's like they figured it would stay out. The doctor said that when he gets an erection, it will just pop right out. I know. She said that a lot of the people still think that you should push it back because they don't know whether or not to wait.

But, ahh, I was pushing it back, you know. Even grandma was, you know and there you go. You can be old fashion, you know. It's I like it. But, ahh, I let it be, just let it push out when he is ready.

In addition, this young first time mother was confused about how to care for an umbilical hernia because of the advice she was receiving from her family. She was expecting the public health nurse to give her information about care.

And he had a, she says he has a hernia on his belly button, too. Because his mother and his grandmother are very concerned about his belly button. When I had him they said make a beautiful belly button, you know. You know when they cut it, I don't know how they cut it but it left a big old bubble, you know. I will show you if you want. And ah, and I asked her, "When you see the doctor, tell him, tell me." But I saw the nurse first before I saw the doctor and they go, "It's a

hernia, you should push it down." I also asked the doctor and he just said, "Just leave it," they just said, "Just leave it." Many people are worried. Like what is wrong. That's his belly button. The doctor just said to leave it. And he will grow and it will just pop right in. And everybody says put a little cotton on it and, ahh. And she seemed like everybody was saying all these things like push his skin back and put the cotton on his belly button and I asked her and she said the same thing. And then I told her that the doctor said not to do nothing. And she said, "I guess that is how they are doing it now." You know. But, I don't know, I guess I was kinda happy that she said the same things as my mom and J's mom, but I didn't listen to my mom and his mom for a while, you know. She was like, "Oh, no. That's what I did with my kids. She said I have no idea why a doctor would say nothing."

A participant whose public health nurse visit was not initiated until approximately two months following her infant's discharge had had concerns about managing 'colic.'

I am willing to ask anybody for any ideas about colicky nights. He gets colicky and very fussy at nights. So anybody that can offer suggestions about that is welcomed. And that's really the only thing I have a hard time with, that I might have questions about.

A young first time mother of twins delivered her babies at 28 weeks. The first twin came by normal spontaneous vaginal delivery and C-Section delivered the second. The second twin experienced a congenital problem requiring a transfer to a different hospital for a ventricular shunt. The second twin caused the most concern, as expressed in her comment.

"I guess kinda like weird, because I never had a nurse come to the house. Unhuh. But I think it is good because you need some body to tell you how to take care of a baby like that." When asked what kind of things the nurse might tell her, she replied, "Maybe how to take care of his head and how would we need to look for if the shunt should clog up or something." Her response when asked if she would like any other kinds of information was as follows,

> No. Just normal, what to look out for the shunt, and what is, how should I position him to sleep? Because I know he is not the same way as this baby. He has to be different. To find, to know about if he is going to be normal with all these operations that he is having. They tell me how to hold him, how should I position him.

Another young first time mother expressed concerns with possible TPN administration and colostomy care.

> Well, one of the nurses told me that because the doctor may leave about an inch because he can't close the tummy and if he is not able to eat he would still need the TPN. And that the nurse is going to check if it is OK. TPN. Or if I clean the bag when he comes home.

Anxieties or Negative Expectations

A third category of expectations at which participants guessed before the home visit was negative in nature. These negative expectations articulated in the initial interview captured participants' *anxieties* in relation to the term "public health." Participants voiced anxiety about the adequacy of their homes and neighborhoods, being

evaluated as a 'bad mother,' anxiety about the nurse's mood or the nurse being a stranger, and the inconvenience of an outsider coming into the home.

There seems to be a universal myth when participants hear "public health," that "public health" has the authority to declare not only parents to be unfit, but also is able to condemn their homes and neighborhoods as being inadequate and unsafe for their infants. In addition, participants' voiced anxiety related to public health nurses' personality and behaviors and their own personal safety with outsiders coming into their homes. The role of public health and public health nurses in the community was unclear to participants. Examples of participants' responses follow:

> Public health! Probably inspect the house. I guess to see if it is suitable for the baby. Especially with her immune system, you know, they want to see if it is going to be a health risk for her. Maybe to check to see if it was OK were she was?

Another participant responded: "They come by and check your house to see if it is all safe enough. I guess to see if it is up to standards for a baby. See if it is clean, I guess." Still another stated her concern that routine visits by a public health nurse would be a "pain in the butt." This statement implies that the participant viewed home visits as an inconvenience for herself and her family.

The most frequently expressed anxiety related to the public health nurse's personality and behaviors. One client stated: "I think it is kinda weird to have the nurse at home." Another acknowledged her anxiety before meeting the nurse for the first time: "For the first time (visit) I am worried. I don't know the nurse." Several participants

expected the public health nurse "to come in her uniform with an ID or some form of identification" indicating that identification was important for her and her family's safety.

Another participant, a young, first time mother who was developing her infant care skills, revealed in her interview her desperate need for parenting knowledge and her anxiety about her parenting being judged as inadequate:

> I was kinda worried. Its like, I worried whether or not I was going to do something and that I wasn't giving him enough food, and that you have to keep him warm, you know. Cause when she (the public health nurse) called the first day and they didn't show up, I was just like, oh, no. I hope she is going to come.

Another inexperienced older first time mother expressed her anxiety. She and her husband were challenged with the every-three-hour feedings around the clock. She acknowledged her insecurity about her parenting. She openly stated that she knew nothing about babies and didn't know if she was doing things right for her baby. She stated,

> Ummm. Well, I don't really know. Most of the nurses are strong, not physically, ah, but in words. Like sometimes they talk to me. That's how I felt at the hospital when I was there. They talked with a lot of authority that sometimes makes me feel like I am too little (laughing). Yeah, like I'm not doing things right. But some others are like more; they can like, like there's an opening for me to ask them questions with confidence, you know. So, well I hope that the nurse that comes will be like that, you know. That will be open.
>
> Some other nurses, you know, I think, they just like they want to do their job and they don't want to be bothered, I think with other questions rather than

what they are doing. If I am going to have someone professionally helping me, you know, I want them to be open so I can, so I can be more relaxed and more not to be nervous every time they are around.

In the second interview, this participant openly admitted that before she met the public health nurse she had been most anxious about the nurse's personality and approach to her care giving of her baby when she shared the above anxiety.

Another participant was afraid that she would be judged as a 'bad mother' if her house was not clean.

I wanted the house to be clean too. I hope they don't think, I was kinda worried what they were going to look at. I'm not a bad mom. I might not throw out the trash but I want to.

Another first time mother voiced her concerns about the public health nurse. She stated,

Like I wouldn't want someone to be mad. You know, and kinda like in a hurry. That's bad. I, what if she will be in a bad mood cause it was hot. And everyone seemed to be in a bad mood, I hoped she wouldn't be in a bad mood when she came to weigh him and check the baby out. Cause then I would have been uncomfortable. I probably would have just let her do her job because the nurses at the hospital, you know, they were kinda like they seemed rough, you know, but they knew how to handle him. And I was just like; I wouldn't handle him like that. I'd just be so much more, you know. I go, I hope she is not in a bad mood, That's it. (Slight laugh.) Just wanting to get in and out, just do her job.

Participants' responses provided insight to client's anxiety related to their perception of the role of public health. Anxiety about the adequacy of their home as well as the neighborhood was evident in this participant's reaction:

> I got a little worried when she (public health nurse) said she was from public health. And I thought, oh my gosh! My first thought was, 'Oh, what if were we live isn't up to par. Because we are trying to put a lawn in our front. And I am thinking these don't meet the standards.' But I didn't realize that had nothing to do with it

Nurse Behaviors

Participant expectations included expectations of public health nurses behaviors. Participants were unfamiliar with the home visit as a means for providing nursing care. One participant stated,

> But I guess in my mind when someone says that they are going to come, that they are going to come you know, to see the baby on a health related issue, I am automatically expecting that they are going to focus on the goal and purpose of the visit.

While there were expectations for public health nurses' professional skills, when *forming expectations* for home visits, participants did not associate previous experiences with health care providers in relation to the knowledge and skills public health nurses would use. When pondering what they might expect from public health nurses, analogies most often related to the personalities and behaviors of NICU nurses, their most recent health care experiences with their high-risk infants.

Attitudinal expectations of the public health nurse included human relatedness and personal qualities. Participants identified personal attributes of friendliness, kindness, sensitivity, a good listener, gentle, calm, vigilant, not intimidating, and 'cares about babies.' Demonstrating respect for participants, their families, and their homes were important to participants. "That is what I would expect that the nurse would listen to me and kinda talk with me about what I should look for, what is wrong."

Furthermore, the nurse should be sensitive to participants' needs; "If I am tired, the nurse should notice these and reschedule for a mutually agreed time." "I expect the nurse to be kinda kind, not be all rude and stuff like that." "I would hope that they would be friendly, would be, you know, friendly and informative. And not condescending in any way, in how I am taking care of him (baby)."

Friendliness was a frequently identified attribute.

> "I expect her to be courteous and helpful and just make me as comfortable but my family (also). It is not just me. It is my family. They're the most important to me. And as long as you (public health nurse) can make them comfortable and you (public health nurse) are explaining things to me. If my boys have questions or are disturbing the works that also is a plus (for demonstrating flexibility and caring)."

Expectations for the nurses' actions were based on personal needs and desires. These related to preplanning and timing of the home visit, personal safety of participants and their families, availability, and competence with babies.

All participants expressed expectations that included preplanning for an appointment for the home visit, an informative introduction, identification on person,

appropriate dress, "code of conduct" during the home visit, and availability after the home visit.

When queried about preferences regarding the timing of home visits, participants confirmed that an appointment for an agreed upon date and time was preferred, though two stated that if the public health nurse was in the neighborhood, it would be alright for her to stop in. They "were always at home." "If they call me, I don't mind them coming."

One participant requested that the public health nurse time her visit after her husband's work hours so he would be home. This first time mother of twins was anxious to learn. She had two reasons for this request; one was a fear that the babies would interrupt the visit and the other, that both she and her husband could learn together and what one didn't understand or failed to recall the other could clarify.

Participants' reasons for the preplanned visit varied. One participant responded, "Better that they call that I have time to prepare something for them." Another stated,

> A little bit of warning! But I, you know, if we don't have an appointment we are always home. And so, you know, people come and so, like now, I don't usually comb my hair until night when I get the kids to bed. There are those days when I am really busy.

Participants had concerns about being prepared and their homes being in order as though a disordered house would portray a 'bad' mother. "I think I have a preference of her calling ahead, because myself, I might not be home or being in my pajamas or something or my house would not be ready for her."

Other participants were mindful of and concerned about the public health nurse's time management:

> Yes. Because sometime we may have plans, you know, to go somewhere and she would just pop in you know, ah, well, 'I'm sorry but we are about to leave right now.' So for her convenience, I think, you know, not to waste her time, driving from wherever she is coming. I think it is a better use, if they call ahead of time to set an appointment. That way she (public health nurse) knows that I am going to be home.

Another expectation related to clients' and family's personal safety. When queried the responses included: "Just that they (the public health nurse) provide a safe atmosphere for us." "Expect her to have proof of identity on her person so I know she is who she says she is." "You just expect a certain code of conduct when they are at (their) work because this is their job."

Personal preventive health concerns were included in participants' concerns for safety. "Ask if she is sick, then (if the nurse is sick) I can't have her. We would reschedule." "I am really funny about washing hands though. If they (public health nurses) were going to handle him (baby) they would have to, they would have to scrub."

Participants want public health nurses' identification nametag to be visible. Several participants elaborated this as a measure for keeping themselves and their families safe.

> "Only they need to have identification, so I know who he or she is. She had her nursing clothes, her nursing bag. She had everything she needed to prove to me that she was here for that reason. And she stated the reason that she was here. So identification was not a problem at all.

An expectation of one young mother identified a very specific strategy for the public health nurse's role:

> I think it is good when they can kinda identify what you feel like because they talk to a lot of other moms. She described her younger sister's experience with her first baby and postpartum depression. Ah, maybe like them understanding that other people go through and when they talk with someone else, they could say that a lot of people go through that stuff and that could help them.

Cleanliness and comfort for the nurse were most important distinctions of public health nurses' dress. A uniform was not necessary.

