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UNIVERSITY OF SAN DIEGO
Hahn School of Nursing and Health Science
DOCTOR OF PHILOSOPHY IN NURSING

KEEPING SAFE:
FIELD PUBLIC HEALTH NURSES' PERCEPTIONS

by

Karen Nielsen-Menicucci, MS, RN, PHN

A dissertation presented to the
FACULTY OF THE HAHN SCHOOL OF NURSING AND HEALTH SCIENCE
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In partial fulfillment of the
requirements for the degree
DOCTOR OF PHILOSOPHY IN NURSING

April 7, 2004

Dissertation Committee

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Abstract

By the year 2005, there will be an estimated 1.25 million workers involved in providing nursing care to individuals in their homes (Bureau of Labor Statistics, 1997). There is limited empirical data available on the issue of safety of nurses within the context of home visiting or in the public health venue. Recent research on safety in home visiting has focused on home health rather than public health nursing. The purpose of this study was to explore and explain the perception of safety among field public health nurses. A purposive sample of 19 public health nurses employed in an official public health department in Southern California participated in semi-structured interviews. Participants in this study had an average age of 45.2 years and an average length of public health nursing practice of 10.5 years. This study used grounded theory research methodology. Findings of this study have provided a substantive explanation on the process of *keeping safe* for field public health nurses. This process had three stages, (a) risk awareness, (b) risk estimation, and (c) risk limitation. Public health nurses maintained risk awareness through vigilance. Universally, the nurses in this study were vigilant regarding idle young men, dogs, suspicious and threatening behavior, substance abuse, angry family members, and communicable diseases. Risk estimation involved the nurses' estimation of their own vulnerability and safety decision-making. The final stage of the emerging theory constituted the actions taken by the nurse while *keeping safe*. Risk limitation were actions that either prevented or avoided actual or perceived risks. The process of *keeping safe* continued to evolve for public health nurses with the influence of peer and supervisory support, family, feelings, and vicarious knowledge. The findings of this study have implications for

nursing education, practice, and research. The need to educate students and novice public health nurses on the process of *keeping safe* is of particular importance.

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(* deceased)

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CHAPTER 1

AIM OF THE STUDY

Phenomenon of Interest

The health care industry, which supplies nurses and other home care workers, is one of the largest and fastest growing segments of the U.S. economy. It is estimated that by the year 2005, there will be over 1.25 million workers involved in providing nursing care to individuals in their homes (Bureau of Labor Statistics, 1997). Included in this number are those nurses who provide public health nursing services to communities, aggregates, and individuals.

In 1994, injury rates for workers from this subgroup were 50% higher than for those who worked in hospitals or institutional settings. Multiple sources of injury were cited in these statistics. Even when highway-related injuries were excluded from the totals, the home health care injury rate still exceeded the hospital rate by almost 25% (Bureau of Labor Statistics, 1997). In subsequent years, statistics showed that nurses who have fatal occupational injuries are more likely to have died from a transportation incident. Over 64% of all deaths were from highway events. Assault and violent acts were cited as the second cause of occupational death for nurses (Bureau of Labor Statistics, 1999).

General population incidence rates of violent crime were at all time highs from 1988 to 1997. In 1999, these rates decreased slightly and returned to pre-1985 levels. Attempted and forcible rape rates have continued to exceed those from the 1980's. Metropolitan and urban areas in the United States continue to experience high rates of violent crime. Rates for aggravated assault and robberies are particularly high in these areas (U.S. Census Bureau, 2001).

Safety is a high priority in the discipline of nursing. Researchers have extensively studied injury prevention within clinical settings, infection control, violence prevention, and safety of patients (e.g., Becker, 2000; Gordon, 1999; Pratt, Runyan, Cohen, & Margolis, 1998; Rogers & Maurizio, 1993; Tilden et al., 1994). Studies have not, however, sufficiently addressed ways to provide for the safety of the nurse in all health care settings. Research on the issue of safety in public health field nursing is particularly lacking. This is unsettling since our current society has seen an increase in traffic congestion, violence, gangs, and crime.

Population rates have increased dramatically, and the cultural mix in communities has changed (U.S. Census Bureau, 2001). With these changes, nurses should not assume that they fully understand the populations with whom they work. There may be additional and more complex dimensions to safety in public health nursing that have not been identified by the current literature, limited as it is. Antecedents to safety and interventions to prevent injury in the field cannot be adequately or appropriately studied without a comprehensive description of current issues. Therefore, without additional research these dimensions cannot be fully explored, explained, or controlled.

Perceived Justification for Studying the Phenomenon

Public health nurses provide care to multiple populations (Allender & Spradley, 2001; American Public Health Association, Public Health Nursing Section, 1996; Clark, 2003). They function independently in multiple settings and most of their time is spent in communities and the homes of clients. Because public health nurses practice in the community, issues of safety need to be determined and explored. Past research has not addressed these issues.

Although there is some empirical data available on the issue of safety of nurses in general, very little is known about this topic within the context of home visiting or in the public health venue specifically. In fact, the majority of recent research that has been completed on safety in home visiting has focused on home health nursing rather than public health nursing (Gellner, Landers, O'Rourke, & Schlegel, 1994; Fazzone, Barloon, McConnell, & Chitty, 2000; George, 1996; Kendra, 1996; Kendra, Weiker, Simon, Grant, & Shullick, 1996; Snow & Kleinman, 1987). While there are similarities between these two venues for nursing care, the differences in the context are significant.

Phenomenon Discussed Within a Specific Context

Many public health nurses in current practice have a strong commitment to home visiting as a valuable and therapeutic intervention (Byrd, 1995a). Most of the literature currently available on safety has focused on the definition of risk for nurses or the sources of fear during the process of the home visit (Hunter, 1997; Kendra & George, 2001; McNamara, 1994). Some authors have highlighted the risks nurses assume while home visiting. (Fisher, 1994; George, 1996; Rickford, 1995; Whitley, Jacobson, & Gawrys, 1996). These same authors have focused on potential dangers

within the communities served. Most are quick to point out that risk may occur anywhere, while traveling to and from the family's home, or during the visit. It is not uncommon for public health nurses to find themselves in potentially dangerous environments. Whether these risks are immediate or long-term, they can have a significant effect on the well-being of the nurse. MacMaster (1999) emphasized this point with an historic documentation of a public health nurse's work in disaster relief efforts after the tornado of 1925 in Benton, Illinois. Public Health Nurses were exposed to communicable disease, marshal law, and environmental hazards after this disaster.

Kendra and George (2001) developed a cognitive-perceptual model for individuals working in the field, such as public health nurses, for defining, measuring, and responding to risk in the community. This model described three components of the process of home visiting, from a framework incorporating the environmental/situational context, perception of threat, and cognitive process used by field workers to respond to risk. Rather than focusing solely on the health care workforce, this model explores the concept from the perspective of multiple disciplines.

Many other articles written on safety offer suggestions for avoiding danger, either from violence or occupational injury (Canavan, 1996; Fisher, 1994; Lewis & Hallburg, 1980; Smith & Brown, 1997; Skillen, Olson, & Gilbert, 2001). These articles have developed strategies or steps to take to remain safe. Nadwairski (1992) has postulated that, with adequate safety, home care providers are able to complete their responsibilities without concern for safety risk factors.

A change in public health nursing that may have affected the safety of nurses in the field is their lack of visibility. In the past, public health nursing practice was

considerably more visible. Most public health nurses wore identifiable uniforms and carried black nursing bags as symbols of their profession (Kalisch & Kalisch, 1995; Mulligan, 1973). Early public health nurses had the belief that living among clients and their families would increase visibility and the trust needed for a therapeutic relationship (Wald, 1915). In fact, Lillian Wald, the first U.S. public health nurse, had entwined her professional and personal life. Wald was so much a part of the community that she was known as the "Head Resident" of the Henry Street settlement house in her district (Coss, 1993, p. 134). She was a responsive professional individual who was intimately familiar with the community and the nuances of safety and risk.

Involvement in community issues provided early public health nurses the opportunity to be politically visible as well. Concern for the health of industrial workers, poor immigrants, and the exploited led to involvement in the labor movement by 19th century public health nurses (Buhler-Wilkerson, 1993; Heinrich, 1983). This concerted effort for group political involvement has not been sustained in current public health nursing practice.

Leipert (1996) found that visibility emerged as one of four themes identified in a phenomenological study of community health nurses that described the essence of practice. The study participants valued visibility for the perspective it brought in 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, in that professional invisibility, separation, and powerlessness are consequences of an uncertain identity.

Heinrich (1983) described the inconsistencies in public health nursing roles. 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-based practice. Moreover, the lack of role clarity has confused the public and nurses alike. With the increased visibility of home health nurses, a closely related field of practice, few members of the community are aware of the purpose or value of public health nursing. Salmon (1993) remarked that assuming a more clinical, illness-oriented role in the community has diverted the role of the public health nurse and led to a "case of mistaken identity" (p. 1674). One might propose that if public health nurses are uncertain of their role, others who are in positions of authority will also be uncertain. Those in protective roles, such as police and community safety personnel, may not be aware of the presence of the public health nurse in the community. Without the high visibility of the past, nurses today are no longer a known entity in the community, and this fact may increase their risk.

Violence against others has been at all time highs in the past decade. Although there are reports of significant decreases in general crime rates nationwide, these reports have not taken into account the high-density areas frequently represented in many districts served by public health nurses (Lichtblau, 2000). Current information demonstrates a downward trend in crime. However, for the public health nurse, this does not suggest that one can presuppose the communities served are without safety issues and concerns. For certain neighborhoods, these statistics are inaccurate. The majority of care received from a public health nurse is outside the walls of a hospital or

clinical facility; nurses must consider the issue of their own safety in every community served.

Relevance to Nursing

Public health nurses have traditionally visited the most disadvantaged members of society. They practice in those areas of greatest need, with the highest crime rates and potential for increased violence. In some cases, the nurse may be visiting those who are the most violent or their family members (Bekemeier, 1995). It is not uncommon for public health nurses to attempt to find individuals who do not want to be found or who have marginal locating information available. Referrals are obtained from many sources. Those who initiate the referral may not have taken the necessary care in transcribing the address or, for some reason, may not have received the correct address. As a result, nurses may have uncertain, incomplete, or inaccurate locating information for clients (Zerwekh, 1992b). Searching for clients in some neighborhoods puts the nurse at a disadvantage and at risk for victimization before the client is even known to the nurse.

Byrd (1995b) categorized the differences between types of home visiting. Home visits are viewed as either voluntary or required. Byrd believed that voluntary visits are more controlled, and entry into the home is accomplished without resistance. The reverse is often the case with visits that are required.

The concept of voluntary home visiting is consistent with the practice of home health nurses. As a result of the funding sources and nature of the visits made by the home health nurse, there is voluntary participation by the client. No visit could be made without the voluntary consent of the client. On the other hand, home visits made by

public health nurses can be either voluntary or required. When the visit is voluntary, the nurse assumes risks similar to those of the home health nurse, but when some external force, such as a court of law, public health department, or child advocacy policy, mandates the visit, the nurse must be prepared for resistance and the potential for the unexpected. Zerwekh (1992c) confirmed this concept, asserting that nurses can and do incorporate some coercion when working with resistant families. In many cases, required home visits are for children in families with substance abuse problems or the potential for abusive family situations. This may predispose the family to violence and put the nurse at greater risk.

Public health nurse educators are concerned with the safety of students in the community. Teaching students ways to remain safe and how to assess for levels and issues of safety within the community are a priority. As novices, students have little experience in assessment, planning, implementation, and evaluation of community health nursing practice. Regardless of previous hospital experiences, students are thrust back into the novice role in their first experiences in community health nursing. They are learning not only a new approach to nursing, but also the methods and processes of the home visit and community assessment. Benner (1984) postulated that, in the novice role, students are characterized by limited and inflexible rule-governed behaviors.

At times, the difficulties experienced by the novice stem from their need to have specific rules to follow. Within the context of public health nursing, the community and the characteristics of its residents not only influence nursing practice, but rules of safety as well. Communities are dynamic and can be unpredictable for both novice and expert. Although there are recommendations for remaining safe in the community, there are no

set guidelines (Clark, 2003; Stanhope & Knollmueller, 2000). Without established safety practices and guidelines for safety in field public health nursing practice, there are potentially more safety issues to be considered by nursing faculty and administrators of public health facilities (Lewis & Hallburg, 1980; Nadwairski, 1992; Whitley et al., 1996).

Purpose of the Study

The aim of this study was to describe and explore the perceptions of safety among field public health nurses. Development and testing of effective interventions to promote safety are hampered without an accurate and complete exploration of the safety issues experienced (Glaser & Strauss, 1967). Grounded theory was used as the methodology to collect, code, and analyze the data. These data were retrieved through semi-structured interviews of nurses engaged in field public health nursing practice.

Assumptions and Biases

The theoretical assumptions of the qualitative method chosen for this study emerged from work by Blumer (1969) on symbolic interactionism. Symbolic interactionism rests on three central premises. First, "human beings act toward things on the basis of the meaning that things have for them" (p. 2). Reaction-based behavior in keeping with this premise does not completely differentiate symbolic interactionism from typical sociological and psychological theoretical approaches. Many contemporary scholars in the fields of social science and psychology ascribe minimal importance to this first premise. These disciplines place greater importance on the factors leading to behavior rather than the meaning of things for the individual. The source of reaction-based behavior had been viewed as stimuli, conscious or unconscious

motives, and attitudes. Blumer believed meaning was taken for granted or ignored as unimportant in these disciplines. Moreover, he postulated, "the meanings that things have for human beings are central in their own right" (p. 3).

It is the second and third premises that allow for a distinction between symbolic interactionism and traditional views of behavior. The second premise is that the "meaning of such things is derived from, or arises out of, the social interaction" that one person has with another. It is important to note that, "symbolic interactionism sees meaning as social products" that are formed as people interact and that occur in the process of interaction between two people (Blumer, 1969, p. 2). From this perspective "individuals and their actions cannot be understood out of social context" (Hutchinson, 1999, p. 182).

Blumer's third premise is that "these meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things he encounters" (1969, p. 2). The implication is that there is a process of interpretation rather than solely the application of meaning. Interpretations should not be considered "mere automatic application of established meanings" (p. 5). Rather, interpretation is a formative process involving use and revision of meaning that ultimately guides actions.

These assumptions are relevant to this study. It was assumed that each public health nurse acts in a particular way based on the meaning that they have assigned to safety. Furthermore, each nurse arrived at that meaning from his or her personal experiences. Finally, the meaning of safety established by the individual nurse changed, or was modified, by events as they unfold or as they were influenced by actual or vicarious descriptions of safety issues of others.

As with all research, there were basic assumptions and biases inherent in this study. The first major assumption was that there were significant and researchable issues surrounding safety, not previously explored or explained, in field public health nursing. Second, that field public health nurses were a reliable source of information regarding safety-related issues in the communities they serve. And third, the knowledge gained from this study would be meaningful and beneficial because it would provide a conceptual framework from which to more fully understand the practice of public health nursing. With an established conceptual framework, further studies can develop appropriate tools for measuring safety and for assessing the usefulness of safety strategies for public health nursing.

Qualitative Research Method

Because empirically based studies of safety are scarce in public health nursing, any attempt to use a method other than one in which a substantive or formal theory could be generated would be premature (Glaser & Strauss, 1967). Unfortunately, the research that has been completed on safety in field public health nursing appears to have been generated by assumptions, common sense, and some theoretical speculations. Qualitative studies are characterized by their emergent design and the inquiry is based on the realities, perceptions, and viewpoints of those participating in the study (Polit & Hungler, 1998). The research tradition proposed for this study was grounded theory, utilizing data collection through semi-structured interviews, coding and the constant comparative method for data analysis, and development of a substantive theory. Grounded theory gives the greatest contribution in research circumstances where little research is available (Chenitz & Swanson, 1986). The general purpose of grounded

theory for this study was to account for and explain the phenomenon of safety in public health field nursing practice.

CHAPTER 2

EVOLUTION OF THE STUDY

Rationale

A review of the relevant research, facts, and opinions on the phenomenon of interest is necessary for qualitative research. In the following section, the sensitizing concepts, gaps in knowledge, and current opinions on safety will be discussed. Justification and the underlying principles for this study have emerged from both historical and experiential perspectives. The need for the study is best explained by the lack of research available on the issue of safety in public health nursing.

Historical Context

Perhaps some of the concerns for safety stem from early American and Victorian beliefs about women. Early American women were considered property of their husbands or fathers and unsuitable for intellectual development. Individuals from the Victorian era viewed women as fragile and needing the protection of men or safety in numbers that required traveling in pairs (Kalisch & Kalisch, 1995). District nursing, an antecedent of modern day public health nursing, was established in England during this era. Nightingale held the belief that all nursing should ultimately be carried out in the homes of the sick rather than in hospitals (Baly, 1986). The movement toward this

goal brought nursing care to those who could not afford the services of a full-time employee. Great care was taken by Nightingale to provide a safe environment for nurses destined to be among the "London Sick Poor" by insisting that nurses be provided a "real home ... where any mother would be willing to let her daughter ... live" (as cited in Baly, 1986, p. 127).

U.S. public health nurses have been making documented home visits to families since 1893. Lillian Wald began her public health nursing practice during this time and soon after, with the help of Mary Brewster, established the Henry Street Settlement in New York.

Safety has long been a concern in public health nursing (Wald, 1915, 1934). An early description of a visiting experience recounts how safety was already viewed as a concern for a newly developed area of nursing practice. On that first visit, Wald (1915) was "led over broken roadways - around dirty mattresses and heaps of refuse" (p. 4). It was evident that the fire escapes were nonfunctional or useless for their function. Wald (1915) spoke of visiting families with her "comrade", as well as visiting families on her own (p. 32). Nurses have heralded this bold and confident attitude and have celebrated other early public health nurses who have continued this legacy. Old photographs of nurses climbing over rooftops, riding on horseback, using bicycles and snowshoes have embedded this image in the minds of public health nursing professionals (Kalisch & Kalisch, 1995; U.S. Public Health Service, 1993).

Mary Breckinridge was another early influence on modern public health nursing practice. In 1925, Breckinridge (1952) founded the Frontier Nursing Service. It was not uncommon to see her on horseback in the mountains of Eastern Kentucky, finding

her way to the homes of the poor and ill. There were several safety issues relevant to her practice. She wrote of incidents where she was lost in the snow, encountered floods, and a time when she was thrown from her horse and broke her lower back.

Although some similarities to past practice of public health nursing and home visiting exist today, much has changed in society in the past century. The past gives modern nursing the basis for much of the current processes and practice of public health nursing.

Nurses continue to make home visits and use various modes of transportation to reach clients. The caseloads of public health nurses continue to include individuals who are poor and underserved. However, today there are new tools and technologies to assist public health nursing. Computers, cell phones, pagers, and telephones have accelerated time-consuming tasks and allowed for immediate access to information and support. Widely used screening tools, such as glucometers and other portable devices, for secondary prevention are also available. Transportation has also improved the practice of public health nursing. Nurses have vehicles at their disposal that far exceed the capabilities and speed of the horse-drawn carriages and slower moving modes of transportation used by early public health nurses. Whereas, nurses used to carry a black bag containing all that was needed for client care, modern nurses now carry equipment and supplies that are valuable and desirable to others. With these modern conveniences also comes additional risk and issues of safety.

Research Context

Textbooks on public health nursing have small sections that provide information on safety and prevention of violence (Allender & Spradley, 2001; Clark, 2003;

Stanhope & Knollmueller, 2000). Journal articles also address the importance and issues of safety. However, little research is available on the safety risks actually faced by today's public health nurses. The research available in home health is more specific to the issue of safety than that conducted in the area of public health nursing. Significant differences between home visiting in the two practice arenas, however, limit the generalizability of findings from one area to the other.

Home Health Safety Research

The current research on the safety of nurses working in communities focuses on the home health nurse rather than the public health nurse (Fazzone et al., 2000; George, 1996; Kendra, 1996; Kendra, Weiker, et al., 1996; O'Boyle, 1996). Most of the research published in this area has been descriptive in nature. A survey, using a convenience sample of 36 home health administrators and 62 staff, reported that several factors influence the perception of risk assumed serving clients in the community (Kendra, Weiker, et al., 1996). These factors included the geographic locale of visits made, the incidence of criminal behavior in the area, the time of day at which visits were made, the behavior of either patient or caregiver, and the presence of infectious disease.

In addition to identifying safety risks associated with home visiting, the participants were asked to provide information on strategies they used to minimize their perceived risk. Using a simple counting of responses for data analysis, the investigators found that preplanning their visits, having an escort or a buddy system in place, personal protective equipment, and safety programs were reported as the most beneficial. The safety programs reported were not defined in the study. Ninety-four

percent of the administrators reported that the agency had standardized protocols for refusing home visit referrals. These protocols included "known safety issues, geographic location, and patient needs exceeding agency policy" (p. 87). Sixty-eight percent of the nurses surveyed reported that even if they felt unsafe or at-risk, they would not refuse the assignment, but rather would leave the situation "as soon as possible" (p. 87).

Fazzone et al. (2000) noted similar findings in a qualitative study exploring personal safety risks and their influence on patient care. Major themes of unsafe conditions, organizational and ethical issues, protective factors, issues of gender, race, age, experience, and education emerged. Of major concern to nurses in this study was the effect of violence or the threat of personal harm on patient care. Most of the staff nurses and all administrators who participated believed that there was a potential for negative patient outcomes when the personnel feared for their safety.

Gellner et al. (1994) undertook a pilot study of nurses from three home health agencies to determine the risks experienced in their practice. Responses to the survey indicated that the majority of nurses had numerous risk factors associated with their work environment and utilized several safety and preventive methods. Over 90% of those polled by the study, believed that they were very knowledgeable on how to assess for the safety of a situation. All participants reported that they had safety concerns on home visits in inner city areas, at night, and during warm weather. Many of the nurses felt safer when they had a symbol of their profession, such as a nursing bag or a recognizable form of identification. Uniforms, however, were reported as having both a positive and negative effect on safety. All of the agencies had escort services available.

Although this pilot study had a stated purpose to merely "gather opinions and ideas on topics of personal safety in home visiting," it does point to a growing interest in the issue of safety in home care nursing (p. 16).

In a descriptive survey of VA Hospital Based Care programs (VAHBHCs), Snow and Kleinman (1987) explored agency safety policies and their impact on patient access to programs. It was determined that 37.5% of the agencies had a policy for exclusion of patients based on safety issues in the neighborhoods of residence. The remaining agencies had no such policy. Eighty-one percent of the agencies provided paired visits to dangerous areas and two of these agencies provided a security guard.

Steinberg (1995) explored the nature and extent of risks to nurses' personal safety and how these risks were addressed while they provided home care to patients in Saskatchewan, Canada. In a descriptive survey utilizing a mailed questionnaire, ninety-five respondents described incidents of risk or assault they had experienced and strategies used to reduce risk. More than thirty-seven percent of those surveyed reported that they had never been assaulted or had an incident of risk. Sixty-two percent stated that they had had at least one experience where their personal safety was at risk or they were actually assaulted. Steinberg (1995) organized the anecdotal responses into five categories. These categories were identified as (a) the nurse-agency relationship, (b) availability of information, (c) communication with a third party, (d) client behavior, and (e) the work environment. Each of the categories included anecdotal excerpts for clarification.

Two comparative studies have been presented on safety in home health nursing. Both of these research studies utilized the Home Health Care Perception of Risk

Questionnaire (HHCPRQ) for data collection.

Kendra (1996) compared the perceptions of actual risk, level of perceived risk, and provisions provided by the agency for risk reduction between home health care administrators (HHCAs) and home health field workers (FWs). Twenty-five of the 48 contiguous states were represented in this study. A stratified random sample from 180 home health agencies was selected. A significant difference was noted between HHCAs' and FWs' perceptions of risk on home visits. Furthermore, a significant difference was found between HHCAs' perceptions of agency support for decreasing risk and their perceptions of support by FWs. FWs did not believe that the agencies provided the level of support reported by the HHCAs. Although significant differences existed in the frequency with which each group reported perceived risk and their perceptions of support, there was no significant difference found in the level of risk assessed. The investigators concluded that these findings are consistent with beliefs and opinions of most field workers currently in practice.

George (1996) attempted to explain the level of risk assessed by FWs by showing a correlation between sense of coherence (SOC) and perceptions of risk. SOC, for the purpose of this study, was described as a pervasive, enduring feeling of confidence. A stratified sample of 653 FWs was studied using the Orientation to Life Questionnaire and a modified version of the HHCPRQ. In this study, those field workers with a strong SOC identified fewer risk encounters than those with a weak SOC. Moreover, a strong SOC was associated with the ability to refuse high-risk assignments. No significant difference was found between the percentage of home

visits involving personal risk and SOC and the need to use behaviors for protection from risk and level of SOC.

Although these studies are helpful in determining perception of risk by home health nurses, agency policies related to risk assumed by the nurse, and factors that may have an affect on perception of risk, there are major differences in the scope of practice in public health and home health nursing. The contexts of practice for these specialties display distinct differences that may affect the safety of the nurse within communities. From the perspective of these studies, many of the issues of safety have not been explored.

Public Health Nursing Research

In a qualitative study of competencies of expert Public Health Nurses in western Washington, Zerwekh (1990, 1991) had unanticipated findings that reflected escalating difficulties experienced in current practice. Several themes emerged from ninety-five anecdotes described by study participants. Issues of nurses working with the most disturbed and struggling families, violence, drugs and poverty were recurring concepts. Overriding themes of uncertainty and danger were evident in the descriptions.

