

LONG-TERM HOME VISITING WITH VULNERABLE, YOUNG MOTHERS

LONG-TERM HOME VISITING WITH VULNERABLE, YOUNG MOTHERS: IMPACTS ON PUBLIC
HEALTH NURSES

By , BSc, BN, RN

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Abstract

The Nurse-Family Partnership (NFP) is a targeted, nurse home visitation program for young, low-income, first time mothers. While the effectiveness of the NFP has been established in the context of the US, and is currently being evaluated in the Canadian public health care system, little has been done to document how work of this nature influences or impacts public health nurses (PHNs), an essential component of this program delivery model, on both professional and personal levels. This qualitative interpretive descriptive study explored PHNs' experiences of long-term home visiting a targeted population of young, vulnerable mothers in a Canadian NFP program. The study was conducted in two phases beginning with a secondary analysis of five focus groups conducted with public health nurses (N = 6) who delivered the NFP intervention as part of the feasibility and acceptability pilot in Hamilton, Ontario. This was followed by further exploration of identified themes and a practice, problem and needs analysis through individual, semi-structured interviews with the original focus group participants and all PHNs who have since delivered the NFP (N =10). Relationships formed with clients, the NFP program and support of NFP colleagues were rewarding factors while workload and workplace factors were significant contributors to stress. The study findings have implications for the identification of strategies to minimize staff turnover, PHN burnout, secondary traumatic stress and compassion fatigue, and improve program delivery.

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List of Abbreviations

BPG	Best practice guideline
BCHCP	British Columbia Healthy Connections Project
CAS	Children's Aid Society
CHN	Community health nurse
HBHC	Healthy Babies, Healthy Children
IPV	Intimate partner violence
HOME	Home Observation for Measurement of the Home Environment
NSO	National Service Office
NFP	Nurse-Family Partnership
PHN	Public health nurse
ProQOL	Professional quality of life
RCT	Randomized controlled trial
RNAO	Registered Nurses Association of Ontario

Introduction

The delivery of patient-care by nurses, regardless of context or workplace, has the potential to impact the physical and emotional health of the health care provider. The National Survey of the Work and Health of Nurses, a Canadian survey completed by nearly 19,000 registered nurses, licensed practical nurses and registered psychiatric nurses, reported on the physical and emotional health of the nursing work force (Shields & Wilkins, 2006). In this study, nurses reported higher rates of chronic health conditions, depression, cardiovascular disease risk factors, and medication use compared to the general employed Canadian population regardless of workplace setting. One in five nurses reported that their mental health status impacted their ability to do their job (Shields & Wilkins, 2006). Community health nurses (CHN)¹, which includes public health nurses (PHNs), comprise 12 % of nurses in Canada, and of these, 34% reported personally experiencing emotional abuse and 9% reported physical abuse by a patient. One-third of community health nurses reported that staffing levels were inadequate. As a result, over half cited arriving early for work and staying late, resulting in an average of over four hours unpaid overtime per week. Approximately two-thirds reported their workload as too heavy for one person. As a consequence, almost half felt they were not meeting expectations and reported feeling unable to carry out their job effectively. Despite these challenges, only 12% of community health nurses stated they were dissatisfied in their role and rated their professional autonomy higher than hospital-based nurses (Shields & Wilkins, 2006).

It is clear that employment as a nurse significantly impacts physical and emotional well-being compared to other forms of employment. Although nurses work in a wide variety of settings, the majority of research has focused on work-related professional and personal consequences for hospital-based nurses who practice in specialty areas (e.g., oncology, intensive care, pediatrics) (Aycok & Boyle, 2009; Burtson & Stichler, 2010; Hooper, Craig, Janvrin, Wetsel, & Reimels, 2010; Poncet et al., 2007). In some studies, a particular nursing specialty was not specified but hospital-based examples were used in their narratives (Boyle, 2011; Coetzee & Kloppe, 2010; Joinson, 1992; Lombardo & Eyre, 2011; Sabo, 2011). To date,

¹ There is no national consensus regarding the use of terms community health nurse and public health nurse. As the National Survey of the Work and Health of Nurses used community health nurse that will be used when discussing those results, however as the study participants refer to themselves as public health nurses that terminology will be used throughout this study.

there is limited research focusing on the potential impact and consequences for nurses who practice in community based settings. Given the varying complexity of community based nursing roles and the populations they serve, the challenges and consequences may differ from the findings associated with hospital based nursing practice.

Nurses who work in the home visiting context practice in isolation and independently, a very different working environment from hospital-based nurses who typically practice in teams. However, these environments also offer variations of autonomy, flexibility and team collaboration; although how these dimensions are supportive to individual nurses may vary.

The delivery of health promotion and health care services in a client's home creates unique challenges and opportunities for home visiting nurses. In working with vulnerable families in the home, Zerwekh (1997b) discusses that PHNs tend to downplay their own unique set of skills that are required to physically locate and build trust with hard-to-reach families, and to identify family strengths and capabilities for those who believe they have none.

The populations served by nurse home visitors are often high-risk and exposed to the effects of poverty (Macdonald, Bennett, Higgins, & Dennis, 2010), complex social conditions, and possibly domestic violence (Jack, Ford-Gilboe et al., 2012). One population that is frequently targeted for home visiting programs are young, socially disadvantaged mothers (Kendrick et al., 2000; Kitzman, Olds et al., 1997; Macdonald et al., 2010; Olds, Henderson, & Tatelbaum, 1988).

Macdonald and colleagues (2010), in their Cochrane protocol of home visiting with socially disadvantaged mothers, summarized the outcomes for this group of vulnerable women. Mothers have less access to material resources with respect to employment, housing and finances, and may have less access to social resources and support. Domestic violence, substance abuse, poor mental or physical health as well as a knowledge or skill deficit around parenting may result in a higher incidence of child maltreatment or neglect. These families are less likely to seek out medical care or use early intervention services so home visiting programs that bring services to these families are a route for them to access supports (Macdonald et al., 2010). One of the key ingredients to the delivery and success of these programs is the relationship the nurse is able to form with the mothers (Kurtz Landy, Jack, Wahoush, Sheehan, & MacMillan, 2012).

In Canada, all provinces offer some level of home visiting to pregnant women or new mothers in the post-partum period (National Collaborating Centre for Determinants of Health, 2009). Across Canada, there are both universal and targeted models of home visiting, with targeted public health programs offering a higher frequency of home visiting services to vulnerable and low-income families (Petitclerc, 2008). PHNs employed within these programs may home visit vulnerable families, experiencing multiple and chronic social and health problems, for extended periods of time.