> I guess you expect that when anyone is coming that their clothing will be appropriate, that if they are nurses they are going to have on their nursing clothing, their equipment. If they are not dressed appropriately, then you are concerned about whether they are there to work or not. You know. Yeah there is an expectation that when you are at work, there is an expectation to dress appropriately. And have a professional conduct while dealing with your client.

All participants, when prompted, had expectations for availability of the public health nurse. One participant stated, "The nurse should give me the phone, the address and her own number. Then when I think of something I want to ask, I can call." Another responded, "I would like her to be available (by phone) because my baby is not the same as a normal baby, being a premature." Other comments included, "I would like a number to call when I want to talk to her" and "I expect to ask questions and have them answered." One older first time mother expressed her ideal expectation, "So especially if I have ah, ah, problem with my baby in the middle of the night, maybe that I don't know

what to do and maybe I can have a little help from her asking, you know." Participants also suggested, after the home visit, "If I have any questions, I should be able to call, be able to contact her somewhere. I should have a number where I can ask my questions about me or my baby."

Due to recruiting difficulties some participants were not interviewed prior to public health nurses' visits, but recalled their prior thinking after the visit occurred. None had had previous experiences with public health nurses, nor did any recall having been informed about the HRI Program while their babies were in the NICU or upon discharge. Expectations that they articulated in their interviews were very similar to those discussed here. Eight interviews provided the opportunity for theoretical sampling.

Interaction

All but one participant recalled being contacted by telephone by public health nurses to arrange for the home visit. Public health nurses further explained the goals and purposes of the HRI Program as well as their role, while arranging for the home visit.

One participant had an unannounced visit by the public health nurse who awoke her from a nap. This unexpected interaction was frightening for this participant as she thought something tragic had happened to a family member. The public health nurse reassured her and explained that she had received a referral from the NICU. Although the young mother was unaware of her baby's enrollment in the HRI Program, she accepted the public health nurse's introduction to the program and invited her to return when the infant was discharged.

Interactions with public health nurses lasted thirty minutes to one and one-half hours. Interventions focused on the infant's transition from the hospital to the home and

the caregivers' concerns with their babies. Most nurses explored infants' needs for local health care, special formulas, medications, and coordination of other agency involvement. In addition, public health nurses were concerned with the mother and the family's needs for housing and smoking cessation.

Consequences

After the home visit, participants were asked to tell the researcher about the home visit. Participant's recounted their experiences with what the nurse did or said during the home visits. They described nurses' characteristics and their interactions.

On the whole, while the home visit was the first introduction for both public health nurse and participant, data supported that the nurse's informative description of the program's goals, her personality, and behavior dissipated the notion of the nurse as a stranger as well as anxieties about having a nurse come into their homes.

The descriptions provided by participants were observable, understandable activities of public health nurses' skills. Many of the public health nurses' assessment skills are performed through observation and questioning. Participants described their experiences with public health nurses as just "sitting and talking," therefore, expertise of professional skills that are not readily observed or understood by participants are lacking in these descriptions and minimized by the characterization of "sitting and talking."

Participants confirmed that public health nurses' home visits in this program met or exceeded their positive expectations and disconfirmed negative ones. In addition, participants identified public health nurses' actions or activities that they did not expect and admitted their surprise.

Confirmation

After describing the home visit, participants were asked whether their expectations of the home visit were met. Confirmation was affirmed in responses such as met or exceeded expectations. Even though some participants articulated expectations that were brief and somewhat vague, all reported that their expectations for public health nurses' visits were met or exceeded. All sixteen participants that had experienced public health nurses' home visits replied positively. Fourteen participants said, "Yes", one said, "Definitely," and one said, "Similar." While expectations had been unformed or not articulated, participants guessed expectations based on their own intuition, imagination, or personal knowledge of health care.

Every participant expected that the public health nurse would "check" on the baby. Some expected only a physical assessment, while others expected the full range of "checking up," physical, environmental, and parenting.

All participants recounted the observable assessment actions of the public health nurse in their descriptions of home visits. These activities included "weighing the baby," "measuring the baby (head and length)," and "listening to them (lungs or heart)" and met participants' expectations of "checking up." Public health nurses exceeded participants' expectations when they explained during their assessments what they were doing, and why, and what was important to look for as well as what they were finding. Clearly, the data indicated that participants wished to be informed if the public health nurse identified a defect or abnormality. For example, one participant stated, "And they tell me. They always talk with me and tell me what they find and if they have any complaints. They sit and talk with me. They have all been really good."

Other actions that met participants' expectations were "Telling me the different things she thought I could do" and "Informed me about WIC (Women, Infants and Children Nutrition Supplement Program) and the different programs I could use. And things like that." An example of a met expectation regarding an infant's development was "Informed of development realities with preemies and resources to stimulate the baby's development."

Participants verified that they were more confident in their caretaking skills after public health nurses' visits as demonstrated by this quote: "She is coming and I feel more better because she checked the baby and everything, and I feel more strong for the baby."

One participant admitted,

> I totally like the idea of the nurse coming and visiting this time. If I was doing something wrong, he needs to do something, eat more, eat less, I just had no idea if I was doing what they told me to do and they (the NICU nurses) go 'Whatever you feel, you're the mom.' About whether I was doing something either right or wrong. Unhum, I wanted her to tell me exactly, like, you know, like for me, he's not gaining enough, or he, you got to do something.

Another participant reported that the public health nurse was sensitive to her and her family's individual needs. This primary caretaker requested that the visit take place at 5:00 p.m. so her husband could be present. The public health nurse agreed, thus, exceeding what she had expected. She further noted that during the visit the public health nurse solicited the family's fatigue level frequently. The visit lasted an hour and a half. The public health nurse additionally assessed and intervened on behalf of the husband

who was a smoker and wished to quit. "She was patient, had personal understanding and was helpful. She was really nice to talk to."

This participant with twins described how the nurse knelt on the floor between her and her husband while each held a baby. "She was comfortable to do that. Yeah, I appreciated her ability to do her work and look us both in the eye. She was really good." The participant further described how this nurse, in her information gathering, prepared them to shift gears in their thinking by prefacing her questions with clarifying statements such as; "Now I am going to ask you about your family history, or this is about the babies now."

Disconfirmation

Participants were relieved that their anxieties or negative expectations about the qualities of the nurse were unfounded. Nine participants used the following words to describe nurses, as follows: "Actually very friendly." "Just a really friendly lady." "She was friendly and nice with the baby and everything." "Very supportive." "Really nice." "Making jokes, friendly." "Listened with interest to my explanation about my baby's physical condition." Other traits that participants enumerated were 'honest," " trustworthy," "courteous human," and "not condescending in any way, in how I am taking care of him (baby)."

The responses from participants who expressed anxiety about the personality of public health nurses before the home visit indicated that their negative expectations were disconfirmed. For example, one participant said, "She was really sweet. She took the words out from me. That really made me feel good!" Others noted, "She wasn't rude and mean like some of the nurses." "Really, really good! She took her time and answered all

our questions." "She really took her time. I didn't have anything that she didn't answer." "She was really interested in her job, what she was doing. So I felt really good about that." The participant also stated that the public health nurse "had confidence with whatever she was doing." Another participant also noted, "She was knowledgeable, she knew what she was doing. So that's what I liked about her."

An older first time mother admitted,

> I had that doubt at first, but after she was here, you know, she told me that I was doing everything right, you know. And I felt really good about that because, first, I was sort of scared that I wasn't doing what I was supposed to do with my baby, so after she was here and she asked me to hold her and to give her the bottle. She told me, well; you are doing everything right like you are supposed to do. That made me feel good, you know, because first I was scared I was not doing everything right, not doing it the right way. So it was good. I really felt good that I am doing everything right. I am doing what I am supposed to be doing.

One particular participant with greater confidence in her abilities, who was a CNA, with medically fragile twin boys initially expressed her annoyance with the idea of public health nurses' visits. She had predicted that the visits were going to be "a pain in the butt." She understood that the nurses were supervising the quality of her caretaking since her babies were on oxygen, ventilation monitors, medications, special formula, and positive pressure breathing treatments. To her surprise, she found that the nurses were "very flexible."

Participants described two contrasting work styles of public health nurses. Some participants described how public health nurses "just kinda sit and talk with me and see if

I have questions, see if I need help." Other participants described the public health nurse's approach as "getting down to business, pretty much. So it was obvious that she was here to see my son." These approaches disconfirmed anxieties voiced about how the nurse might relate to primary caretakers in their homes.

Some, but not all, public health nurses inspected the house. Some participants reported that the public health nurse requested to see the baby's crib, while other nurses only asked about the infant's sleeping arrangements. One participant reported that the public health nurse asked, "She didn't sleep in the bed next me, that she sleeps in her own bed and stuff like that, 'cause she will get used to her sleeping with me and stuff like that."

Surprises

While all participants reported that the public health nurse met or exceeded their positive expectations, several reported actions of the nurse that were unexpected and, consequently, a surprise.

Since most of the participants expected the public health nurse to focus on the baby, they were surprised when nurses' interactions were directed beyond the baby's physical needs and well-being. Several participants expressed surprise that the public health nurse was interested in them (the mothers) and their well-being. The public health nurse asked, ". . . about my source of health care, the birth control method I had chosen. I thought that she would be more interested in the baby. It didn't really bother me too much. It was just that I wasn't expecting it." Another participant reported that the nurse "asked me about myself. She asked if I was on medications and things."

Several participants were surprised by the public health nurse's encouragement of their time for self, away from the daily care of a high-risk infant, and self-renewal. A participant who was primary caretaker for the high-risk infant grandson and seven other grandchildren as well as a husband experiencing physical and communications limitations from a stroke expressed her surprise when the public health nurse counseled,

> And she told me, do you have some time to go to one place. No. Or go together? You need a day to take for yourself because you are no super woman. And now I understand, it is true. She talked to the boys and she said; 'You should help your grandma.' She talked to the children and she talked to me. And I liked what she told me. You are no super woman.

A young 20-year old first time mother living with her mother, her father and her siblings, who awakens every hour during the night to administer medication to her high-risk infant recuperating from an intestinal repair, was handling her situation with her working mother's help. The infant experienced much discomfort after eating and was chronically fretful. The public health nurse encouraged this mother to get away, "Go to the mall or a movie or spend some time with your friends." She continued with her experience:

> Ahhhhhh. Oh, remember when I told you about that she was telling me that I have to take some time for me, she was really strong. You have to and you have to and when I come back you tell me what you did to take some time you know. Unhuh.

Another participant was surprised and pleased that the public health nurse responded to her husband's need to stop smoking and that she should be concerned with her need for anti-depressant medication. The public health nurse shared her own

experience with quitting and provided smoking cessation resources that the family could use and counseled her about monitoring her medication and signs and symptoms to be alert for.

A participant living in a one bedroom apartment with her five children was delighted that the public health nurse was able to provide her with resources for low-cost housing. This participant admitted that the nurse exceeded her expectations in that she didn't think that the nurse would be so easy to talk with.

Most participants expected public health nurses to be concerned about infant safety issues in the home; however, one participant who had a variety of domestic animals in and outside of her home shared the following comment:

> She was the only one that told me anything about being careful with pets. I don't think anybody ever said anything. Although I know not to leave him (son) with the dogs or anything like that, but she made a point to point that out. She saw that we had dogs and cats.

Another participant reported that the public health nurse unexpectedly brought formula for her infant. Another client whose formula had been changed gave an unopened can to the nurse who then shared it with this participant.

A participant confided an unexpected personality trait of the public health nurse, "Well actually I thought the nurse would be more like serious, but she was funny. We were joking about, about things. She was real nice. She was relaxed."

Several participants expected that since the nurse came from public health that he/she would "inspect the house to see that it is suitable for the baby, if it will be a health

risk for the baby." They were surprised when the public health nurse did not do an inspection.

Another participant with twins who had spent the night in the emergency room with them and was sleeping reported that she expected the public health nurse to make another appointment for the home visit, but to her surprise, the nurse asked her husband,

> I just, I just know that I had told my husband that she (public health nurse) would be able to ask if she could come back at a different time just because I am so exhausted from the night before. But she (public health nurse) asked him if it would be all right if she could visit with him. I was not expecting that. I thought that she had to more or less meet with me. He (husband) was OK with it.