Participants reported both professional and emotional costs related to these uncertainties. For example, a participant stated that one of the most demanding threats of violence "was not knowing" about her safety (1991, p. 60). Others stated concerns regarding dogs, guns, and dangerous neighborhoods in which others would not "even set a toenail" (p. 60). Emotional costs were those related to psychosocial well-being. Nurses reported that the violence they saw in the field had the potential for triggering their own anger. These feelings of anger and the possibility of depression were cited as

potential risks to well-being.

Another descriptive study addressed the issue of general work hazards in public health nursing. Work hazards studied included physical and psychosocial stressors experienced in the workplace. By using secondary data analysis, Skillen, Olson, and Gilbert (2001) examined unanalyzed interview segments from a previous exploratory descriptive study describing organizational factors and work hazards experienced in community health nursing. While home visiting was not specifically addressed, this study described the overarching theme of “framing personal risk in the work environment” (p. 670). Subthemes of “framing for no action” and “framing for action” were also described (p. 671-673). Skillen et al. found that framing for personal risk had four distinct categories. These categories included becoming aware, recognizing influences, comparing with others, and knowing right and freedoms. Two-thirds of the nurses in the study decided to take no action when confronted with personal risk. By taking no action, nurses stated they were unconcerned or avoided trouble. The remaining third of the nurses framed for action. Framing for action was described as finding humor, taking responsibility, using voice, collecting support, and struggling for action.

Older studies have also looked at issues of safety in public health nursing practice. Mulligan (1973) studied public health agencies providing preventive services to populations in 36 cities, between 1965-1969. In this descriptive study, it was found that there was a potential relationship between changes in services and the increase in crime rate. One of the most frequent reasons given for nursing personnel refusing or objecting to assignments in certain areas was that husbands or relatives objected to their

type of work. Some of the agencies studied reported difficulty in hiring qualified personnel for certain high-risk geographic areas. Likewise, other investigators have found that the influence of significant others, colleagues, patients, and supervisors have a considerable influence on the perception of environmental fear among public health nurses (Brown, 1977; Castles & Keith, 1971; Keith & Castles, 1973).

Three published articles exploring safety of community health nursing students and nurses, in both official and non-official public health agencies, were completed using data from a single study (Castles & Keith, 1971; Keith & Castles, 1973, 1976). The earliest article reported on nurses and their levels of environmental fear (Castles & Keith, 1971). The participants described several salient issues. Respondents reported that they were most afraid in halls, stairways, and elevators while on home visits, yet the client's home itself was not perceived as a place to fear. Nurses in official agencies had significantly higher Environmental Fear Scale (EFS) scores than those in non-official agencies. However, nurses with more experience in public health had lower EFS scores, regardless of the district they served. Bodily injury was the most frequently noted fear.

A second article described the survey data from the original study (Keith & Castles, 1973). Results were reported as number of responses. Concerns expressed by the participants were categorized as either "General" or "Specific" aspects of the community (p. 202). General aspects were those that did not relate to a specific event, but rather to behaviors or environmental conditions. Specific aspects were those events that had transpired during the nurse's experience and were later cited as reasons for not wanting to work in a particular area. Sixty-seven of the 159 participants were most

concerned about "general" environmental aspects of the community. Very few of the participants, between 7 and 11%, reported that they were unafraid to go into any of the areas they served or that they would refuse to see a patient with a specific type of disease or physical condition. However, 64 respondents stated that they would refuse to accept a patient because of community characteristics. One hundred forty-one of those studied were able to describe both the location and the environmental characteristics of a community in which they were afraid.

Finally, systems of protection and issues of role evasion and role performance were reported by Keith and Castles (1976). The systems of protection offered for consideration included (a) a driver accompanying the nurse to the home visit destination and then returning when the nurse finished, (b) nurses going on the home visit in pairs, (c) a member of the community meeting the nurse when entering the community and then accompanying her to the home visit, and (d) a hired bodyguard accompanying the nurse on the home visit. Student nurses preferred systems of protection that enabled them to remain unobserved by others. Stated reasons were that this allowed a detached position, away from the purview of peers and supervisors, and the maintenance of the ideal one-on-one relationship. Significant differences were found for the type of protection preferred by students and nurses. Students gave the highest "endorsement" for a bodyguard, while nurses reported that they preferred to be accompanied to a high-risk area by another nurse (p. 253).

The investigators identified two major categories of role behavior, role evasion, and role performance. Role performers were conceptualized as those nurses who stated that they would accept clients for service regardless of the safety characteristics of the

environment in which they lived. Conversely, role evaders were those nurses who would refuse clients based on their environmental characteristics.

Role evasion and role performance did not directly affect preferences for systems of protection. However, there was a trend for those deemed role evaders to prefer some type of system of protection and to feel at ease with the presence of protectors. Students who were deemed role evaders were significantly more likely to approve of a driver than student performers. In today's economy and with issues of confidentiality, most of the proposed systems of protection suggested by this study would not be considered viable options.

Three of the studies that have a direct link to the issue of safety in public health nursing have been undertaken for psychometric development and refinement of an instrument (Carroll, Morin, Hayes, & Carter, 1999; Carter, Carroll, & Hayes, 1993; Hayes, Carter, Carroll, & Morin, 1996). This instrument purports to measure perceived threats to safety in the community. Junior students in a baccalaureate-nursing program were studied in each of these three investigations. Each time acceptable reliability and validity were found for the revised version of the tool.

Hayes et al. (1996) asked students to respond to the Environmental Comfort Scale II (ESC II) prior to beginning the clinical portion of their community health course. Although the purpose of this study was to test the ESC II, the study did suggest that there are both personal-emotional and cognitive components to fear regarding safety. The authors proposed that fear may have a protective quality and that it may not be something that should be removed.

The instrument used for the studies by Carter et al. (1993), Hayes et al. (1996), and Carroll et al. (1999) was originally developed by Castles & Keith (1978) and was titled the *Environmental Fear Scale* (EFS). This instrument attempted to operationalize the perception and frequency of threat associated with a given spatial area.

The EFS consisted of nine items and one category of *other*, which were rated on a Likert-type five-point scale. Questions such as, "Are you afraid driving along the street" and "Are you afraid walking along the street" were asked (Castles & Keith, 1978, p. 9). The items were scored from 1-never to 5-always. These items were then summed for a total score, with a possible range of 10-50. A higher total score on the EFS indicated that the individual was more fearful. Conversely, a lower score indicated the respondent was more comfortable. This scale corresponds to "environmental or place dimensions" where the nurse "would most likely experience fear" (Castles & Keith, 1971, p. 246). Data from this instrument is interval in nature and parametric statistics could be utilized for analysis (Polit & Hungler, 1998; Waltz, Strickland & Lenz, 1991).

Original psychometric testing found that the instrument had adequate reliability. Psychometric testing was based on a sample of 159 public health nurses, students, and staff employed at official and non-official agencies. Preliminary reliability testing of this instrument produced a Cronbach's alpha of 0.91 and a Scalogram Analysis reliability coefficient of 0.93. Although no information is given on the methodology for achieving validity, Castles and Keith (1971, 1978) reported that they had achieved some evidence of construct validity, in that respondents who had higher scores on the EFS had family or colleagues who expressed concern about their safety. Since three of the

pieces of research are based on this initial tool, it is important to look at this instrument critically.

In evaluation of this instrument, the point must be made that this is the only available tool that addresses some attribute of safety in public health nursing. It is possible that the tool measures a character trait specific to the individual, such as timidity or apprehension. The general concept of this tool focuses on fear, or the perception of threat, rather than the perception of safety. The argument could be made that this tool measures the absence of safety. This point was addressed in a subsequent pilot study in which the original *Environmental Fear Scale* was modified and renamed the *Environmental Comfort Scale*. The stated reasoning for changing the title of the tool was to decrease the "possible negative effects of the term fear on the respondents" (Carter et al., 1993, p. 302). Although the title was changed, in the modified version, the item stems still addressed the same questions. The respondents continued to rank the items using a Likert-type five-point scale denoting their level of "being afraid".

As stated previously, the reliability of the tool was established utilizing a sample of 159 public health nurses, students, and staff involved in community outreach. The ratio of items to subjects was appropriate for reliability testing (Nunnally & Burnstein, 1994). Although the exact method of obtaining internal consistency reliability was not discussed, an acceptable Cronbach's alpha of 0.91 was achieved.

In addition, further analysis using the Cornell Technique of Scalogram Analysis found a reliability coefficient of 0.93 (Castles & Keith, 1978). Scalogram analysis is used for development of a Guttman scale. This form of scaling attempts to arrange the items in such a way as to produce a pattern of responses. This method has an intuitive

appeal, yet according to Nunnally and Burnstein (1994) is highly impractical. There are several criticisms of this method; primarily that it is considered unrealistic that items on a measurement instrument could correlate perfectly with a human attribute.

One major area of weakness in this scale is the lack of a clearly defined concept underpinning the measurement instrument. Castles and Keith (1978) used interviews of graduate students who had recent experience in public health as the primary development method for items in the scale, yet they had no conceptual framework from which to draw. Each of the subsequent tool revisions failed to formulate a conceptual framework (Carroll et al., 1999; Carter et al., 1993). Recommendations for insuring a valid scale include the need for a clear definition, review of the literature, mapping of the conceptual meaning, and a statement of a theoretical definition (Waltz et al., 1991). None of these recommendations were followed in developing this measurement instrument.

The authors are unclear as to how face validity was established for the instrument. It appears that after the items were developed, public health nurses evaluated them for content validity. It has been recommended that content validity be established through review of each item by a panel experts in the field and should consist of a minimum of five members (Polit & Hungler, 1998). There is no mention of the number of public health nurses asked to participate or if this step was completed in a panel format, so the adequacy of the method to establish validity cannot be determined. Clear evidence of construct validity is deficient for this tool.

In summary, the Environmental Fear Scale, and its subsequent revisions, is one of the only measurement instruments available to measure some aspect of safety in the

context of public health nursing. The tool is easy to administer and has adequate internal consistency. The validity of this tool is questionable, in that the exact concept of safety that it measures is unclear and unsubstantiated. It may be reliably providing a score, but there is no assurance that the tool is valid in its claim to measure the concept of safety. Although this tool has been modified twice, the underlying concept has not been adequately developed. Research utilizing this tool should be carefully evaluated for the emphasis placed on its validity.

Because of the limited information available, further studies are needed to explore the basic nature and description of safety as experienced by public health nurses. This should take place before development of measurement tools or determining methods for interventions.

Experiential Context

It is not uncommon for research interests related to a particular topic or issue to come from personal experience. In fact, Creswell (1998) has noted that qualitative research cannot escape the fact that there will be a personal stamp on the interpretation of the data. This is true for the issue of safety in field public health nursing for this study. In the early years of my career in nursing, I was a public health nurse (PHN) in an ethnically and economically diverse city in Southern California, and I have taught community health nursing to baccalaureate students for 20 years. During the time I was a PHN, my district included the downtown and rural areas of the city. I have since had student clinical placements in a very large urban county, which included areas of the inner city and very densely populated areas. In general, there have been very few safety

concerns; however, several incidents have remained in my memory as potentially hazardous to either my students or me.

There are only two events, which occurred during the years as a PHN that I would conclude influenced my interest in the issue of safety. The first occasion was when I was in a very rural area and had a shotgun pointed at me for a brief period. The second was when I found myself between two siblings and had an airborne wine bottle pass very close to my head.

Teaching students of public health nursing is another aspect of the experiential context for this study. Whether it is based on ensuring the best clinical experience for the student or from the possibility of liability for the University, safety is a concept that I attempt to thoroughly discuss prior to any student making an unsupervised home visit. I have found that having the student hear methods for maintaining a safe environment from the public health nurses in the facility provides an arena for discussion. I also encourage students to make joint home visits to allay their fears and to provide a second set of eyes for the visit. This has been cause for debate among other faculty members who believe that students should get the real experience of public health nursing and make independent visits. Without adequate research on any of these issues, there is no scientific evidence that one way is a more effective teaching method, or more safe for the student, than the other.

CHAPTER 3

THE METHOD OF INQUIRY

Introduction to the Method

This study used the qualitative research method known as grounded theory. Developed by Glaser and Strauss (1967), grounded theory is a research method that explains social interactions from the epistemologic framework of symbolic interactionism. This method of qualitative inquiry, predominantly used in social sciences such as sociology and anthropology, has been espoused by the discipline of nursing. Nursing has found that the use of grounded theory has enriched understanding through the description, exploration, and explanation of many phenomena important to current practice, particularly in the areas of caring, homelessness, and cultural sensitivity (Streubert & Carpenter, 1995; Chenitz & Swanson, 1986).

Outcome of Method

Glaser (1992) saw grounded theory as a bridge to viewing the same problems and processes in varied situations, thus allowing theory to develop from the substantive form to formal theory. Glaser (1992) described his philosophy of theory development, stating "it is grounded systematically in the data and it is neither forced nor reified" (p.15). Theory generated from this method is grounded in data obtained from

individuals experiencing the phenomenon of study. Through observation and interviews, grounded theory provides a systematic way to develop theories about phenomena and "is done to produce abstract concepts and propositions about the relationships between them" (Chenitz & Swanson, 1986, p. 8).

Theory may be presented in two forms. According to Glaser & Strauss (1967) these forms may be a well developed and a "codified set" of propositions, such as in formal theories, or a "running theoretical discussion" using categories and detailed properties, as in substantive theory (p. 31). The explanation developed in this study was substantive in nature. The aim of this study was to account for relevant behavior and to describe and explain issues of safety among field public health nurses.

Sample

Nineteen public health nurses from three official public health departments in Southern California comprised the sample for this study. Each participant was a Registered Nurse and held Public Health Nurse certification in the State of California.

The study participants were purposefully selected to meet specific criteria. Participants were public health nurses employed by an official city or county health department and were involved in client, group, or aggregate-focused nursing practice. Each participant was engaged in field public health nursing and provided home visits to families, schools, inpatient facilities, occupational settings, and to the homeless.

Purposive sampling for recruitment of participants was used. Groups of participants were solicited from a variety of public health facilities in various socioeconomic areas including urban, suburban, and inner city communities. Both male and female nurses from a variety of ethnic groups were asked to participate in an

attempt to include an ethnically diverse sample.

Of the nineteen participants, two were male and seventeen were female. The participants ranged in age from 25 to 63 years, with an average age of 45.2 years. Three ethnic groups were represented in the study; stated ethnicities included twelve Caucasian/White, four African-American/Black, and three Hispanic participants. The nurses had been working in public health nurse (PHN) positions from 2 to 30 years. The average length of public health nursing practice was 10.5 years. They had been registered nurses from 3.5 to 40 years, with an average of 20.7 years in nursing. All of the nurse participants had a bachelor's degree in nursing or higher, as required for PHN certification in California. Eight had advanced degrees, four of whom held master's degrees in nursing. The participants' caseloads were in a variety of settings and were represented evenly between urban, suburban, and inner city neighborhoods. Table 1 provides an aggregate description of the sample.

Project Setting

The Los Angeles and San Bernardino County Health Departments and Pasadena City Health Department were approached for access to public health nurses. These jurisdictions included multiple health centers from which to recruit PHN participants. The community health centers were in diverse communities and served all ethnic, cultural, and socioeconomic groups. Some of the areas served were large, metropolitan cities while others were smaller cities or unincorporated rural areas.

Gaining Entrée

Entrée into the county and city health department settings was achieved through a

Table 1

Demographic Description of Sample

Sex	N	%
Female	17	89.5
Male	2	10.5
TOTAL	19	100%
Age		
25-29	3	16
30-39	3	16
40-49	5	26
50-59	5	26
60-63	3	16
Ethnicity		
White, non-Hispanic	12	63
African-American/Black	4	21
White, Hispanic	3	16
Education		
BSN	13	68
MSN or equivalent	6	32
Years in Public Health Nursing		
<5.9	9	47
6-15	6	32
16-25	2	11
>25	2	11
Years as Registered Nurse		
<5.9	4	21
6-10	3	16
11-20	2	10.5
20-30	3	16
>30	7	37

Primary Area of Service

Inner City	5	26
Urban	6	32
Suburban	5	26
Mixed	3	16

Usual Number of Field Visits per Week

<3	1	5
3-9	5	26
10-16	12	63
>16	1	5

combination of what Chenitz & Swanson (1986) termed "entrée from the outside" and "entrée from the inside" (p. 49-51). As a faculty member and a previous district public health nurse at Los Angeles County Department of Health Services, entrée to this group of public health nurses was facilitated through the network I have maintained over the past twenty years. Directors of Nursing for two of the agencies were contacted informally during a professional community health nursing meeting to determine their potential interest in the study.

This study received approval by the Committee on the Protection of Human Subjects of the University of San Diego (see Appendix A). Permission to contact PHN participants was granted for three agencies. A written formal request and proposal was sent to the director of nursing at two of the agencies soliciting approval to contact public health nurses in their jurisdiction. The nursing directors, with the assistance of their nursing supervisors, identified public health nurses who met the criteria for selection. The supervisors gave a copy of the consent form explaining the process for participation in the study to those nurses identified as interested in participating. A list of interested participants was given to the researcher with contact telephone numbers. The participants were then individually contacted by telephone by the researcher. During the telephone contact, the study was fully explained and an interview appointment date and time was scheduled. Interview data obtained during a pilot study, from an additional seven participants, was included in the analysis. The participants from the pilot study were recruited through direct contact by the researcher, after an informal agreement had been made with the nursing supervisor of the third agency. Consent to participate was obtained from each of the participants.

An attempt was made to recruit additional participants through a local chapter of a public health professional organization. A written announcement about the study was placed in the Southern California Public Health Association newsletter (Appendix B). This announcement generated interest in participation and requests for the results of the study. No additional participants were recruited however; as the announcement was published after all participants had been interviewed and saturation of the categories had been obtained.

Data Collection

A semi-structured interview technique was used for this study. Open-ended questions were developed and were incorporated into each interview to elicit the richest data possible on the issue of safety (see Appendix C for the interview guide). The interview guide consisted of three open-ended questions. These questions were pilot tested during the advanced qualitative research course at the University of San Diego during the spring semester, 2000. Seven public health nurses were interviewed and the questions were refined. Seven secondary probes were developed and used during the interview if the participant needed additional cues and for theoretical sampling.

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. Written informed consent was obtained from each participant prior to data collection. All participants gave their permission for their responses to be audiotaped. Each of the audiotaped interviews was transcribed verbatim and field notes were written to describe the context of the interviews and relevant observations. The interviews were professionally transcribed. When the notes and tapes were returned, the researcher

listened to the original interviews and verified their completeness and accuracy. By listening to the tapes several times, inflections and nuances were identified. This added to the richness of the data and provided additional insight for analysis. Theoretical notes were used throughout the project to refine questions, document analyses, and develop theory. Data collection continued until each of the categories was saturated.

Theoretical Sampling

In grounded theory, initial sampling is not based on a preconceived notion or theoretical underpinning. This study followed the guidelines for theoretical sampling in that sampling was controlled by the emerging theory, as the grounded theorist simultaneously collected, coded, and analyzed the data. The intent of sampling was to obtain data slices from multiple groupings (Glaser & Strauss, 1967). Sampling was guided by emerging themes, gaps in the theory and by research questions generated by previous data and data collection (Glaser, 1978, 1992; Glaser & Strauss, 1967). As themes emerged and gaps were identified, questions were revised or added. Sampling continued until all identified categories were saturated. The criterion of saturation was met when additional data acquired through interviews or observations fit into the categories already generated (Creswell, 1998; Glaser & Strauss, 1967; Morse, 1995).

Protection of Public Health Nurse Participants

Before recruiting participants for this study, approval was obtained from the Committee on the Protection of Human Subjects of the University of San Diego. Initially, all participants were recruited through personal contact by phone and it was determined at that time that they would consent to participate in the study. Additionally, the study purpose, time necessary to complete the interview, and need for

an audiotaped interview were explained. An interview appointment was then scheduled at a mutually agreed upon site, date, and time.

Informed Consent

At the time of the interview, the study purpose, time involvement, issues of privacy and confidentiality, and permission for an audiotaped interview were reviewed. Written consent was then obtained from each participant (Appendix D). Any questions related to participation in the study were answered prior to beginning the audiotaped interview. Participants were told that their participation was voluntary and that they could withdraw from the study at any time or stop the interview without consequence.

Confidentiality

Participants were informed of their right to privacy and the steps that were taken to ensure that their information would be confidential. Audiotapes were coded with first names only for privacy and all identifying information was removed from the verbatim transcripts. After the tapes had been transcribed and checked for accuracy, the tapes were stored in a locked cabinet accessible only to the researcher until the study's completion. When no longer needed for verification of transcripts, the tapes were destroyed. Signed consent forms were stored in locked cabinet in a separate location.

Subjects' Risks and Benefits

There was minimal anticipated risk as a result of participation in this study. No negative feelings emerged during the interviews due to memories from previous experiences and none of the participants chose to postpone the interview or withdraw from the study. Had participants experienced emotional distress, the researcher was prepared to use those counseling skills necessary to assist the participant.

There was no monetary or other measurable benefit from participation in this study. The only benefit expected from participation was the satisfaction of contributing to nursing knowledge.

The benefits of this study outweighed the potential risk to the participants. There was minimal risk to the participant. In addition, there was no expense to participants in this study. The only cost to the participants was the value of their time spent participating in the interviews. Interviews were planned at the participants' convenience and no cost was incurred.

Data Analysis

QSR NVivo® Version 1.3.146, a qualitative data analysis software (QDAS) application, was used for data analysis, incorporating three levels of coding identified for grounded theory data analysis (Hutchinson, 1999). Data analysis began with open coding, which was the initial stage of constant comparative analysis (Glaser, 1992). At this stage, it was imperative that the researcher avoid 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 supposition by the researcher. Second, the interview questions were asked in a similar manner to each participant. Third, 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 (Glaser, 1978).

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 category emerged. At the end of open coding, there were ninety-seven (97) initial codes identified. Open coded data were then broken down into incidents and analyzed for similarities and differences. The fundamental processes for the constant comparative method were carried out through comparison of incidents with incidents, incidents to concepts, and concepts to concepts. Properties of each category were generated using this process. Categories that lacked foundation, when compared to subsequent data, were eliminated (Streubert & Carpenter, 1995). Open coding ended when the core categories were identified (Glaser, 1992)

As data were coded, they were compared to other data. As this second level of coding progressed, the data were assigned to "categories according to obvious fit" (Streubert & Carpenter, 1995, p. 157). 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 until the conclusion of the study (Glaser, 1992). Data were continually compared with additional data generated in each subsequent interview. 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.

The goal of grounded theory is the discovery of the core category (Glaser, 1992;

Hutchinson, 1999; Streubert & Carpenter, 1995). The third level of coding “describes the basic social psychological process” (Streubert & Carpenter, 1995, p. 157). The basic social process identified in this study was “keeping safe”. Identification of this basic social process was achieved with the help of a peer debriefing group. The analysis was stalled after the second level of coding. Identification of the lower level categories resulted in a very good description of the findings but did not yield a basic social process. Emergence of the basic social process of “keeping safe” 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 conceptualize how the substantive codes related to each other and led to the development of a substantive theory. Additionally, by reviewing the codes for alternate explanations this researcher avoided over focusing on a particular interpretation of the data. Initially, the “six C’s” and “process” coding families were considered in the development of the basic social process.

Glaser (1978, p. 74) described the “six C’s” as the first theoretical coding family to be considered when coding data. The label “six C’s” was derived from the terms (a) causes, (b) contexts, (c) contingencies, (d) consequences, (e) covariances, and (f) conditions that become properties in a causal, consequence, or condition model.

The best fit for the data in this study emerged when the stages of keeping safe were identified. The process of *keeping safe* emerged with three distinct stages. Further development of the emerging theory was enhanced through selective sampling of the literature and data and reduction of categories. Reduction and integration of substantive codes provided the conceptual linkages between the emerging stages,

categories, and properties. Memos written throughout the coding process were sorted and became the basis for theory formation (Glaser, 1992).

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 slices of data could correct data inaccuracies. However, grounded theory cannot be deemed complete until one has established its credibility and rigor.

Credibility refers to the believability of the theory. Judgment of credibility is twofold, in that the reader must be "sufficiently caught up in the descriptions so that he feels vicariously that he was also in the field" (p. 230). Secondly, the reader must be convinced as to how the researcher arrived at the conclusions. Thorough theoretical sampling of multiple comparison groups was included in this 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, peer debriefing, and member checks.

Steps were taken in this study to assure that data analysis, theoretical sampling, and development of theory would have sufficient credibility. Prolonged engagement was achieved by the length of time necessary for completion of the study. Data collection for this study spanned three years. Data were obtained from the first pilot study interviews in May 2000 through the member check in June 2003. Interviews were 90 minutes to one and one-half hours in length and provided ample opportunity for persistent observation.

In addition, all three dissertation committee members for this study have

completed research using grounded theory. In fact, one faculty committee member has published several qualitative research studies using grounded theory. The dissertation chair and faculty committee member are experts in community health nursing and the issues involved in current practice. Also, a qualitative research interest group at California State University, Los Angeles, reviewed the data and subsequent analysis for this study. This group was composed of doctoral students currently working on grounded theory research.

When further measures are needed to demonstrate credibility of data analysis, member checks using individual or group interviews can be included. Glaser (1992) was adamant that verification of data is of secondary importance to the emerging theory, however establishing credibility using a member check was seen as necessary for this study.