Healthy Babies, Healthy Children (HBHC) is the existing provincial prevention/early intervention program for children identified as at risk for poor psychosocial, cognitive, communication or physical outcomes (Queen's Printer for Ontario, 2012). Children may be identified prenatally up to age six. This voluntary program is offered in addition to, and in collaboration with, existing services and has a screening, intervention and referral mandate. Local health boards administer each HBHC program and thus variations in program delivery (i.e. ratio of home visitor to PHN visits, duration of program) may be seen across the province. In most cases, the initial home visit and assessment is performed by a PHN who then develops a plan of care involving the use of lay home visitors, specifically trained parents from the community. The lay home visitor may provide information on a range of topics including healthy child development, feeding or make linkages to other community resources and is under the supervision of the PHN.

The Nurse-Family Partnership (NFP) is another example of a targeted nurse home visitation program for vulnerable families and is a primary prevention program that is an evidence-based nurse home visiting intervention for young, low-income, first time mothers (Olds, 2002). The NFP program has been rigorously evaluated in the United States (Eckenrode et al., 2010; Kitzman, Olds et al., 1997; Kitzman et al., 2000; Olds et al., 1988; Olds, 2002; Olds et al., 2002) however given the differences in health care system and social services delivery, effectiveness in the Canadian context needs to be established before the program can be implemented. Women are enrolled in the program prenatally (i.e., before 29 weeks gestation) and continue until their child's second birthday. Nurses follow a schedule of frequent home visiting that includes up to 14 prenatal home visits and a maximum of 50 home visits following the birth of the infant. Home visits are scheduled weekly or biweekly depending on the phase of the program, however nurses may adjust the frequency of visits based on the needs of the mother (Dawley, Loch, & Bindrich,

2007; Olds, 2002). In the last three months of the program, visits are reduced to monthly. The three overarching goals of this program are to: 1) improve health-related behaviours during pregnancy to optimize fetal and maternal health; 2) improve parenting skills to promote both child health and development; and 3) assist parents to attain employment and meet educational goals, as well as planning for future children (Olds et al., 2002). Visit guidelines have been created centering on content related to the pregnancy, infancy and toddler periods (Nurse-Family Partnership, 2010).

As part of the Canadian implementation process, the acceptability and feasibility of delivering the NFP intervention through public health services was evaluated in a pilot study conducted in Hamilton, Ontario (2008-2012) (Jack, Busser et al., 2012). International replication of the NFP requires a four-phase adaptation and testing model (The Regents of the University of Colorado, 2013). The first phase of adaptation requires an examination of the local context to determine what changes are required to deliver the program without deviating from the key model components. Phase two consists of a feasibility and acceptability pilot study. A randomized controlled trial (RCT) to evaluate the NFP in the new context is phase three followed by phase four, full implementation or expansion of the NFP pending successful findings from the RCT. Throughout all phases, implementing agencies are required to deliver the NFP with fidelity to 18 model elements that guide client eligibility, home visit structure, professional qualifications of PHNs and supervisors, community collaboration, and supervision and support structures (Nurse-Family Partnership, 2010).

The process of establishing a NFP pilot program in Hamilton began in 2008 with approval granted by the University of Colorado Prevention Research Center Nurse-Family Partnership International Program to the City of Hamilton Public Health Services and McMaster University (Jack, Busser et al., 2012). Phases one and two were completed in Hamilton, Ontario in collaboration between McMaster University and Hamilton Public Health Services. The feasibility portion of the pilot study examined recruitment, retention and issues around delivery of the NFP program while the acceptability was examined from all perspectives including the mothers, extended family, PHN's, program managers, other health care providers involved in provision of care as well as community service providers (Jack, Busser et al., 2012). Additionally, the

ability to maintain fidelity to the NFP core elements, use of PHNs as the primary visitor and collaboration with community stakeholders was evaluated.

Eligible mothers for the Hamilton NFP pilot are first-time mothers, enrolled less than 29 weeks gestation, and either have no income or were receiving Ontario Works (provincial social assistance program) or Employment Insurance prior to becoming pregnant (Jack, Busser et al., 2012). Over the period of 2008-2012, of the 424 referrals made to the NFP feasibility study, 135 were eligible mothers and 108 consented to participate exceeding the study goal of 100 families. As of September 2012 the program had graduated 67 mothers, and the remaining 41 mothers were discharged early from the program or were lost to follow up (D. Busser. Personal communication, September 21, 2012). The effectiveness of the NFP is currently being evaluated in a RCT as part of the British Columbia Healthy Connections Project (BCHCP).

In the Hamilton pilot study, six PHNs were recruited from the HBHC program, the existing provincial long-term home visiting program. Of these initial nurses, five were full-time and one part-time. Initial clients were recruited in 2008 and the last cohort of mothers enrolled in the pilot graduated from the NFP in 2012. The NFP is currently offered as part of service delivery for young, first-time mothers in the Hamilton area.

While there is evidence available supporting the effectiveness of the NFP and describing challenges of nursing, there is little understanding of the PHNs experience of delivering an intense, and largely relationship-based, long-term home visiting program. Although Zeanah, Larrieu, Boris and Nagle (2006) provided an account of American NFP PHNs perspectives, their study included only experienced PHNs and directed the focus to the challenges of client's mental health issues. The purpose of this study was to identify and describe the nature of the challenges and perceived benefits experienced by all PHNs working in the NFP program in Hamilton, Ontario. In applying van Meijel, Gamel, van Swieten-Duijfjes and Grypdonck's (2004) framework for using qualitative methods to develop nursing interventions, a problem, needs and practice analysis was included in this study. For an intervention to be meaningful and effective the nature of the problem, what providers need and what is currently being done in the practice environment must be described.

Chapter 1: Literature Review

A literature review was undertaken to address specific objectives, including to: 1) provide a brief overview of home visiting; 2) outline the NFP home visiting intervention and related outcomes; 3) describe the nature of therapeutic relationships in home visiting; and 4) understand potential work-related impacts of home visiting vulnerable families on PHNs. The following databases were searched: CINAHL, Web of Science, PsycInfo, Canadian Health Research Collection, and Social Sciences Abstracts (summary search strategy and results can be found in Appendix A). Years searched ranged from 1992, the year compassion fatigue was first coined, to December 2013. The following search terms were used: nurs*, home visit*, stress, community health nurs*, home health, maternal child nurs*, public health nurs*, home nurs*, nurse-patient relations, professional impact*, effect*, burnout, compassion fatigue, compassion satisfaction, secondary traumatic stress and vicarious trauma. Article reference lists and resource lists from relevant agencies were also hand-searched for additional references. Searches were also carried out with key authors.