The husband responded,

> I think that she was a little more than I expected. I didn't expect a nurse to come and help me with my boys and stuff. She was really cool. It was more like you could tell like a mother or grandmother and knew how to handle it. I appreciated her. She was there to watch my back.

This father further described the public health nurse as being more than a nurse.

> She helped me with the boys while we dressed and undressed the girls (twins) because the boys wanted to see what I was doing with the girls. She helped me with the boys as she kept them entertained and kept them from jumping all over.

Another participant who had a two year old and high-risk twin boys with fragile respiratory systems and required special ventilation and medications and stated that she expected the nurses' visits to be a "pain in the butt," shared her experience. The nurses scheduled their return visits with her so as not to interfere with her family routine. She

also found that the nurses even helped her with her two-year old daughter during the visit when the toddler's behavior was a challenge.

> Just to be so cooperative and they put up with a lot from me. They would come sometime and I would get really busy sometimes, and I would be behind and they would wait for me. One time I had my daughter in the bathtub and they would be out here with the boys, you know, and I would be running back and forth, and yeah, they were really nice. They helped me a few times. One lady (nurse) came in one time and I was like, 'I'm sorry. ' I had two babies screaming, I was trying to work with one and walking with the other one and she took one baby. Home visits *have* worked out really good.

Regarding infant assessment by the public health nurse, two participants were surprised by the services the public health nurse provided in the home. One participant responded, "I was, ahh, but it wasn't an 'oh, my goodness surprise. It was a surprise like, 'Oh, thank you surprise." This participant had been referred to the follow-up program of the hospital at which she had delivered but had not been able to return because of a lack of transportation.

The second participant who had never heard of nurses coming to the home for babies reported:

> Well, I only saw that done at the hospital or clinic. Every visit that I went they weighed so that was something that I never knew that nurses would come to a house, you know. So that was something new, you know, that I saw she had all the equipment and everything with her. Yes, how to give a massage, how to ah make her do a little bit of exercise, and ah, how to stimulate her, how to do

exercise, and eat and go to sleep. She was really interested in my baby and everything I do.

Another participant expressed her surprise and appreciation that the public health nurse would make her professional expertise available to her,

She gave me her phone number and she told me I could call if I had questions to talk to her anytime. I liked that too. Ahh, I didn't like know who to call that one time that I called the NICU and they just told me to come to the Emergency Room."

Unexpected public health nurses' actions revolved around the public health nurses' interest in primary caretakers' and families' well being. A universal expectation was checking the baby and the safety of their environment. Only one young participant expressed surprise that the public health nurse would want to see the infant's room and adequacy of supplies to care for the infant. "Yes, when she told me that if she could see my room, to see if I have everything. I didn't know that she would do that, that she would check every thing. But I don't mind, you know."

Expectation Reformation

Expectation reformation is the second phase of the process of *forming expectations.* Data confirmed that *expectation reformation* dynamically progressed throughout interactions with public health nurses. *Expectation reformation* began with public health nurses' introduction, continuing through the home visit interaction, and retrospectively through participants' cognitive processes after the home visit had ended.

One example of *expectation reformation* is demonstrated in this participant's response. Initially, she had not known what public health nurses do. When asked after the nurse's first visit what she expected of the nurse on the next visit, she responded

> Oh, almost the same thing. Come and weigh him, see how he is doing, and am I feeding him and all that. It's a good thing how the public health nurse helping you out with your baby 'cause it is always helpful things that they can teach you and how to care for the baby and all that.

Another example was the mother with fragile twin boys who admitted that she thought public health nurses' home visits would be "a pain in the butt." She found that the nurses were willing to work within her schedule and also assisted her when they came in and the babies and/or toddler needed mother's care and attention. The nurses' became her resource for questions about her infants' special care needs.

Another older 'English-as-a-second language' mother who had had some unpleasant interchanges with nurses in the NICU, who did not seem to listen to her, had initially expressed anxiety about the public health nurse coming to her home. She admitted that her inexperience as mother and her difficulty in adjusting to the around the clock three hour feeding routine was challenging. She expressed relief that the public health nurse did not come until the infant was three months old. The public health nurse was intuitive to her lack of confidence in her mothering skills. She described the visit:

> I had that doubt (unsure about caring for my baby) at first, but after she was here, you know, she told me that I was doing everything right, you know. And I felt really good about that because, first, I was sort of like scared that I was not doing what I was supposed to do with my baby. So after she was here and she asked me

> to hold her and to give her the bottle. She told me, 'Well you are doing everything right like you are supposed to do.' That made me feel good, you know because first I was scared I was not doing everything right, not doing the right way. So it was good. I felt really good that I am doing everything right. I am doing what I am supposed to do.

While the home visit lasted about two hours, the participant stated that the time went fast. She further stated how pleased she was that the public health nurse was sensitive to her and caring with her infant. "She knew what she was doing. So that's why I like about her. She was knowledgeable and knew about babies." This participant's expectations changed to view the nurse as a partner in her infant's care that, in turn, disconfirmed her anxieties about public health nurses. *Reformed expectations* have the potential to positively influence future interaction with public health nurses. Public health nurses' skills and competence are most influential at this phase.

Summary

Public health nurses' characteristics, non-judgmental behaviors, and competent knowledge and skills were identified factors in meeting participants' articulated pre-visit expectations. *Expectation formation* and *reformation* was an ongoing interactive process that occurred during, and after the actual home visit interaction. The face-to-face interaction during the home visit was pivotal to the conversion or *reformation* of participants' expectations.

Expectation reformation was apparent in participants' accounts of home visit interactions. All participants reported that their expectations for public health nurses' home visits were met or exceeded. While expectations were unformed or not articulated,

participants were able to state normative expectations (if they had been informed about the HRI Program), or guessed expectations based on their own intuition or imagination or personal knowledge of health care and/or nursing or personal values or desires. Participants with less life experience were able to predict that the public health nurse would check the baby and tended to stay with unformed expectations. They further stated that their expectations were met indicating formation of expectations during the home visit. While participants with more life experience verbalized general and specific categories of expectations, they stated that they did not know what to expect of a public health nurse.

In summary, findings of this study have provided a substantive theory of the process of *forming expectation* among primary caretakers of high-risk infants. Situated in the context of prior experience the process has two phases, (a) forming expectations and (b) reforming expectations. The process of *forming expectations* continued to evolve with the influence of family, public health nurse, personal feelings, and vicarious knowledge. The following chapter discusses the findings in light of prior literature and addresses the limitations of the study, implications for public health nursing practice, and the need for further research.

CHAPTER V

SUMMARY AND CONCLUSIONS

This study explored the expectations of primary caretakers of high-risk infants for public health nurses' home visits. Data revealed a process of *forming expectations.* Participants' had little or no knowledge of public health nurses' services in the home. The objective, then, became to determine a substantive theory of the process of *forming expectations*. Chapter IV explored participants' prior experiences and summarized the findings, identifying two phases of the process of *forming expectations*: *expectation formation* and *expectation reformation.* These phases and their dimensions were delimited using exemplars disclosed during twenty-seven interviews with 19 primary caretakers enrolled in a HRI Program.

This chapter summarizes and discusses the discoveries that emerged in the context of existing literature and research related to expectations of public health nurses' home visits. In addition, study limitations and implications for nursing practice and research are addressed.

Summary of the Discoveries

Findings in this study suggested that primary caretakers of high-risk infants had not formed expectations of public health nurses' home visits. This finding is supported in

the literature. West (as cited in Williams, 1994) noted that expectations for health care might be waiting to be formed when individuals come in contact with the health care system for their first treatment. Williams (1994) further postulated that the greater the perceived esoteric nature of a service the more likely the service user would be reluctant to hold their own expectations.

Participants repeatedly admitted that they had no knowledge of public health nurses' services and did not know what to expect. Two-thirds of the participants had no recollection of having been informed about the infant's enrollment in the HRI Program. Therefore, they did not know that a public health nurse would be coming to their homes. This finding concurs with those of Kearney, York, & Deatrick (2000), who documented that public health nursing is not universally understood and expectations of public health nurses' home visits may be unformed.

Unformed Expectations

The health care literature supports that expectations for health care may not be formed until individuals have knowledge or experience (Thompson & Sunol, 1995, Williams, 1994) and that unformed expectations may be temporary until individuals are knowledgeable about the situation (Kravitz, 1996; Thompson & Sunol, 1995). In addition individuals may resist voicing their thoughts because of their lack of certainty (Bell, Kravitz, Thorn, Krupat, & Azari, 2001; Thompson & Sunol, 1995; Williams, 1994).

The public health nursing literature provides insight into the lack of formed expectations of the public health nurses' home visits. Leipert (1996) found that visibility emerged as one of four themes identified in a phenomenological study of community health nurses who described the essence of their practice. The study participants valued

visibility for the perspective it brought to clarifying their role to clients, other professionals, and to nurses themselves. Lack of role clarity was purported to undermine awareness and valuing of public health nursing practice. Zerwekh (1992a) proposed that the lack of group identity has made public health nurses a population at risk; professional invisibility, separation, and powerlessness are consequences of an uncertain identity. Zahner and Gredig (2005) recommended "increasing public awareness of public health functions, services, and public health nurses' roles" (p. 426). This recommendation included increasing visibility for public health among other professionals, community members and leaders, community organizations, policymakers, and the general public. Greater awareness of public health nurses' roles was also recommended within city and county governmental departments.

Some participants had experienced the services of a home health nurse. With the increased visibility of home health nurses, a closely related field of practice, few members of the community are aware of the purposes or value of public health nursing. Salmon (1993) noted that the assumption of a more clinical, illness-oriented role by public health nurses has diverted the role of the public health nurse. Inconsistencies in public health nursing roles have been recorded for some time (Heinrich, 1983). Nursing focus in the community has shifted between sets of opposites, from individual to community, health education to illness care, and community-based practice to population-focused practice. This lack of clarity has confused the public and nurses alike (Salmon, 1993).

Forming Expectations

Not all participants knew what to expect of a public health nurse during a home visit. The concept of the home visit was unclear to participants. Their expectations had not been formed over time. The first stage in the process of *forming expectations* was discovering that expectations were not formed.

In the second stage of the process of *forming expectations,* participants engaged in guesswork regarding expectations, with prompting from the investigator. Participants prefaced their statements with "Maybe the public health nurse will" or "I guess the public health nurse will." Their guesses were based on prior experiences with their high-risk infants, their knowledge of nurses' work in other settings, their specific needs in caring for their infants, and their imaginations and ideals. This began a process of *forming expectations*.

Participants had little or no knowledge of public health nurses' work. The researcher's questions were the stimulus that initiated the process for *forming expectations* for most participants. Most psychosocial theories suggest that individuals' expectations are formed and are the common cognitive pathways leading to their behavior. This belief that expectations are formed before individuals experience a situation concurs with psychological theories (Ajzen & Fisbein, 1980; Bandura, 1986, 1989; Rotter, 1966, 1982; Tolman, 1932, 1955). While participants in this study had not yet formed their expectations, these theories are fruitful in clarifying the internal dynamics of cognition, emotions, and human behavior as they relate to primary caretakers' prior and on-going experiences and their role in expectation formation. The expected outcomes in these theories are stimulus expectancies.

Forming expectations was an interactive process that began with the researcher's interview questions, information provided by a health care professional, the invitation letter from the HRI Program Coordinator, public health nurses' introductions over the telephone, and lay person's stories. Prior experiences were utilized in cognitive processes in *forming expectations.*

Kravitz et al. (1997) compared three different approaches to the measurement of patients' expectations for medical care with in a randomized controlled trial with clients attending a clinic in a lower socioeconomic community. Participants in Kravitz et al.'s study reported more expectations by structured questionnaire than semi-structured interview. Unstructured interview questions may have been too vague for participants to be specific in their responses. These findings lend support for asking the secondary cue questions in the unstructured interview to assist participants to articulate expectations with more specificity and greater clarity for this study.