Wuest and Merritt-Gray (2001) affirmed that group interviews could be a valuable tool for eliciting some data that might not be available in individual interviews and are useful as a method to establish consensus of thought. Morse (2001), however, provided a caveat that data collected from group interviews would, at best, be "snapshot data" rather than containing the entire storyline (p. 7). This was found to be true during the member check for this study. Approximately two-thirds of the conversation by the members provided no new data and focused on concepts related to professional responsibility, autonomy, and licensing issues, but not public health nursing safety.

The membership of the member check group was comprised of public health nurse participants from San Bernardino County Health Department. The purpose of this group was to determine if the emerging theory was readily apparent. Of the eight public

health nurses originally recruited from this county, three were available and willing to attend the member check. It is not uncommon for original participants to be unable or unwilling to be a part a second interview or group interview (Janesick, 2000; Wuest & Merritt-Gray, 2001). Although the participation was less than 50%, the validation of the emerging substantive theory received from this group was valuable and provided verification and amplification of the data analysis and findings.

The remarks from the nurse participants provided verification of the findings. One nurse stated, “your dissertation should be used as a tool for education.” Another confirmed this by stating, “this is a very good teaching tool. I think it would be good for the new PHN’s to see the way the assessment goes and what things to look for.” The remainder of the observations by the nurse participants offered amplification of the findings. Most had a similar story to impart that confirmed those mentioned by the researcher or were repeated stories from their original interviews. Those in the group concluded that the final analysis of the study was consistent with their experiences in the field.

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 those working in the field of public health nursing. 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. 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 a QDAS insured that all data was reviewed for fitness and understanding and provided audit trails that could be easily scrutinized (St. John & Johnson, 2000). This program allowed the researcher to view and organize data with multiple perspectives. All data were immediately available for analysis and similarly coded data could be compared with minimal effort. No data were lost or misplaced. If the data did not belong it was returned without losing the original context or flow. Secondly, the member check and peer debriefing groups provided confirmation that the findings were understandable.

Finally, 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 "keeping safe". It shows the stages public health nurses follow and the decision-making processes necessary for maintaining safety in the field. In the following chapter, the concepts and interrelationship of the concepts of these processes are described and explained.

CHAPTER 4

FINDINGS

This chapter describes and explains the perceptions of safety among field public health nurses. Based on the qualitative methodology described in Chapter three, a total of nineteen (19) individual interviews were transcribed, coded, and analyzed. The participants ranged from 25 to 63 years of age and had 2-40 years experience as field public health nurses. Seventeen participants were female and two were male. Three ethnic groups were represented, 63.2% Caucasian, 21% African-American, and 15.8% Hispanic.

The Process: Keeping Safe

The core category discovered in this study was the process of *keeping safe*. Public health nurses in the field must make specific assessments, interpret data, and formulate actions to guard their safety. Most of the public health nurses entered into the field without a great deal of concern for their safety. In fact, most interviewed believed they were relatively safe. Several nurses expressed this during their interviews, either by stating, “I don't feel unsafe making home visits”, or “Usually I feel safe; usually I do . . . So, on a given day, like yesterday, I had quite a few visits. I felt safe the whole time.”

Conversely, participants interviewed for this study recognized that there were issues of safety that had to be addressed on every field visit made. As one nurse illustrated “you’re not really safe, it’s a vulnerable job.” Nurses were sufficiently realistic to realize that public health nursing could have risks and safety issues, regardless of their action or inaction.

Estimating and planning for the possibility of risks was part of the process of *keeping safe*. As one nurse acknowledged, “just try to anticipate that things can go wrong. They generally don’t, but it’s always good to have some ways out, to give yourself a way out.”

As they discussed their nursing practice, participants were mindful of the process of *keeping safe*. The process of *keeping safe* will be presented in this chapter; it was constantly influenced by conditions, context, and consequences of the field visit.

Stages of the Process

Three stages emerged within the process of *keeping safe*. The first stage, *risk awareness* required the public health nurses to assess for potential and actual risks in the environment. During the second stage, *risk estimation*, the nurses determined their degree of vulnerability. During this stage, a critical juncture was reached and decisions were made to determine the appropriate risk limiting strategy for use during the final stage -- *risk limitation*. The level of tolerance for risk varied for each nurse. Throughout the process of *keeping safe*, the public health nurses’ perceptions regarding their degree of safety evolved. The evolution of their perceptions was predicated on feelings and previous experiences, peer and family perceptions, supervisory support, and vicarious knowledge. (See Figure 1 for a schematic representation of the process of

Figure 1. The Process of Keeping Safe

keeping safe.)

Risk Awareness

Risk awareness was the first stage of the process of *keeping safe*. The public health nurses achieved awareness of risk through vigilance. Assessment and awareness were essential components of this stage.

Vigilance

Public health nurses attempted to maintain a constant vigilance in their assessment, interpretation, and actions in the field. Most nurses verbalized that they were relatively safe in their work environment, however the potential for situations to change and become less secure was always present. Vigilance, according to field nurses interviewed for this study, was a state of “heightened awareness” or “paying attention.” When describing vigilance, public health nurses acknowledged that they must always be on their guard and be watchful during every phase of the field visit. The practice of this skill was inherent in the nurse’s behavior. It even translated into every day tasks outside of the work environment. As one nurse stated,

I try not to just look down on the ground and follow my nose when I go to a house. I try to take note of ... you know, is there anybody out on the streets? Is there anybody in the little courtyard? Is there a lot of noise coming from one of the apartments? Are the kids crawling in and out of the windows of one of the apartments? I mean I try to be aware of the environment. So I just ... I feel more comfortable with it. So I try to learn, just going from my car from the grocery store, to be aware of what’s around me, so that I don’t get into trouble.

Another nurse confirmed this by stating,

I don’t live in the area, but I live in an area, which is not that far away. So, just by virtue of that, I’m watching when I’m not at work. I’m watching when I’m off the clock. That’s just natural. I’ve just always been cautious just growing up.

Vigilance continued from the work setting into the nurse’s own neighborhood

and one nurse made personal decisions on housing based on her assessment of neighborhoods. This nurse reported,

Like when I'm looking at a community to work in for example, or to live in. In this situation, you know, I live and I work in the same community, which is you know, to me pretty neat. But one of the things that I look for in assessing a neighborhood, or I guess a neighborhood surrounding a home, that I'm going to visit, uhm, is I guess, you know, making kind of a judgment as to how well kept the area is, is there a lot of trash around?

There was a constant stream of visual, auditory, tactile, and olfactory data that bombarded the nurse during each field visit. These sensations had to be perceived and deciphered by the nurse as the visit progressed. The public health nurses in this study were very specific regarding the areas of vigilance that they believed to be of particular importance. This section will address and detail the situations or hazards of both actual and potential risk.

The nurses described multiple perceived risks within the context of home visiting. Data suggested that public health nurses prioritized these risks. Several of the perceived risks were universal to all the nurses in the study. Without exception, all of the nurses had issues of safety with both groupings of men and the presence of dogs. Men in a group with no apparent purpose or in clandestine communication with each other or the presence of dogs, regardless of where they were seen, were of major concern to the field public health nurse. Other high priority risks were angry family members, individuals under the influence of drugs and alcohol, or persons exhibiting mental instability. Risks that were present, but were perceived by public health nurses as more easily controlled were considered secondary risks. A discussion of the perceived risks described by the nurses will be presented in the following section. These risks were identified as: (a) idle young men, (b) dogs, (c) suspicious and

threatening behavior, (d) substance abuse and unusual behavior, (e) angry family members, and (f) communicable disease.

Idle young men. When public health nurses saw a group of men they made an immediate assessment of the age, ethnic distribution, and activities of the group. As one nurse stated,

I remember uhm, going into this neighborhood and it was apartment building ... apartment buildings. And there were a bunch of, groups of males, like I don't know, ranging from maybe teens to like late 20s. And they were pretty much Hispanic race and African-Americans. I don't know, it was like they were kind of into drugs and things like that. And I was oh, my gosh, here I come. And you know, it just got real quiet as soon as I walked up. I had been to the neighborhood before but I had not been there at this time which I think the time that I went was probably around like 2. Usually I had been there in the morning, but this is the first time I saw these people hanging out and I just felt uncomfortable. You know, they just ... we had never seen each other before, that's what the problem was. And so I'd been coming in the morning, so they stopped talking as soon as I pulled up and I just got these stares, and I just went "hi", you know. And at that moment I was like should I say I'm a nurse? And should I say ... but I was like walking past them to get to where I had to go, so it was not really like I had to tell them. But... so I was kind of debating should I tell them, oh well, I just said, "hi".

Another nurse discussed her actions when she had the feeling she was at risk in a situation where she encountered a group of men, she stated,

Yeah, there was a couple of times where I felt unsafe; that uhm, there was some men hanging out at a patient's apartment building that I needed to go to. And I just got a feeling and I said, you know what, this is just not a safe place to go right now.

With the presence of females in a group, there was a perception that the group was less hazardous, thereby reducing the anxiety or discomfort experienced by the nurse. Additionally, when young children and their mothers were present there was a belief that the situation was less risky. Another nurse acknowledged this in the following statement.

In the beginning, I remember when I first started, there was like groups of people hanging out of males, they were all males. I think that was what made me feel uncomfortable because they were all males; (when) there was like some women, I'd feel a tad bit more comfortable. But they were just all males hanging out.

Nurses did not always see the presence of females as a lesser risk, however. As in this example, the nurse had additional concerns about her personal safety due to the response of the females in a group.

The first group, that were the boys and girls, they were all African Americans. And uhm, I think at that time I think I was more nervous about the girls, than the boys. Uh, I think the boys... they were looking more at the car. You know, what kind of car I was driving. They were looking at the tires. So they were looking at that. The girls were looking more at me. The way I felt is if I make eye contact with the girls they're going to misunderstand as a challenge. So, I avoided that. With the males, I didn't want to make eye contact with them, because I didn't want the girls to think something else was going on, or ... that's how I felt with them. With the young men at the apartment complex, the Hispanic males, I just didn't make eye contact. When they turned around and looked at me, it just didn't feel right. And then with their drinking, you don't know what kind of... how they're going to behave. So I didn't want to wait to find out.

In situations where drug use or gang activities were present, the influence of fear was more profound. Several nurses related their experience with groups of individuals selling drugs in their presence. One nurse explained the relationship between drugs and gangs in the following example,

If I go to a house, and there's a group of men, or something that feels like maybe drug things going on, I don't go there. Because it's... when you get yourself in a situation, you're the only one there. And even if you have a pager or cell phone or something, you know, I'm no, I cannot fight gangsters, and I cannot fight drug dealers, and I cannot get myself out of situations once I've gotten in.

Another nurse stated,

I made my home visit and as I was leaving, the individuals who had shot up were still there, but this time they had you know, five or six other individuals with them and I needed to go in that direction regardless because my car was there; there was no way for me to avoid it. And that really made me feel uneasy.

A third nurse suggested, "I don't put anything past somebody who's selling drugs. They were doing something illegal; what's to stop them from doing something illegal, nothing."

One nurse, with 26 years of experience in public health nursing, related several stories about her incidents with drug and gang activities. She had learned to be more vigilant regarding these activities in public housing projects. She recalled,

Oh, in the projects there was the time I had the "Gardens". And I remember hearing whistles and it was their codes, as you would progress and where you would park and so forth. Of drug deals and, you know, so you have to know what's always kind of ... the lurking -- One time, oh my, I think I came upon a drug deal. It was so frightening as I look back. I know that I was just... spared. I parked the car, I saw a man, kind of halfway in the block. I walked back to this corner house and called to the woman because the gate was locked. Chain link fence, gate with ... a chain with a little lock. And so she came out and by this time the man was right up to me and heard me talking about prenatal and all the stuff and just then a car pulled up and out of -- I don't know where -- maybe four or five people ran to the car and it was like they were getting their supply. A delivery of Avon, (Laughter) who knows -- everybody getting something at the open car doors and then I just looked and turned back immediately and just kept talking to this woman. When I went back to my car this guy said something like, "get out of here", or something -- when I think back on that they could have thought I was an undercover agent. Or something, so that was really scary.

In addition, nurses were placed in situations where there was the potential for involvement in police activity surrounding drug use. This was a major concern for the nurses, because they might be involved in surveillance activities or an actual arrest. Although the concern was primarily for their immediate situation, there was a concern that by being involved they could be required to testify during a proceeding. One nurse explained the immediate risk of being involved or shot during police activity, "if you see a group of people ... together, and they look suspicious looking, it might be something that is waiting to happen. It might be that the cop is on their way, and there

might be, you know, exchange of gunfire.”

Most of the nurses were less fearful of groups of men if they were outside or in an open, area. They expressed heightened concern however, if the men were inside the home, particularly when they appeared after the nurse had entered the dwelling. This situation was viewed as one of increased risk. One nurse described her experience as follows,

And I entered into the home, and then after being there for a few minutes, I think he may have had one or two friends that were there with him at the time, all male. So, I just kind of hung out for a little while and then the more ... I think some more men came out from the back bedroom. And at the time, I started feeling a little bit more uncomfortable, because I started thinking to myself you know, gosh, you know, I could, you know, really be outnumbered in a situation like this. And uhm, and so ever since then, that's the reason I think if I'm in a situation where I feel like it could be like a male-female outnumbered type of thing, I usually don't go. Now, if it's a house full of females, I usually don't feel nervous. Although I'm sure an outnumbered situation could occur there as well, but probably more unlikely.

In some circumstances, there was a sexual undercurrent present where there were groupings of men. Female public health nurses expressed this concern when they were in areas where inappropriate remarks, gestures, or staring occurred. Male public health nurses did not have these concerns with either male or female groupings of individuals.

In areas with decreased visibility or inside of a client's home, the concern of female nurses for their personal safety increased when several men were present. Some comments and particular actions by the group of men were more likely to produce a sense of discomfort on the part of the nurse than others. Usually this harassment was in the form of seductive remarks, leering, or staring during their work. This discomfort was usually expressed in a statement such as, “I just felt uncomfortable.”

Public health nurses had many concerns with the grouping of individuals, whether outside or within the building where the visit took place. This was particularly important when there was the potential for drug or gang activity or in any situation when there was a perception by the nurse that there was an immediate risk.

Dogs. The presence of dogs in the field was a constant safety issue for the public health nurses in this study. Regardless of the nurse's individual preference for or aversion to animals, dogs were considered a risk. Vigilance for and around dogs in the field was a focus for all of the nurses in this study. Many of the nurses interviewed stated that they had more concern with dogs than they did with other safety issues. One PHN suggested that she actually had more trouble with dogs than with people. She stated,

Sometimes I have more of a problem with dogs. (Laughter) sometimes I go to a house and I can't complete my home visit or I can't go up to the front door to drop off of a message card because they have a wrought iron fence and there is some vicious dog barking at me that I am afraid of, sometimes I have more problem with dogs than I do with actual people.

As with groups of men, the nurse would usually not complete the home visit when a dog was out on the street, in the front yard, or not well controlled. Instead, the nurse would either come back another day or call the client to ask that the dog be restrained. Many nurses expressed their fear of dogs and the possibility that they could be bitten or attacked by the animal. Many times this fear was influenced by an experience from childhood or from knowledge they had gained from other public health nurses. One nurse stated,

I hate dogs cause I had my brother... he was bitten by a dog right in front of me. His hand was bit. So ever since then, that happened probably like 4 years ago. Ever since then I've been kind of scared of dogs. So every time I see a dog in the yard and he's not tied up, I'm like I'm not going in. I'm not going in. Even

if he is tied up, if they happen to have a phone, I'll call them and say I'm here; kind of scared of your dog you know. Oh, we'll put him in the back, don't worry. Or I'll wait out... if they don't have a phone, I'll wait out there and I'll beep and I'll just kind of wait out there and they'll see me. So I've done that.

Another nurse described how a colleague's experience influenced her outlook on dogs. She stated,

Yeah, that's a problem in this area. (There) are loose dogs. And uhm, children getting bitten by dogs, so that's a safety. And we've had like maybe one PHN has gotten bitten by a dog. So it's something that is a big problem in our area, but it hasn't been addressed. And you know, you keep constantly reporting it, but ah, still there's nothing that has been done about it, but that is a very big safety issue. There has been times where I'll sit in my car and watch the dog go past. And I wait. And I wait. You know, I don't know if it is vicious or you know, so I just sit and wait. And so that's really it. That's really a large problem in itself.

Personal experiences with dogs on home visits also influenced the perceptions of the public health nurses. One nurse was actually bitten by a dog on a home visit and recalled her experience in the following example.

I had a family I hadn't seen in years and they had a dog. The dog didn't do anything and he didn't bother you. And one day, I went to where the kids were playing outside, and he bit me ... Yeah, it wasn't a big dog and it didn't need stitches or anything like that. I felt pretty secure with that dog, because you know I've been going there for quite a while. They moved from one address to another, and it was the same dog. And so I didn't feel as though I was threatened, I wasn't threatened by that dog. But after that I had a different feeling about the dog; even though we have dogs, and it's not as though I'm afraid of dogs. You know, we have two big ones, but as I tell people now, as long as he has teeth, he can bite.

One of the public health nurses was wary of even the sign purporting that a dog was present. However, her knowledge and experience in the community allowed her to make judgments about the veracity of the clients' *Beware of Dog* warning signs. She made the following assessment,

You know, I tend to feel pretty apprehensive when I'm going to a house and there's a big sign that says, "beware of dog". And then I'm always looking

around or trying to make some sounds to see if the dog's going to come running out. Many times the sign is just to scare other people away from the property and there is no dog in fact.

The breed of the dog was a concern for nurses in the field, particularly large dogs that were bred for fighting or protection. Pitbulls, Rottweilers, German Shepherds, and Doberman Pincers were types of dogs that prompted the nurses to increase their vigilance. Many families seen by public health nurses have dogs, but the trend to have particular breeds has changed in today's society. As one nurse commented, "a lot of people have dogs. And not just like little 'fufu' dogs, we're talking like big German Shepherds, Rottweilers, Pitbulls. Dogs you don't want to get into anything with."

Another was emphatic that the breed of dog was how she came to her decision on whether or not to enter the home or yard. She stated, "The dogs are an issue as far as I'm concerned. Most dogs... just because of the breed, I won't go in a yard where there's a Pitbull."

Even when the nurse was unafraid of dogs in general, the breed influenced the perception of safety. This was evident in the following statement,

Now if the dog is friendly and I can get acquainted with that dog, then I'm okay. Cause I like dogs. But most of my clients are into Pitbulls. And I'm not into Pitbulls and I'm not friendly with Pitbulls. Period. So, no, I don't march into their yard with a Pitbull in their yard.

Suspicious and threatening behavior. Within the context of home visiting, the nurses maintained a constant vigilance regarding the behavior of individuals on the street, clients, and family members within the home. Any one of these groups could become angry or difficult or be under the influence of drugs or alcohol. As previously discussed, the presence of dogs also threatened many nurses.

There were multiple forms of suspicious or threatening behavior that were

assessed by the nurses. There were the obvious threats made to their safety, as well as interpretations of gestures and facial expressions. In situations where the individual in question made openly hostile remarks or threats, the nurse had sufficient information to assume that the threat was real. Many of the nurses interviewed for this study acknowledged that “screaming and yelling” or statements that could be interpreted as an immediate threat were easily understood. As one nurse noted,

But hostility... people flat out telling me you know... I don't want to come to your doctor. I don't want you to come to my house any more. I don't want you to call, leave me alone. Those kinds of behaviors.

Each nurse had their own level of tolerance for threatening behavior and assessed remarks and gestures made in his or her own way. One of the nurses interviewed clarified how she assessed threatening behavior.

Uhm, someone who looks suspicious to me, would be maybe somebody who's pacing back and forth, looking around, scoping the area, may be doing things that are irrational and that's not too uncommon in the part of town I work in such as talking or screaming to themselves, or in an irrational manner, or uhm, just observing their behavior and you have to ask yourself what exactly are they doing? Is there something wrong with these individuals? Could it be a sight problem? Could it be drugs? But yeah, observing the individuals that are doing or acting irrational or suspicious again, just looking around pacing. Maybe uhm, observing you a little too long or observing your car or somebody else's car.

Openly hostile remarks and threats were easily assessed and interpreted by the nurses. However, data suggested that interpretation of body language and inferred meaning was much more difficult. As one nurse related, what concerned her most was the manner in which the individual spoke and the look in his eyes.

And I pressed the button for the elevator and he looks at me... and I'll never forget this. Because I mean, this is the only time... I was absolutely petrified. Because his eyes had kind of this unnatural glitter, and he said you know, he said, “you have such a pretty smile. I bet you've had a really nice day, haven't you”? And I thought, “you're going to screw it up for me.” (Laugh) There was something so menacing about that. And I instantly felt afraid that he was going

to assault me, or something. And I thought, and then I was irritated at myself. Here I'd put myself in this situation. And I thought, I have to get rid of him, I don't want to get into the elevator with him. And I said, you know, uhm, I've had... I think I said something like yeah, I think I just looked at him and kind of smiled and nodded. And I said, "okay, well thank you very much for your help." But he still didn't leave; he didn't let go of the cart. And the elevator came and the door opened, and I thought ... I'd done everything wrong up to this point; I'm not getting into the elevator. And he had something in his pocket.

Nurses in the field had further concern when individuals who were angry or intoxicated or had, or might have, a weapon. In the scenario above, the fact that the individual possibly had a weapon was frightening to the nurse. Another nurse in this study also described her experience with an individual with a weapon.

I had a woman pull a gun on me when I was a brand new public health nurse, and I relate information that this is always possible. And the important thing is I think you have to be calm, but yet when the woman did that to me, and she said how did you get into my home, and her brother had allowed me in. I just said to her, "you know, your brother told me to come in but I see it bothers you, so I'm going to leave." And I said, you know what? I don't think I'm going to come back. And of course, that turned her. She was a speed addict. But my safety was on the line, and you know... I felt number one, this had to be reported, of course which I did do. But the issue was I did not want to... I felt threatened and that was it, you know.

Once inside of a client's home the public health nurse might become fearful or uneasy. Many times this was due to the appearance of individuals that they did not know that behaved in a suspicious manner or had a threatening appearance. One nurse stated, "And if a person acts weird and doesn't let me into the home, I am happy not to go in. Because those are the ones that I don't want to set foot in." As with other situations of increased risk, the nurse might choose to leave the setting, return later alone or with an escort, or contact a supervisor regarding the potential risk within the setting.

Substance abuse and unusual behavior. Drug and alcohol use by individuals

added further risk to situations experienced by the nurses in the field. Not only did the demeanor and perceptions of the individual using drugs change, it also changed their perspective on the rights of others.

Specific types of drugs and situations surrounding their use could also change the experience of the nurse. Data suggested that heroin or any other drug that causes irrational behavior was cause for unease for the public health nurse. The following two excerpts highlight the importance of vigilance when assessing clients and others with substance abuse problems.

Heroin is a scary drug and I've encountered...I've had some patients with heroin addictions. The female patients with heroin addictions, and as far as field safety, I wouldn't put anything past a female patient with a heroin addiction. When they have that need, when they have that urge to get a fix, there's not much that they won't do to get it. No, I was just as intimidated by her when she was acting a little irrational than I was by men. Granted I didn't feel she could overpower me but when somebody's got that addiction, there's not much that I would put past them and I wouldn't put past them hurting me.

I walked to my car and pulled out of there, and nothing happened. But uhm, that street or that situation really made me uneasy about going back to that site. Because you just never know; people are on drugs, especially heroin, they really... their way of thinking is completely changed and you just never know what they're going to do. Even worse is if they have an addiction and they're hurting and they need a fix, you know, I could easily be a target to one of them and not much is going to get in the way of their need for that fix.

Regardless of the type of drug or form of substance abuse, the need for vigilance on the part of the nurse increased when an individual's behavior was irrational or angry. Even in those situations where the nurse had no actual need to make contact with someone abusing a substance, the possibility of risk increased when the behavior was present. Assessment and interpretation of behavior were necessary actions by the nurse. It was difficult for nurses to explain the process of vigilance when individuals were under the influence or in some way unstable. Their primary concern was with

identifying the behavior and having sufficient ability to deal with the situation. There were multiple scenarios that concerned the nurse. As one public health nurse stated,

For personal safety, you know, you have to be in this day and age, and in (a major city) it is just as bad as... you know, we have a lot of people that use drugs and we have a lot of homeless people; we have people who have mental health issues. And we have to know how to deal with those. And you just... you hear about people getting shot in cars, home invasions. So I think it's something as a person, I'm pretty... I try to be familiar with.

The presence of multiple risk factors intensified the nurses' perception of risk.

However, the data did not suggest that visits were refused or in any way modified.

When the risk to the public outweighed the risk to self, the nurses continued following the client. The nurses continued to remain vigilant as to the actions of the client. One nurse explained this issue in the following way.

Well, we have a TB patient who I think is a mentally ill man, who is an active TB patient who is in an apartment in the (well known) Hotel. And he's up on a floor by himself because he's such a nuisance. He's very incoherent a lot of the time. And he has polished long knives that are the kind that you hang on the wall, except that he has them out. And I know that's perfectly legal but it doesn't feel comfortable to go in to do direct observations there for his INH and his Rifampin and his other medicine, when he has these weapons out. And luckily (the community worker) ... He doesn't feel like that about it, but I do. When I've done the DOT (directly observed therapy), I don't like going there, cause I don't like the weapons. Plus the fact that the man is very difficult, he takes drugs, and he may just be very like a schizophrenic or something, and not on the right medicine. But we have him on home isolation so what are you going to do with him at this point?