Overview of Home Visiting

Maternal/Child Home Visiting Programs

Nurse home visiting is an early-intervention strategy for parents and children that is commonly included as part of a larger program supporting the improvement of maternal and child health outcomes (American Academy of Pediatrics, 1998). Home visiting programs may target specific populations such as mothers with premature or low-birth-weight infants (Shapiro, 1995), teenage parents (Olds, 2002), families with infants born with specific disease processes (Black, Dubowitz, Hutcheson, Berenson-Howard, & Starr, 1995) or children who are at risk for maltreatment (Chapman, Siegel, & Cross, 1990). Programs may also differ in terms of level and education of service provider (Olds et al., 2002), onset of service (pre or postnatal), number of visits, duration of program, frequency of visits, use of a targeted or universal approach and aim or focus of the intervention (American Academy of Pediatrics, 1998). Variation can also be noted from the perspective of the provider in terms of designation, type and duration of training, adequacy of supervision, and size of caseload (American Academy of Pediatrics, 1998). Major outcome categories that have been reported with home visiting programs may include pregnancy outcomes, quality

of parenting, improvement of maternal life course and child outcomes (Macdonald et al., 2010) however these varied with each program. Regardless of the particular nuances and structure of each program, the overall goal was to optimize both maternal health and child's early development through providing services to parents in the home environment (Gomby, Culross, & Behrman, 1999).

Several systematic reviews and meta-syntheses have compared existing home visiting programs, although the approach and focus of each review were distinct, which makes comparisons between reviews challenging. Kendrick and colleague's (2000) systematic review and meta-analysis of studies using a randomized or quasi-experimental design examined effectiveness of postnatal home visiting programs on parenting and quality of the home environment. Quality of the home environment was represented by the Home Observation for Measurement of the Environment (HOME) score and was reported in 17 of the 34 studies. As the HOME score only reflected some aspects of parenting, the authors included additional studies with other measures of parenting. Of these, 27 studies reported parenting measures including parent-child interaction, parental attitudes toward their child or childrearing behaviours. Ten studies reported both HOME scores in addition to at least one additional parenting measure. Of the 17 studies reporting HOME scores, five studies did not report adequate statistical information (p value, mean or standard deviation) to be included in the meta-analysis. Home visiting was found to be statistically significant in improving HOME scores ($\chi^2=126.9$, 28 df, $p<0.001$), suggesting improvement in the quality of the home environment. Given the wide range of parenting outcomes reported in the remaining studies, a meta-analysis was not possible, however reported benefits included improvements in child behaviour, child intellectual development and reducing rates of childhood injuries. Maternal benefits included improved screening and management of postpartum depression and building of effective social supports. Limitations of the study noted by the authors included the wide variety of outcome measures limiting comparisons between home visitation programs. Further they noted that measuring 'parenting' was a complex task. Home visiting programs may vary widely in terms of frequency and duration of program, point of initiation, training of home visitors (professional compared to paraprofessional), public health care context, targeted or universal program and type of services, or nature of the intervention, offered. This review was unable to comment on what aspect of any given home visiting program may have contributed to its success.

Combining outcomes of programs with a single home visit, the inclusion criteria for the study, with a intensive home visiting schedule should be done cautiously as benefits from an intensive home visiting programs may inappropriately be attributed to programs with less intensity. Further analysis of program design elements would be useful.

The actual number of home visits required to achieve desired outcomes has not been established (McNaughton, 2004) although Gomby and colleagues, (1999) suggested a minimum of four visits with the same nurse. In their meta-analysis of programs targeting at-risk families, Nievar, van Egeren and Pollard, (2010) found that even across diverse program delivery models the most important predictor of differences in the effect size of maternal outcomes was the frequency of home visits. They described a nearly two-fold increase in effectiveness for intense home visiting programs with at least three visits per month. With increasing health care costs, decision makers need to justify where to direct their efforts and programs and while a low frequency of visits are seemingly more cost-effective, they may not achieve the program benefits. In universal programs, services are provided regardless of level of risk (Nievar et al., 2010). While universal visits may serve a screening function, intense home visiting will likely not benefit broad populations and those with the most need may show the greatest effects as they have more areas for growth (Gomby et al., 1999). Olds (2002) noted that low-income, unmarried women experienced the greatest benefit from intense home visiting programs.

In a descriptive review article, Gomby and colleagues (1999) summarized the findings of six nationally running home visiting programs in the United States, including the NFP, that have been evaluated through the use of RCTs. Outcome measurements varied widely among the six programs and the authors acknowledged difficulties comparing models due to varied program foci and the range of outcomes measured. While the authors noted that no program was overwhelmingly more effective than another, the NFP was consistently reported as resulting in improvements for mother and child. The NFP was methodologically much stronger than the other programs with a wider range of measured outcomes and followed both mother and child for a longer term. The NFP was the sole program to provide both prenatal visits and evaluation of prenatal outcomes (use of prenatal care, birth weight and preterm birth rate) and was effective in decreasing preterm births and low birth weight infants among young smokers (Olds &

Kitzman, 1993). Of the four programs evaluating child abuse and neglect, only the NFP noted a decrease in substantiated reports of child abuse or neglect in nurse-visited mothers, as shown by Child Protective Services reports, when compared to the control group. As one of two programs examining health care service utilization as an additional measure of child maltreatment, only the NFP saw a reduction in service utilization. Young mothers in the NFP were the sole group to demonstrate a decrease in subsequent pregnancies, or an increase in the interval to their next child, rely less on social welfare, have less involvement with the criminal justice system and a decrease in substance abuse (Olds et al., 1988). Of the two programs that assessed children's behaviour change years after the program conclusion, only the NFP was able to demonstrate improvement such as fewer episodes of running away, a decrease in criminal justice involvement, decreased cigarette and alcohol use as well as less sexual promiscuity. Only the NFP conducted long-term follow-up, at 15 years at the time of the review article (Olds et al., 1998) and 19 year follow-up has since been published (Eckenrode et al., 2010). At the 15-year follow-up, children whose mothers were home visited had a decreased tendency to run away, less involvement with the criminal justice system, smoked and drank less and demonstrated a decrease in verified reports of child maltreatment compared to their control peers (Olds et al., 1988).

This article was a moderate review of home visiting programs. It was not a systematic review but a descriptive comparison of nationally implemented models of home visiting in the US. No inclusion criteria, search strategy or statistical analysis comparing program outcome measurements was performed however this accurately reflects the challenges and complexity of the state of home visiting reporting and research and raised important questions such as were the programs carried out as intended (e.g. comparing actual versus prescribed content, assigned versus actual number of home visits); the use of self-report versus independent assessment outcome measures; and difficulties in obtaining accurate rates of abuse or neglect. They further observed that programs universally struggle to enroll and keep participants; nurse turnover rates are high; emphasis needs to be placed on effective, quality program implementation; limits be placed on expectations of home visiting outcomes; and home visiting be a part of a larger community of health services.

The Home Visiting Context

Meeting with a mother in her home environment allows for a better understanding of that family's unique culture and lifestyle (Kitzman, Cole, Yoos, & Olds, 1997) and allows the home visitor to assess and see the real world of that family (Nievar et al., 2010). When maternal interventions take place in the home there is greater potential for maternal participation, engagement in learning, and play behaviours occurring in the mother's natural environment (Macdonald et al., 2010) as opposed to an artificial setting such as a clinic or community centre. Home visiting helps access populations that are more difficult to reach and provides an ongoing link to other community and health services (American Academy of Pediatrics, 1998). Bringing services to the home eliminates transportation costs and childcare issues for parents. Furthermore, this convenient service delivery model may enhance the recruitment and retention of harder to reach populations (Nievar et al., 2010). Despite this convenience, the practice of home visiting, where an outsider routinely enters the home to encourage behaviour change (Gomby et al., 1999) may not be openly embraced by all families.