General and Specific Expectations

General and specific expectations coexisted and were stated in terms of having learned from another, guesswork based on participants' individual knowledge and experiences with nurses in other settings, and their ideas of professional behaviors or individual needs. Following participants' admission of unformed expectations, when prompted, participants responded with expectations based on a guess drawn from their previous experiences with nurses in the acute, clinic, or home settings. Kravitz (1996), in his review of expectations related to medical care visits found that expectations were both general and visit specific. Participants in this study supported that the same is true for public health nurses' home visits as indicated below.

Identified general expectations of the home visit included checking the baby, checking the environment, checking parenting, teaching infant care, and referral. These activities are overt and observable. General expectations were identified by a majority of participants.

Articulated specific expectations were based on participants' identified special needs with their infants. Primary caretakers' specific expectations for the home visit included skills or strategies and teaching to help the infant avoid aspiration of formula, manage short bowel syndrome symptoms, perform colostomy care, provide care of an infant with a ventricular shunt, supervise surgical rehabilitation, and teach techniques for comforting a colicky baby.

Missing in participants' expectations was identification of professional attributes that are covert skills. Essential skills which public health nurses utilize were neither apparent nor articulated by the participants. These include counseling, supporting clients' strengths, redefining or reframing clients' situations for improved understanding, asking questions to consider alternative strategies for solving problems, encouraging primary caretakers to set goals for their future, and other strategies. Participants perceived these skills as "just talking." Reutter and Ford (1997) and Zerwekh (1992b) identify these skills as enhancing clients' competence through a melding of shared knowledge. Public health nurses' use of these skills may have contributed to participants stating positively that their expectations were met while negative expectations were unmet.

Anxieties as Expectations

Participants expressed their anxieties or negative expectations that could be rooted in public health nurses' attitudes, behaviors, and the inconvenience of home visits to

them and their families. Since these expectations were automatic and came from participants' emotions, they concur with the definition of response expectancy theory (Kirch, 1985; 1990). Response expectancies are anticipations of one's own automatic reactions to various situations and behaviors (Kirsch, 1985). Studies demonstrate that response expectancies predict outcomes of treatment in a variety of medical and psychiatric settings.

Participants' in this study identified anticipations and perceptions of the home visit that included anxiety for their safety, because the nurse was a stranger, being judged as 'bad mother,' their homes or neighborhoods being judged as inadequate for their infants, unacceptable mood of the nurse, and home visits being an inconvenience. These negative expectations had the potential to directly influence the interaction between participants and public health nurses. However, contrary to response expectancy theory, participants' final evaluation of the home visit did not self-confirm the negative expectations they had previously stated nor did participants experience the anticipated negative responses from public health nurses (i. e., inconvenience, nurses in a bad mood, authoritarian communication styles). These anxieties highlight the confusion the public has about the role and authority of the public health nurse. Public health nurses do have the duty to protect children, and they work collaboratively with social workers in those situations. The anxiety expressed was congruent with a child protective services role rather than a public health nurse role.

Nurse Behavioral Expectations

Other visit specific expectations included expectations of professional behaviors and actions of public health nurses in arranging for and implementing the home visit.

These were prefaced with "I would like" and included human virtues and professional courtesies. These visit-specific expectations of public health nurses' demonstration of professional courtesy included making an appointment for home visits, being flexible with setting a time and date for home visits, wearing a visible identification badge when calling at the home, being available to participants by leaving a business card with the nurse's telephone number, and being respectful of participants' home and family. In this study participants identified expectations of human virtues in nurses as itemized by Kirk (1993). These included friendliness, being a good listener, being sensitive to participants' needs, being competent and knowledgeable in the care of infants, and demonstrating compassion for babies. These are ordinary human virtues or courtesies that all professional nurses need to be diligent in practicing.

Kendra & George (2001) defined risk in home visiting for field workers. However, participants in this study confirmed that they had concerns for their own safety as well as their family's safety. In this age of violence from many sources, it was important for participants in this study to see an identification badge on the nurse. One participant admitted that she notifies a relative when strangers visit her home so that they would check on her if she were not heard from in a reasonable period of time. This concern for clients' personal safety with public health nurses' home visits should be investigated further.

Reforming Expectations

Participants admitted that expectations formed before the public health nurses' home visit underwent modification over time, and, as the interaction in the home visit proceeded, the second phase of *reforming expectations* occurred. For most of the

participants, the initial expectations were unclear. During the home visit, participants perceived various events to occur. These perceptions were based on the actual face-to-face interaction during the home visit, filtered through participants' neurosensory system and cognition. Evaluation of the home visit began during the interaction and continued through out and after the home visit. In this phase of *expectation reformation*, a comparative process continued in which perceived occurrences were contrasted with participants' expectations and values. This evaluation process was further affected by other factors such as age, ethnicity, and public health nurses' behaviors and skills. The findings of this study concur with those of Wagner and Turner (1998) that while initial expectations had reciprocal, mutual effects within participants' descriptions, they further interacted to *re-form* participants' expectations as the result of the actual interaction with the public health nurse.

The Interaction

Health care literature confirms that relationships in health care contribute significantly to both the process and outcome of care (Kane, 1997). The home visit, the face-to-face interaction with public health nurses, provided the opportunity for bi-directional influence of continuing expectation *formation* and *reformation*. Turner's (1999; Wagner & Turner, 1998) theory of the sociology of emotions in the face-to-face interaction was confirmed in this study. Participants described the overt interaction between the nurse and the participant as mutually signaling and interpreting gestures that determined the flow of the interaction in the home visit. In addition, participants' descriptions identified diverse sources that influenced the reformation of their expectations. Diverse sources included demographics of participant and public health

nurse, the structure of the home visit, cultural sensitivities of the nurse, and transactions between public health nurses and participants. All these forces in the interaction came together as components of the definition of the home visit, and participants formed general and specific expectations about what would or should occur in the home visit. Emotions were aroused by the degree of congruity or incongruity between what was expected of nurses' behaviors and skills and what was experienced in the home visit situation.

Even though according to the literature, emotions are a major influence within interactions, emotional arousal was not evident during participant interviews. Initial expectations delineated anxieties before the home visit related to possible nurse qualities and actions that would offend participants. Review of the field notes made during interviews confirms that their graphic descriptions left no question in the researcher's mind that emotions were at the core of their articulated anxieties. However, participants' interactions with public health nurses disconfirmed anxieties and facilitated participants' relief and partnering with public health nurses for caring for their infants. Thus, e*xpectations* were *reformed,* replacing negative expectations with positive ones during interactions with nurses.

Reformation continued through personal reflections on the interaction that occurred during the home visit. Participants described unexpected public health nurse actions as 'surprises', yet the profession defines the identified 'surprises' as standard public health nursing practice.

Consequences of the Interaction

All participants stated that their expectations of public health nurses' home visits had been met or exceeded, and all participants reported positive experiences with public health nurses. Rover and Isenor (1988), Byrd (1997), Messner & Lewis (1996) documented the importance of the interpersonal interaction between nurse and client as a positive influence on the outcomes of public health nurses' home visits. Barkauskas (1983) related that the nurse's skills in assessing and monitoring, legitimizing and supporting, teaching, and linking to health care were essential for meeting clients' expectations and positive outcomes. Participants reported that the anticipated anxieties initially articulated were dissipated when they met and interacted with public health nurses in their homes, largely due to the competence and skill of public health nurses.

Participants also identified actions of public health nurses that were unexpected or a surprise. Besides the fact that the public health nurse did not wear a white uniform, the other surprises related to public health nurses' broader focus and concern for the primary caretaker, other family members, and future planning. Participants identified public health nurses' concerns about caretakers' health needs, birth control, time out for self-renewal, observing the baby's room, teaching about pets in the home, and smoking cessation for a family member as surprises. The fact that the public should be surprised at the preventive, encompassing focus of public health nursing, provides further evidence that public health nursing needs to be marketed as "the way to the future" (Leipert, 1996, p. 55) for primary prevention and greater visibility in health care.

During a final interview, one participant recalled and confirmed her initial anxiety. She further acknowledged that after meeting the nurse it was a non-issue. To her

surprise and delight, the public health nurse fulfilled and exceeded her expectations through her acceptance and affirmation of her skills as a primary caretaker. No participants expressed disappointment with public health nurses' home visits.

Categories of Expectations Identified

Within the interactive process of *forming expectations*, participants developed expectancies using their past experience and knowledge to form beliefs about and predict expectations of public health nurses' home visits as documented by Olson, Roese, & Zanna (1996). Expectations identified in this study met the definitive descriptions of the four categories of expectations suggested by Thompson & Sunol (1995): (a) unformed, (b) normative, (c) predicted, and (d) ideal expectations. All four categories were identified in this study in response to the primary research question. "What are your expectations of public health nurses' home visits?"

Unformed expectations occur when individuals are unable or unwilling to articulate their expectations because they do not have any, they find them too difficult to express, or they do not wish to reify their feelings due to fear, anxiety, or conformity to social norms (Bell et al., 2001; Thompson & Sunol, 1995). Most participants had never heard of a public health nurse before and were unaware that they had been enrolled in the HRI program.

Unformed expectations were prefaced with words such as "I don't know," or "I honestly don't know what to expect" or "I don't know what a public health nurse does." For example, a participant stated four times that she had no expectations. Her replies are chronicled here. "I really didn't have too many expectations. I really didn't know." The question was reframed and she responded, "Ah, I really wouldn't know." Again, "Hum, I

don't know." And her last response, "It is really hard at this point in time. I don't know what to expect. A lot is going on."

Others echoed similar responses, "I don't know what kind of service they provide," or "I have no idea," or "I have no idea what is going to be done. I didn't think to ask when the nurse called." One participant thought that checking the baby would include looking in the mouth and listening to the chest but could not identify what else would be important in checking the baby. She admitted, "But I don't know what else they can do." Whether any participants in this study refused to articulate their expectations because they were unsure or afraid of embarrassing themselves is not clear. All seemed sincere in their responses.

Normative expectations represent what should or ought to happen based on what individuals have heard or were led to believe or deduce about what should happen (Thompson & Sunol, 1995). Normative expectation is learned and is always based on a story, some prior personal experience, or media portrayal of what nursing is about. Participants own experience or a story they heard about public health nurses was referred to in their statements of expectation.

Five participants identified previous experiences with public health nurses or stories relayed by acquaintances that had had the services of a pubic health nurse. Examples of normative expectations were: "Well, one of the nurses (NICU) told me that, if her surgeries were not finished and she needed to return to the hospital for another surgery, that a nurse would be coming to my home to check on her." Another stated that the public health nurse in her introduction over the telephone spoke of her purpose for making the home visit, "She told me that she would come and just assess the babies,

weigh them, see their length. Just kind of answer any questions I may have." Another told of the public health nurse's unannounced home visit before the infant's discharge and how she had informed her. She stated

> I was just under the impressions that they (the nurse) would be coming to check on the baby, to make sure that she was doing well after her discharge from the hospital, you know, that the house was safe for her.

Predicted expectations are realistic, practical, or anticipated and match what individuals believe will happen based on their previous personal experience. Individual judgments lead to conclusions (Thompson & Sunol, 1995). Cognitive theorists label *predicted* or probability expectations as predictions about the future (Tolman, 1932, 1955; Rotter, 1966, 1982; Rescorla, 1988; Bandura, 1986; Seligman, 1975).

Predicted expectations arose from the researcher's prompts. Participants' guesses were based on their own experience with nurses in other settings. Examples follow. "I assumed that they (the nurses) would come check her breathing, check her vitals, see that her lungs are clear," or "Probably inspect the house," or "I guess to make sure we had an environment that was safe and that I was doing things right," or "Maybe they can check to see that everything is OK," or "I guess to basically see if I am doing everything alright." Predicted expectations were prefaced with words such as "I guess," "probably," "maybe," and "I assume."

An *ideal expectation* is expressed as a desire, a wish, or preferred action or outcome. Ideal expectations reflect the individual's subjective affinities or values (Thompson & Sunol, 1995). With prompting by the researcher, participants stated preferred behaviors or actions of public health nurses for the home visit. Ideal

expectations were congruent with cognitive theorists' value expectations (Tolman, 1932, 1955).