Angry family members. In several instances, public health nurses discussed the angry family member of a client. Several of these individuals were parents of a pregnant teen. They had a sense of entitlement to information that was not being fulfilled due to issues of confidentiality. The nurse may be "cussed out" as a result of the need to maintain patient confidentiality. To some extent, the parents attempted to scapegoat the nurse, and the anger was projected at them rather than at the teen or the

situation. The data suggested that the nurse was a catalyst for previously unresolved issues within the family. One nurse's story illustrates the escalation of risk when a family member became threatened and angry.

And another time I had an incident where I was very young, it was about my second week in public health going out alone. And I went and talked to this girl about her perpetrator (sexual partner) as far as her STD. Well, what I didn't know, she was outside on the porch with me, but her perpetrator was listening through the screen and he brought out a gun and he said get out of my yard. And so I said, "I'm out of here." And then I went back and told my supervisor ... she got a phone call when I was there and he said, "So do you know S. P., is that one of your nurses"? And she said yes. And he said, "Well I'll tell you what I told her, if you send anyone out to this house again, I'll shoot them." Well, it ended up he was the father and he was incesting (sic) his daughter. So we sent a PHI out with the police back-up to get the daughter into STD clinic, who told the story that she was underage and this was her father had been molesting her for years and it ended up being a safe situation, but there again I mean, it's a situation that could of ended up being a disaster.

Some family members became angry due to a lack of information or a misinterpretation of the nurse's purpose in visiting the client. In other circumstances, the anger was partially due to guilt or fear on the part of the angry individual. The following example addresses both misinterpretation of purpose and fear related to previous behavior.

Well, apparently her little brother who is like a gang want-to-be told her boyfriend that the nurse had been there, ... and then he saw the paper and he thought I had been trying to talk her into having an abortion. So he called me and he told me he didn't want me making any more home visits over there, and he was very arrogant. And I said, "Well that's really not something that you can control." And he said, "You think that I can't stop you from making a home visit over here"? And I said, "Are you threatening me"? I called him on it right away and he backed off, and I then... you know, I told him that I thought that he could use some counseling for anger management and if he wanted his girlfriend to have a healthy baby that he needed to not be pushing her down stairs. Well, then of course, he got upset. "Well, I only pushed her down 2-3 stairs, you know." "We're not arguing about the number of stairs you pushed her down." So anyway... but he was not a happy camper when he got off the phone with me. In fact, he ended the conversation by calling me an F...ing bitch. So that had happened about 2-3 weeks prior.

Communicable disease. Public health nurses have a responsibility to provide follow-up to clients and surveillance of communicable diseases in the field. Although data does not suggest that they were overly concerned with this risk, nurses did use their knowledge regarding infection control and epidemiology to protect their own health. Two excerpts describe how nurses protected themselves from exposure to known cases of tuberculosis.

Well I tell you, not usually CDs (communicable diseases), but usually tuberculosis. When I get a case of a TB (tuberculosis), I won't do the interview in the house. I'll do it on the porch. I'll do it on the back porch. I'll do it on the side of the house... with the case if they're able... talking to me through a screen, or through a window, and hopefully with another family member. That's what I do, especially if I know it's TB. And I do that for... I've done it forever, and I'll always do it. Because how many times have we said, or we just have our preliminary diagnosis, you go into the home and you're unmasked, and eight weeks later you find out then it was TB. And you were in the house, it's an intensive interview face-to-face without a mask, on either part, and you find out that the person has TB, now you're getting skin tested every three months.

Oh, the only one that I can really think of would be a clear positive case (of TB). And uhm, some of the things that we do is we wear our mask in the house for safety reasons, and to prevent us from coming down with TB. And that's the only thing. You know our salmonella, other enterics - all those I feel comfortable with. Uhm, but just the TB. Like, sometimes if you don't. If they haven't documented correctly that this patient is positive, and we go out or we go out without our masks, and that will be a safety issue. Yeah. But most of the times I've never experienced that. I usually always know that my patient is smear positive. And even if they're not smear positive, they're TB cases, usually I always have my mask in my car to prevent me from coming down with the disease.

Likewise, nurses were aware of the potential for contact with other communicable diseases. Field public health nursing had a certain measure of sociability that was expected behavior for someone visiting a client's home. For many, refusal of hospitality was difficult, but due to the potential for exposure to a communicable disease it was viewed as a necessary consequence. In an effort to protect themselves,

nurses weighed the possibility of being discourteous.

I didn't always accept drinks or food from folks, not knowing first of all, if I was there for an ACD (acute communicable disease) kind of thing I didn't want to drink or eat anything. (Laugh) Usually, you know, if I ask for anything, I just ask for tap water if they offered me something. I mean that's safe.

Another nurse gave the following example.

And of course, uhm, the other issue is we're not allowed to have anything, to eat or drink from these homes. And often times they do offer you ... many times they offer you something to drink. And they tell you go ahead and have it, I won't say anything. But you know, we're not allowed because of the safety issue. Or, uhm, they want you to come in and eat. Here's someone who's diagnosed with Hepatitis A; they offer you a glass of water, you know, things like that.

There were other risks, within the context of communicable disease prevention, over which the nurses had some concern. This concern was not only for themselves, but included their families. The data suggested that nurses tried to avoid bringing disease or pests home with them from a visit. These risks could be actual or perceived in nature. One nurse observed that the home she visited was "so filthy that you do not want to sit on anything for fear of carrying home things that you didn't bring with you."

Another nurse identified her concern regarding common pests.

Sometimes I'm concerned about, I don't know if this falls under safety but, I'm afraid that I'm gonna catch umm, maybe some lice. Or, you know, roaches, umm, because I have had head lice once from a home visit. So, umm, I don't know if that particularly falls under safety, but I'm more aware of my surroundings where, you know, the environment within the home is unkempt, unclean. That sort of thing.

Dealing with the unknown was also a part of the nurses' experience. Although, the mode of transmission was unlikely to occur, nurses found that taking extra precautions with disease prevention and control gave them more security regarding their own safety. This need for precaution was more likely to occur when the nurses had

physical objects or specimens come in contact with their person or clothes. In the following example, the unpleasant nature of the contact with feces gave the nurse a reason for concern.

Well, I think there are issues of safety other than that. I mean the kind of diseases we go out on, are high-risk diseases. And we don't. Like we've discussed the fact that if you're going out, like I went on a very nasty kind of worm that affects the brain, and there was feces in the back yard and it got on my shoe. Well then I didn't have any shoe coverings. So what I had to do was take the shoe off, get in my car without the shoe, you know, go home and bleach the bottom of my shoe at my lunchtime. Because I didn't, I don't know whose feces that was, if it was infested or not. But I mean, we do the kind of job is a high-risk job in the first place as far as the organisms that we deal with.

There was the potential for nurses to become so vigilant regarding their responsibilities for follow-up of communicable diseases, that they eroded the level of vigilance, regarding other safety risks. One nurse illustrated this point in the following way.

I used to many times, go out in the night because the men are off their jobs and so to try to get their TB follow up I would go there. I really quit that because I didn't get such a good yield. I would have a yes, yes, I'll be there and not show up and I was putting myself at risk and staying late hours and you know, now it's like, we have to take some responsibility and I just was so diligent that I felt that I had to do that. It's an endless thing to do that, so, I'm glad I don't do it any more.

Risk Estimation

The second stage in the process of *keeping safe* was *risk estimation*. In this stage, the nurses estimated their level of risk by determining their vulnerability and ultimately deciding if the level of risk was manageable or too risky to pursue the visit. Determination of the level of vulnerability by nurses was dependent on the several factors. These factors included time of day, presence of assessed risk factors, extent of the nurses' visibility, and characteristics of the home visit, family, and neighborhood.

After these factors were considered, the nurse determined the level of risk. Data suggested that the majority of the nurses' decisions were reached through instinct and feelings.

Vulnerability

Within the context of home visiting, there were certain conditions to which field public health nurses responded and maintained their vigilance. The importance of these conditions varied in different situations and among public health nurses. The nurses assessed vulnerability as being at risk for the possibility of injury or harm. These risks were either physical or emotional hazards or risks to their property. Multiple factors or conditions influenced the nurses' perception of vulnerability they included: (a) temporality, (b) visibility, (c) recognition as a public health nurse, (d) protection by the community, (e) perception of police protection, and (f) mistaken identity.

Temporality. As a condition of vigilance and vulnerability, time of day and season of the year had a considerable influence on the practice of public health nursing. Universally, public health nurses interviewed for this study reported that time of day was a deciding factor in whether or not a visit would be attempted or completed. One of the nurses was very specific regarding the influence of time of day. She stated:

Well, mostly what I've learned, since I've been here, they've told me, emphasized that, and what I've seen and experienced is that in the morning is when pretty much people that have been up all night, the night before into drugs or any sort of... (laugh) criminal activity, pretty much, they're pretty much sleeping in the morning, so I've just kind of made it a habit to try to do my mornings up until like 12; after 12 you get a little bit more of like groups of people hanging out... But time of day is very important because again you know, you have pretty much mostly the people that are into like any crime or drugs, they're sleeping at that time and it's kind of more peaceful. You know, just ah you feel more safe because of that. There are less groups of people around. After maybe 12 is when you get more of the groups of people hanging out. So I would say time of day is really important to the individual and how

they make some ... adds to their comfort level.

The primary reason time of day had an influence on practice, was that there was less activity on the streets earlier in the day. As another nurse noted:

Time of day, usually earlier in the morning before 10 or 10:30 in the morning, when neighborhoods are kind of still quiet, sleepy, lazy. That would be the primary time to go out ... The other time of day that I would try to go out would be 3:30-4:00 in the afternoon, as kids were coming from school. And you had moms picking up kids and walking kids back home and stuff. So there was a lot of family, kid activity around. Those would (be) the kind of two times that I would choose to go out when I was in Pico & Union area. I wouldn't go out later than 4, or try to be back in the office by 4, especially in the wintertime when the sun is starting to set down, and beyond that when it was dark. Skid row same thing; early in the morning. Most folks if they've done their drinking and drugging, they're going to be passed out early in the morning. And chances of trying to find people at home or in the hotels were greater earlier in the morning. You'd end up waking them up, but you'd find them. And so that would be a good time to go out and do things. Starting around 11, lunch time, is when people started packing up their boxes and getting more active, being out on the street, and I wouldn't want to walk around Skid row in the afternoon, there's too much going on, and it's too hard to keep track of everybody and everything that was going on.

Even those with little concern for their safety on home visits acknowledged that time of day has a direct influence on their practice. As one nurse stated, "I don't usually feel unsafe. And I guess... it's my... attitude that I expect the best from people. The only time that I do feel uncomfortable is going late in the afternoons when there is a lot of activity out on the streets."

Seasons of the year also influenced the perception of safety among public health nurses. These times of the year included the summertime, schools breaks, and warm spring or fall days, when truancy was an issue. These seasons tended to allow teenagers and young adults to have more interaction on the streets. Another time of the year that was noted to be problematic was during Christmas time. As one nurse stated,

To me ... gosh, I ... for some reason during the holidays especially around

Christmas time, it's when I'm a little bit more aware of what uhm, I don't know people are needier or more desperate to provide for the family, and they're going to try to get it anyway they can.

Visibility. When in the field the nature of the roles and responsibilities of the public health nurse created a setting for visibility. In contrast, there was also the possibility that the nurse would not be visible, either by choice or as a function of the process of the home visit. There were situations where the nurse chose to remain anonymous in the field when protection of the client's confidentiality was at risk. However, most situations lend themselves to recognition of the nurse as a positive influence for the family and the neighborhood. Both visibility and invisibility in the field provided situations and perceptions of increased vulnerability for the nurse. In the following section, the visibility of the public health nurse is discussed.

Recognition as a public health nurse. The data suggested that being recognized, as a public health nurse was the primary means of visibility for nurses in the field. In general, most of the nurses interviewed for this study voiced the belief that there was some protection from risk when clients and neighborhoods had knowledge of and respect for their vocation. One nurse illustrated this belief in the following excerpt,

I feel safe all the time. I mean, I think that I feel very fortunate that I'm a public health nurse, because nursing is one of the few professions left where people have a lot of respect for nurses. And they... if you say that you're a public health nurse that opens the door to you and diffuses the hostility right there.

Another nurse stated, "Pretty much the neighbors, they know who I am. There is an understanding that I'm a nurse and I'm going to visit these people, so I don't have any problems."

The nurses, however, were realistic in their beliefs and realized that some clients and communities are unfamiliar with the roles and responsibilities of the public health

nurse. At times, there was a need for the nurses to educate the public to their value in the community. One nurse illustrated the need to educate the public about both the role of nursing and the expanded role of the public health nurse.

Especially because a lot of the public don't know what a PHN is. ... If you're an RN, you know, registered nurse, they get that. But you almost have to explain to them what a PHN is, so I just say I'm a nurse, you know.

Likewise, nurses could not take for granted that all families who showed respect had the best interest of the nurse in mind. In the following excerpt one nurse described how culture usually had a positive relationship to recognition of the public health nurse. However, she had had an experience with a family that led her to believe that if possible they could have placed her purposefully in harm's way. The nurse believed that had the family had a chance, they might have set her up. This nurse remarked,

Often, you know, with some families that you see at all times, because of environment, how clean it is, who lives there, their attitude towards you. Some families know you are coming back. That gives you a good feeling. The other thing is the class of people you are dealing with. They can go across the board. You know that sometimes they do not respect us. Some cultures, the countries, you are in their home and ... their culture is to protect, you know, but here they don't have that fear. So sometimes, they are going to set you up. (Laughter)

Care must be taken by nurses to not depend too heavily on the respect that one has in the community. There was a need to balance the recognition of authority and helping nature of public health nursing with the rights of the client and family. As one nurse noted,

I think I just try to be down to earth with people, and not... I don't come in there with the whole thing I'm the nurse, on my sleeve. You know, yes I'm here. I'm the nurse, but I'm here to help you and I'm not trying to talk over you, or trying to make you feel like you need to do exactly what I say.

There were also negative features to being recognized as a public health nurse. Being recognized as an authority figure in the community altered the perception of

clients and families. This negative perception of the public health nurse crossed all socioeconomic levels. The data suggested that not all individuals, regardless of where they are in the strata of the community, regarded public health nursing as a helping relationship. As one nurse stated,

I think going into some of the ultra-rich areas, is just as hard as some of the high-risk drug areas, because they don't like public health; they don't believe in public health; they don't want government interference. And sometimes you don't get in. You know, they have a gate, they have a walkie-talkie at the gate, and as soon as you say public health, they just shut you out; they close it; they turn it off. So, uhm, you know, both ends, both extremes are harder to deal with than the middle.

It is the responsibility of nurses to notify each client in their caseload of their identity, purpose, and business affiliation. Being identified as a nurse was not taken for granted or assumed. The nurses confirmed that this was their responsibility. As one nurse stated, "Always before I go in, I always introduce myself and tell them where I'm from, why I'm here."

Nurses were faced with a dilemma in the community when looking for clients and needing to be recognized as a public health nurse. In some situations it would have been safer for nurses to identify themselves and their purpose. However, due to the confidential nature of public health field visits, the nurse remained somewhat anonymous. Nurses struggled with the complexity of staying visible and yet maintaining the confidentiality of their clients. Community members did not always recognize the need for nurses to protect their clients' information. As the following example illustrates, nurses have to develop ways in which to remain visible but protect their clients.

I get a lot of questions from people. "Who are you"? "What do you want"? And when I have the badge on it's easier for them to identify me as a public

health nurse, and I think that, if I'm going out into the community to see a patient for TB, other people don't need to know. And actually confidentiality mandates me not to inform them why I'm there. I need to maintain the patient's confidentiality, and so that avoids that you know, well if you're a public health nurse, why are you here, what's wrong with him? Generally, I just say I'm looking for this individual and it's a personal matter, or it's important that I get a hold of him, or something else other than I'm a nurse looking for this individual. So by not wearing it, they just don't identify me as a nurse and they don't identify whatever individual I'm looking at as someone who's ill or something. And that way I can maintain confidentiality for the patient.

Seeing and being seen. Another, slightly different, perception of vulnerability emerged from the data, "seeing and being seen". The category of recognition as a PHN related to clients and the community's understanding and respect for the public health nurses. "Seeing and being seen" had to do with the physical process of seeing and being seen by others. In some respect, this concept was closely linked to vigilance, as the nurse must be acutely aware of the surroundings and plan to stay in view. There was a second component of this concept. The nurses made others aware that they were seen as well. The data suggested that there were particular situations and/or environmental factors, which supported or limited the nurse's ability to see and be seen. In areas where they could see and be seen, nurses were more likely to perceive themselves as safe. Conversely, when visibility was limited, they were more likely to feel more vulnerable. Aspects of seeing and being seen included physical environmental characteristics of buildings such as corridors, elevators, and stairwells.

Universally, the nurses in this study reported that long apartment corridors, elevators, and dark stairwells were areas most likely to be perceived as unsafe. In these areas, the potential for the nurse to lose sight of others and for others to lose sight of the nurse increased.

A premonition or "gut feeling" usually accompanied the nurse's personal

experiences in these areas. The following two excerpts illustrate both the perception of risk and the accompanying premonition or “gut feeling.”

The elevator was located... actually it was very dangerous. I have even said. You had to walk underneath that area where like once you walked underneath the flight of stairs, nobody could see, there could have been anybody lurking back there. Then you'd open the door, go into the lobby of the first floor, which was usually deserted, and reeked from urine from you know, the homeless people that would hang around. And then you would take the elevator up. And I had told people in the past, you know, this isn't safe for our families.

But uh, I went into a dark hallway in a building with a dark hallway and had to go upstairs in the dark. And it's just like you know, you go... this red flag comes up and you get this feeling of oppression maybe even ... And it's like you want to look over your shoulder because you're not sure. Even with young kids sitting in the stairwell and you're having to ask them to move so that you can go up this dark stairwell. It's an uneasy feeling; I guess maybe it's in your gut ... I've had a couple of clients in situations like that where I was not comfortable going into their building. Narrow hallways, dark hallways, numerous doorways coming off from the hallway ... Well, it's like you don't know what's lurking right inside that door that you're passing.

Some of the thought processes of the nurse might be considered by some as irrational. These perceptions of risk, however, were very real to the nurse. As with the following excerpt, the nurse associated the risk of darkness with a potentially dangerous outcome.

And another time I felt, uh, I don't know, I guess it was a really, dark, dark apartment building, but it was in a hallway and I said, you know, something could really happen to me and no one can find my body back here ... I don't like to be in the dark. That's why I was saying I felt unsafe when it was really dark. A dark area where I can't see much; I can't see anyone coming towards me, so that's when I don't feel safe.

When the nurse perceived a risk or an increased level of vulnerability, vigilant assessment of the area increased, particularly in the assessment of other individuals in the area. When there were multiple problems assessed during the home visit, the perception of risk increased. In the following example the nurse had multiple issues to

assess.

The four-story building where the elevator is broken down and I have to go up the darkened stairwell. That I know I am very, very cautious, in those types of areas where I watch my back and behind me. And make sure there is nobody following me and also there are some buildings that have, that have long corridors and are poorly lit, and sometimes the apartment that I need to go to is way down the hallway.

Seeing and being seen was an important condition during the process of *keeping safe*. The nurses avoided situations where their ability to be seen by others and to see the environment around them was limited. Darkness and hidden areas were among those that were vigilantly assessed.

Additional areas of concern were those in which the environmental characteristics permitted the possibility of concealment. Concealment could either be related to a potential risk or to the possibility that the nurse might become hidden from the view of others. One nurse' story illustrates both of these areas of concern.

I had to find a teen once. She lived in a trailer. Then I went to this area; there were so many trailers in this one... They all belonged to one person, one family but they were... quite a few of them are little... He, let you know, he was the type of guy that put up on his own electricity, this type of thing. And I had to go up to these trailers, and there were dogs tied. And I had to find (one) that was way in the back, and I am trying to see how far it is from the street. It almost looked as though I was in another country, after going to these trailers, trees, that could hide me... this sort of thing. And I felt, felt unsafe. I felt as though, you know, I could get into something behind there, nobody would know I'd disappeared type of thing.

Protection by the community. Data suggested that the level of vulnerability determined by the nurse was connected to the degree to which they believed they were valued in the community. Nurses were sustained by a belief that their clients and the community they serve respected them, thereby providing some protection for their safety. Nurses in this study described this belief with statements such as, "the clients do

protect me” or “There are people, in some neighborhoods, there are actually people who watch out for us, because they know we’re the nurse.” At times this protection was verbal in nature, in that the client warned the nurses of a dog in the yard or that the neighborhood was unstable. In other examples, the clients walked nurses to and from their cars or physically separated them from angry clients. One nurse explained the connection between public health nurses and the protection they receive from the population they serve.

In general, uhm, you’re out in the community on a daily basis, the community gets to know you, and they get to know you as who you are. The public health nurse who is out there trying to improve the community. And they respect that, and in general they take care of you; they look forward to seeing you. They extend their arms out to you.

Perception of police protection. The nurses reported some reliance on the presence of the police in the areas they serve as they measured their level of vulnerability during field visits. Most had their cell phones available and related that if they got into an emergency situation they would “dial 911.” However, the data suggested that the police were often unaware of the presence of the public health nurse in the community. The nurses acknowledged that they had had police officers remark that nurses should not be out in the field in certain areas. One nurse recalled, “I was approached ... by police officers, asking me in the middle of the day what was I doing in this area.” Part of the perception of the nurses regarding their safety in neighborhoods was directly influenced by the attitudes of the police officers in their districts. Many of the nurses concluded that the police in their areas were not even aware of them. As one nurse stated,

They didn’t know we were out, even you know, they didn’t know... had never heard of public health nurses. Didn’t know we were out there. But were very

nice about it, “if you guys need anything, just let us know.”

Mistaken identity. A consequence of lack of recognition was mistaken identity. Mistaken identity in the community increased the sense of vulnerability if the situation was considered one with increased risk.

In addition to the public health nurses, there were many individuals who had business in communities. Nurses visiting in the field were frequently thought to be from a different discipline or job classification. Examples of the roles they were mistaken for included doctors, social workers, immigration or police officers, and welfare workers. They were also mistaken for evangelists or as one nurse noted, “Jehovah’s Witnesses.” It was not uncommon for the nurses to report that when first introducing themselves to families, they said, “hey, I’m not from Immigration, I’m a nurse.”

Some of the disciplines working in the community were seen as a threat, particularly those in positions of authority. As one nurse noted, “a lot of it can just be them knowing who are you. We’ve had bad experiences with whoever’s coming into our neighborhood, CPS or whatever, police.” The data suggested that nurses perceived themselves as more vulnerable when they were incorrectly identified as being a person of authority. The following two excerpts illustrate the perception of risk by public health nurses when they were given a mistaken identity.

I feel safer going into someone's home, than if I was a social worker, for some reason, but things are changing. ... I am not quite (the) threat that a social worker is. So that would give me a feeling of more safety, a more safe feeling.

Oh most of the time when you show up, I would say at least 50% of the time, when you show up on somebody’s doorstep unannounced, and this is a family usually with multiple issues, they’re going to assume you’re from Department of Social Services. They’re going to... oh, excuse me, Department of Children

Services or Department of Social Services. They either think that you're a social worker or you're there as a probe investigator. So yeah, initially that's who they think you are. And even if you were wearing a nametag, they are still going to think you're them. Because... all of the nametags have that (county logo).

Issues of gender played a significant role in mistaken identity. Female nurses were more often mistaken for social workers or evangelists, and male nurses were more often mistaken for police and immigration officers. One of the male nurses explained that a prostitute had mistaken him for a potential client on one occasion. A female nurse's story illustrates the initial response to her unannounced visit.

One time I was out on a case for chronic head lice. And the woman opened the door, and literally said, "Who the 'F' are you"? That's the greeting I got. And I told her ... my name ... and I'm here, I'm the public health nurse, I'm here to try and help you get rid of the head lice. Oh, I'm so sorry; I thought you were someone else. See, she probably thought I was from child protective services, or not the health department, Children's Services. So immediately, come on in. And then, I mean they talk to you and they give you more information. Or give you the information more readily. Because they don't feel threatened by you. And so really, I used to feel that public health nurses were just more competent than social workers. But that's not really a completely fair thing to say. Social workers are in a more difficult situation. I mean, how good is a reception going to be when you announce okay, I'm a social worker with the department of children services and we got a referral? That you know, that you were neglecting Johnny. So I don't know if I get a little bit more willingness from the people that talk to me, until they find out I'm a nurse. You can tell right away. I tell them you know, I'm not a social worker, I'm a nurse; I'm here to talk about health issues and see how we can help you. Then you can tell... or I can tell right away, they kind of breathe deep and they kind of let their shoulders down, as if they are relaxing. So I think at first, when I first walk in, I don't know, if they think I'm a person of authority, and you know, they must let me in not knowing ... it's voluntary, I don't have to go in, you don't have to allow me in.

A male nurse's story elucidates this issue further,

It's not typical for a male public health nurse to go out into the community. I was actually the first male public health nurse in the ... district. And when I'd walk into some of the hotels on certain occasions I'd get some people, and people out in this area they usually don't hold back; if they want to say something they'll say it. And you know I'd walk into a place and people would question me. They'd look at me and say are you a narc? No, I'm not a narc.