Kitzman, Cole and colleagues (1997) recognized that there were numerous challenges faced by PHNs delivering the NFP to a vulnerable population. In their qualitative study to identify common challenges in the NFP, PHNs ($N=17$) provided narratives of their experiences working with a range of families. The home environment itself was identified as a source of many challenges. Distractions, such as the television, or the presence of other people, may not provide the peace or privacy for meaningful engagement with the mother. Overcrowding and the presence of other children made it difficult to participate in the cognitive-growth-fostering activities that are part of the NFP protocol. Competition for toys with other children in the household made it challenging for the NFP infant to keep their toy and engage in play. Many families were unable to provide cribs for their infants and maintaining a hazard-free environment was difficult with other families sharing a living space. PHNs were often faced with decisions about what recommendations to suggest given what the family could realistically accomplish and what factors in their environment they were able to control (Kitzman, Cole et al., 1997).

Safety in both the women's homes and neighbourhoods was an additional challenge that PHNs contended with. Compared to a hospital or clinic setting that had built-in supports, NFP PHNs worked in

isolation. Compared to a hospital or clinic where the patient actively sought care and control remained with the health care provider, home visited women were able to control the schedule, duration and content of the home visit more so than the PHN. Missed appointments and having to locate families that have moved with no notice are common challenges (Zerwekh, 1997a). The mother may view the curriculum topic addressed at the visit as irrelevant or low priority (Kitzman, Cole et al., 1997) so PHNs needed to be flexible and ensure they are meeting the mother's needs and not their own, to facilitate the mother's advancement and engagement in the process. Unlike a hospital or clinic environment, the sole provider of the curriculum or program content was the PHN and while deviation from the model may be appropriate to manage imminent issues, this may also impact program outcomes (Gomby et al., 1999). However, PHNs were able to be autonomous in their work, and to flex their decision-making skills to best meet the needs of their clients.

The Nurse-Family Partnership and Related Outcomes

The NFP intervention has consistently resulted in improved maternal and child outcomes across three RCTs and long term follow-up, with young, first-time, low-income mothers (Kitzman, Olds et al., 1997; Olds et al., 1988; Olds et al., 2002). The first RCT sample ($N = 400$) consisted of a largely white, young, semirural population in Elmira, NY (Olds et al., 1988). The four experimental treatment conditions of this RCT were: 1) sensory and developmental screening at 24 and 48 months; 2) treatment one and free transportation to prenatal care and well-baby clinics; 3) treatment two and bi-weekly nurse home visits during pregnancy; and 4) treatment three in addition to home visits with a modified schedule until the child's second birthday. Early benefits of the full program included decreased rates of prenatal smoking (equating to a 4 cigarettes per day reduction, $p = .001$), a decrease in kidney infections ($p = .005$), a 75 % reduction in preterm labour for those mothers who smoke ($p = .04$), and for mothers less than 17 years of age, babies were an average of 395 g heavier ($p = .02$) compared to controls (Olds, Henderson, Chamberlin & Tatelbaum, 1986). Based on HOME scores measured at 34 and 46 months, nurse-visited mothers demonstrated an improvement in the home environment ($p < .05$) (Olds, Henderson, & Kitman, 1994). In a 15-year follow-up, nurse-visited mothers were less likely to be identified as perpetrators of child maltreatment or neglect (0.29 vs. 0.54 reports per participant, $p < .001$), had fewer subsequent pregnancies (1.5 vs. 2.2, $p = .03$) and a longer gap between the first and second pregnancy (65 vs. 37 months, $p = .005$)

(Olds et al., 1997). In a 19-year follow-up examining outcomes of the children in this study, the researchers connected with 78% of the families. When excluding families where the child had been adopted, suffered from mental disability or had passed away, follow-up rates rose to 88%. Enduring effects noted for daughters of nurse-visited mothers ($N = 44$) compared to those in the control group ($N = 73$), included a decreased likelihood to be arrested (10% vs. 30%; RR 0.33; 95% CI, 0.13-0.82), fewer pregnancies (rates not reported) and were less likely to use Medicaid (Eckenrode et al., 2010). No explanation was provided as to why effects were found for daughters and not sons, and understanding this difference was identified as a future research direction.

The promising results from Elmira led to a replication trial in Memphis, TN, to evaluate if similar success would be found in a primarily urban, African American population (Kitzman, Olds et al., 1997). First-time mothers, with at least two conditions of: less than 12 years of education, unmarried or unemployed were eligible to participate ($N = 1135$). The four treatment groups in this study were: 1) free transportation to prenatal care; 2) treatment one and developmental screening and referral at 6, 12, and 24 months; 3) treatment two with the addition of intensive prenatal home visits, and two post-partum visits (one in hospital, one at home) and 4) treatment three with the continuation of post-partum visits until the child's second birthday. Results noted at the child's second birthday, the conclusion of the program, PHN-visited mothers had fewer episodes of pregnancy-induced hypertension (13% vs. 20%, $p = .009$), fewer subsequent pregnancies (36% vs. 47%, $p = .006$), and fewer reports of childhood injuries or ingestions (0.34 vs. 0.55, $p = .05$) (Kitzman, Olds et al., 1997). Follow-up at child age nine noted lasting effects of the program: nurse-visited mothers had fewer subsequent pregnancies per year (0.81 vs. 0.93, effect size (ES) = -0.14, $p = .045$) or longer intervals between pregnancies (40.73 vs. 34.09 months, ES = 0.29, $p = .002$), longer relationships with their current partner (51.89 vs. 44.48 months, ES = 0.23, $p = .006$) and a decreased use of welfare (5.21 vs. 5.92 months, ES = -0.14, $p = .008$) and food stamps (6.98 vs. 7.8, ES = -0.17, $p < .001$) per year compared to controls (Olds et al., 2007).