Responses that were congruent with ideal expectations in the theoretical literature covered a broad range of desires and were specific for the special needs of participants making them. Desires identified included nurse behaviors, skills, courtesies, and safety concerns for themselves and their families. Participants used words such as "I want the nurse to," "I hope the nurse will," "I prefer the nurse to," or "It is important that the nurse do," or "I think that they would come and give me information." Examples of ideal expectations follow.

> "I think it is good when they can kinda identify what you feel like because they talk to a lot of other moms. Because I know my sister had a normal baby, but it was hard for her. She cried a lot. It was her first baby. It's like she would go crazy. Then she would talk to me and she would feel better because that is how I felt with him. Ah, maybe, like them (public health nurses) understanding that how other people go through and when they talk with someone else, they could say that lot of people (moms) go through that stuff and that could help them.
>
> A mother with triplets stated her ideal expectation,
>
> I hoped they (the nurses) could come more. So, ahh, like for my kids, because it is so hard for me to take three of them to the doctor. If come I would be so thankful. I don't have to bring three of them. Hopefully, the nurse could come and visit me for the shots and something like that. Vaccinations and things like that.

Other participants stated, "I want her to tell me exactly, like, you know, like for me, he's not gaining enough, or he, you got to do something, like feed him more, change

the feeding!" and "I would expect that the nurse would listen to me and kinda talk with me about what I should look for, what is wrong," or "I would want the nurse to observe that I was tired and reschedule the visit or something."

Ideal expectations frequently related to nurse behaviors. Examples follow: "I want them to know that the baby is special to me and I want them to be nice to me and patient with me," or "I expect her to be gentle with my son," or "I want them to be more open so I can be more relaxed and not be so nervous when they are around," or "I expect that the nurse will not be condescending in any way in how I am taking care of him," or "I expect the nurse to be a good listener that can answer my questions."

In this study all four categories of expectation, unformed, normative, predicted, and ideal coexisted among most participants. It was the researcher's prompts that assisted participants to form predicted and ideal expectations.

In summary, prior research and literature on expectations provided validation for many of the dimensions of the process of *forming expectations*. Dimensions identified by participants in this study provided further richness and breadth to the knowledge available on expectations of public health nurses in the context of the home visit.

Evaluating Trustworthiness

Lincoln and Guba's (1981) criteria for establishing trustworthiness of qualitative studies were utilized. Credibility was achieved in this study through use of the constant comparative method with recorded and transcribed interview data and field notes. The findings of this study are entirely based on interview data with which the researcher had prolonged engagement. Interviews were obtained over an eleven month period and analysis continued for another 20 months. Persistent observation of participants and

environments during one to three interview sessions with participants assisted in validating nuances essential in the analysis of data. Because of the extended period for collecting and analyzing data, a member check of the final analysis results was not done with the participants. However, debriefing was achieved with two committee members and public health nurse colleagues through out the analysis. This debriefing helped guide the development of the model and the process: *forming expectations*.

Applicability was achieved through the recorded experiences of primary caretakers of high-risk infants, clients of public health nurses, thus, making the substantive theory understandable to public health nurses. General enough, the substantive theory suggested a process of forming expectations relevant for public health nurses' home visits and other home visiting programs.

Control was manifest by the adequate portrayals of the interrelationships of concepts of forming expectations and reforming expectations that describes the process of *forming expectations.* The thick description the interviews provided assists this substantive theory to articulate specifically the expectations of primary caretakers of high-risk infants from which it was derived thus making it transferable.

A dependable and confirmable audit is found in the audit trail maintained with the assistance of the QRS N6 Student Version of Nudist Software. This audit trail confirms the audit. Reflexive journaling was begun with the first interview and continued through the design of the substantive theory. These reflective journals are filed within the audit trail.

Study Challenges

Challenges for this study are similar to any study using qualitative methodology. There were five challenges related to sampling in this study that need to be recognized. These factors contributed to modifying the plan for recruitment. A purposive sample was replaced with a convenience sample due to the following challenges.

First, the recruitment protocol was challenged in a number of ways. The NICU discharge planner at one site had too great a workload. Because of her large caseload and many responsibilities, she did not have time to consult with other NICU case managers and discharge planners to identify and contact eligible primary caretakers to inform them about the study and refer those who were willing to participate. As a solution to this problem, the researcher was invited to attend the bi-monthly discharge-planning conferences. This provided the researcher with information for contacting eligible primary caretakers to describe the study and invite participation. This solution created another dilemma as it placed the researcher in a setting that identified eligible infants, but lacked certainty regarding whether or not the family would enroll in the HRI Program. The public health nurse representing the program did not have the authority to make the decision to invite the infant's enrollment, nor was the supervising public health nurse always accessible to the researcher for confirmation.

Second, the mailed invitation to recruit participants had a response rate of 26%. By the time the primary caretakers received the researcher's mailed invitation, the infant had often been discharged, and, in most cases, the public health nurse had made the home visit, thus the researcher missed the opportunity to interview before the participant had a public health nurse's home visit. Interviews with these participants may not have

generated accurate memories of initial expectations and the expectations they shared could already have been unconsciously reformed as a result of the home visit interaction.

Third, a number of participants had had visits by home health nurses, usually beginning the day after the infant was discharged. This confused participants' responses about their expectations, as they were unclear about the differences between home health nursing and public health nursing practice.

Fourth, due to discretionary funding of the HRI Program and a budget deficit, the HRI Program policies were compromised. Public health nursing staff was at a minimum and home evaluation visits were often not made prior to the infant's discharge. This reduced the potential opportunities for interviews from three to two per participant thus limiting the possibility of describing the process of *forming expectations* over time.

Finally, the sample for this study was limited to a metropolitan area of only one county in the Inland Empire of Southern California. By not including a larger number of primary caretakers of high-risk infants, these findings may not be generalizable to other public health nursing practice areas.

These challenges were overcome as data saturation was achieved with the convenience sample. Participants with differing experiences and different stages in expectation formation facilitated variation and helped to give categories precision and explanatory power for the substantive theory. Rigor resulted from these varied shared experiences.

At the beginning of analysis the researcher too quickly identified in the data the categories of expectations defined in the literature and used these categories to group themes in the data. It was only after returning to the raw data and using participants' own

words that the concepts, forming expectations and reforming expectations and their interrelationships became apparent and the two phases of the process were identified.

This study demonstrates empirical grounding as discussed by Strauss & Corbin (1998). Concepts were generated from the data. The concepts are systematically related. Conceptual linkages were formed and the categories well developed. Categories have conceptual density. Variation is built into the theory and explained a process that has been identified. The theoretical findings are significant for public health nurse home visits and other home visit venues, and, thus, are relevant to public health nursing and professional home visiting groups.

The intent of this study was to explore, describe, and explain primary caretakers' expectations of public health nurses' home visits and to determine a substantive theory of the process of *forming expectations*. Further qualitative studies are necessary to explore expectations of clients for other programs for a broader spectrum of *expectation formation* and *reformation* based on face-to-face interaction with public health nurses. More specifically there is a need to explore with participants how their expectations were reformed in the interaction with public health nurses.

Implications for Nursing Practice

This study provides a framework for the process of *forming expectations* for public health nurses' home visit to high-risk infants enrolled in a HRI Program. Participants had no expectations of public health nurse home visits. Public health nursing was invisible in their communities. Public health nursing and the nursing profession need to develop strategies to increase visibility in communities.

This study indicates that clients need knowledge of the referral in order to begin to form expectations of services that would be offered them. This lack of information about why a public health nurse is calling on a client creates a dilemma for clients forming expectations of nursing services and a challenge for public health nurses to elicit clients' expectations. In the everyday world, most health care providers do not inform clients that a referral is being made to a public health nurse for their health care follow-up. If knowledge of the referral for public health nursing services is important in forming expectations for nursing care, and thus, meeting client's health care needs, what skills are essential in eliciting client's expectations and partnering with clients for agreed interventions for positive measurable outcomes of nursing care?

Primary caretakers of high-risk infants were chosen for this study because public health nursing follow-up is planned to begin with a referral determined by a team of inpatient and community agencies, an NICU discharge planner, and an invitation to enroll in the HRI Program. Even with these protocols, most participants had no knowledge of their referral to and enrollment in the HRI Program and had formed no expectations for nursing services in their homes. Study needs to be given to improving the effectiveness of these protocols.

The findings of this study support the concept that client-nurse interactions are the core of public health nursing practice. Stories of participants acknowledged that when the needs, strengths, and expectations of clients' in the interaction during the home visit were met, negative expectations were not confirmed. Affirming clients' skills for their care giving with their infants was an important strength in public health nurses interactions that supported confirmation or disconfirmation of expectations. Participants' descriptions

of public health nurses in this study portrayed professional nurses who were sensitive to issues participants experienced and related to participants' culture, values regarding intrusion and authority figures, and needs for personal safety. These skills were important to participants and pivotal for all home visitors because they lead, in turn, to confirmation, disconfirmation, and surprises in meeting participant' expectations for nursing care. These nurse behaviors lead to positive health outcomes.

Implications for Nursing Research

The purpose of this study was to explore, describe and explain participants' expectations of public health nurses' home visits to high-risk infants. With the emergence of an innovative substantive theory on the process of *forming expectations*, new research questions were identified for study. Of primary interest is whether future qualitative studies with clients enrolled in different field services programs within this health department or different regions of the United States would have similar findings? Although this study population was selected because home visits were preplanned, in reality, participants were unaware of their enrollment in the HRI Program. Most had not received information about the program before the public health nurse contacted them. Participants, therefore, were not that different from other clients in other health department programs. Other public health nurse clients may share a process of *forming expectations* similar to that revealed in this study. Specific expectations would be the variables for future study.

Questions that still need to be answered are:

Do public health nurses elicit, evaluate and understand clients' expectations for care? If so, how does this occur?

Would increased visibility of the public health nurse in the community change clients' expectations of public health nurses' home visits?

Does prior experience with public health nurses' work change clients' expectations of public health nurses' home visits?

Does planning and providing care based on clients' expectations lead to cost-effective outcomes?

Does meeting clients' expectation for care lead to satisfaction with public health nursing care?

Does meeting clients' expectation for care lead to improved health outcomes for clients served?

More in-depth interpretive studies of how expectations are conceptualized and articulated by clients of public health nurses' home visits (Byrd, 1999; Meleis, 1997; Thompson & Sunol, 1995) are particularly needed.

Conclusion

The findings of this study suggest that *forming expectations* is an interactive process influenced by a variety of factors. In addition, the findings of this study are congruent with those of expectation research in other areas. Based on these findings, the work of the public health nurse needs to be made more visible, clients need information regarding referral before they can even develop expectations, and competent public health nurses can confirm positive expectation, disconfirm negative expectations, and surprise clients with the breath of their practice.

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Appendix A

Letters of Support

DEPARTMENT OF PUBLIC HEALTH

COUNTY OF SAN BERNARDINO
HUMAN SERVICES SYSTEM

351 North Mt. View Avenue • San Bernardino, CA 92415-0010 • (909) 387-6280
TDD (909) 387-6359 • Toll Free 1-800-782-4264

JAMES A. FELTEN, MPA
Programs Administrator

THOMAS J. PRENDERGAST, JR., MD, MPH
Health Officer

December 5, 2002

Institutional Review Board
University of San Diego
5998 Acala Park
San Diego, CA 92110-2492

Dear Chairperson:

I have reviewed the proposed study entitled "Clients' Expectations of Public Health Nurses' Home Visits" with Eva Miller RN, MS, and DNSc candidate on December 5, 2002.

I find the protocol for recruiting participants, interviewing participants and conducting the study are appropriate and within this agency's policies. The subjects are at minimal risk.

However, studies involving access to clients of the San Bernardino County Department of Public Health require clearance of the San Bernardino County Institutional Review Board. Dr. Andrew Lowe, Chairperson can be reached at (909) 580-6365. His email is lowea@armc.sbcounty.gov.

I give my permission for the study to be conducted with the primary care takers of infants enrolled in the High Risk Infant Program who are willing to participate in the study. This permission is contingent on obtaining the official clearance of the San Bernardino County Institutional Review Board.

Eva Miller has agreed to inform me of any changes recommended by your Institutional Review Board.