Are you a police officer? And I'd have to tell them I was not. And try to avoid getting into who are you. No, I'm here to visit somebody. But for some reason or another, walking into these hotels, uhm, even though I try to dress the part, sometimes it was clear to them or a lot of times it was clear to them that I wasn't somebody who belonged there. And I was questioned and usually their first inclination was that I was a narc, a probation officer, or a cop. And uhm, I had that problem more so the first six months that I was here, probably because I think they sensed that I was a little more uncomfortable back then. I wasn't... I tried to fit in a little too hard, maybe. And they caught on to that and questioned me. There was an occasion when I made... (Visits with another male public health nurse) ... And he made a home visit with me, and both of us walking in there, it, was even more ... odd for them. And then the one day we went into an SRO, we were stopped 3-4 times people asking us whether we were probation officers or narcs. So, as a male public health nurse, you get that a little bit more I think. You're not ... the typical public health nurse.

Distractions. When the nurses were unable to successfully complete the assessments necessary for vigilance in the field, their perception of vulnerability was increased. There were several conditions that presented in the field which were considered by the nurses to prevent vigilance from occurring. These conditions will be described in the following section.

Public health nurses were faced with multiple distractions. While driving they needed to find the address, park, or determine if an area is safe. There were several distractions that decreased the nurses' ability to interpret their environment. According to the nurses in this study, distractions created the potential for them to drop their guard and increased the potential for vulnerability.

Transporting records and supplies was an example of a distraction. One nurse spoke of how she let her guard down while transporting a large number of patient files. She felt more responsible for the confidentiality of the files than for her personal safety. She might not have noted this behavior had she not felt threatened by the behavior of a person following her. After this experience, she realized that her own safety was more

important to her than the files.

Another example of a distraction for nurses was looking for an address. In most cases, the process of mapping out the route to follow occurred while at the office, but nurses unfamiliar with an area needed to find the address while driving to the destination. One nurse remarked,

I always pay attention when I am out in the field. And it is easy not to pay attention sometimes. Because you are really busy doing what you're doing. Looking for an address and I try to look, well before I get out of my car I am always aware of that and surroundings.

Distractions occurred when the nurse was looking for an address. Many client homes were in garages, small structures behind the main home or in campers on the property and were difficult to find. The need to maintain focus while traveling from destination to destination was very important. As one nurse stated, "And I guess, that you know, you always turn the radio off when you don't want to be distracted and you want to focus on things."

Safety decision-making

The second element of *risk estimation* was *safety decision-making*. Once the nurses had determined their level of vulnerability, they needed to make decisions regarding their safety and the action required. If the nurses believed that their risk was manageable, they would continue the visit. Continuing the visit was predicated on the probable success of risk limitation actions taken by the nurses. Conversely, if the risk was determined to be too great or considered unmanageable by the public health nurses, they would terminate the visit. One nurse stated that decisions to terminate a visit were made in a "nanosecond." Data suggested that there was a frequent conflict between *keeping safe* and completing the home visit. The following section will discuss safety

decision-making within the context of getting the job done.

The ultimate outcome of the field visit was “getting the job” done while maintaining safety. As one nurse stated, “Sometimes getting the job done, may put the PHN at risk. This risk is known to the PHN. Or at least it is assumed. Taking risks is a part of getting the job done.” However, the nurses were aware that they had the right and the responsibility to protect their safety. As one nurse observed, “no home visit is so important you can't leave. This is not a life-and-death situation.”

Focusing on the fear of risk could be paralyzing for nurses. One nurse described how she avoided dwelling on negative thoughts and was thus able to complete her tasks.

I guess, most of the time I do feel safe... I wouldn't say I feel unsafe; I don't feel like I'm in danger all the time. Let me put it that way. I feel that there is always a chance that something is going to happen wherever you are. But I try not to dwell on the negative, or else I wouldn't be able to do my job. I'd always be looking over my shoulders. I don't know.

Another nurse attempted to focus on the positive aspects of getting the job done. She realized that the potential for danger existed, but viewed her job as pleasurable. She stated,

And it's not scary; it's a fun job to have. And it's not always scary. And there's going to be sometimes where the patients don't like you, and they don't agree with what you're telling them to do. And just enjoy the job and relax. Usually, it's rare that things happen, but just, aware that they could happen.

The desire to get the job done became a condition for placing the nurse at risk. In the following excerpt, the nurse recognized that she had occasionally placed more importance on the job than on her safety.

There are some clients that we're just not going to find, you know, and I don't want my safety in danger, but you're really thinking about your job sometimes more than you're thinking about your own personal safety, which can be bad.

Much of the decision-making by the nurses regarding perceived and actual risk

was influenced by instinct and feelings. Visits were rescheduled or terminated if the nurses felt unsafe or had a “gut feeling” that they were in danger. Many of the nurses reported that they would leave an area or client home if they felt “really scared” or if things were “just too weird.” Nurses experienced more gut feelings in some situations than others, such as dark hallways and elevators. The nurses usually paid attention to these feelings when they were experienced.

In summary, *safety decision-making* was complex. It was also personalized to the tolerance level of the nurses. However, certain conditions such as the presence of weapons or threatening behavior were unmistakable clues for the nurses. *Safety decision-making* was ongoing; in that when risks were identified as manageable or absent the nurses continued their assessment regarding their level of vulnerability as the visit progressed. Nurses attempted to maintain control in guarding their safety throughout their field visits.

Risk Limitation

The final stage in the process of *keeping safe* was *risk limitation*. In this stage the nurses advanced from determination of risk and *safety decision-making* to implementation of a selected course of action. If the identified risk in the situation was deemed manageable, the nurses continued their visits. Conversely, when the situation was deemed uncertain or too hazardous the nurses determined the appropriate way to extricate themselves safely from the visits. Nurses reported two general properties of *risk limitation*, strategies implemented by the nurse that either prevented risk or avoided impending risk.

Risk Prevention

As vigilance and determination of vulnerability progressed during home visiting, each nurse began to develop techniques and strategies for preventing risk, maintaining safety, and increasing their awareness of the environment. In the following section, the preventive strategies reported by public health nurses will be discussed.

Peeking in the door. Many of the techniques developed by public health nurses for preventing risk revolved around entering and planning an exit from a home or neighborhood. Data suggested that these were the times nurses perceive their vulnerability to be highest. Many public health nurses would not enter a home without first knowing what was going on inside. They made a quick assessment of the interior of the home by looking for people, listening to sounds, and assessing smells. Reasons for not entering the home were varied; predominant concerns were the presence of drugs and weapons. One nurse's story illustrates these concerns.

I got out there bright and early, and I was still several doors down from the apartment complex, when I could smell the pot. I thought, okay, God it's 9:00 and they're already getting high. I thought I wonder if that's coming from the place I want to visit, cause it was very strong. And so uhm, well anyway I knocked on the door and a male voice said come in, and I never go in you know. And I knocked again, and the person said come in. And I've noticed too at homes where there is drug activity, they have very strange boundaries. There's always people coming in and out without knocking. A lot of times they don't bother going to the door. I mean I'd certainly want to go to the door if... you'd think that if they are doing illegal activity that they'd be a little more cautious. But anyway, he just kept saying come in. So after like three times of this, he uhm, all of a sudden the door opens and there's this tall black man standing there in pajamas and he has a handgun tucked into the waste of his pajamas. And I see the gun, and I thought, you know, I see the gun and then he sees... and the expression on his face was of total shock and surprise. Obviously he wasn't expecting it to be me. He was expecting someone else. So right away, he looks kind of flustered, and he closes his pajamas really fast like, hoping that I hadn't seen the gun. And I pretended that I absolutely hadn't seen it, no problem, you know, and I just announced who I was, and who I was there to see. I was there to check on the baby. He said the mom isn't here right now, but you

can come in and you can... the baby is asleep in the crib; you could check the baby out if you want. And I said no that's okay, I'll come back at a time when she... when do you think she might be around? Now, and I really... I don't think he had any bad intentions.

Peeking in the door was more than visual. It involved the use of all senses. The nurses also relied on the vibes they got from the client's reactions. One nurse explained, "Before I walk into a patient's home, I try to do a little... try to feel the client out a little. And if I sense... uneasy about the client then I just won't walk in." Another nurse described a peek in the door as,

Generally, like if someone... well, usually a lot of people that answer the door, they kind of crack the door. If someone is really cracking the door, like all I can see is like one eye then I know they probably don't want me there. But uhm, but that's pretty infrequent I have to say, and I, uhm, usually people will open the door up enough for me to get a clear view of their entire being. Uhm in addition to allowing me to kind of peek around them a little bit into the background as to what the situation is in the house, you know. If it's looking pretty messy in there, or dark, or if there is more people in the house, usually there's some background noise, you know, kids playing or TV on. So I can kind of get a quick idea of you know, what the environment is and if it is something that I want to or might feel safe doing. So, but usually people's appearance. Sometimes people are just getting out of bed; work the night shift or whatever their situation might be. So, uhm, but generally I find people to be pretty welcoming and just surprised in general that somebody's there. That a nurse is standing there on their doorstep, you know, and how did you find out.

Having an escape route. There was a tendency for the field public health nurses to stay close to the exit when on a home visit. As one nurse stated, "I'm always aware of the entrance and where I could go to get out." Unless public health nurses really "knew" the family and felt comfortable with the environment they would not venture deep into the home or structure. Nurses usually needed a reason for leaving their comfort zone. The following two excerpts describe the assessment and decision-making process when assessing for exits in a home.

If I've been there lots of times and I know the family, I know the circle of

friends, and whatever, and say they want to show me... Oh, look, I just took a picture, it's on this wall. I'll go back out. Or look, I have something in my room. That would make me feel more comfortable, but that depends on how often I've been there. I already know pretty much their circle of friends and family. I know what's going on. So that kind of makes me feel more comfortable to go back into the house.

Usually, until I get to know the person, I don't venture too far from the front door. Usually there's a couch, sofa, or chair within you know, the front door area. So I try to stay close to the front door; try not to get trapped, go over furniture, or way across the room, and I couldn't get out.

Data suggested that the nurses maneuvered families and directed the visits in such a way as to protect their safety. Nurses recommended that the visit take place in a particular area of the home or out on the porch, when necessary. As with accepting refreshment, the nurses reported having to balance safety and the potential of being seen as discourteous when entering and exiting a home. One nurse illustrated how she politely directed where the visit took place in the home.

But I don't like to go too far back in the house so I can just... can we just sit right here? (Laugh) Unless it's someone I feel comfortable with, and then I'll go, okay if you want to go in your room, let's go. But other than that, it's like it's the closest walk to the door. Can we sit here? I'll tell them.

The need to identify the exits extended to where the nurses parked their cars during the home visit. The next two excerpts describe the thought processes of nurses when determining the safest areas to park.

Uhm, in terms of street parking, being on a well-traveled kind of place as opposed to parking in like an alley way or some little back dead-end place, you know... an escape route. Those kinds of things.

Uhm, you park your car in the same direction that you want to be facing when you leave, especially if you're in a cul-de-sac. You don't park in a driveway because you don't want your car to be blocked in.

Blending in. Another strategy for preventing risk employed by the nurses was blending in. Blending in was an important issue with public health nurses in the field.

Nurses spoke of the need to avoid being overly obvious during field visits. As one nurse remarked, "I think you just have to think about where you're working and what you're doing. And just try to melt into the population, but still do your job, still make sure that everybody gets what they need."

The ways in which nurses blended in was by dressing in a way that is not "flashy" and by avoiding the use of jewelry. The reasoning behind this need for blending in was two-fold, first so nurses were not viewed as having something of value resulting in victimization, and second, so clients were not overwhelmed by the difference in socio-economic class.

Jewelry, in particular, was to be avoided in the interest of safety. Whether it was real or imitation, the appearance of wealth might cause nurses to be viewed as "targets" or, as one nurse stated, "easy prey." One nurse described her concern regarding jewelry and the appearance of wealth,

So, umm, but I try to, umm, I kind of dress in, umm, ordinary, plain clothing without wearing lots of jewelry and diamonds and expensive clothes. And I think that's to my advantage ... Umm, and we've had some nurses that wear a lot of jewelry. Wear a lot of diamonds. Sometimes they are real diamonds and sometimes they are cubic zirconium. But robbers don't know the difference. And so I don't think it's appropriate to go into the field, dressed with big diamond stud earrings or a big diamond pendant, or a tennis bracelet, and a huge wedding ring, that sort of thing. Because I think it makes one more easy prey.

While most nurses tried to blend in, this was not true for all of the nurses. One nurse remarked, "I'm my own person." She believed that she did not need to blend in. She could get her job done without changing the manner in which she dressed.

The car the nurse drove was also a means of blending in. As one nurse remarked, "I wouldn't advise anybody to drive like a flashy car. You know, leave that car at home, get another little car."

Blending in had an advantage in that when working with people, nurses with similar clothing projected an atmosphere of approachability. Individuals were more trusting and willing to impart the information sought. The data suggested that this was essential when working with teenage girls. One nurse remarked on the balance between approachability, blending in, and professionalism necessary for the public health nurse.

And I would also tell them not to dress in a way that attracts attention. If you wear something that anybody would wear to work. I'm not saying if you're going in a gang area to dress like a gang is, but dress professionally, but not flashy. I noticed that some nurses go out in high heels. I am not a fast runner and if I had to run, I would not want to run in heels (laughter) and so I think that is a safety issue, too. I think you need to be ready to move fast, if you have to, maybe you don't have to, but be prepared.

Being "low-key" was another way nurses blended in. As one nurse observed,

I say I look at what's going on around me. I do it in a way that's not real obvious. I don't stare at people. I glance around to see what's going on, without making it obvious. It's important, a lot of clients and neighbors, they don't want to feel like we are nosey social workers, coming to check up on her.

Some of the sensitivity expressed by the nurses in this study toward needing to blend in evolved from the perceptions of others, particularly mentors and supervisors. Departmental dress codes and supervision mandated the form of dress for most of the public health nursing units.

Nurses reported that they would tell others of how they should or should not dress in the field. The evolution of one nurse's perception is illustrated in the following excerpt.

Well, when I first started working for public health, I remember one of my supervisors telling me you don't want to call attention that you're a nurse because you don't want... you don't want them to think that you might be carrying drugs; you don't want them approaching you, you don't want them taking anything from you.

Dressing the part. In order to protect their own safety and their clients'

confidentiality, the nurses reported that they attempted to stay anonymous. The need to remain anonymous extended to the outward appearance of the nurse. Identifying clothing and name badges were seen, by some of the nurses interviewed, as detrimental to maintaining confidentiality. As in the following two excerpts, nurses noted how they faced this dilemma,

I try to avoid that. I don't... some of the public health nurses they'll wear a lab coat. I don't like to wear anything that will identify me as a nurse. Depending on where... I usually know where I'm going to go a day before, or maybe even more ahead of time. So I know what to wear, and usually I'll wear according... I'll wear clothing that's appropriate for whatever neighborhood I'm walking into. Today I'm wearing my jeans and my shirt. And that's probably typical as far as going out on a home visit; I'll just wear attire that is appropriate to that neighborhood so I kind of blend ... cause I don't want to be identified as a nurse.

But I should get into the habit of wearing a nametag. But then see sometimes I have mixed feelings about that because... because of protecting the privacy of the people that I'm going out to see. Because I don't necessarily want their neighbors and everybody to know oh, they have a public health nurse going out to see them. Although the people know that you're going out in some official capacity because I have this bag on my shoulder, so they know I'm going out in some official capacity. So, uhm... but sometimes I think the more anonymous you look, the easier it is to elicit the information. But, I'm not adverse... I mean it's just a nametag; it's really not a big thing.

According to the data, as the need for vigilance increased, the tendency to require more visibility increased. When nurses working in the inner city were asked their preference for wearing lab coats, name badges, or some other form of outward identification, their responses were mixed. Each had compelling reasons for their choice. As one nurse illustrated,

I think for me in our area that would be a mistake. Because you know, if you just go, like go to a person's house and go behind their house and you have nothing on, to me you're really putting yourself on the line. Don't... somebody could come out and think that you're trespassing or think that you're... you know, you're not supposed to be there ... It's better that we have on something you know, identifying who we are. When you're on people's property, which

we are all the time, you need something to identify you as being a nurse. Once people know that, they're usually okay.

Public health nurses took pride in being recognized as a positive influence on the health of their communities. Being appropriately attired for the recognition they receive was seen as valuable. As one nurse stated, "... you represent ... public health. I just always feel we need to dress a certain way." Additionally, the recognition they received for their roles and responsibilities was also a source of pride, as the following two excerpts illustrate.

There was a client down on Skid row; Ruby, and Ruby has been chronically homeless for years and years and years. And she wanted to take me around Skid row and introduce me to her friends. And I remember just this one day, going with Ruby and seeing her neighborhood through her eyes. And the people that were important to her. You know, again all homeless street people that were important to her in her life. And how proud she was that I've got a nurse that is working with me and I want you to meet my friends, kind of thing. And seeing those people subsequently after you know, she had finished her TB treatment, and then they remembered who I was.

If you kind of go in looking like a helper person; and often times I thought well you know, perhaps for safety I ought to put my white lab coat on, and then they would perceive me as the person who brings diapers and formula to the baby, and not perceived as a threat.

Building rapport and showing respect. The data suggested that respect for clients by public health nurses was crucial in maintaining safety in the community. A benefit of being recognized by the community was increased visibility. Part of the development of showing respect to clients was the building of rapport. Rapport building started with the first contact with a client, as well as with individuals and families within the neighborhood. A nurse described how she acknowledged individuals in the area of a family she needed to visit, and how she afforded them respect and started building rapport within the community,

So if I see someone on the street, and they speak to me, you need to speak to them. You know, if they say, “Hi, how you doing? Can I help you with something?” that type of thing. You know, (I reply) “I found it, or could you direct me to such and such a place.” Usually, you won’t have any problems.

Nurses also afforded clients respect at the first encounter. The following excerpt is a nurse’s story describing how respect was given to a client and how rapport was built.

I’m here to help you and I’m not trying to talk over you, or trying to make you feel like you need to do exactly what I say. You know. Yes, I know what you need to do, but this is totally your choice but I’m just telling you what you need to do. This is what I recommend, this is what I would like you to do, but in the end it’s your decision. So I just try to put it in the person’s hands so they can make their own decisions. I inform, I educate you, whatever else you need, you can ask me. If I can do it, I will... You know, it’s a certain way that you should talk to your patients ... not be very authoritative. But I have some things to say to you also... I’m usually just very polite and uhm, straightforward. Like this is, I’m here for this reason. And I’m here to help you do this, and I need you to do this in order for me to help your family. So that’s what I really try to let them know. I’m not here to tell you what to do, but I’m here to help your family. So that’s very important; that’s a way to develop rapport with the patient.

Rapport building was also valuable for nurses when working with clients who did not understand the need for or want public health nursing services. Another nurse described how building rapport, through listening and respect, was used. She stated,

If the client isn’t receptive to me, it may not be a good time for me to go in. It may be that I need to do a little more ... establish a little more rapport with the patient at that time. Maybe talk to the client a little bit more, explain why I’m there; try to get some feedback from the client, to find out where he’s at, at that moment. Because at that moment, that client may not want anything to do with you. And if that’s the case, then it’s important that we listen to that and not try to push our way in. So that’s one thing that I always do with my clients. And if I sense that the client is not receptive, again, I do push a little if it’s something urgent.

One nurse attributed the respect he gave to individuals as part of his general attitude. His ability to get his job done through casefinding and promoting the health of the community was improved when he was seen as a person who was respectful of

individuals. Here is his story.

I generally... walk around with a smile. And I greet people, and I try to be as polite as I possibly can when I'm out there and it's not because I'm worried about my safety, it's just who I am. I enjoy talking to people; I enjoy establishing bonds and relationships with the people and I think that helps. I think it's truly important to have a good attitude when you're out there; to uhm extend a hand, even if you don't need to; whether it's opening a door for somebody, or just saying hello with a smile, it's so important. I think that's one of the things that really uhm, you know, that first impression I believe does make a difference. And when that first impression is how are you doing with a smile, and actually waiting to hear what that person you know, how that person is actually doing. Not just saying how are you doing and walking away makes a difference. I think people will approach you differently; people will look at you differently when you actually uhm, when you have a positive attitude and you're there to listen to people. You know, I may be going to make a home visit for a certain individual, but if I get stopped by somebody else who tells me they have an issue, and I stay and help them, that's going to increase my chances of avoiding a situation in that neighborhood. You establish some bonds with people and you get to know them, and you assist them with whatever way you can, and they'll be there to look out for you too.

The attitude of the nurse was also important when approaching a potentially threatened or difficult individual. In situations where the nurse was making a mandated or required visit, the client had an increased potential to feel vulnerable or uncomfortable. Respect shown by the nurse to the client had the potential to diffuse unpredictable situations. The following excerpt describes one nurse's experience with this type of situation.

I basically tell people that if you treat people with respect, you're going to be pretty safe. I really do believe that. That... because a lot of times things occur because people aren't treated respectfully and the situation escalates... And if you come across as judgmental, well I'm here to see how you're screwing up; they're not going to want to let you in, whether you're... it doesn't matter who you are, they're not going to want to let you into their house. And so you have... I think it's very important. You have to... you have to go prepared with at least one positive thing. Something that you can tell them about what they're doing right. That will get you in the door. Because they're used to having people show up on their doorstep telling them what they're doing wrong... and it's just the same way with asking intrusive questions. If somebody doesn't want to... I mean do we feel like we have to have that information about...

They have a right to refuse to answer the question. You say, “yeah, that’s cool; you don’t want to answer it, that’s fine.” And you explain the reason why you’re asking. And if they still don’t want to answer you move on to the next one. And then, again, 90% of the time they’ll give you that information even later on in the home visit, but you’re still going to get the information. So it’s the same way, about getting in. You just say, “I don’t need to come in.”

A secondary benefit of respect was the awareness individuals had that they had been noticed. This benefit was two-fold. First, there was an acknowledgement of the individual as a person with worth, and second, the individual was aware that they had been seen. One nurse noted that most crimes in the community were those of opportunity. There may be an increased risk that a crime could be committed without witnesses, when an individual believed that they could move around the neighborhood unnoticed. One nurse’s insight regarding this is illustrated in the following excerpt.

I think just acknowledging people is the thing I keep coming back to, because I’m real consistent in doing that. Uhm, passing people in the hallways in apartment buildings and saying hi to them. You know, like I said, it’s really kind of off-putting in a way, so in that sense if they’re startled, you know, then chances of something happening to me then are ... at least I perceive in my mind... I’ve talked myself into it that it’s not going to happen to me. But, again, I think my experiences in Skid Row and stuff, saying hi to folks and... cause in that environment, I think people are so anonymous, transparent, invisible, that when someone acknowledges them, they become visible and that kind of just puts a spark of again humanity back in them that they may not of had. And that creates just good feelings on their part, and again I feel very safe then.

Self-protection. In addition to protection by clients, nurses also drew from their ability to protect themselves. Two examples of self-protection emerged from the data. The first was their ability to protect themselves emotionally and the second, their ability to protect themselves physically; particularly from communicable diseases. The following excerpt by one of the nurses interviewed describes these two examples of self-protection.

So it's a lot of subtleties. It's at all levels ... all levels, you try to protect yourself emotionally, and you try to ... oh and health wise ... I think I have been exposed to many unhealthful situations. And there was a TB patient that when I would go there, it was in the winter, and it was all closed up and the windows were steaming. And, you know, I just felt like I'm breathing in this moist tuberculosis air, you know, and I ended up taking her to the hospital and we open the windows and my hair was flying. But I thought, I'm not breathing it. And now I mean, I wear a mask when I have multi-drug resistant cases and I just don't feel at all bad. I say, I work with a lot of TB and I am going to wear this now when I come in your house. And we're going to give you a mask so when you come to the clinic you will be wearing it. So, you know, I don't have to wear it that often, I have only done that maybe three times. But ... so I see it as many things, emotionally trying to stabilize yourself because there's endless struggles that you can get caught up in people's lives and then the germs and so forth, just keeping yourself healthy, the environment, the traffic, the freeway, it's dangerous. And so there are lots of risks. You have to be on your toes, you have to know that you are teaching, you have to be organized. And yet you have to be your own advocate because no one is going to take care of you but yourself. No one is really there to help you. You have to be your own captain of your ship (laughter) and get back to a safe harbor.

The public health nurses with longer years of service had had a class in self-defense. They reported that the county had provided a class in either the use of mace or conflict avoidance. The consensus of those who had taken a course was, while the information had some value, it was not generally useful in the field. As one nurse illustrated,

I don't carry any mace with me. Or, I don't know of, if any nurses do that. Umm, we have had some seminars or speakers come. We had a speaker from the Glendale police department that was probably about three years ago. Talking to us about our safety and simple things we could do if we were ever attacked. Umm, and to scream, or yell at the top of your voice. Or, you know, to knee someone in the genital area.

The nurses did not accept the prospect of carrying mace or pepper spray. One nurse stated that she would be willing to use pepper spray on a "vicious" dog. Many stated that they were afraid that they would have the spray turned on them or would be unable to use it effectively in the field, particularly if their attacker was another human

being. In the following excerpt a male nurse explained his hesitance to use defensive weapons when he could defend himself using logic or by leaving the situation,

Uhm, before even coming into public health nursing, it's just my belief that uhm, if you're going to carry a weapon, you'd better know how to use it, and you'd better be willing to use it. Uhm, you know it's kind of pointless to carry anything if you don't know how to use it and you're not willing to use it. I'm not sure I'm willing to hurt somebody because of my insecurities or because of my uneasy feelings and when you carry something around with you, I just... I think that you run a risk of doing that. You may make a mistake in a situation that is dangerous, that may not be dangerous and hurt somebody. I think that by defusing the situation with words, usually with kind words, is better than taking out a can of mace and (saying) I'm going to spray you, if you don't back up. You set yourself up for a lot of things, especially if you have to go back to that neighborhood again, over and over. And so it's just my belief that I don't need to carry any type of weapon; any type of instrument that could cause damage that way. Uhm, I usually carry a good pair of running shoes.