Building on the successful findings of both Elmira and Memphis, a third trial ($N = 735$) was designed to evaluate program delivery between nurses and paraprofessionals in Denver, CO (Olds et al., 2002). Three treatment conditions were used in this trial: 1) developmental screening and referral at 6, 12,

15, 21 and 24 months of age; 2) treatment one and paraprofessional home visits prenatally ending on the child's second birthday; and 3) treatment one and nurse home visits prenatally and ending on the child's second birthday. Given limitations due to sample size, the paraprofessional ($N = 245$) and nurse-visited ($N = 235$) groups are not compared to each other but to the control group ($N = 255$). The authors then compared the two intervention groups using a secondary analysis. Mothers in the intervention groups demonstrated decreased prenatal smoking based on cotinine levels at beginning and end of pregnancy (259.00 vs. 12.32 ng/ml, $p = .03$), had fewer subsequent pregnancies (29% vs. 41%, $p = .02$), increased time intervals between pregnancies ($p = .02$), and increased length of employment in the year following their child's first birthday (6.83 vs. 5.65 months, $p = .02$). Children of nurse-visited mothers showed a decreased likelihood to have language delays (6% vs. 12%, $p = .05$), demonstrated interactive responses and improved language and cognitive development (101.52 vs. 96.85, $p = .02$) at 21 months of age compared to controls. These effects were noted particularly when the mother had poor psychological resources. While the paraprofessional-visited group did demonstrate effects, those in the nurse-visited group saw a nearly two-fold effect size, a statistically significant finding.

In McNaughton's (2004) review of 11 nurse home visiting studies, dropout rates were reported between two and 35%. Programs running over longer term tended to have higher drop-out rates (Black et al., 1994; Booth, Mitchell, Barnard, & Spieker, 1989) compared to lower rates in programs of shorter duration (6 weeks) targeting groups with previous perinatal problems (Bryce, Stanley, & Garner, 1991) or at high-risk for poor newborn outcomes (Armstrong, Fraser, Dadds, & Morris, 1999). Factors influencing retention were described in terms of both parental and infant factors (McNaughton, 2004). Many of the populations targeted by home visiting programs were described as high-risk and relocations, drug use, incarcerations and refusal to participate may influence dropout rates. Infant-related factors such as adoption, miscarriages or infant death also resulted in program termination. Despite these factors, the NFP has achieved relatively low dropout rates within the program and has achieved impressive follow-up rates over time. Notably, at the 15-year follow-up of the Elmira study, a 19% dropout rate was noted (Olds et al., 1997). When considering success within the duration of the program, the drop-out rate in the Memphis trial was 9% at the 2 year mark (Kitzman, Olds et al., 1997).

One critique of home visiting programs was lack of a theoretical framework to explain why or how the intervention was expected to be successful (Kendrick et al., 2000). The NFP however does have a theoretical foundation based on ecological, self-efficacy, and attachment theories. Human bio-ecological theory recognizes the interrelationship of many factors, such as community and family background, that contribute to how parents interact with their child, which in turn influences their child's development (Bronfenbrenner, 1979). With this knowledge, PHNs involve the extended family where possible to enhance community support for the mother-child dyad (Olds, 2002). Self-efficacy theory provides some background to understand human behaviour: people will choose to engage in behaviours where they can anticipate the outcome and believe they can be successful (Bandura, 1977). The NFP curriculum was designed to link behaviours to health outcomes for both mothers and their children, and achievable goals were set by the mother that when met, increased mothers confidence to take on bigger challenges (Olds, 2002). Attachment theory supports that when mothers are attentive, nearby and are able to respond appropriately to cues, children feel loved and secure (Bowlby, 1969). The NFP nurses engage mothers in discussing positive engagement with their infants as well as reviewing the mother's own experience of childhood (Olds, 2002). In this way, the NFP addresses the cyclical history of maladaptive parenting.

PHNs were specifically chosen as the home visitor in the NFP program as they were shown to produce larger effects on important maternal and child outcomes compared to paraprofessionals (Olds et al., 2002). PHNs were well suited to this role given their education and expertise in women's and children's health, labour and delivery, knowledge of the health care system, and their ability to navigate the often complex realities of at-risk families (Olds et al., 1999). Mothers also identified that they valued the PHN's health knowledge with a particular appreciation of expertise relating to infant health and development (Kurtz Landy et al., 2012).

Kitzman, Cole and colleagues (1997) identified challenges specific to the content and model of the NFP. Despite some flexibility built into the model, nurses struggled with the balance between urgent daily needs and the overarching program objectives related to promotion of improved health behaviours. With the varied educational and literacy levels of their clients, nurse home visitors were required to adapt content or create a base level of understanding before proceeding. Expanding further on the concept of balance, was

the need to focus on either maternal or child/family needs and goals. While future-oriented goals were promoted by the NFP protocol, many young mothers were unable to look beyond the stresses and demands of daily life.

While the NFP program has resulted in impressive results in infant and maternal outcomes (Kitzman, Olds et al., 1997; Olds et al., 1988) how PHNs develop the skills to actually achieve this success, or how delivering this program impacts them has not been well articulated.

The Therapeutic Relationship in Nurse Home Visiting

A strong therapeutic relationship has been shown to be an essential foundation of home visiting programs (Jack, DiCenso, & Lohfeld, 2002; Kitman, Olds et al., 1997; Kurtz Landy et al., 2012; Zerwekh, 1992). For home visiting programs to be effective, three key components of family engagement, curriculum content and delivery, and relationship-forming skills of the home visitor must be developed (Gomby et al., 1999). Zerwekh's study of PHNs who engaged in home visiting with vulnerable populations of young families revealed three key competencies that were foundational to program delivery (1992). They were locating the family, building trust, and building family strengths. Unstable families often moved, had no phone or changed numbers and were inconsistent with keeping appointments. The competency of locating families included becoming familiar with the community and local agencies as well as an understanding that this was a necessary first step to accessing the family (Zerwekh, 1992). Before further progress can be attempted, trust must be established. This in itself may be a long process, as this vulnerable population of young mothers may not have a history of positive, trusting relationships. Mothers often had histories of abuse and/or neglect and low self-esteem. Building strengths began with identifying and validating capabilities as well as reinforcing behaviours that contributed to making positive life choices (Zerwekh, 1992). Zerwekh further noted that novice nurses might not dedicate adequate time or attention to these crucial and fundamental building blocks before any change interventions take place. At times, the only goal of the PHN is to maintain contact with the family, which can be a difficult challenge when balanced against the need to deliver program content (Kitzman, Cole et al., 1997). The PHN then needs to balance the concepts of backing off and persisting, subthemes identified by Zerwekh (1992) in the formation of trust building. As part of maintaining the therapeutic relationship and despite acknowledging that change and

internalizing of new information took time, nurses stated they felt an urgency for the mother to take action with respect to contraceptive decision making and the developmental needs of their children (Kitzman, Cole et al., 1997). In this instance the nurse was caught between her knowledge of child development, best practices and what the mother is capable to take on at that time.

In a qualitative study exploring mothers' experiences in the Canadian NFP pilot study, participants overwhelmingly reported positive experiences with their nurse home visitor (Kurtz Landy et al., 2012). The mothers reported three major themes: accessing the program, the NFP nurse as expert and friend, and the NFP improving their parenting skills. For many of these mothers, they accepted the program as a means of support and much of the feedback they provided about their experience centered on the relationship formed with the PHN. Given the positive reports from the mothers, it was possible that the relationship formed with the PHNs, and the social support this provided, that kept the mothers enrolled in the program.