Sincerely,

Claudia J. Spencer, RN.MPH
Division Chief
Child, Adolescent and Family Health Services

Cc: Eva Miller

DEPARTMENT OF PUBLIC HEALTH

COUNTY OF SAN BERNARDINO
HUMAN SERVICES SYSTEM

FAMILY SUPPORT SERVICES
505 North Arrowhead Avenue, Suite 211 • San Bernardino, CA 92415-0048
(909) 388-5670 • Fax (909) 388-5685

DOUG HALLEN, MBA
Public Health Programs Administrator

THOMAS J. PRENDERGAST, JR., MD, MPH
Health Officer

November 22, 2002

Institutional Review Board
University of San Diego
5998 Acala Park
San Diego, CA 92110-2492

Dear Chairperson:

I have reviewed the proposed study entitled, "Clients" Expectations of Public Health Nurses' Home Visits" with Eva Miller RN, MS, DNSc (candidate) on November 22, 2002.

I find that the protocol for recruiting participants, interviewing participants and conducting the study are appropriate and within this agency's policies.

- The subjects are at minimal risk

Eva Miller has agreed to inform me of any recommendations for change that your group should have.

I give my permission for the study to be conducted with the primary care takers of the High Risk Infants who are willing to participate in the study.

Sincerely,

Betty Ansley
Program Manager

LOMA LINDA UNIVERSITY CHILDREN'S HOSPITAL

11234 Anderson Street
Loma Linda California 92354
(909) 824-0800

February 13, 2003

Eva Miller, RN, MS, DNSc (c)
8090 Reche Canyon Road
Colton, CA 92324

Dear Eva,

On behalf of the Nursing Research Council, I have the pleasure of informing you that your research proposal entitled, "Client's Expectations of Public Health Nurses' Home Visits" has been approved.

You may proceed at this time and submit your study to the IRB. Upon completion of your study the Council requests that you present your findings to the group.

Good luck with your project. If we can be of any further assistance please contact me. Phone: 909-558-4000 ext. 42008.

Sincerely,

Danilyn Angeles, PhD, RNC
Chairman, Nursing Research Council

Loma Linda University Children's Hospital

11234 Anderson Street
Loma Linda, California 92354
(909) 825-KIDS (5437)

17 March 2003

Office of Sponsored Research
11188 Anderson Street
Loma Linda, CA 92350

Dear Ms. Halstead,

Last week Ms. Eva Miller, RN, MS met with Dr. Garberoglio, one of our attending neonatology staff members regarding her dissertation research project entitled "Clients Expectation s of Public Health Nurses' Home Visits". She has requested permission to conduct this study with the parents of our NICU patients who might require home visits and follow up.

The study requires our NICU case management staff to identify potential subjects (patient's parents) to be enrolled in her study. Contingent on the approval of NICU nurse manager (Ms. Laurel Slater) and on the approval of NICU case management, I support this study.

Sincerely,

Ricardo Peverini, MD
Medical Director
Neonatal Intensive Care Unit
Loma Linda University University Children's Hospital

LOMA LINDA UNIVERSITY CHILDREN'S HOSPITAL

Neonatal Intensive Care Unit

11234 Anderson Street
Loma Linda, California 92354
(909) 558-4403
FAX: (909) 558-4241

March 17, 2003

Office of Sponsored Research
11188 Anderson Street
Loma Linda, CA 92350

Dear Ms. Halstead:

I have reviewed the proposed study entitled "Clients' Expectations of Public Health Nurses' Home Visits" with Eva Miller, RN, MS, DNSc Candidate..

Pending approval by your board, I give my permission for NICU case managers to recruit primary caretakers of High-Risk Infants who volunteer to enroll in the High-Risk Infant Program of San Bernardino County Department of Public Health for this study.

Sincerely,

Laurel Slater, RN
Nurse Manager
Neonatal Intensive Care Units

Appendix B

Institutional Review Board Approval Forms

ARROWHEAD
REGIONAL MEDICAL CENTER
OWNED AND OPERATED BY THE COUNTY OF SAN BERNARDINO

The Heart of a Healthy Community
400 NORTH PEPPER AVENUE ▼ COLTON ▼ CALIFORNIA ▼ 92324-1819
www.arrowheadmedcenter.org
909.580.1000

Director
Chief Executive Officer
MARK H. UFFER

Medical Director
CARL JANSEN, MD

March 18, 2003

Eva Miller, R.N.
Department of Oncology/Internal Medicine
400 North Pepper Avenue
Colton, CA 92324

APPROVED

PROTOCOL #: 03-05-00

PROTOCOLClients Expectations of Public Health Nurses' Home Visits

Dear Eva Miller, R.N.,

This is to certify that the above-referenced grant, contract or study which was submitted to the Arrowhead Regional Medical Center Institutional Review Board for consideration has been given an expedited approval with respect to the study of human subjects as adequately protecting the rights and welfare of the individuals involved, employing adequate methods of securing legally effective informed consent from these individuals, and not involving undue risk in the light of the potential medical benefits to be derived therefrom.

As a research investigator, you are responsible for the following reporting requirements:

- You are responsible for reporting research progress to the IRB at one-year intervals. You will be sent a questionnaire that is to be completed and returned in a timely manner.
- You are responsible for promptly reporting immediately to the IRB any serious adverse reactions, events or complications, at any site which may occur as a result of this study.
- You are responsible for promptly reporting to the IRB proposed changes in a research activity.
- You are responsible for notifying the IRB of study completion or study termination.

Human subjects research activity approved from March 14, 2003 to March 13, 2004.

Sincerely,

Andrew Lowe, PharmD., Chair
Institutional Review Board

AL:sg

Appendix C

Protocol for Recruitment of Potential Participants
for Research Study

1. Criteria for Invitation to Parents/Primary Caretakers of High-Risk Infants:

   A. Voluntary enrollment in San Bernardino County Department of Public Health High-risk Infant Program (HRI).

   B. No previous experience with a HRI Program.

   C. Speaks English fluently enough to share personal experiences.

   D. Resides within a 30-mile radius of Arrowhead Regional Medical Center (ARMC), and Loma Linda University Children's Hospital (LLUCH).

2. Responsibilities of NICU Case Manager/Discharge Planner

   A. Screen enrollees in SBCDPH HRI Program using the above inclusion criteria.

   B. Inform parents/primary caretakers meeting the above inclusion criteria of the research study with the following script:

Eva Miller, a nursing doctoral student, is studying what parents/primary caretakers of high-risk infants expect of nurses who make home visits. She is interested in your ideas and viewpoint about public health nurses' care giving in the home so that public health nurses can make better home visits. She has the support of the San Bernardino County Department of Public Health for the study.

The doctoral student would meet with you three times. The first time would be before the public health nurse visits. The second time would be after the nurse has visited you, but before the baby comes home from the hospital. The third time would be after the baby comes home from the hospital. She would ask you questions about your expectations and your experiences with home visits. There are no right or wrong answers.

She is willing to arrange with you convenient times and places to meet for the interviews. This information sheet gives you more specifics about the study. I will let you review it and come back to learn your decision. (Allow adequate time to read.)

LATER: May I call the researcher (Eva Miller) to come over and talk to you today or give her your name and telephone number so you may ask your questions of her and arrange for your participation in the study?

3. If answer is YES, call primary investigator (PI) to come to the hospital to verbally invite participation (Appendix H) or provide PI with the names and telephone numbers of potential participants and days and times they visit the infant in the hospital (Appendix F).

4. If answer is MAYBE but would like to think about it, may present Invitation Letter (Appendix D), cover letter from Supervising Public Health Nurse, HRI Program, SBCDPH (Appendix G), information sheet (Appendix E), and interest in taking part in study form (Appendix F). Encourage individual to decide within one week and call PI or mail interest in taking part in study form to PI in self-addressed, stamped envelope.

5. P I will provide to the case managers/discharge planner:

   A. Supply:

      1. Information Sheets (Appendix E) for further detail about study.
      2. Interest in Taking Part in Study form (Appendix F) for recording contact information of interested individuals to be shared with PI.

   B. Packets with the following stapled together:

      1. Written invitations to participate (Appendix D).
      2. SBCDPH, HRI Program Supervising Public Health Nurse cover letter (Appendix G).
      3. Information Sheet (Appendix E).
      4. Interest in Taking Part in Study form (Appendix F).
      5. Self-addressed, stamped envelopes.

6. After the Discharge Planning Conference and the voluntary enrollment of the infant in the HRI Program by the parents/primary caretakers, the PI will check with case manager/discharge planner regularly at an agreed upon time and place to monitor the process and obtain consenting individuals names and telephone numbers.

7. Contact:
   Eva Miller at (909) 825-3175 (home) or
   (909) 558-1000, extension 45431 (work);
   FAX: (909) 558-4134 Campus: 44134
   E-mail: eva.miller@worldnet.att.net

Thank you for your support and assistance on behalf of public health nursing research!

Appendix D

Mailed Letter of Invitation to Participate in Research Study

Dear Parent of a High-risk Infant,

I am a doctoral nursing student at the Hahn School of Nursing and Health Science, University of San Diego. I am conducting an important study to learn what parents of high-risk infants expect of nurses who make home visits.

You are invited to take part in this important research study. Your ideas and viewpoint are very important and will help Public Health Nurses. Your Public Health Nurse will not know that you are in this study or what you have told me. The information from the parents participating in the study may help Public Health Nurses do a better job with home visits they make.

If you decide to take part in this research study, I will be talking with you three times. The first time will be before the nurse has visited your home. The second time will be after the nurse has visited you, but before your baby has come home from the hospital. The third, and last, time I talk with you will be after your baby has come home from the hospital. The attached Information Sheet may be helpful to you.

Thank you for reading this letter. I hope to hear from you as soon as possible. You may call me or fill in the blanks of the enclosed form. Place the form in the enclosed self-addressed stamped envelope and mail it. Your responses and story are important to the success of this research. My telephone number is (909) 825-3175 and my E-mail address is eva.miller@worldnet.att.net.

Sincerely,

Eva Miller, RN, MS, DNSc(c)
Principal Field Researcher

Appendix E

Information Sheet

Purpose of the Study

The purpose of this research study is to learn what you expect of the public health nurse who comes to your home to give nursing care and your story about that experience.

Procedure

I will talk with you three (3) times: one time before the nurse comes to see you at your home, once after the nurse sees you but before the baby comes home, and once after your baby comes home. You may choose the day, the time, and the place for each time we talk. I will come to you.

The first two times we meet will take a little under an hour each time. The third time may take an hour or a bit longer. This adds up to be 2-3 hours of your time over a 2-3 week period.

I will ask questions and tape-record your words so I do not have to write while we talk. There are no right or wrong answers to my questions. Each tape-recording will be typed just as you say your words so I may study them for meaning. Only dissertation committee members and I will hear the taped-recordings.

At the end of the study you may be invited to a group meeting of other parents who shared their stories for the study. The researcher will share what she learned from all the stories. You do not have to come.

Your rights and privacy will be protected at all times.

Your Rights

You may choose not to take part in this study. Your decision either to take part or not to take part will not affect your service from San Bernardino County Department of Public Health or the High-risk Infant Program. The Public Health Nurse will not know of your decision or the information you share for the study.

You may drop out of the study at any time without any negative affects to you or your baby. If at any time you decide to drop out, what you have told me will be destroyed and not included in the study.

Informed Consent: When the researcher receives the enclosed form (or a call from you), she will call you for an appointment to answer your questions about the study. All questions about the study, your rights and privacy must be answered to your satisfaction before you sign to give consent to talk with the researcher.

Privacy: Code numbers will be assigned to each tape, computer diskette, and transcribed story. The list with your name and code numbers, and signed consents will be locked in a different safe place than the coded tapes, computer diskettes, and transcribed stories to protect your privacy. Only the researcher and her dissertation committee members will read your story.

Information shared during the interviews will not be shared with the Public Health Nurse. Care will be taken that you can not be identified in the reporting or publishing of the findings.

The story you share is private except information that suggests possible child abuse. In this case, as a nurse, the researcher is required by law to report this information to Child Protective Services. Anyone reported will not remain in the study. All information shared before the report was made will be removed and destroyed.