Safety rituals. The data suggested that public health nurses had safety rituals they adhered to before, during, and after field visiting. Public health nurses reported faithfully following these detailed behaviors. Most of these rituals were based in common sense approaches to safety. Universally, the nurses kept valuables hidden from view, maintained their vehicles, and locked their car doors. As one nurse stated, "I keep my phone charged. I try to keep gas in the car." Another remarked, "As soon as I get in the car, I lock my doors, make sure my windows are up, and take off. (I) don't stay still too long anywhere." The female nurses remarked that they kept their purses in the trunks of their cars or in the office; however, they always had sufficient supplies and currency with them to facilitate their needs. As one nurse stated,

We never take purses out in the field. I never have a purse on me. I'll take my ID, my gas card, my AAA card, my business card, and a little bit of money. I'll have... maybe have like \$6-\$7 on me, something like that. And I'll just stick that down in my pocket. It will be like in a little wallet, and I'll stick whatever I need on me, in my pockets. I never take a purse. I always leave it at the office. I think that would bad. You can be, that can be very cumbersome. So you need to take as little as possible with you, because you have a clipboard with different

information, that's really all you need. Unless, you need like some extra stuff in your car, but never, like all my credit cards and nothing like that ... Just what I need and that's it.

Another nurse was assured that she could find her keys when she leaves the home visit by keeping them on a particular style of key chain.

And always have a chain that's like a bungee cord thing that has your key and you just put it on your wrist ... I used to be losing the key in between the cushions of the sofa or dropping it or something. So this way I know it's on my arm and I know it's there. I can reach it quickly.

Other nurses relied on their faith to keep safe. One nurse remarked, "Every single time, even if it's a good neighborhood or a bad neighborhood, I'll pray."

As previously discussed, a common perceived risk for nurses was the presence of dogs at the home. Most dogs were contained in some manner in urban and suburban areas, however there were times when dogs were out on the streets. Large breed dogs were viewed as an obvious safety issue by virtue of their size and power. Smaller, "sneaky" dogs also required action on the part of the nurse prior to entering the yard. Most nurses had safety rituals that involved rattling the gate or producing a sound to wake or get the attention of dogs that were asleep or hidden.

If a patient has a fence, I always rattle the fence before I go in, cause I just don't feel you know, safe. I might get bit by a dog. And that's like my most... it's like a really big issue with me, a big fear. So that's one thing that I usually do. That's sort of a ritual; I forgot about that one. But I always make sure; I look around; make sure everything is okay; I get out; I look around, you know, in their yard; make sure there's no dogs, and then I go ahead and proceed and do my job.

Several of the nurses had specific approaches they used when they came in reach of a client's residence. Many of these approaches were based on movement away from the door, once the nurse knocked on the door or rang the doorbell. The following three excerpts describe the movement of the nurse from the front of the door to the side.

In the first example, the nurse concentrated on the approach she uses.

And so, then I get out of the car, I approach the address, I make sure I look left, right, up and down the street. Because you never know what's coming behind you. And then, I make sure when I knock on the door, I kind of... I don't know, it's just my little thing. I knock on the door and then I step back, I don't stand in front of the door when I knock. I stand to the side of the door. Cause you never know what's coming out that door.

The second example shows how the nurse maintained her vigilance on the visit through her safety ritual.

You knock on the door, step back, don't stay right in front of the door; kind of step back, cause you don't know who's going to open the door. And think twice before you go in...so when I knock on the door, I stand back. It gives me a few feet (Laugh) closest to the gate. You know what I mean? So that when they open the door, and they say she is not, she is there. I've had a guy come to the door, and he's said oh, she's there, she's in the bathroom, come on in. And I said, you know, I have some work to do, so I'll sit in the car; when she's out, tell her I'm there, this type of thing. Because you really don't know. You know, it's somebody that I don't know, I've never seen before, you know, going to go into the house, and close the door behind you, and there you are... you know. And so staying back after you knock on the door gives you a little room.

In the third example, the nurse also shows how she increased her visibility as the public health nurse to the client, by having her business card in hand.

When I knock on the door, and they answer, I always have a business card in my hand and I immediately let them know who I am and why I'm there. That's the first thing I do. I always get my business card out before I even get out of the car; it's always on my clip board, and it's in my hand, by the time I'm knocking on your door. So I'm not going to stand there, you know, going through all these things, and you don't even know who I am.

Further examples of safety rituals were evident. As previously discussed, nurses maintained some control over the home visit by directing where the visit takes place. In the next example, the nurse explained how she directed the home visit and prepared for her exit. She also described how her feelings influenced her safety rituals.

You don't enter the home unless the client is there. You let the client walk in front of you, you walk behind them. You try not... you know, you try to sit with

your back to the wall, you know. Uhm, you park your car in the same direction that you want to be facing when you leave, especially if you're in a cul-de-sac. You don't park in a driveway because you don't want your car to be blocked in. Probably the most important thing is to listen to your gut. Because if it's not... if you feel there's something wrong you need to listen to that.

Safety rituals were particularly important when the nurse cannot see or be seen by others. In the following example the nurse described her action to direct the home visit and provide the means for her to see her surroundings and those around her.

... Once I'm inside, I like to look around. I try to stay in well-lit areas where I can keep track of whose behind me or whatever. I mean, I went into one house, not too long ago, and you know it's been so hot, they have all the lights off, they don't have air conditioning, so they have a fan on. All the lights are off, and walking in from outside, it was pitch black all I could hear was voices when I was... it was like, "hi I can't see you, I know you're there." And then I went uhm, back into the kitchen it was right next to that room. I said, "Well I think we'd better meet in the kitchen because I need to be able to see something." So I stayed over in that area where I was able to see my surroundings.

Safety rituals were employed before and after the home visit. As nurses drove from one visit to the next, there were safety behaviors that were regularly followed, these behaviors that limit distractions. One nurse described her behavior to maintain her focus while driving to a visit. She recalled,

And also I have a tendency, especially if it's a visit where I haven't been there before, when I'm a few... as I close to the visit, if I have the radio on or anything, I turn the radio off. I have a tendency when I'm out in the field, when I'm on my way to a visit, I don't have the radio on. When I'm on my way to... I turn, you know now that I think about it; I usually turn the radio on when I'm on my way back to the health department. When I'm on my way to a visit, I have the radio off and I'm looking around and just getting a feel for the environment I guess. And I guess, that you know, you always turn the radio off when you don't want to be distracted and you want to focus on things.

Other safety rituals were more general in nature, such as emergency preparedness. As one nurse states,

I think it's important for us to have -- and I carry in my car, the trunk of my car, earthquake preparedness. I carry my Red Cross disaster manual and a hard hat.

I have gloves and a pair of old shoes, walking shoes, jeans, and underwear. I used to have like food, that I would rotate and then I took it out and used it and have not put it back. But you know, I feel like I want water and I always try to have water and a battery-operated radio. And just you never know when you are going to have an earthquake, and natural disaster, or a wreck or something, or that you might help some other person.

Those in supervisory positions usually directed one of the safety rituals of public health nurses. Most health departments required nurses to provide a route sheet or clinical log for each day's activities. Most nurses held this safety ritual as a necessary part of their jobs, while others believed this was just a way for supervisors to measure nurses' efficiency. However, the nurses in this study had the predominate belief that leaving a route sheet was a positive technique to maintain safety. The following two excerpts illustrate the positive view the nurses had regarding route sheets.

I always, you know, keep a copy of, like I said, of where we're going. And sometimes I'll tell... if I feel a little bit uneasy, I'll tell one of the other nurses I'm going to such and such a place. You know, if I don't ask her to go with me, I'll say if I don't come back by such and such a time, call me on my cell phone.

Like you leave, you leave a route slip like where you're going to be. And then what time you're expected back. So if you don't come back, theoretically people will start looking for you. I have to say that is a problem with this health department.

In summary, nurses in this study reported various strategies they used to limit risks to themselves and property through preventive actions. These preventive strategies were employed throughout the home visit, even when no risks were encountered.

Risk Avoidance

Public health nurses may be placed in situations where there is actual or potential risk. They may also be unable to maintain a level of courage or confidence that permits them to get their job done. As previously described, this can be a voice of

reason or a “gut feeling” that cannot be ignored. Vigilance was of primary importance in the process of *keeping safe*. Nurses must make decisions about the safety and wisdom of continuing a visit based on the assessments they make.

In addition, there are situations where nurses lose their nerve and need to exit the visit for self-protection. One young public health nurse recounted how she cut a visit short due to the presence of insects. She recalled how the teenager laughed at her discomfort with the situation.

The presence of weapons and drugs are among the examples of when nurses were most likely to lose their confidence regarding their ability to complete a home visit. Other situations such as sexual harassment or threats also required the nurses to rethink their approach to getting the job done.

Nurses in this study were very clear that they would never refuse to visit a client merely due to a perceived risk. Refusal to make or complete a visit would only occur when there was an actual threat. The nurses differentiated between refusing to complete a visit and taking the options of (a) returning later, (b) returning with an escort, or (c) changing the venue of the visit.

Partnering up. In public health nursing, the decision to make a home visit was ultimately left to the discretion of the nurse. If safety was an issue, nurses could choose to “partner up” with either another nurse or an escort. Escorts included public health investigators (PHI), sheriffs, nurse’s aides, or community health workers. Partnering up was a term used by one of the nurses, but was a common theme among many. The data suggested that public health nurses preferred to take another nurse, community worker, or a nurse’s aide with them before taking out a PHI or authority figure.

Many female nurses preferred taking a male as an escort. This was particularly prevalent in situations, with sexual overtones. As one nurse detailed,

I told you I had to go in... yes, the second time I went there, I did take you know, one of the male social workers with me. And uhm, then what I found out was that the girl's father-in-law who owned the place, and he was very eccentric. And he would, you know, he would come onto you at times ... and then that kid ended up was being abused by them. But they had her hid, they hide her way back there, and she would call the police and by the time they'd get there they would have ushered her away somewhere else for another... One time they took her to San Diego, at a relative, you know, things like that. So there have been times... oh many times, I would take somebody with me.

A younger nurse noted that one of the reasons she partnered up was when there were issues of gender differences among her clients and she felt uncomfortable regarding the sexual overtones of previous conversations.

Several of the nurses stated that it was not their preference to take other individuals with them. Taking an escort appeared to mean that they could not get their job done, and in some way was an indication of defeat.

Others believed that their ability to show respect and build rapport with their clients was compromised by the use of escorts. As one nurse illustrated,

I actually would not take somebody ... if I had to make a home visits and I felt unsafe, I think that taking somebody who is not familiar with the area, who is not known in the community is really a waste of that individual's time and can actually get you in more trouble. That may seem a little more standoffish to the client; it may seem a little more untrusting to the client. The client may think well, why is this individual coming with somebody else. I mean, time to actually think, hey these people want to fight; maybe they're thinking we're going to fight and so they grab backup. Usually on the streets they say I've brought my "homies" with me and you know, he's here to back me up. And so I don't like giving anybody that impression. You know, if I'm going to take somebody with me, it's got to be somebody who's well respected in that community, who's known in that community, and who has experience working with that community. Cause generally they know how to talk to those clients and sure enough, I initially could not break her down and my community worker got off ... he was in a county van... he got off of the county van, and he just did a number. I mean he just spoke to the clients so well where he convinced the

client to come for evaluation and it was... I felt my communication skills were great out in that community, but I learned that having somebody who's out there all of the time is even better. And there's some individuals who can just communicate so well with clients and it's generally somebody from that same neighborhood.

There were other reasons for the use of partnering up during home visits.

According to the nurses interviewed, escorts did not need to go into the home to be effective. Secondary reasons for escorts could also include their ability to speak a language that the public health nurse was not comfortable or fluent in. The following excerpt illustrates both of these secondary reasons for partnering up.

If the area is potentially dangerous, high risk, sometimes you feel safer taking somebody even if they sit in the car, so that you know they... if you don't come out in a certain time, you know there's somebody out there. And just seeing somebody with you, people might think twice you know. When you're unsure of what's going on in the house. And uhm, there are times when I've taken somebody but it wasn't really safety, it was probably a language problem.

Perceptions of supervisory support. The perspective of how, why and when to partner up with another nurse or escort, was predicated on the level of supervisory support for public health nurses. Most of the nurses interviewed believed that they could use this method if they needed to, however most stated that they would first ask their supervisor. One nurse confirmed this belief when she stated, "you have to go back in. That situation, you have to go back. What I would do is, first of all, I'd inform my supervisor."

When the need for an escort or company of another nurse on a visit arose, most nurses believed that their supervisor would support them. One nurse stated, "We're getting enough encouragement and support from supervisors and management to say, you don't have to do this alone." In fact, a nurse recounted that she had been instructed to take someone with her when she was in an unsafe environment.

Conversely, some of the nurses felt that the pressure exerted on supervisors to limit the use of finances was a driving factor in their decision making process on the use of partnering up. There was a belief among some of the public health nurses that supervisors had not had sufficient current practice in the field to fully understand the safety issues encountered by nurses. One nurse illustrated this point by stating,

They want to get the job done; there's the stress and pressure of the supervisors to get the job done. And I don't think supervisors ... (have) been really sensitive ... because they had been out of the field for so long, ... the supervisors wanted that piece of paper...

A nurse who was concerned that her supervisor saw partnering up as a deterrent to nursing care further emphasized this problem. She had been told that over use of this safety technique was not good practice. She explained her concern in the following excerpt.

But they don't know, because they haven't... they haven't been a PHN for a long time. So I just feel that if they can see the community, then they will see the necessity of taking a buddy out with them... Yeah, because they won't mind like it is just once every so often, but if you do it all the time they're going to say something to you. That you know, you guys should be doing separate visits, you shouldn't be going out together. But I really don't know how they can really determine how often we should use a buddy.

Many of the nurses interviewed were understanding of the pressures of supervision and were supportive of the roles that their immediate supervisor had to perform. They were more critical of those in administrative positions in regard to their view of safety issues of field workers. The following three excerpts illustrate the criticism expressed by public health nurses. The first nurse's statement reflects the belief that there was lack of awareness by organizational administrators.

And it's something that to me the ... County has not addressed. And I feel that ... they're not going to address it until something happens to us. And I kind of feel that they don't care. Unless something big happens to one of us, then it's

going to be an issue.

The second nurse based her perception of lack of organizational support on vicarious knowledge she had regarding serious safety incidents at other county facilities. She stated,

And it's only when the incident happens, that they reluctantly, like when people were killed at the (Main County) Medical Center, shot in the waiting room, that they reluctantly put in, at (the Northern County Medical Center) and other country facilities, metal detectors; until then they did nothing... But when reform happens, like with (the) County and the metal detectors... it's at someone's expense. And another thing it didn't happen to me, it happened to a social worker but it was a public health situation.

In the third excerpt, the nurse relates her belief regarding placement of blame for unsafe conditions or injury. Her perception of administrative support was as follows,

Just like they tell us, you as public health nurses, get out of the situation, don't put yourself in the situation. But then they'll give you an assignment that puts you in that situation and say, it's your assignment and you have to do it. But don't put yourself in that situation. I mean, we talk out of both sides of our mouth.

Smoothing the butter. Another technique used by nurses to maintain safety was "to play both ends." In one example the nurse needed to get support from both the teen and the parent. However, the parent believed that the nurse was overstepping her boundaries. As a result, the parental roles and responsibilities were threatened. Prior to the situation escalating, the nurse convinced the parent that she was there for her, when in fact the nurse's responsibility was for the teen. This nurse stated,

Also, uhm, we are being, lots of times the parents in the home feel as though we are taking their roles and sometimes they get jealous. And I try to show them; look I'm on your side. Because what I'm going to be telling her some of the same things that you're telling her, but sometimes coming from somebody from outside, they listen whereas they won't listen to you. Or just hearing somebody else reinforce what you said would help. So this way we try to stay in good stead with the parents, whereas as also we're trying to stay in good stead with the teen because it's the teen... you tell the teen I'm here for you. But then we

cannot... we not tell them in front of the parents. (Laugh) Because if the parent gets really annoyed and said we don't want you here, then you're not there

Another way in which public health nurses used psychology was when they were trying to gain entrance into the home. At times nurses reported that they were unable to say exactly what they wanted with the client due to confidentiality or the potential for client anger. One nurse spoke of the need to use supportive comments regarding inconsequential positive behavior or a positive attribute rather than pointing out the problem for which the client was referred. The following excerpt describes a situation encountered by a public health nurse and the resulting need to extricate her from an unpleasant or potentially dangerous situation. She called the method she used "smoothing the butter."

Now when I was very, very new at this many years ago, I came up this house, chart in hand, handouts, formula, etc, etc. All spiffy, just, you know, real prissy gal going in there to fix the world. Knocked on the door and said is so and so home, and he says, "yes come in." And of course I came in, and all of sudden was in the reality of she wasn't there. And he then changed from nice guy to why are you here? And why are you bothering us? And why do you think you have the right to come in and tell us how to raise our children? So I had to do a lot of back peddling, and actually I felt very threatened for about 10 minutes until... I couldn't get out the door. He was blocking it. And thought to myself, oops, little miss priss you're dead meat. So after about 10-15 minutes looking around the room real fast, finding some pictures, and saying oh is this the baby? Why he looks exactly like you; you're tall and thin. Your son is going to be tall and thin. So I don't see that he's going to be failure to thrive here, let's just... and then about 15 minutes later the woman came home with the infant. We weighed and measures, he was like 5 percentile on the gross grid; yes he was failure to thrive. However, at that point in time I wasn't going to say well, you guys have to do something. We're going to see to it. I'm just saying this is genetics talking; he's just like the dad. You're a wonderful dad, look what you're doing here, look at what you've provided, yada, yada, yada. And after 10 minutes they wanted to show me everything, and I was the best friend of the world, and you know, they didn't want me to leave, and all of that. By the time I got out, oh thank God, and then of course wrote out my report. But sometimes you just have to have that gut feeling, are you in danger? How can you get out of that danger the best way? And sometimes the best way is to smooth the butter about 3 feet thick

In situations where the presence of a parent or angry family member limited the communication with the client, the nurses sometimes found it necessary to reschedule the visit. This was particularly necessary when there was clear indication that privacy could not be maintained adequately or if the information would not be forthcoming due to the presence of others.

Terminating the visit. The last option used by the nurses for risk avoidance was terminating the visit. There were three ways to utilize this option. The nurses could choose to drive past the intended field visit site without stopping, leave the visit site if a risk presented prior to the initial contact with the client, or leave once the visit was initiated. Universally, the nurses stated that they would make another attempt at a later time to contact the client, unless a direct threat had been made.

The presence of a weapon or a threat of immediate danger is one of the circumstances in which nurses refused to continue in or return to the setting. The data suggested that the nurses returned to the home only when there were adequate safe guards in place to finish the necessary interaction with the client. In the following example, one nurse had developed a perception of what safety measures could be useful in a setting where homeless individuals were seen.

We had a patient come that somebody in (a homeless program), one of our nurses promised something we couldn't do. So he came up here with an agenda, which we didn't do, the chest doctor didn't do it, whatever he wanted. So he went back there with a gun, and held them all hostage, so then he was put in jail. And that's within the last two months that happened. Well, he could have been just as mad and held us all hostage, because he was very angry when he was here, we didn't do what he wanted. What he wanted was HIV results and he wanted them right then at that moment and he didn't want to go to the address of the clinic. And the chest doctor said, "No, I'm not going to deal with him he's angry and he's not my patient, and I don't know why the nurse promised the Chest Clinic would do that." So luckily he got angry and went back there.

Cause they have a guard and they are used to mentally ill people. So they arrested him and took away his weapon. And we had no idea he even had a weapon. If we had metal detectors coming into this building, say, that man's weapon would have been detected. And I think we should have metal detectors. When I worked out at (the county hospital), we had metal detectors.

Refusing to make initial or continuing visits to a client was the last option for nurses in this study. Most stated they would refuse to visit a client in very hazardous circumstances, but then said "it has never been the case for me" or "I've never had to do that." If the group of individuals and their activities were assessed as questionable, the nurse might opt to leave the setting. All of the nurses interviewed stated their preference for completing all of their visits, but the option of not completing the visit was always available. Most nurses would arrange to return alone or with an escort at another time, call the client on the phone and arrange another venue for the visit, or notify their supervisor of the potential risks for completing the visit.

Bravery. There is a confidence or sense of courageousness in every successful field public health nurse. The data suggested that characteristics of bravery, whether learned or inherent, were consistent in each of the nurses interviewed for this study. The nature of a career in public health nursing is outside the confines of a physical structure and personal control. There were inherent risks that had to be balanced with the need to get the job done.

The nurses described their sense of risk in various ways; primarily they described their feelings or concerns regarding home visits, particular situations, or geographic areas. However, in most situations, they completed their visit even when they saw a potential risk. In the following situation, a nurse described his assessment of risk factors when encountering idle young men in a darkened hallway and how he was

able to move past them and complete the visit.

I had to go into this building and look for this patient up on the third floor. And so walking through the bowels of this building trying to get to the third floor with these guys hanging out. And I didn't feel unsafe for myself, cause I'm pretty confident in my ability to deal with escalating situations. But again it's just that first kind of offsetting experience and ... again just saying hi to the folks, moving past them and getting into the building.

Even with the conflict between getting the job done and potential dangers in the field, there needed to be a voice of reason. Public health nurses needed to protect the public and themselves. But nothing was so important that one needed to risk too much. As one nurse stated,

One of the best rules of thumb is if you feel the hair standing up on the back of your neck or you feel kind of gut instinct like this could be, even like in the remotest way, an unsafe situation, uhm, it's not worth it to try to get that job done and make that contact or try to make that contact, ... that particular time. There's always going to be another day to do that, and there's always going to be if you go back to your office and tell different people that you need someone to go out with you that next time, there will be somebody that will avail themselves to do that with you. Uhm, I think going through one traumatic event you know, it could be your first and your last traumatic event, so it's just better to err on the side of caution and not try to be the overzealous you know, I'm not going to get a medal of making the most home visits without anything negative occurring.

Balancing needing to get the job, listening to their "gut feelings" and maintaining bravery was part of the process of *keeping safe*. However, there were conditions where the nurses disregarded the balance between these elements of *keeping safe*. The following section will describe the use of bravado while getting the job done.

Bravado. In certain conditions, the nurses relied on bravado for both avoiding risk and getting the job done. Bravado was demonstrated by the use of pretense or defiance to get their job done.

Within the context of using bravado, the data suggested that there is potential for nurses to rationalize their reasons for completing visits that they know they should not,

based on their vigilance in assessment of the situation or individuals present.

Rationalizations can be made for several reasons. In the following excerpt, a nurse attempts to explain, through rationalization, why she completed visits she assessed as ones with increased risk.

Ah, they just kind of... they just kind of... not in a threatening way, just in an appraising way, like okay, they recognize... maybe they recognized that I didn't live there at that apartment complex and whatever. But you know, I wasn't driving a county car or anything. So, you know. But then again, that wasn't really; there was another situation, after. This is an example of a situation where I didn't... I didn't really get that feeling. A lot of people would of probably been scared, but I didn't have the feeling because I knew that I was not a threat to the gentleman. For example, one time I was making a home visit, the situation was that uhm, and a toddler had been admitted, had been seen in the ER and later admitted for uhm, acute cocaine intoxication. So apparently he had gotten into the cocaine stash. Uhm, interestingly enough they discharged the toddler home, and then they sent a referral to public health. Could you please check out the safety of the home? And I'm thinking, it should have been done before you sent the kid home, but that's the way it is a lot of times.

Other reasons for bravado by the nurses included the need to get the job done, in order to protect a client, child, or the public. Several of the nurses interviewed reported that when a client had to be seen, particularly a child or someone with a communicable disease, their tolerance for risk increased. An example of one of these conditions is illustrated in the following statement.

Especially if there's like ah, I'm out on a sexually transmitted disease, and there's a husband/wife situation or boyfriend/girlfriend situation, uhm, I try my best to keep it from exploding into like a bigger situation. I'll, you know, try to just speak to the woman about it, no matter how upset their partner is.

An additional condition that predicated the need for bravado on the part of the nurse was when the nurse believed that child advocacy was necessary. When a child's safety was at risk, the potential risk to the nurse was often discounted. In the following example, the potential risk to the nurse was disregarded.

Well, I'll be honest with you. I've done this twice. And you may... and people say it's kind of stupid. But it's important for me to make the visit. And I recently, and I've only done it twice. Once was about 12 years ago, where I've climbed over the fence. And the reason I did it the first time was because I was with a social worker and it was a very fragile case, it was a diabetic concern and I was concerned ... there was a lot of danger as far as this baby was concerned. And I was not going to leave there until I knew what was going on ... And I was ... going to be ... damned if I was going to leave that home without a visit. ... And so I... you know, so it took me climbing the fence and I figured what the hell, you know? I can do it.