Agreement to enroll in a home visiting program however, does not ensure active participation on the mother's part. While frequency of visits was reported to relate to program effectiveness, this number does not represent the level of engagement of a particular family (Nievar et al., 2010). How a family engages, or does not, with a home visitor is a complex process. Previous experiences with social and health organizations as well as the nature and availability of social supports will influence how a mother engages with the home visitor (Jack, DiCenso, & Lohfeld, 2005). Nurses needed to adapt their approach to suit individual mother's needs, assess the readiness of mothers to take on new challenges, and determine when the nurse should assume responsibility to protect the mother's fledgling sense of self-efficacy (Kitzman, Cole et al., 1997).

While the nature of the NFP is to target the mother-child dyad within the context of the family, where appropriate, the focus was also extended to the father and maternal grandmother (Kitzman, Cole et al., 1997). Awareness of the shifting dynamics of relationships within the family, the power structures at play, how to present information in order to minimize family tensions as well as maintain boundaries to the provision of services to other members of the household were additional challenges (Kitzman, Cole et al., 1997). The health of the mother-infant dyad may be closely linked to those in the household, so PHNs may discretely assist other family members as a means of maintaining that initial relationship. An understanding

of meaning behind various behaviours, such as sleeping or disciplinary practices, were important for the nurse to determine if behaviours were bounded by culture as opposed to a maladaptive lifestyle (Kitzman, Cole et al., 1997).

Nurses form effective therapeutic relationships based on empathetic engagement with their clients however, it is the nature of this relationship that can precipitate work-related stress (Sabo, 2011). PHNs formed a relationship with the families for over two years and were then expected to disengage. The PHNs were working closely with a young, socially disadvantaged population facing complex social and personal challenges. Poverty, cyclical familial issues, and domestic violence were only some of the overwhelming range of issues facing mothers on a daily basis and may be in stark contrast to the PHNs own, often middle-class backgrounds (SmithBattle, Diekemper, & Leander, 2004b). Given the nature of their work, the PHNs delivering the NFP experienced both positive and negative effects related to the nature of their work. While the PHNs had the flexibility of an autonomous working environment, they were also responsible to both the mothers and the program. While the challenges facing the PHNs from a day-to-day program delivery aspect have been described (Kitzman, Cole et al., 1997) further exploration on the impact of PHNs is required.

Work-Related Impacts

The 2005 National Survey of the Work and Health of Nurses highlighted some of the challenges and impacts of working in the nursing field (Shields & Wilkins, 2006). The overall rates of depression were 9% in both Canadian male and female nurses, higher than the rates reported for the general population of employed males (4%) and females (7%). Over two thirds of nurses reported a workload that was too heavy, approximately half reported insufficient time to meet job expectations, and 60% reported feeling unable to do their job well. Almost one in five nurses reported that personal mental health factors made their workload difficult to manage, and consequently, over 60% were required to take time off for health reasons, and of these 10% were related to mental health. However beyond the general category of depression, the survey did not delve further into the nature of how working as a nurse in any setting can impact the person.

There are several terms used to describe work-related stress and impacts including burnout, compassion fatigue, secondary traumatic stress, vicarious trauma, countertransference and compassion satisfaction. While these terms attempt to address specific, distinct concepts, there is often overlap between

them and the definitions of these terms are subject to ongoing debate in the literature. While the terms reviewed here were not exhaustive, they represented major themes of both positive and negative impacts experienced by those who do caring work. How individuals identified with each term may vary and the stigmatization of the terms may be defined by a particular workplace culture.

Burnout.

Burnout is defined as “a syndrome of emotional exhaustion, depersonalization, and reduced accomplishments that can occur among individuals who do ‘people work’ of some kind” (Maslach, 1982, p. 3). Burnout develops and worsens over time (Burtson & Stichler, 2010) and may result in the nurse gradually withdrawing from their work (Boyle, 2011). A gap, or disconnect, between role expectations and the workplace structures and supports are thought to contribute to burnout (Sabo, 2011). Productivity, morale, and motivation are negatively affected and nurses may resort to substance use (Slatten, David, & Carson, 2011).

Compassion fatigue.

In contrast to burnout, compassion fatigue is a term that was first identified to capture the change or loss in the ability to nurture patients (Joinson, 1992) and is a natural response to helping someone experiencing trauma or suffering (Figley, 1995). Compassion fatigue has been described in many professional groups including nurses and first responders such as firemen, police, paramedics and military personnel, and where the caring element of the role is linked with personal identity (Boyle, 2011). Coetzee and Klopper (2010), in a concept analysis of the term specific to nursing, developed a definition of compassion fatigue as “the final result of a progressive and cumulative process that is caused by prolonged, continuous, and intense contact with patients, the use of self, and exposure to stress” (p. 237). Coetzee and Klopper (2010) conceptualized compassion fatigue as a continuum from compassion discomfort, through compassion stress and then to fatigue. The current state of the literature around compassion fatigue has not reached the level of theory, where the relationships between concepts are outlined (Peterson, 2004). Ideally, a practice theory of compassion fatigue would outline mitigating or protective factors and provide some explanation as to how one moves along the continuum in either direction.

Symptoms of compassion fatigue include avoidance or reluctance to work with certain patients or clients, overuse of sick time and inability to experience joy from work. Physical symptoms that may manifest in the worker may include: headaches, digestive problems, sleep disturbances, fatigue, cardiac symptoms, mood swings, restlessness, anxiety, anger, depression, loss of objectivity and poor concentration or judgment (Aycock & Boyle, 2009; Coetzee & Kloppe, 2010).

Secondary traumatic stress and vicarious trauma.

Secondary traumatic stress (STS) has been used as another term to describe compassion fatigue (Abendroth & Flannery, 2006; Sabo, 2006) or as a distinct concept (Aycock & Boyle, 2009; Coetzee & Kloppe, 2010). Although both STS and compassion fatigue are terms that are used interchangeably in the literature to capture the negative consequences of caring work with patients, the terms are distinct. STS was described as symptoms that mimic post-traumatic stress as a result of exposure to trauma through the stories and experiences of their clients (Boyle, 2011). Stamm (2010) conceptualized compassion fatigue as consisting of elements of both burnout (e.g., exhaustion, frustration and anger) and secondary traumatic stress (e.g., consisting of fear and work-related trauma). However, the term STS does not capture the loss of caring or nurturing ability (Coetzee & Kloppe, 2010). Vicarious trauma was similar in that no direct trauma was experienced by the practitioner, however the result was a permanent change in the practitioners world view, as a place that is no longer safe (McCann & Pearlman, 1990). Within this study, the distinction between STS and vicarious trauma will not be further explored however the concepts will be used to signify changes to the PHN in response to their clients experience of trauma.

Countertransference.