Possible Risks: There is minimal risk to you and no risk to your baby. You may get tired because of the length of the interviews. If this happens the interview will be stopped and resumed at your convenience.

Potential Benefits: While you may not benefit personally, the information you share may help other families to have a good experience with Public health nurses.

A gift certificate from Wal-Mart will be given at the end of the third interview in appreciation for your time and the knowledge that you shared.

Costs: There are no costs to you.

Contact Person:

Eva Miller, RN, MS, DNSc(c)
Telephone: (909) 825-3175 or (909) 558-1000, extension 45431
E-mail: eva.miller@worldnet.att.net

Appendix F

Interest in Taking Part in Study
"Clients' Expectations of Public Health Nurses' Home Visits"

☐ Please call me. I have questions._____
Name

_____
Telephone Number

_____
Date

☐ I would like to be a part of your research study.

_____
Name

_____
Telephone number

I visit at the hospital on the following days of the week. Please circle.

Sunday Monday Tuesday Wednesday Thursday Friday Saturday

Time of Day _____
(Please write in)

Should you move or change your telephone number, please share the name and telephone number of someone who would know where I might find you:

_____
Name Telephone Number

Call, FAX, or place this filled in page in the enclosed self-addressed, stamped envelope and mail to:

Eva Miller
School of Nursing
Loma Linda University
Loma Linda, CA 92350
Phone: (909) 825-3175
FAX # (909) 558-4134; E-mail: **eva.miller@worldnet.att.net**

Appendix G

Cover Letter for Mailed Invitation

DEPARTMENT OF PUBLIC HEALTH

COUNTY OF SAN BERNARDINO
HUMAN SERVICES SYSTEM

FAMILY SUPPORT SERVICES
505 North Arrowhead Avenue, Suite 211 • San Bernardino, CA 92415-0048
(909) 388-5670 • Fax (909) 388-5685

JAMES A. FELTEN, MPA
Public Health Programs Administrator

THOMAS J. PRENDERGAST, JR., MD, MPH
Health Officer

April 10, 2003

Dear Parent of a High-risk Infant,

We at the Department of Public Health are always looking for ways to improve the services we provide. A nursing doctoral student has offered to gather information for us as part of her research study. At the end of the research study she will then tell us what types of service people expect from Public Health. This will help us to improve the services we provide. All people in the study will be anonymous.

Please read the letter and information sheet from this doctoral student. If you agree to be in the research group, please contact her. Please do not contact Public Health about the study or tell your Public Health Nurse that you are in the study. We should not know if you are in the study.

If you do not wish to be in the study, please discard the letters and the information sheet.

Thank you for allowing Public Health to be of service.

Sincerely,

DeAnne Nevarez
Supervising Public Health Nurse
High Risk Infant Program

Appendix H

Primary Investigator's Verbal Invitation to Participate

Hello!

My name is Eva Miller. I am a doctoral student at the University of San Diego, Hahn School of Nursing and Health Science.

I am studying what parents of high-risk infants expect of nurses who make home visits.

I hope you will agree to be part of this study. Your ideas and viewpoint are very important and will help public health nurses make better home visits. Your public health nurse will not know that you are in the study or what you have told me.

Being in this study would involve meeting with me three times. The first time would be before the public health nurse comes to your home; today, if you have time. The second time would be after the nurse has visited you, but before the baby comes home from the hospital. The third time I meet with you will be after your baby has come home from the hospital. I would ask you questions about what you expect when the nurse visits and your experiences with the public health nurse. There are no right or wrong answers.

The first two times we talk will take 30–45 minutes. The third time may take an hour to an hour and a half. The total time required would be two-three hours over a 2-3 week period. These meetings would take place at a place convenient to you.

I hope you will be able to take part in this study. Your input would be very helpful in my study.

If the potential participant is interested:

1. Review Information Sheet (Appendix E).
2. Answer questions about the study.
3. Review and obtain signature on Informed Consent Form (Appendix I).
4. If client has time, conduct interview #1, otherwise, make an appointment.
5. Make arrangements for client to call PI when PHN makes first visit. (or ask the PHNs to call PI after the visit, since clients are apt to forget).

If not interested:

1. Ask if they would like to think about it. If, YES;
2. Give Information Sheet (Appendix E).
3. Give Interest in Taking Part in Study form that may be mailed (Appendix F).
4. Call them back for a decision within one week
6. Encourage to make-up mind soon (within the week).

Appendix I

Informed Consent Form

Arrowhead Regional Medical Center (ARMC)

Clients' Expectations of Public Health Nurses' Home Visits

This form is called an "informed consent form." Its purposes are to inform you about a nursing research project and invite you to consent to participate in the project. You should read the form carefully and ask questions before you decide whether or not to participate in the project. You may take as much time as you like to make up your mind on whether or not to participate.

In the research project we hope to learn what people expect of public health nurses visiting in their homes and their experiences with the home visit. You were selected as a possible participant because you have chosen to enroll your baby in the High Risk Infant Program of the San Bernardino County Department of Public Health. This program provides the researcher with the opportunity to speak with you before and after you have any contact with a public health nurse. Your story will help public health nurses make better home visits. The principal investigator is Eva Miller, a doctoral student of the Hahn School of Nursing and Health Science, University of San Diego. You may call her at (909) 825-3175, if you have more questions at a later time. You may also call her dissertation chairperson, Dr. Mary Jo Clark at 1- (619) 260-4574 if you have concerns about this study.

You should know the following information about the project:

If you take part in this study, Eva Miller will interview you at three separate times about what you expect during the nurse's visit and what happened during the visits. The interviews will be tape-recorded and will take place at a date, time, and place you chose. She will come to you. The first interview will take place before the public health nurse makes the first home visit and will take 30-45 minutes. The second interview will take place after the public health nurse makes the first home visit, and before your baby comes home and will take 30-45 minutes. The third interview will take place after your baby comes home and the public health nurse has made a visit to the baby. This interview will take approximately 60-90 minutes. You may also be invited to attend a group meeting with other parents to hear the researcher's findings and share your thoughts about them. You do not have to come to this meeting.

_____

Participant Initials

_____

Date

Informed Consent to Participate in a Research Study of Clients' Expectations of Public Health Nurses' Home Visits

The total time needed for the three interviews is estimated to be 2-3 hours within a 2-3 week period. An additional 60-90 minutes would be added if you choose to attend the group session at the end of the study.

Any information you provide during the interviews will be kept private. The only exception is information that suggests possible child abuse. The researcher is required by law to report this information to Child Protective Services. If this should happen, you will be excluded from the study and information that you have shared with the researcher will be destroyed.

Tape recordings, interview transcripts, and computer diskettes will be coded with a number. Your name will not appear on any of them. They will be kept in the researcher's locked files separate from the signed consent form and the code assignment sheet. Only the researcher will have access to the separate file that identifies you by name. Members of the dissertation committee will listen to a sample of the coded tape recordings and read your coded stories with the researcher. Care will be taken that your identity is not shared and identifiers in your stories removed from the transcripts. You may review a typed copy of your interview and remove any information, if you wish to do so. When study results are reported, the names of persons taking part in the study will not be used.

Taking part in this study is voluntary. You may withdraw from the study at any time without negative consequences or prejudice to you or your baby. If you choose not to take part, or to withdraw from the study, services you and your family receive from San Bernardino County Department of Public Health, including the High Risk Infant Program, will not be affected.

There is minimal risk to you and no risk your baby. You may get tired during the interview. If this happens, the interview will be stopped and re-scheduled at your convenience. While there is no personal benefit, sharing your story may benefit other parents by helping public health nurses to make better home visits. A gift certificate will be given to you after the third interview in appreciation of your time and knowledge.

_____

Participant Initials

_____

Date

Informed Consent to Participate in a Research Study of Clients' Expectations of Public Health Nurses' Home Visits

Sharon Gautier, RN is an impartial third party who is not associated with this study. You may address complaints or questions about the study to this person, who may be contacted at Arrowhead Regional Medical Center, 400 North Pepper Avenue, Colton, CA 92324, Telephone Number: (909) 580-6365.

In signing this form, you agree to take part in the research study described above. There is no agreement written or verbal beyond that expressed on this consent form.

You will be given a copy of the Experimental Subject's Bill of Rights to keep. You will be given a copy of this consent form to keep.

You are making a decision whether or not to participate in a research study. Your signature on the informed consent form indicates that you have read and understand the information provided in this form, that you have been verbally informed about the study, that you have had a chance to ask questions, that you have been given a copy of the experimental subject's bill of rights, that you have decided to participate, and that you consent to the procedures or treatment described above.

I, the undersigned, understand the above explanations and, on that basis, I give consent to my voluntary participation in this research.

Signature Date and Time

Witness Signature Date and Time

The undersigned hereby certifies that she has discussed the research project with the participant and has explained all of the information contained in this informed consent form to the participant, including the experimental subject's bill of rights. The participant was encouraged to ask questions and all questions were answered.

Principal Investigator Signature Date and Time

Informed Consent to Participate in a Research Study of Clients' Expectations of Public Health Nurses' Home Visits

_____ Check here if you would like to take part in the group meeting. (If yes, please provide a phone number where you can be reached.)

_____

Phone

_____

Participant's Initials

_____

Date

Appendix J

Arrowhead Regional Medical Center

Experimental Subject's Bill of Rights

ARROWHEAD REGIONAL MEDICAL CENTER
EXPERIMENTAL SUBJECT'S BILL OF RIGHTS

You have been asked to participate as a subject in an experimental procedure. Before you decide whether you want to participate in the experimental procedure, you have a right to:

1) Be informed of the nature and purpose of the experiment;

2) Be given an explanation of the procedures to be followed in the medical experiment, and any drug or device to be utilized;

3) Be given a description of any discomforts and risks reasonably to be expected from your participation in the experiment;

4) Be given an explanation of any benefits reasonably to be expected from your participation in the experiment;

5) Be given a disclosure of any appropriate alternative procedures, drugs or devices that might be advantageous to you; and their relative risks and benefits;

6) Be informed of the avenues of medical treatment, if any, available to you after the experimental procedure if complications arise;

7) Be given an opportunity to ask any questions concerning the medical experiment or the procedures involved;

8) Be instructed that consent to participate in the experimental procedure may be withdrawn at any time and that you may discontinue participation in the medical experiment without prejudice;

9) Be given a copy of this form and the signed and dated written consent form; and

10) Be given the opportunity to decide to consent or not to consent to the medical experiment without the intervention of any element of force, fraud, deceit, duress, coercion, or undue influence on your decision.

I have carefully read the information contained above and I understand fully my rights as a potential subject in a medical experiment involving people as subjects.

Date: _____ Time: _____ AM/PM

Signature: _____
(patient/parent/conservator/guardian)

Signature: _____
(parent/legal guardian)

If signed by other than patient, indicate relationship: _____

_____ _____
Witness Date and Time

A COPY OF THIS FORM MUST BE GIVEN TO THE PATIENT.
THE ORIGINAL MUST BE PLACED IN THE MEDICAL RECORD.

Appendix K

Notices of Privacy Practices

SAN BERNARDINO COUNTY DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

EFFECTIVE APRIL 14, 2003

Your health information is personal and private, and we must protect it. This notice tells you how the law requires or permits us to use and disclose your health information. It also tells you what your rights are and what we must do to use and disclose your health information.

We must by law:

- keep your health information (also known as "protected health information" or "PHI") private
- give you this Notice of our legal duties and privacy practices regarding your PHI
- obey the terms of the current Notice in effect

Changes to this Notice: We have the right to make changes to this Notice and to apply those changes to your PHI. If we make changes, you have the right to receive a copy of them in writing. To obtain a copy, you may ask your service provider or any DBH staff person.

HOW THE LAW PERMITS US TO USE AND DISCLOSE INFORMATION ABOUT YOU

We may use or give out your health information (PHI) for treatment, payment or health care operations. These are some examples:

- **For Treatment:** Health care professionals, such as doctors and nurses working on your case, may talk privately to determine the best care for you. They may look at health care services you had before or may have later on.

- **For Payment:** We need to use and disclose information about you to get paid for services we have given you. For example, insurance companies ask that our bills have descriptions of the treatment and services we gave you to get payment.