The data suggested that the longer nurses were in the field, the more likely they had an increased tolerance for risk. Some of the nurses in this study spoke of taking what they did for granted or that they had "gotten used to it" to some degree. There was a realization that there are potential dangers associated with field visits; however, they were discounted as part of getting the job done. One nurse illustrated this point as follows.

So you do what you have to do. And then when you, once you get into public health, and you've been a public health nurse for a while, you really don't think about your surroundings that much anymore, you just... it's just where you work, and you take it for granted that nothing is going to happen. You're aware; you know what I'm saying? But you know, like it's not a big deal, just knock on the door, and go in. But, you don't know these people at all, really. So you're really taking some chances, but I don't think we think about it on a daily basis.

Further areas of bravado were evident when nurses discussed what their own families thought about their job. Most of the nurses stated that they did not tell their families what their jobs entailed. They rationalized that their family would just worry about them if they really understood what public health nurses did in the field. As one nurse illustrated,

But when I first applied for this job, or when I was getting ready to change areas, I really didn't tell my parents. Until later, when I already took it. Then I told them where I was going to be working, and I don't tell them information I think is going to make them worry. I don't tell my mom that I'm in the projects

all the time. I don't tell her this person looked threatening, or that person; she wouldn't get any sleep. Neither one of my parents would, so why tell them? So I don't. Unless it is something I cannot hide, I don't bother with reports to them every day. So, I don't bother with that, so they're worried about what they know.

When nurses got into situations in which they believed the show of authority was necessary, they identified themselves as public health nurses. This was termed by one public health nurse as “flashing your badge.” As previously described, nurses may or may not regularly use their badges as a form of identification in the field. However, many nurses used their badges as an act of authority or as a way to extricate themselves from a situation. As one nurse stated, “Because once I show them I'm a nurse, and I have my badge, they back off.” Nurses also stated that handing someone a business card could have the same effect. As with partnering up, participation in situations where nurses lose their nerve or have a “gut feeling” they cannot ignore predicated the use of this method. Most nurses acknowledged that the badge would do little to protect them from a dangerous situation.

One nurse was in a situation where she felt sexually vulnerable. She had walked into a backyard of a home looking for her client and found the client's brother home alone. He made an inappropriate remark and was looking at her in a suggestive manner. She utilized her authority to change the subject and left the area quickly. She described her actions in the following statement, “And I just felt very uncomfortable, ... with him doing that, so I quickly gave a card to him and said, would you please have your sister call me when she gets home.”

Several of the nurses stated that they would use the technique of “flashing your badge” with individuals they had to interact with on the street, rather than with clients.

The following two excerpts describe the use of this technique while engaging individuals on the street. In both of these examples the nurses were discussing how they usually responded to groups of individual on the street they suspected had gang affiliations. In the first excerpt there is evidence of bravado. The first nurse stated,

At that point I would of just calmly said “Oh I’m the public health nurse”, you know, and I would of showed them my badge and then visiting this family kind of just told them briefly what I was there for. And I think... when I’ve done that in the past if people have asked who are you and where are you from? They’ve been like okay fine. You know, I’ve had no problems, I go right in.

In the following excerpt there was evidence of the reaction of the group and an indication that recognition as a PHN was a powerful tool for acceptance. In this second excerpt the nurse illustrated this by stating,

But now it’s just like I have my badge on, I say, “I’m a public health nurse, I’m going to see this family just to make sure they’re okay physically.” And I just stick to that and they’re like, “Okay, she’s a nurse leave her alone.”

In summary, findings of this study have provided a substantive theory of the process of *keeping safe* for field public health nurses. This process had three stages, (a) risk assessment, (b) risk estimation, and (c) risk limitation. The process of *keeping safe* continued to evolve for public health nurses with the influence of peer and supervisory support, family, feelings, and vicarious knowledge. The following chapter will discuss the limitations of the study, implications for PHN practice, education, and the need for further research.

CHAPTER 5

SUMMARY AND CONCLUSIONS

This study explored the perceptions of safety among field public health nurses with the objective of determining a substantive theory of the process of *keeping safe*. Chapter four summarized the findings and explored the issues of safety as perceived by public health nurses. The stages of *keeping safe* and their dimensions were delimited using exemplars disclosed during nineteen interviews with nurses employed in field public health nursing practice.

This chapter summarizes and discusses the discoveries that emerged from the study in the context of existing research and literature related to safety in home health and public health nursing. Study limitations and implications for nursing practice, education, and research are also addressed.

Summary of the Discoveries

Findings in this study suggested that public health nurses take a proactive approach to their safety during home visits. This is contrary to findings on home visiting from previous studies. Past research in the area of field safety has predominately focused on environmental risk factors, dangers, and the fear associated

with potential threats (Brown, 1977; Castles & Keith, 1971, 1978; Keith & Castles, 1973, 1976; Kendra, Weiker, et al., 1996; Mulligan, 1973, Rogers & Maurizio, 1993; Snow & Kleinman, 1987). In retrospect, these studies viewed actions taken by the nurses as a reaction to their environment. Participants in this study suggested that nurses used risk awareness and risk estimation to predict risk. As a result, nurses planned either risk prevention or risk avoidance strategies to counter those risks they experienced or perceived in the field.

The scientific literature outlines the issue of safety in public health nursing; however, it does not fully describe or explain the process nurses use to keep safe. The majority of the dimensions of the process of *keeping safe* were identified in prior literature but no prior study has addressed all of them. Table 2 identifies the dimensions of the process of *keeping safe* in applicable research and scholarly literature related to home health and public health nursing.

Actual and Perceived Risk

This study explored the perspective of both actual and perceived risks. Most of these risks are well documented. The dimension of idle young men, identified in this study, appeared recurrently in the literature as a specific risk or was included in the more general inference of men standing in a group outside of a residence (Carter et al., 1993; Fazzone et al., 2000; Gellner et al., 1994; Kendra & George, 2001; Lewis & Hallburg, 1980; Zerwekh, 1991). McNamara (1994) suggested that gangs of young men were a specific risk in underserved areas and nurses were “easy targets” for their intimidation and violence (p.194). The many inferences to the dimension of idle young men as a potential risk to public health nurses in the literature validated the findings of

Table 2

Dimensions of the Process of Keeping Safe Identified in the Literature

Idle Young Men	Dogs	Temporality (Time of day)
Carter, Carroll, & Hayes (1993)	Carroll et al. (1999)	Carroll et al. (1999)
Fazzone et al. (2000)	Fazzone et al. (2000)	Fazzone et al. (2000)
Gellner et al., (1994)	Hayes et al. (1996)	Gellner et al. (1994)
Keith & Castles (1973)	Hunter (1997)	Kendra (1996)
Kendra & George (2001)	Gellner et al. (1994)	Kendra, Weiker, et al. (1996)
Lewis & Hallburg (1980)	Keith & Castles (1973)	Kendra & George (2001)
McNamara (1994)	Kendra & George (2001)	Lewis & Hallburg (1980)
Zerwekh (1991)	Steinberg (1995)	Schulte et al. (1998)
	Zerwekh (1991)	Snow & Kleinman (1987)
Suspicious & Threatening Behavior (Crime, gangs, weapons, and dangerous neighborhoods)	Substance Abuse & Unusual Behavior (Sexual harassment, drug use, and mental health issues)	Partnering Up/Escorts
Carroll et al. (1999)	Carroll et al. (1999)	Castles & Keith (1971)
Carter, Carroll, & Hayes (1993)	Carter, Carroll, & Hayes (1993)	Fazzone et al. (2000)
Castles & Keith (1971, 1978)	Fazzone et al. (2000)	Gellner et al. (1994)
Fazzone et al. (2000)	Fisher (1989)	George (1996)
Gellner et al. (1994)	Gellner et al. (1994)	Keith & Castles (1973, 1976)
George (1996)	George (1996)	Kendra (1996)
Hayes et al. (1996)	Hayes et al. (1996)	Kendra & George (2001)
Hunter (1997)	Hunter (1997)	Kendra, Weiker, et al. (1996)
Keith & Castles (1973, 1976)	Keith & Castles (1973)	Lewis & Hallburg (1980)
Kendra (1996)	Kendra & George (2001)	Mulligan (1973)
Kendra, Weiker, et al. (1996)	Kendra, Weiker, et al. (1996)	Nadwairski (1992)
McNamara (1994)	Lewis & Hallburg (1980)	Smith (1988)
Mulligan (1973)	Najera & Heavey (1997)	Snow & Kleinman (1987)
Schulte et al. (1998)	Rogers & Maurizio (1993)	
Snow & Kleinman (1987)	Schulte et al. (1998)	
Steinberg (1995)	Snow & Kleinman (1987)	
Zerwekh (1991)	Steinberg (1995)	
	Zerwekh (1991)	
Angry Family Members	Communicable Disease	Police Protection
Hunter (1997)	George (1996)	Fazzone et al. (2000)
Kendra & George (2001)	Kendra (1996)	Kendra, Weiker, et al. (1996)
Kendra, Weiker, et al. (1996)	Kendra, Weiker, et al. (1996)	Mulligan (1973)
Steinberg (1995)	Keith & Castles (1973)	Whitley et al. (1996)

Distractions (Driving/Traffic)	Seeing and Being Seen (Stairwells, elevators & darkness)	Vigilance (Becoming aware)
Carroll et al. (1999) Castles & Keith (1971, 1978) Fazzzone et al. (2000) Hayes et al. (1996) Steinberg (1995)	Carroll et al. (1999) Carter, Carroll, & Hayes (1993) Castles & Keith (1971, 1978) Fazzzone et al. (2000) Keith & Castles (1973, 1976) Hayes et al. (1996) Steinberg (1995)	Fisher (1989) McNamara (1994) Skillen et al. (2001) Smith (1988)
Supervisory Support (Education and training & communication)	Self-protection (Cell phones, pagers, & mace)	Blending In (Jewelry, dress & behavior)
Fazzzone et al. (2000) Finney (1988) George (1996) Hood & Smith (1994) Kendra (1996) Kendra & George (2001) Kendra, Weiker, et al. (1996) Leiba (1987) Mulligan (1973) Nadwairski (1992) Rogers & Maurizio (1993) Smith (1988) Snow & Kleinman (1987) Steinberg (1995)	Fazzzone et al. (2000) Finney (1988) Gellner et al. (1994) George (1996) Kendra (1996) Kendra & George (2001) Kendra, Weiker, et al. (1996) Lewis & Hallburg (1980) Mulligan (1973) Nadwairski (1992) Schulte et al. (1998)	Finney (1988) Fitzpatrick (1971) Gellner et al. (1994) Kendra & George (2001) Lewis & Hallburg (1980) Mulligan (1973)
Changing the Venue	Terminating/Shortening the Visit	Refusing to Visit
Kendra, Weiker, et al. (1996) Nadwairski (1992)	Fazzzone et al. (2000) Kendra, Weiker, et al. (1996) Lewis & Hallburg (1980) McNamara (1994)	Gellner et al. (1994) George (1996) Keith & Castles (1973, 1976) Kendra & George (2001) Kendra, Weiker, et al. (1996) Snow & Kleinman (1987)

this study.

The universal risk associated with the presence of dogs in the community has been described in prior studies. Many authors discussed the need for nurses working in the field to be particularly cautious regarding dogs and animals they might encounter (Carroll et al., 1999; Fazzone et al., 2000; Hayes et al., 1996; Hunter, 1997; Gellner et al., 1994; Keith & Castles, 1973; Kendra & George, 2001; Steinberg, 1995; Zerwekh, 1991). The findings of this study added to the description of the risks related to dogs and provided insight into the reasons for nurses to be concerned about their presence during home visits.

There has been a predominant focus in prior literature on the risk of suspicious and threatening behavior and the potential for injury while in communities (Carroll et al., 1999; Carter, et al., 1993; Castles & Keith, 1971, 1976; Fazzone et al., 2000; Gellner et al., 1994; George, 1996; Hunter, 1997; Keith & Castles, 1973, 1976; Kendra & George, 2001; McNamara, 1994; Mulligan, 1973; Snow & Kleinman, 1987; Steinberg, 1995). The threat associated with violence is thoroughly discussed in the literature related to safety in field nursing. Most authors discussed the potential threats of crime, gangs, the presence of weapons, and dangerous neighborhoods as those features most likely to lead to fear associated with assault or injury. The presence of crime or the identification of a particular neighborhood as dangerous was reported as a common reason for nurses to refuse to visit to a client (Snow & Kleinman, 1987).

Schulte, Nolt, Williams, Spinks & Hellsten (1998) surveyed field workers in sexually transmitted disease (STD) clinics in Texas. The findings of their study showed that 38% of all workers had been involved in a violent incident. The violent incidents

reported during fieldwork included verbal threats, weapons, physical attacks, and rape. Findings also indicated that white males, with more than five years of fieldwork experience, were the most likely to report that a weapon was involved in the threat of violence. Conversely, in a report on workplace assaults on minority health workers in Los Angeles, Sullivan and Yuan (1995) found that workers in public health programs had the least incidence of assault when compared to all other workplace settings. While little evidence is provided in the literature as to the impact of suspicious and threatening behavior on public health nurses, the process of keeping safe recognized that it is a concern for all individuals working with families and communities.

The potential risks posed by individuals under the influence of drugs and alcohol and with mental illness addressed in prior literature were validated by the findings in this study. The dimension of substance abuse and unusual behavior appeared frequently in previous studies (Carroll et al., 1999; Carter, Carroll, & Hayes, 1993; Fazzone et al., 2000; Fisher, 1989; Gellner et al., 1994; George, 1996; Hayes et al., 1996; Hunter, 1997; Keith & Castles, 1973; Kendra & George, 2001; Kendra, Weiker, et al., 1996; Lewis & Hallburg, 1980; Najera & Heavey, 1997; Rogers & Maurizio, 1993; Schulte et al., 1998; Snow & Kleinman, 1987; Steinberg, 1995; Zerwekh, 1991). Likewise, angry family members and their impact on the perception of safety of nurses providing care in the home have been discussed (Hunter, 1997; Kendra & George, 2001; Kendra, Weiker et al., 1996; Steinberg, 1995). Many of the descriptions of these dimensions were discussed in the context of home health nursing, however they could also be applicable in the practice of public health nurses.

Public health nurses in this study had professional responsibilities that were

centered on the surveillance and control of communicable diseases. The nurses in this study accepted their role in working with clients actively infected or exposed to communicable diseases and saw their level of risk for contracting these infections as minimal. This is contrary to the perceptions described in the literature (George, 1996; Kendra, 1996; Kendra, Weiker et al., 1996; Keith & Castles, 1973). In a study by George (1996), the threat of an infectious disease was seen by administrators of home health agencies as the fourth highest risk for nurses. Finding from this study were not supported by the literature in regard to the perception of minimal risk from communicable diseases in the community.

Public health nurses in this study recognized that there were potential risks associated with home visiting. However, they did not believe that risks alone were sufficient to cause harm. Their belief regarding risks were validated by the cognitive-perceptual model proposed by Kendra and George (2001). Additional factors were necessary for the risks to be evaluated as an actual threat to safety.

Within the context of the dimensions described above, this study validated the need for vigilance by the public health nurse while in the community. The dimension of vigilance, as described by the participants in this study, however, has not been well delineated, but has been inferred or implied in previous literature (Fisher, 1989; McNamara, 1994; Skillen, Olson & Gilbert, 2001; Smith, 1988). Alternate descriptions of vigilance were “becoming aware” (Skillen et al., p. 670) and the need to “be aware” (Smith, 1988, p.10). Vigilance was seen as necessary when there was increased risk or actual danger in a patient care situation, however there is no clear indication in the literature that vigilance was a constant facet of public health nursing practice, as was

found in this study. In a study on the process of dangerousness in psychiatric nursing, Fisher (1989) described how nurses incorporated hypervigilance into their practice and needed to “pay attention” to both external and internal cues to violence (p. 162). Both Fisher (1989) and McNamara (1994) specifically described the assessment necessary for dangerous situations as vigilance.

Findings in this study supported vigilance as a learned response. Theoretical work on automaticity in everyday life purports that, while many human responses to stimuli evolve from not-conscious processes, as an individual engages in a skill, less and less conscious attention is necessary to master it (Baugh, 1997; Baugh & Chartrand, 2000). The participants in this study incorporated perceptions that evolved through personal experience, theoretical foundations, and vicarious knowledge to determine the risks within their environment. Within this same context, information and sensations taken in by the participants were consciously processed and filtered with active and intentional interpretation. The speed with which decisions were made regarding those risks identified by the participants is supported by Neely (1977). Research has determined that preconscious decisions regarding environmental factors or risks labeled as expected or unexpected can be evaluated in as little as 250 nanoseconds, while conscious decisions can be made in 500 nanoseconds.

Issues of Vulnerability

Consistency exists between the findings of this study and the literature related to time of day, as it is well documented (Carroll et al., 1999; Fazzone et al., 2000, Gellner et al., 1994; Kendra & George, 2001). Most studies include this dimension as an issue when addressing conditions in the late afternoon or evening that increase fear or reasons

for refusing an assignment. Schulte et al. (1998) found that 54% of the field workers (FW) surveyed regularly scheduled their visits early in the day as a safety precaution. Visits during evening or night hours were not an issue for the participants in this study; however, they reported that the time of day influenced their perception of vulnerability.

Studies using the environmental fear scale (EFS) or environmental comfort scale (ECS II) measured attitudes of public health nurses and nursing students to distractions and environment factors, such as traffic, driving, stairwells, and elevators. These studies have found that these factors are influential in the perception of safety during home visiting (Carroll et al., 1999; Carter et al., 1993; Keith & Castles, 1973, 1976; Hayes et al., 1996). While the research on these factors has focused on the negative impact, their findings are similar to the responses by the public health nurses in this study.

Mistaken identity and visibility in field public health nursing emerged as new concepts from the experiences of the participants in this study. There are no studies or scholarly literature that describe the dimension of mistaken identity and those that discuss visibility in public health nursing, have done so from a very different context. Data suggested that public health nurses decided the extent of their visibility to others in the community depending on the situations they encountered. This is contrary to the view in the literature, as visibility is seen from the feminist perspective of invisibility of the profession, rather than personal visibility (Clendon & McBride, 2001; Goodman, 1996; Rafael, 1999; Vukic & Keddy, 2002). In this same context, Keith & Castles (1976) viewed visibility related to safety as either a threat to person privacy or an opportunity to show others their abilities in the field.

Safety Decision-making

Several parallels exist between the findings of this study and the models developed regarding safety, particularly in the concepts of risk estimation and risk decision-making. Kendra and George (2001) noted that field workers use an “appraisal of the home visiting situation” and “behavioral response” to prevent or control risks (p. 133). While this model implies a reactionary response to risk, it corresponds to this study’s finding on both risk estimation and safety decision-making. Skillen et al. (2001) also described how nurses recognize the influence of personal risk in the environment and planned either “no action” or “action” (pp. 671-672). While similar in context, this is contrary to the findings of this study that support the concept that nurses proactively determine the necessary risk prevention or risk avoidance strategies.

Risk Limitation Strategies

Risk limitation strategies or actions taken by nurses during home visiting, such as (a) blending in, (b) partnering up, (c) self-protection, (d) changing the venue, and (e) terminating or shortening the visit, are well documented. Many authors described the dimension of blending in by the manner of dress, absence of jewelry, and professional demeanor of the nurse (Carter et al. 1993; Finney, 1988; Gellner et al., 1994; Kendra & George, 2001; Kendra, Weiker, et al., 1996; Lewis & Hallburg, 1980; Mulligan, 1993). Older literature focused on the nurses’ attire, and some proposed that safety could be enhanced with a particular form of dress or an outward symbol of the profession (Lewis & Hallburg, 1980; Mulligan, 1973). Another author predicted that uniforms provided no protection (Fitzpatrick, 1971). For public health nurses in this study, blending in included many similar facets to those described in the literature.

One of the major risk avoidance strategies described in the literature was the use of escorts or police protection on home visits that have a potential for violence or an uncertain outcome (Castles & Keith, 1971; Fazzone et al., 2000; Gellner et al., 1994; George, 1996; Kendra & George, 2001; Mulligan, 1973; Nadwairski, 1992; Smith, 1988; Snow & Kleinman, 1987). Choices regarding who would accompany the nurses in this study varied slightly from those discussed in the literature, particularly in regard to individuals in official positions who might change the atmosphere from advocacy to one of authority and power. Nurses in this study preferred to have other nurses or community workers accompany them on visits when they needed additional personnel for protection.

The dimension of self-protection is also well documented in the literature (Fazzone et al., 2000; Finney, 1988; Gellner et al., 1994; George, 1996; Kendra, 1996; Kendra & George, 2001; Lewis & Hallburg, 1980; Mulligan, 1973; Nadwairski, 1992; Schulte et al., 1998). Devices such as cell phones and pagers are frequently discussed as necessary equipment to maintain contact with those who can help in a given situation. In addition, mace and self-defense classes were described. While nurses in this study regularly reported the use of cell phones, they disapproved of the use of mace or other forms of defensive weapons. Some believed that a weapon might ultimately be used on them and cause injury.

Many authors have reported the options to change the venue or terminate a visit when necessary (Fazzone et al., 2000; Kendra & George, 2001; Kendra, Weiker et al. 1996; Lewis & Hallburg, 1980 & McNamara, 1994; Nadwairski, 1992). Consistent with the concepts reported in the literature, nurses in this study confirmed that it was

ultimately their decision to implement this risk avoidance strategy when they believed that the visit had actual risk or threat of impending danger.

Most of the above risk limitation strategies described in the literature were in the context of impending risk or danger and were instituted for risk avoidance. It is interesting to note that research regarding home health nursing lists refusal to visit as a common issue in practice. Studies report that when unsafe areas were identified, agencies had policies that allowed exclusion of patients from services based on the perceived risk or danger of the neighborhood of residence (Gellner et al., 1994, George, 1996, Keith & Castles, 1973, 1976; Kendra, Weiker, et al., 1996; Snow & Kleinman, 1987). This practice did not occur in any of the sites utilized for this study.

In sum, research and literature on safety in public health and home health nursing practice provided validation for many of the dimensions of the process of *keeping safe*. Some dimensions identified by the nurses in this study provided further richness and breadth to the knowledge available on safety or expanded previous findings in the context of public health nursing.

Study Limitations

Limitations of this study are similar to any other study using a qualitative method. There are two limitations related to sampling in this study that need to be recognized. First, nursing administrators in the health departments selected the last twelve participants. Qualities and characteristics for inclusion in the study were purposively requested, however the supervisors chose the final sample. As a result, public health nurses chosen could have been individuals with a more positive attitude regarding their experiences. It is also likely that individuals with negative attitudes or those with actual

safety incidents in the field may have been excluded. The possibility that additional or different conclusions might have been discovered from a more diverse sample exists. Second, the sample for this study was chosen from only one region of the United States, had limited representation from male public health nurses, and did not include nurses of Asian or Native American ethnicity. By not including a more complete representative sample, these findings may not be generalizable to other public health nursing groups.

The intent of this study was to describe, explore, and explain the perception of safety among field public health nurses and determine a substantive theory on the process of *keeping safe*. Further quantitative studies would be necessary to determine the magnitude and consequence of the issues of safety in field public health nursing practice.

Implications for Nursing Practice

This study provides a framework for practice for seasoned and novice public health nurses and is applicable for the multiple venues of public health nursing practice. Safety is a concern for all nurses practicing in the community and does not change in importance at different levels of responsibility or experience. With a clear explanation of the process of *keeping safe*, there may be additional individuals who enter into the practice of public health nursing. In an atmosphere of uncertainty or fear regarding safety, nurses considering employment options in public health might be hesitant to enter the field. Public health nurses need to be made aware and reminded of the importance of *keeping safe*. With open communication and safety programs developed by nursing administration, each nurse will have the support and information they need to maintain their safety (Leiba, 1987).

Assessment, planning, and intervention programs that address the issues of safety for health care workers in community settings have been described (Najera & Heavey, 1997). Areas that are purported to be the most beneficial for employees include programs that enhance communication between administration and nurses, self and organizational assessment, appropriate supervision and support of employees, and education and training on safety and workplace violence prevention (Fazzone et al., 2000; Finney, 1988; George, 1996; Kendra & George, 2001; Leiba, 1987; Mulligan, 1993; Nadwairski, 1992; Rogers & Maurizio, 1992; Smith, 1988; Snow & Kleinman, 1987; Steinberg, 1995). Currently, the Occupational Safety and Health Administration (OSHA) requires employers and agencies to maintain a record of all injuries and threats against employees; however, there are no legal requirements for agencies to develop a plan for nurses working in the community (OSHA, 2003). Any prevention program developed would be voluntary on the part of an employer.

This study highlighted the need for appropriate supervisory support. Nurses in this study reported their concern about the lack of support by administrators at higher levels in their organizations. Most nurses however, believed that immediate supervisors were concerned about their safety and maintained appropriate safety nets for their protection. In a study by Hood and Smith (1994), nurses and support personnel who had leaders that expressed personal concern and support for their employees had higher job satisfaction and were more likely to state that they would be continuing in their present job situation. Increased attention to issues of safety by administrators at all levels will be necessary for agencies experiencing high turnover or inadequate recruitment rates due to these concerns. Public health nurses should be their own

advocates regarding safety in the field. Issues and problems should be openly discussed and effective safety plans should be joint efforts between the nurses and supervisors. Ultimately *keeping safe* is the responsibility of the field public health nurse.