The concept of countertransference comes from the psychodynamic perspective and is the negative response of the therapist or nurse to the stresses or trauma experienced by their patient (Berzoff & Kita, 2010). All practitioners experience countertransference to some degree, as it is thought to be a normal and expected part of a clinical encounter, but how it is experienced will vary (Berzoff & Kita, 2010).

Compassion satisfaction.

The terms introduced to this point have all captured various elements and nuances of negative work-related impacts, however there is also capacity for people to derive great reward or personal

satisfaction from their professional roles. Compassion satisfaction encompasses the sense of fulfillment of helping others to experience less suffering (Radey & Figley, 2007) or improve their circumstances (Coetzee & Klopper, 2010). A focus on promoting the positive aspects of caring work, rather than avoiding negative ones may have a protective function (Radey & Figley, 2007), however more research is needed to further explore how compassion satisfaction is fostered and how it relates to the negative impacts of caring aspects of work.

Screening measures.

There are several screening measures to detect compassion fatigue, secondary traumatic stress or burnout. The most commonly known screening tool is the Professional Quality of Life - Revision Five (ProQOL- RV) (Stamm, 2010), a 30-item self-report measure addressing both positive and negative work-related impacts experienced by respondents over the last 30 days. The measure consists of three subscales: positive experiences are addressed on the compassion satisfaction subscale, and negative experiences on the secondary traumatic stress and burnout subscales. While these last two scales are not summative they are considered two distinct contributing elements to compassion fatigue. For example the STS scale measures a fear component, one not present in burnout, but both make-up the experience of compassion fatigue (Stamm, 2005). Scores are given for each subscale and risk is categorized as low, medium or high in each element. Previous versions of this measure, the ProQOL R-IV, had burnout as one subscale and secondary traumatic stress/compassion fatigue as another (Stamm, 2005). This change may reflect an evolving understanding of the concepts however this shift has not been widely adopted. Caution should be used with interpretation, as there may have been particular experiences in the 30-day time frame that may result in temporary variations in scores. Compassion fatigue symptoms may be intermittently experienced as a normal reaction to exposure to those who are suffering, however ongoing monitoring is recommended to identify more problematic responses (Bride, Radey, & Figley, 2007).

Relationship between concepts.

The relationship between these negative concepts is neither clear nor mutually exclusive. There are many similarities and overlapping symptoms and minor expressions of any of these concepts may be indistinguishable from another. Given their names, it would seem that compassion fatigue and compassion

satisfaction are on opposite ends of a spectrum however, a study by Hooper and colleagues (2010) has not supported this. In their study, conducted in the United States, nurses (N=114) who work in hospital-based specialty areas including emergency, oncology, intensive care, and nephrology completed the ProQOL R-IV yielding scores on the subscales of compassion satisfaction, STS/compassion fatigue and burnout. The authors hypothesized that emergency room nurses would experience higher levels of compassion fatigue and burnout compared to nurses in other inpatient settings as a result of issues unique to that department, such as overcrowding, delays in admitting patients and nurse exposure to patients experiencing trauma. In the development of their hypothesis, the authors failed to acknowledge stressors and challenges in the inpatient areas that would also place those nurses at risk for compassion fatigue or burnout, however this oversight was later acknowledged. The authors could not support their hypothesis and found that burnout risk was highest in intensive care nurses, compassion fatigue risk was highest in oncology nurses and emergency room nurses were at risk for less compassion satisfaction. The relationship between compassion satisfaction and compassion fatigue was insignificant but there was an inverse relationship between compassion satisfaction and burnout. The study used a cross-sectional design and could have been strengthened by using a repeated measure to confirm their findings. The ProQOL R-IV was reported to be valid and reliably measure the three distinct concepts (α reliabilities of compassion satisfaction = .87, burnout = .72, and compassion fatigue = .80) (Stamm, 2005). The ProQOL R-IV was not diagnostic but measured relative risk within each concept with scores reported as low, medium, or high risk reflecting experiences over the past 30 days. Although a small sample size was used and was restricted to one site, an important finding was that nurses in a variety of settings were at risk of negative consequences of their work.

Burtson and Stichler (2010) examined the relationship between nursing work environments and nurse caring in a study of hospital-based nurses (N = 126) across 13 units (nine medical-surgical, two emergency and two critical care) in an academic medical centre. They found there was a moderate positive correlation between nurse caring and compassion satisfaction ($r = 0.51, p < 0.001$), and a weak, negative correlation between stress and nurse caring ($r = -0.21, p < 0.05$). The authors hypothesized that compassion fatigue and nurse caring would be negatively correlated and while this was not found, a weak negative

correlation was noted within the nurse caring subscale of knowledge and skill and compassion fatigue. This subscale was not described in the paper but suggested that a component of caring might reside in the nurses perception of use of knowledge and application of skills in practice. Work place factors that limited development in these areas may ultimately play a role in the development of compassion fatigue. While this study examined nurses across 13 different hospital-based units, only a small number of participants were sampled within each unit, which may have made trends more difficult to detect. Although their findings that caring may increase compassion satisfaction, the relationship between compassion satisfaction and compassion fatigue requires further study.

Protective factors.

Why some nurses experience the negative consequences and others revel in the challenge of their work is also the subject of debate. Factors that potentially contribute to compassion fatigue are lack of self-care, personal unresolved history or trauma, lack of ability or willingness to control work stressors, and lack of fulfillment from work (Figley, 1995). Age may be a contributing factor with younger nurses at higher risk for compassion fatigue as older nurses may have developed their own strategies to deal with workplace stress (Burtson & Stichler, 2010). The potential for one to experience either compassion fatigue or compassion satisfaction is influenced by one's positivity-negativity ratio, which is in turn influenced by affect, resources (intellectual, social, and physical) and self-care (Radey & Figley, 2007). However, this ratio model does not allow for both concepts to be experienced simultaneously, which contradicts the findings of Hooper and colleagues (2010). What should be noted though is that the development of compassion fatigue or satisfaction is influenced by multiple factors.

Kanter (2007) has identified five factors that influence how a social worker may be affected by stressful client encounters. The first is competence, does the staff member have adequate training for their role, including identification of compassion fatigue in themselves and relationship formation with their clients? Secondly, do staff have realistic expectations of their clients? A mismatch between actual and unrealistic, desired outcomes may lead to distress. A third potential source is the cumulative impact of similar issues among the client population. As well, some clients are more challenging to work with and elicit a countertransference reaction that may be minimized with appropriate supervisor consultation.

Lastly, there are times when some clients know how to “push your buttons” (p. 292). This response may reflect earlier life experiences, individual personalities, differences in temperament and can also be addressed in consultation with a supervisor. In many ways, the factors listed above are readily applicable to any clinical encounter. Adequate training, appropriate expectations, self-awareness and the realities of working with people are transferable considerations for anyone in a clinical role, including PHNs in the NFP.

Impacts of compassion fatigue and work-related stress.