- **For Health Care Operations:** We may use and disclose information about you to make sure that the services you get meet certain state and federal regulations. For example, we may use your protected health information to review services you have received to make sure you are getting the right care.

USES AND DISCLOSURES THAT DO NOT NEED YOUR AUTHORIZATION

- **To Other Government Agencies Providing Benefits or Services:** We may give information about you to other government agencies that are giving you benefits or services. The information we release about you must be necessary for you to receive those benefits or services.

- **To Keep You Informed:** We may call or write to let you know about your appointments. We may also send you information about other treatments that may be of interest to you.

- **Research:** We may give your PHI to researchers for a research project that has gone through a special approval process. Researchers must protect the PHI they receive.

- **As Required by Law:** We will give your PHI when required to do so by federal or state law.

- **To Prevent a Serious Threat to Health or Safety:** We may use and give your PHI to prevent a serious threat to your health and safety or to the health and safety of the public or another person.

- **Workers' Compensation**: We may give your PHI for worker's compensation or programs that may give you benefits for work-related injuries or illness.

- **Public Health Activities**: We may give your PHI for public health activities, such as to stop or control disease, stop injury or disability, and report abuse or neglect of children, elders and dependent adults.

- **Health Oversight Activities**: We may give your PHI to a health oversight agency as authorized by law. Oversight is needed to monitor the health care system, government programs and compliance with civil rights laws.

- **Lawsuits and Other Legal Actions**: If you have a lawsuit or legal action, we may give your PHI in response to a court order.

- **Law Enforcement**: We may give your PHI when asked to do so by law enforcement officials:
    - In response to a court order, warrant, or similar process;
    - To find a suspect, fugitive, witness, or missing person;
    - If you are a victim of a crime and unable to agree to give information
    - To report criminal conduct at any of our locations; or
    - To give information about a crime or criminal in emergency circumstances.

- **Coroners and Medical Examiners:** We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

- **National Security and Intelligence Activities**: We may give your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

- **Protective Services for the President and Others**: We may give your PHI to authorized federal officials so they may protect the President and other heads of state or do special investigations.

Other uses and disclosures of your PHI, not covered by this Notice or the laws that apply to us, will be made only with your written authorization. If you give us authorization to use or give out your PHI, you can change your mind at any time by letting your service provider know in writing. If you change your mind, we will stop using or disclosing your PHI, but we cannot take back anything already given out. We must keep records of the care that we gave you.

YOUR RIGHTS ABOUT YOUR PROTECTED HEALTH INFORMATION (PHI)

- **Right to See and Copy**: Federal regulations say that you have the right to ask to see and copy your PHI. However, psychiatric and drug and alcohol treatment information is covered by other laws. Because of these laws, your request to see and copy your PHI may be denied. You can get a handout about access to your records by asking your health care provider.

  DPH medical staff will approve or deny your request. If approved, we may charge a fee for the costs of copying and sending out your PHI. We may also ask if a summary, instead of the complete record, may be given to you.

  If your request is denied, you may appeal and ask that another DPH doctor review your request.

- **Right to Ask for an Amendment**: If you believe that the information we have about you is incorrect or incomplete, you may request changes be made to your PHI as long as we maintain this information. While we will accept requests for changes, we are not required to agree to the changes.

  We may deny your request to change PHI if it came from another health care provider, if it is part of the PHI that you were not permitted to see and copy, or if your PHI is found to be accurate and complete.

- **Right to Know to Whom We Gave Your PHI:** You have the right to ask us to let you know to whom we may have given your PHI. Under federal guidelines, this is a list of anyone that was given your PHI not used for treatment, payment and health care operations or as required by law mentioned above.

  To get the list, you must ask your service provider in writing for it. You cannot ask for a list during a time period over six years ago or before April 14, 2003. The first list you

ask for within a 12-month period will be free. For more lists, we may charge you for the cost of copying and sending the list. We will let you know the cost, and you may choose to stop or change your request before it costs you anything.

- **Right to Ask Us to Limit PHI:** You have the right to ask us to limit the PHI that the law lets us use or give about you for treatment, payment or health care operations. *We don't have to agree to your request.* If we do agree, we will comply with your request unless the PHI is needed to give you emergency treatment.

  To request limits, you must ask your service provider in writing. You must tell us (1) what PHI you want to limit; (2) whether you want to limit its use, disclosure or both; and (3) to whom you want the limits to apply.

- **Right to Ask for Privacy:** You have the right to ask us to tell you about appointments or other matters related to your treatment in a specific way or at a specific location. For example you can ask that we contact you at a certain phone number or by mail. To request that certain information be kept private, you must ask your service provider in writing. You must tell us how or where you wish to be contacted.

- **Right to a Paper Copy of This Notice:** You may ask us for a copy of this Notice at any time. Even if you have agreed to receive this Notice by e-mail, we will give you a paper copy of this Notice. You may ask any DPH staff person for a copy.

COMPLAINTS

If you believe your privacy rights have been violated, you may submit a complaint with us or with the Federal Government.

Filing a complaint will not affect your right to further treatment or future treatment.

To file a complaint with the Department of Public Health, contact:	**To file a complaint with the County Complaint Officer, contact:**
Office of HIPAA Compliance **351 North Mt. View Avenue** **San Bernardino, CA 92415** **Phone # (909) 387- 6222** **Fax # (909) 387- 6228** **E-mail: hipaa@dph.sbcounty.gov**	**Jim Pesta , Ethics Resource Officer** **504 North Mountain View Avenue** **San Bernardino, CA 92415-0038** **Phone # (909) 381-7960** **Fax # (909) 388-4281** **E-mail: jpesta@hss.sbcounty.gov or ethics@hss.sbcouty.gov**

To file a complaint with the Federal Government, contact: Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights, Attention: Regional Manager, 50 United Nations Plaza, Room 322, San Francisco, CA 94102

For additional information call (800) 368-1019 or (866) 627-7748 or fax the U.S. Office of Civil Rights at (415) 437-8329 or (866) 788-4989 TTY or (415) 437-8311 TDD.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of the Notice of Privacy Practices, which explains my rights and the limits on ways in which the County may use or disclose personal health information to provide service.

_____ _____

Client Name (printed) *Client Signature*

Date _____ _____

If signed by other than client, indicate relationship.

Note: ***Parents must have legal custody. Legal guardians and conservators must show proof.***

OFFICE USE ONLY

Client did receive the Notice of Privacy Practices but did not sign this Acknowledgement of Receipt because:

- ☐ Client left office before Acknowledgement could be signed.
- ☐ Client does not wish to sign this form.
- ☐ Client cannot sign this form because: _____

_____

Client did not receive the Notice of Privacy Practices because:

- ☐ Client required emergency treatment.
- ☐ Client declined the Notice and signing of this Acknowledgement.
- ☐ Other: _____

_____

Name: _____

(Print name of provider or provider's representative)

Signed: _____

(Signature of provider or provider's representative)

45 CFR §164.520 Except in an emergency situation, ... make a good faith effort to obtain written acknowledgment of receipt of the Notice.... and if not obtained, document...good faith efforts to obtain such acknowledgment and the reason why...(it)...was not obtained.

ACKNOWLEDGEMENT OF NOPP

County of San Bernardino
DEPARTMENT OF PUBLIC HEALTH

NAME:

DOB:

PROGRAM:

INSTITUTIONAL REVIEW BOARD
Authorization for Use of Protected Health Information (PHI)

OSR#53083
194

Per 45 CFR §164.508(b)

OFFICE OF SPONSORED RESEARCH
Loma Linda University • 11188 Anderson Street • Loma Linda, CA 92350
(909) 558-4531 (voice) / (909) 558-0131 (fax)

TITLE OF STUDY: Clients' Expectations of Public Health Nurses' Home Visits

PRINCIPAL INVESTIGATOR: Eva J. Miller

Others who will use, collect, or share PHI: None

The study named above may be performed only by using personal information relating to your health. National and international data protection regulations give you the right to control the use of your medical information. Therefore, by signing this form, you specifically authorize your medical information to be used or shared as described below.

The following personal information, considered "Protected Health Information" (PHI) is needed to conduct this study and may include, but is not limited to: name, sex, age, ethnic/cultural background, martial/family status, family composition, and previous experience with a public health nurse.

The individual(s) listed above will use this PHI in the course of this study or share it with the Institutional Review Board (IRB) of Loma Linda University, the sponsor of the study LLU School of Nursing and its affiliates, government agencies such as the Food and Drug Administration (FDA), other research sites involved in this study, health care providers who provide services to you in connection with this study, central labs, central review centers and central reviewers.

The main reason for sharing this information is to be able to conduct the study as described earlier in the consent form. In addition, it is shared to ensure that the study meets legal, institutional, and accreditation standards. Information may also be shared to report adverse events or situations that may help prevent placing other individuals at risk.

All reasonable efforts will be used to protect the confidentiality of your PHI, which may be shared with others to support this study, to carry out their responsibilities, to conduct public health reporting and to comply with the law as applicable. Those who receive the PHI may share with others if they are required by law, and they may share it with others who may not need to follow the federal privacy rule.

Subject to any legal limitations, you have the right to access any protected health information created during this study. You may request this information from the Principal Investigator named above but it will only become available after the study analyses are complete.

This authorization does <u>not</u> expire, and will continue indefinitely unless you notify the researchers that you wish to revoke it. You may change your mind about this authorization at any time. If this happens, you must withdraw your permission in writing. Beginning on the date you withdraw your permission, no new personal health information will be used for this study. However, study personnel may continue to use the health information that was provided before you withdrew your permission. If you sign this form and enter the study, but later change your mind and withdraw your permission, you will be removed from the study at that time. To withdraw your permission, please contact the Principal Investigator at (909) 825-3175.

You may refuse to sign this authorization. Refusing to sign will not affect the present or future care you receive at this institution and will not cause any penalty or loss of benefits to which you are entitled. However, if you do not sign this authorization form, you will not be able to take part in the study for which you are being considered.

.....

I agree that my personal health information may be used for the study purposes described in this form.

Signature of Patient *or* Patient's Legal Representative	Date
Printed Name of Legal Representative (if any)	Representative's Authority to Act for Patient
Signature of Person Obtaining Authorization	Date

Appendix L

Interview Guide

Interview #1: Prior to public health nurse home visit before infant discharge at an arranged convenient time and place.

a. Demographic data: age, gender, ethnic/cultural background, marital/family status (mother or primary caretaker), family composition, previous experience with a public health nurse.

b. You have a new baby who has had to stay in the hospital for a while. Before the baby comes home, a nurse will be coming to visit you.

   Why do you think the nurse is coming to see you?

c. What do you expect the nurse to do during the visit?

d. What do you expect to gain from the visit?

e. Has anyone talked with you about home visit services? If so, what did they tell you?

Interview #2: After the public health nurse's home evaluation visit (at a convenient time and place).

a. Tell me about the home visit. What did the nurse do?

b. Was the visit similar to what you expected?

c. What do you expect of the next home visit?

Interview #3: Following the public health nurse home visit after the infant's discharge (at a convenient time and place, may be the home).

a. Did the nurse do what you expected him/her to do?

b. What didn't he or she do that you expected?

c. What did he or she do that you didn't expect?

d. Is there anything else about the nurse's visit that you would like to tell me?

Appendix M

Secondary Cues

Tell me about yourself and your baby.

What do you think the nurse will do?

Do (Did) you have ideas about what the nurse's visit is (was) going to be like?

You mentioned 'checking out the baby'. How do you think the nurse will do that?

What were your thoughts when the doctor/nurse/social worker told you that a nurse would be coming to your home?

Tell me about the home visit. What did the nurse do?

How did the experience compare with the ideas you had before the nurse came? Say more.

Did the nurse do what you expected him or her to do?

Was there anything you liked about the nurse or what she did?

Was there anything you disliked or didn't expect?

Sounds like you are expecting her to do an examination of the baby. What kinds of information do you expect to get about the baby?

What are your expectations of the public health nurse's personal qualities?

What expectations do you have regarding the nurse's ability to recognize your individual qualities and needs?

What expectations do you have about reaching the public health nurse when you have questions?

What actions/courtesies do you expect of the nurse coming to your home?

What expectations do you have for the nurse's dress?