Implications for Nursing Education

Historically, home visit safety for nursing students has been an area of concern and research (Carroll, et al., 1999; Carter, et al., 1993; Castles & Keith, 1971, 1978; Fitzpatrick, 1971; Hayes, et al., 1996; Keith & Castles, 1973, 1976; Whitley, Jacobson, & Gawrys, 1996). Moreover, research has shown that attention to the social issue of violence has been inadequately addressed in nursing curricula (Hoff & Ross, 1995). Public health nursing education can derive much from the findings of this study. The 19 nurses interviewed were either at the competent or expert level of nursing practice (Benner, 1984). They had an average of 10.5 years of public health nursing experience and were working in field nurse positions. Their stories and experiences have great value for novice and advanced beginners as they learn to perform the roles of the public health nurse and deal with the issues of safety in home visiting. The process of *keeping safe* could be integrated into nursing curriculums to teach students how to maintain risk awareness and the elements of vigilance described in this study. In addition, students could benefit from the experiences revealed as scenarios for discussion.

Parallels can be drawn between Benner's (1984) model of skill acquisition and the potential benefit this study may have in nursing education. This study's findings might be useful for all stages from novice to expert, but are most likely to be used in nursing education for the novice and advanced beginner.

At the novice stage, beginners with no experience could be educated on the basic

process of *keeping safe*. From Benner's perspective students could be taught about field safety with "objective attributes" and be given "context-free rules" to guide their actions in situations that may put them at risk (1984, pp. 20-21). Objective attributes in this study could be viewed as the elements of vigilance and risk estimation. Attributes of vigilance, such as identification of idle young men, dogs, suspicious behavior, drug abuse, angry family members, and communicable diseases would be entry level skills. Context-free rules would include education regarding the best time of day to visit families, safely maintaining visibility, avoiding mistaken identity, and potential distractions. Because of the concrete nature of a novice's decision-making, any sign of risk or threat would be countered with a risk avoidance strategy. Nursing educators should encourage students at this stage to leave a setting in which they have reason to be fearful. Nurses transferring into public health could also be considered at the novice stage and might benefit from similar nursing education during their orientation. Many authors have described the need for specific and direct teaching strategies for novice nurses on the topic of field safety (Fitzpatrick, 1971; Lewis & Hallburg, 1980).

Moreover, advanced beginners or students with some level of experience could add to their level of skill acquisition by being taught guidelines to follow during home visiting to maintain safety and increase understanding of the context of each of the attributes of vigilance. These guidelines would incorporate safety decision-making and utilize risk limitation strategies during field visits. As a learning exercise, experiences and stories told by the nurses in this study could be used as exemplars for education of both novices and advanced beginners.

Implications for Nursing Research

The purpose of this study was to explore and explain the perceptions of safety among field public health nurses. With the emergence of an innovative substantive theory on the process of *keeping safe*, new research questions can be identified for study. Of primary interest is whether future qualitative studies with public health nurses in different regions of the United States or in strictly rural settings would have similar findings. One research question that might be explored is “are perceptions of safety for rural public health nurses different from nurses in suburban and inner city areas?” A study comparing perceptions would be valuable for nurse educators preparing individuals for service in multiple settings.

Greater richness and understanding might be forthcoming with research including recruitment of additional male participants or individuals from ethnic groups not represented in this study. Experiences of individuals from different ethnic groups may add to the understanding regarding perceptions of safety from a cultural perspective. Studies with additional male representation might add to the understanding of risks in the field specific to men during home visiting.

Further knowledge and understanding regarding the breadth of safety issues in public health nursing field visits might be found through descriptive surveys that measure the number of injuries or assaults on public health nurses. Data in this study suggested that many of the perceptions held by the nurses were vicariously known as a result of stories they had heard from or about others. Much of the research in the current literature presupposes that the risk of injury or assault is elevated in public health practice. There is little evidence to support this assumption. Research completed

with students in public health experiences have focused on the fear or threat they experience during their rotation (Carroll et al., 1999; Carter et al., 1993; Castles & Keith, 1971, 1978; Keith & Castles, 1973, 1976). These studies have helped to identify fear as a potential negative influence on student learning. However, no studies have measured the long-term effect of the perception of threat or fear on students and their ability or willingness to perform the roles of a public health nurse.

For higher levels of inquiry, tool development would be necessary for further exploration of the concept of safety in field nursing. In concert with the literature on the topic, the findings of this study could provide the dimensions necessary for development of a valid and reliable measurement of perceptions of safety. With this tool, research could focus on correlational or experimental studies. Correlational studies might ask questions such as:

1. What is the relationship between perception of safety and length of public health nursing employment in underserved areas?
2. Is there a correlation between perception of safety and the rate of injury and assault among field public health nurses?
3. What is the correlation between perceptions of safety and the incidence of traffic related injury and death among public health nurses?
4. Do perceptions of safety differ between novice and expert public health nurses?
5. Is there a correlation between perception of safety during student rotations and employment rates in public health nursing?

As higher levels of research are completed more complex and predictive research

questions could be asked. Teaching strategies and safety intervention plans could be measured for effectiveness. Public health nursing administration might be able to match nursing candidates with orientation and inservice courses to prepare them for field positions. These studies are just a few of those that could possibly increase nursing knowledge in the area of safety in public health nursing. The potential for new research will increase as more hypotheses are studied.

Conclusion

The findings of this study suggest that public health nurses maintain their safety through the proactive process of *keeping safe*. As a result of the constant comparative method of data analysis, the literature supported these findings. There are multiple nursing practice, education, and research implications associated with this study. Further research will be necessary to determine the applicability of these findings to the education and practice of public health nurses.

References

- Allender, J., & Spradley, B. (2001). *Community health nursing: Concepts and practice* (5th ed.). Philadelphia: Lippincott.
- American Public Health Association, Public Health Nursing Section. (1996). *The definition and role of public health nursing-A statement of the public health nursing section*. Washington, DC: Author.
- Baly, M.E. (1986). *Florence Nightingale and the nursing legacy*. London: Croom Helm.
- Baugh, J.A. (1997). The automaticity of everyday life. In R.S. Wyer Jr. (Ed), *Advances in social cognition: Vol. X*. (pp. 1-61). Mahwah, NJ: Erlbaum.
- Baugh, J.A. & Chartrand, T.L. (2000). The mind in the middle: A practical guide to priming and automaticity research. In H. Reis & C.M. Judd (Eds.), *Handbook of research methods in social and personality psychology* (pp. 253-285). New York: Cambridge University Press.
- Becker, H. (2000). An analysis of the epidemiology of latex allergy: Implications for primary prevention. *MEDSURG Nursing*, 9, 135-143.
- Bekemeier, B. (1995). Public health nurses and the prevention of and intervention in family violence. *Public Health Nursing*, 12, 222-227.
- Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice*. Menlo Park, CA: Addison-Wesley.
- Blumer, H. (1969). *Symbolic interactionism: Perspectives and method*. Englewood Cliffs, NJ: Prentice Hall.

- Breckinridge, M. (1952). *Wide neighborhoods: A story of the Frontier Nursing Service* (Rev. ed.). Lexington, KY: University Press of Kentucky.
- Brown, C. (1977). *The nurse and the urban crisis: An examination of environmental fear in public health nursing today*. Unpublished master's thesis, University of Illinois, Chicago.
- Buhler-Wilkerson, K. (1993). Bringing care to the people: Lillian Wald's legacy to public health nursing. *American Journal of Public Health*, 83, 1778-1786.
- Bureau of Labor Statistics, U.S. Department of Labor. (1999). *Fatal occupational injury by occupation*. Retrieved August 1, 2000, from <http://stats.bls.gov/special.requests/ocwc>.
- Bureau of Labor Statistics, U.S. Department of Labor, in cooperation with Census of Fatal Occupational Injuries. (1997). *Fatal occupational injuries by worker activity at the time of incidence*. Retrieved August 1, 2000, from <http://stats.bls.gov/special.requests/ocwc/oshwc/cfoi/cftb0074.txt>.
- Byrd, M.E. (1995a). A concept analysis of home visiting. *Public Health Nursing*, 12, 83-89.
- Byrd, M.E. (1995b). The home visit process in the contexts of voluntary vs. required visits: Examples from fieldwork. *Public Health Nursing*, 12, 196-202.
- Canavan, K. (1996). Steps taken to protect health care workers from violence. *The American Nurse*, 28, 3.
- Carroll, M., Morin, K., Hayes, E., & Carter, S. (1999). Assessing students' perceived threats to safety in the community: Instrument refinement. *Nurse Educator*, 24, 31-35.

- Carter, S.V., Carroll, M.C., & Hayes, E.R. (1993). Environmental safety preparation for community-based nursing educational experiences: Measurable indices. *Public Health Nursing, 11*, 300-304.
- Castles, M., & Keith, P. (1971). Correlates of environmental fear in the role of the public health nurse. *Nursing Research, 20*, 245-249.
- Castles, M. & Keith, P. (1978). Environmental fear scale. In M. Ward & C. Lindeman (Eds.), *Instruments for measuring practice and other health variables* (pp. 9-11). Washington D.C.: U.S. Government Printing Office.
- Chenitz, W.C., & Swanson, J. (1986). *From practice to grounded theory: Qualitative research in nursing*. Menlo Park, CA: Addison Wesley.
- Clark, M .J. (2003). *Community health nursing: Caring for populations* (4th ed.). Upper Saddle River, NJ: Prentice Hall.
- Clendon, J. & McBride, K. (2001). Public health nurses in New Zealand: The impact of invisibility. *Nursing Praxis in New Zealand, 17*(2), 24-31.
- Coss, C. (1993). Lillian D. Wald: Progressive activist. *Public Health Nursing, 10*, 134-138.
- Creswell, J.W. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks, CA: Sage.
- Fazzone, P., Barloon, L., McConnell, S., & Chitty, J. (2000). Personal safety, violence, and home health. *Public Health Nursing, 17*, 43-52.
- Finney, G. (1988). One false move. *Community Outlook, 8-9*.

- Fisher, A. (1989). The process of definition and action: The case of dangerousness. (Doctoral dissertation, University of California, San Francisco). *Dissertation Abstracts International*, 50 (05B), 1851. (UMI No. 8917915).
- Fisher, D. (1994). Violence puts home care nurses in harm's way. *The American Nurse*, 26, 16.
- Fitzpatrick, L. (1971). Safety and the community nursing experience. *Nursing Outlook*, 19, 527-531.
- Gellner, P., Landers, S., O'Rourke, D., & Schlegel, M. (1994). Community health nursing in the 1990's - Risky business? *Holistic Nursing Practice*, 8(2), 15-21.
- George, V. (1996). Field-workers' sense of coherence and perception of risk when making home visits. *Public Health Nursing*, 13, 244-252.
- Glaser, B.G. (1978). *Advances in the methodology of grounded theory: Theoretical sensitivity*. Mill Valley, CA: Sociology Press.
- Glaser, B.G. (1992). *Emergence vs. forcing: Basics of grounded theory analysis*. Mill Valley, CA: Sociology Press.
- Glaser, B.G., & Strauss, A.L. (1967). *The discovery of grounded theory: Strategies for qualitative research* (Rev. ed.). Hawthorne, New York: Aldine.
- Goodman, C. (1996). District nursing and the National Health Service reforms: A case for clarification. *Journal of Nursing Management* 4, 207-12.
- Gordon, G. (1999). Practice behaviors of RNs related to hazardous risks within the clinical setting. *MEDSURG Nursing*, 8, 174-178.
- Hayes, E., Carter, S., Carroll, M., & Morin, K. (1996). Managing fear associated with nursing in urban environments: First steps. *Public Health Nursing*, 13, 90-96.

- Heinrich, J. (1983). Historical perspectives on public health nursing. *Nursing Outlook*, 31, 317-320.
- Hoff, L.A. & Ross, M. (1995). Violence content in nursing curricula: Strategic issues and implementation. *Journal of Advanced Nursing*, 21, 137-142.
- Hood, J.N. & Smith, H.L. (1994). Quality of work life in home care: The contribution of leaders' personal concern for staff. *Journal of Nursing Administration*, 24, 40-47.
- Hunter, E. (1997). Violence prevention in the home health setting. *Home Healthcare Nurse*, 15, 403-409.
- Hutchinson, S. (1999). Grounded theory: The method. In P. Munhall & C. Boyd (Eds.), *Nursing research: A qualitative perspective* (2nd ed.) (pp. 180-212). New York: toExcel.
- Janesick, V. (2000). The choreography of qualitative research design: Minuets, improvisations, and crystallization. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed.) (pp. 379-399). Thousand Oaks, CA: Sage.
- Kalisch, P., & Kalisch, B. (1995). *The advance of American nursing* (3rd ed.). Philadelphia: Lippincott.
- Keith, P., & Castles, M. (1973). Impact of environmental fear on public health nurses. *Health Service Reports*, 88, 201-204.
- Keith, P., & Castles, M. (1976). Community health nurses' preferences for systems of protection. *Nursing Research*, 25, 252-255.
- Kendra, M. (1996). Perceptions of risk by home health care administrators and field workers. *Public Health Nursing*, 13, 386-393.

- Kendra, M., & George, V. (2001). Defining risk in home visiting. *Public Health Nursing, 18*, 128-137.
- Kendra, M., Weiker, A., Simon, S., Grant, A., & Shullick, D. (1996). Safety concerns affecting delivery of home health care. *Public Health Nursing, 13*, 83-89.
- Leiba, P.A. (1987). Violence: The community nurse's dilemma. *Health Visitor, 60*, 361-362
- Leipert, B. (1996). The value of community health nursing: A phenomenological study of the perceptions of community health nurses. *Public Health Nursing, 13*, 50-57.
- Lewis, I., & Hallburg, J. (1980). Strategies for safe home visits. *Urban Health*, (July/August), 40-41.
- Lichtblau, E. (2000, May 8). U.S. crime falls 8th year in row, setting record. *Los Angeles Times*, pp. A1, A15.
- Lincoln, Y., & Guba, E. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage.
- MacMaster, J. (1999). The public health nurse in tornado relief. *Public Health Nursing, 16*, 72-75.
- McNamara, D. (1994). Gang violence and the street smart nurse. *Journal of Community Health Nursing, 11*, 193-200.
- Morse, J. (1995). The significance of saturation. *Qualitative Health Research, 5*, 147-147.
- Morse J.M. (2001). Situating grounded theory within qualitative inquiry. In R.S. Schreiber & P. Stern. (Eds.), *Using grounded theory in nursing* (pp. 1-15). NY: Springer.

- Mulligan, J. (1973). Agencies in cities of crisis: A descriptive study of selected characteristics. *American Journal of Public Health*, 63, 46-51.
- Nadwairski, J. (1992). Inner-city safety for home care providers. *Journal of Nursing Administration*, 22(9), 42-47.
- Najera, L.K. & Heavey, B.A. (1997). Nursing strategies for preventing home health aide abuse. *Home Healthcare Nurse*, 15, 758-767.
- Neely, J.H. (1977). Semantic priming and retrieval from lexical memory: Roles of inhibitionless spreading activation and limited-capacity attention. *Journal of Experimental Psychology: General*, 106, 226-254.
- Nunnally, J., & Burnstein, I. (1994). *Psychometric theory* (3rd ed.). New York: McGraw-Hill.
- O'Boyle, M. (1996). Preparing for a safer home health care visit. *Journal of Home Health Care Practice*, 8(1), 34-43.
- Occupational Safety and Health Administration, U.S. Department of Labor. (2003). Voluntary Protection Programs (VPP): Policies and Procedures Manual. Retrieved February 20, 2004, from http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=DIRECTIVES&p_id=2976.
- Polit, D., & Hungler, B. (1998). *Nursing research: Principles and methods* (6th ed.). Philadelphia: Lippincott.
- Pratt, L., Runyan, C., Cohen, L., & Margolis, P. (1998). Home visitors' beliefs and practices regarding childhood injury prevention. *Public Health Nursing*, 15, 44-49.

- Rafael, A. (1999). The politics of health promotion: Influences on public health promoting nursing practice in Ontario, Canada from Nightingale to the nineties. *Advances in Nursing Science*, 22, 23-39.
- Rickford, F. (1995). Saved by a bell. *Nursing Times*, 91(34), 15-16.
- Rogers, J., & Maurizio, S. (1993). Prevalence of sexual harassment among rural community care workers. *Home Healthcare Nurse*, 11(4), 37-40.
- St. John, W. & Johnson, P. (2000). The pros and cons of data analysis software for qualitative research. *Journal of Nursing Scholarship*, 32, 393-397.
- Salmon, M. (1993). Editorial: Public Health Nursing - The opportunity of a century. *American Journal of Public Health*, 83, 1674-1675.
- Schulte, J.M., Nolt, B.J., Williams, R.L., Spinks, C.L. & Hellsten, J.J. (1998). Violence and the threat of violence experienced by public health field-workers. *Journal of American Medical Association*, 280, 439-442.
- Skillen, D.L., Olson, J.K., & Gilbert, J.A. (2001). Framing personal risk in public health nursing. *Western Journal of Nursing Research*, 23, 664-678.
- Smith, N., & Brown, L. (1997). Dealing with aggressive patients and avoiding overinvolvement. *Home Healthcare Nurse*, 15, 131-132.
- Smith, S. (1988). Take care, be aware. *Community Outlook*, 11-12.
- Snow, D., & Kleinman, L. (1987). The impact of crime on home care services. *American Journal of Public Health*, 77, 209-210.
- Stanhope, M., & Knollmueller, R. (2000). *Handbook of community-based and home health nursing practice* (3rd ed.). St. Louis: Mosby.
- Steinberg, A. (1995). Safety and home care nursing: A study. *Concern*, 25(5), 24-26.

- Streubert, J., & Carpenter, D. (1995). *Qualitative research in nursing: Advancing the humanistic imperative*. Philadelphia: Lippincott.
- Sullivan, C. & Yuan, C. (1995). Workplace assaults on minority health and mental health care workers in Los Angeles. *American Journal of Public Health*, 85, 1011-1014.
- Tilden, V., Schmidt, T., Limandri, B., Chiodo, G., Garland, M., & Loveless, P. (1994). Factors that influence clinicians' assessment and management of family violence. *American Journal of Public Health*, 84, 628-633.
- U.S. Census Bureau. (2001). *Statistical abstract of the United States, 2001* (121st ed.). Washington DC: Author.
- U.S. Public Health Service. (1993). *A century of caring: A celebration of public health nursing in the United States 1893-1993*. Washington DC: American Public Health Association.
- Vukic, A. & Keddy, B. (2002). Northern nursing practice in a primary health care setting. *Journal of Advanced Nursing*, 40, 542-548.
- Wald, L. (1915). *The House on Henry Street*. New York: Henry Holt and Company.
- Wald, L. (1934). *Windows on Henry Street*. Boston: Little, Brown, and Company.
- Waltz, C., Strickland, O., & Lenz, E. (1991). *Measurement in nursing research* (2nd ed.). Philadelphia: F.A. Davis.
- Whitley, G., Jacobson, G., & Gawrys, M. (1996). The impact of violence in the health care setting upon nursing education. *Journal of Nursing Education*, 35, 211-217.

- Wuest, J., & Merritt-Gray, M. (2001). Feminist grounded theory revisited: Practical issues and new understandings. In R.S. Schreiber & P. Stern (Eds.), *Using grounded theory in nursing* (pp. 159-175). NY: Springer.
- Zerwekh, J. (1990). A qualitative description of the competencies of expert public health nurses. (Doctoral dissertation, Seattle University, 1990). *Dissertation Abstracts International*, 51, 2824.
- Zerwekh, J. (1991). At the expense of their souls. *Nursing Outlook*, 39, 58-62.
- Zerwekh, J. (1992a). Community Health Nurses - A population at risk. *Public Health Nursing*, 9, 1.
- Zerwekh, J. (1992b). Laying the groundwork for family self-help: Locating families, building trust, and building strength. *Public Health Nursing*, 9, 13-21.
- Zerwekh, J. (1992c). The practice of empowerment and coercion by expert public health nursing. *Image: Journal of Nursing Scholarship*, 24, 101-105.

Appendix B

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draw the line between infrastructure problems and preparedness and Congressional thinking that an increased budget for public health is only needed once or twice. The practical challenges are convincing local decisionmakers of "dual" use of bioterrorism dollars to prevent declining public health funding, hiring people and keeping them once bioterrorism funding goes away and developing relationships with law enforcement without increasing distrust in public health. The overall challenge is developing a permanent infrastructure.

She pointed out that New York demonstrated the importance of preparedness in their handling of 9/11. They had created a task force to deal with West Nile virus and were able to reactivate. She also emphasized the importance of community...getting the word out to community organizations and collaborating with organizations such as schools. She said that if public health isn't integrated into the community it can't function. She sees the biggest bridge to be built is with organized medicine and said that doctors are thinking more about community based approaches to problems. She also indicated the importance of communication. There needs to be a bridge built to the media. Public health people need to understand how news media work and who adheres to standards. In some situations reporters need to speak to real scientists not just spokespersons. Attendees were certainly challenged by Ms. Garrett's address.

President's Message

By Ben Neufeld, President

These are great times to be in public health.

Everyone (almost) says nice things about us and says how we are important and says we are deserving of credit for doing good things for our country. And then not doing much about it.

In Los Angeles, the Department of Health Services is short of funds again, and while this is not the only place with a looming budget shortfall, it is one of the largest. LA is said to be again considering closing hospitals and converting to more outpatient clinics. Now, this is not a total loss. Health people have been talking for decades about moving services – and medical education – away from hospital emergency rooms into less intensive outpatient clinics. This was going to be good for patients for four main reasons: It would reduce waiting times by separating out real emergency patients who would naturally get treatment priority; it would reduce costs by removing many high-tech machines and their staffs from the billing process; it would improve service by staffing with appropriate medical and nursing specialists rather than trauma experts; and, through this combination of advances, make it possible to establish more facilities in less costly buildings better located to serve the public.

But, it was expected that there would be a gradual shift in this direction. There would have to be public education programs and the creation of the needed new facilities. These would create public confidence in the new system before the old system was cut back and placed off limits to run-of-the-mill health problems. We seem to be losing this temporal "luxury." While the President has come to advocate improving mental health coverage to match physical health coverage, is the latter instead in danger of following mental health service's decline with its move into "the least restrictive setting"?

Field Public Health Nursing Safety Study

Participants are needed for a study currently being conducted on the perceptions of safety among field public health nurses. Participation would include a 45-90 minute interview, scheduled at your convenience.

If you are a PHN interested in taking part in this qualitative study or would like more information, please call Karen Nielsen-Menicucci at 818.353.2838 or 323.343.4194.

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Appendix C

Semi-structured Interview Guide

1. What would you tell a newcomer to public health nursing about safety?
2. Tell me about times you have felt safe.
3. Tell me about times you have felt unsafe.

Secondary Probes

- How do you recognize a situation as safe?
- Tell me about clients and safety.
- How does time of day and/or weather affect safety?
- What has your spouse, family, or significant other said about your safety as a PHN?
- What links do visibility and recognition have to safety?
- Are there things you wear or don't wear for safety?
- When would you refuse an assignment due to lack of safety?
- Tell me about searching for clients.
- Tell me about weapons.

Demographic Data

Number of years in field public health nursing, _____

Number of years in nursing? _____

Number of census tracts or population in district _____

General description of the field area/district _____

Estimated number of field visits per week or month. _____

Age in years _____

Highest earned degree _____

Gender _____

Ethnicity _____

Appendix D

Consent to Participate in Research

A nurse researcher and doctoral candidate at the University of San Diego, Karen Nielsen-Menicucci, RN, MS, C.N.S., is completing an investigation of perceptions of safety among field public health nurses.

Interviews will be semi-structured tape-recorded conversations about the PHN's experiences with issues of safety. Participants will be asked to share their thoughts and feelings about client encounters, previous experiences with safety issues and current safety issues in the communities served. Participants will be asked questions about their ages, nursing education, and the amount and nature of their experience as a registered nurse and public health nurse. It is expected that interviews will take 45 to 90 minutes. All interviews will be tape-recorded. The tapes will be stored in a locked cabinet accessible only to the investigator. When no longer needed for verification of transcripts, the tapes will be destroyed.

To maintain confidentiality only first names will be used on the tapes. Transcripts will be made from each tape and any information identifying an individual or a facility will be omitted from the transcripts. Only the transcripts will be used in any sharing of research data for educational and research purposes or publication about the research. Consent forms will be kept separately in a different locked cabinet.

As a participant in this study, I understand that several people will read the transcript of my interview. I understand that sections of what I say may be extracted and used in research reports or articles to illustrate an idea or theme but that identifying information will be removed and the findings presented in such a way that my identity will not be revealed.

I understand that the only cost to me as a participant will be the value of the time I spend participating in the interviews. There is a minimal anticipated risk as a result of my participation in this study. Negative feelings may emerge due to memories from previous experiences. Should this occur, I may choose to move on to another

topic, postpone the interview, or withdraw from the study. The only benefit I expect from participation is the satisfaction of contributing to nursing knowledge.

I understand that participation in this research is voluntary and that I may withdraw without penalty at any time, even in the middle of an interview, if I no longer wish to participate. There is no agreement, written or verbal, between the participant and the researcher beyond what is recorded on this consent form. I, the undersigned, understand the above explanations and on that basis, I give my consent to voluntary participation in this research.

_____ Signature of Participant	_____ Date	_____ Location
_____ Signature of Principle Researcher	_____ Date	

If you have questions about the investigation, contact the nurse researcher, Karen Nielsen-Menicucci at (818) 353-2838 or her dissertation chairperson, Dr. Mary Jo Clark, PhD, RN, PHN at (619) 260-4574.