Employers, patients, clients and nurses alike should be concerned about the potential negative impacts of work-related stress. Those experiencing compassion fatigue are at higher risk for impaired clinical judgment, loss of objectivity and reduced empathy towards clients (Lombardo & Eyre, 2011) placing client safety at risk and jeopardizing the nurse-client relationship. Work-related stress can interfere with nurse caring (Burtson & Stichler, 2010) and ultimately impact the nurse’s ability to achieve satisfaction from his or her work. Recruitment and retention of skilled nurses is impacted by the presence of compassion fatigue as nurses may choose to work elsewhere or leave the profession altogether (Boyle, 2011).

As nurses are often taking care of others before themselves, warning signs of compassion fatigue may go unnoticed until they have reached a crisis stage (Hooper et al., 2010). If not addressed early, the impact of compassion fatigue can permanently affect the nurses’ ability to provide empathetic care (Boyle, 2011; Burtson & Stichler, 2010) and have significant effects on their personal lives.

Current literature examining compassion fatigue in nurses has attempted to capture the consequences of the caring element of nursing work. Compassion fatigue has been examined from varying perspectives among nursing sub-disciplines. Quantitative studies have: evaluated the impact on nurse caring of compassion satisfaction, compassion fatigue, stress, and burnout on acute care nurses (Burtson & Stichler, 2010) compared risks of burnout, compassion fatigue and compassion satisfaction among nurses in inpatient specialties (Hooper et al., 2010) and surveyed interventions available to support oncology nurses (Aycock & Boyle, 2009). Others have debated the concept of compassion fatigue as a means to capture the impact of caring work on nurses (Coetzee & Klopper, 2010; Sabo, 2006). The majority of the literature

provided a general overview of compassion fatigue with a focus on signs and symptoms in the context of nursing (Boyle, 2011; Joinson, 1992; Lombardo & Eyre, 2011; Sabo, 2011). Qualitative studies included an institutional ethnography of the nature of nurse's ($N = 23$) stress, including the experience of compassion fatigue in a pediatric ICU (McGibbon, Peter, & Gallop, 2010) and provided an interpretive description of nurses ($N = 5$) who self-identified as having experienced compassion fatigue across varying, but largely hospital-based, work settings (Austin, Goble, Leier, & Byrne, 2009). Regardless of the specific concept, research method, measurement tool, or study focus, all researchers identified that nurses were experiencing personal and professional impacts as a result of their work. Much of the current understanding of these experiences was based on research conducted in institutionalized hospital settings, focused primarily in high-acuity practice settings where death and trauma are common, such as palliative care, ICU or oncology. How this phenomenon is experienced in home visiting, a very unique setting where clients are faced with mostly social, rather than physical challenges and the focus of care is prevention rather than treatment, is not known.

Summary

The NFP home visiting program with high-risk young mothers has been shown to be an effective early intervention program (Chapman et al., 1990). While the evidence-based curriculum of the NFP serves to support the health and development goals of the program, it must be acknowledged that a fundamental component in achieving these goals is the interpersonal relationship established by the PHN with the NFP client. Given their educational background, knowledge of maternal and childcare, expertise in forming therapeutic and empathetic relationships, PHNs are ideally suited to deliver the NFP. However, when PHNs work closely with vulnerable mothers and children they are at increased risk of compassion fatigue among other work-related impacts. Strategies are needed to support the PHNs who deliver important and successful programs like the NFP. The first step is to explore how delivering this program impacts the PHNs. Current literature does not capture the unique challenges of nurse home visiting with a complex population of high-risk, young mothers in their home environment. Little attention has been paid to the impact on the PHN who is often encountering unexpected and possibly dangerous situations in people's

homes. Given that the PHN is usually working in isolation, it may be more challenging to offer support that occurs in a timely way compared to hospital based nursing practice.

Little is known about the impact or experience of nurse home visitors working with a high-risk population of young mothers. Rather than investigate a specific labeled concept in detail, such as compassion fatigue, the PHNs themselves can give voice to their experiences using their own words. In this way, their experiences can be compared to current concepts described in the literature to see if and how they differ.

Although the NFP has a structured program-delivery model, in essence, the PHN *is* the intervention. They are the sole provider of program content, and must continually balance between emerging family issues and the curriculum (Gomby et al., 1999). Given the emphasis placed on the importance of this relationship for the success of the program it is interesting that McNaughton (2004) observed in her review of 13 nurse home visiting programs, no studies reported on how this nurse-client relationship was developed, or noted to be successful. While literature on the forming of the nurse-client relationships in home visiting is substantial (Jack et al., 2002; McNaughton, 2000; McNaughton, 2005; Zerwekh, 1992) this crucial component is often glossed over in reporting program outcomes. It is not surprising then that the impacts on the PHNs themselves are further off the research agenda and poorly understood. To continue and ensure further success of the NFP it is essential that the impact of delivering the NFP program on a key component, the PHN themselves, be better understood and supported. This will not only result in improved program delivery but will also maintain the health and well-being of PHNs who work in this important home visiting context.

Chapter 2: Methods

Purpose Statement

The purpose of this qualitative interpretive descriptive study was to explore PHNs' experiences of long-term home visiting a targeted population of young, low-income first-time mothers in a Canadian NFP program. While the effectiveness of the NFP has been established in the context of the US, and is currently being evaluated in the Canadian public health care system, little has been done to document how work of this nature influences or impacts nurses on both professional and personal levels; this is important to understand so that strategies can be identified at individual, team and organizational levels to support PHNs in doing this work to minimize staff turnover, PHN burnout and improve program delivery.

Research Questions

The overarching research question guiding this qualitative study was: What are the impacts of long term home visiting work on PHNs who deliver the Nurse-Family Partnership program to eligible families receiving services through an Ontario public health unit? Additionally, four specific sub-questions guided the conduct and analysis of this study:

1. What are the experiences of PHNs who deliver the NFP, an evidence-based home visiting program with vulnerable mothers?
2. What practices do PHNs describe related to the delivery of the NFP?
3. What problems have PHNs encountered in delivering the NFP?
4. What do PHNs say they need to be supported in the delivery of the NFP?

A qualitative research approach allowed for an in-depth exploration of a range of concepts to understand a phenomenon in its natural context and from the perspective of the study sample (Mays & Pope, 1995). An interpretive description research approach was used to guide sampling, data collection, and data analysis decisions for this study. This specific research design extends beyond being simply a qualitative description to include both a practice goal as well as generating an understanding of both what is known and not known about a given area (Thorne, 2008). The practice goal for the proposed study was to describe the experiences and challenges faced by PHNs in the delivery of the NFP in a Canadian context and to deepen the understanding of how all aspects of the work environment played into these experiences.

It was important to establish from the PHNs' perspectives, what challenges they were facing, what was needed, and what workplace features help or hinder in this regard prior to the development of further interventions for this population. Interpretive description describes a phenomenon and places it back in its context, with all its nuances and influences without presuming to provide an explanatory model (Thorne, 1998). Lincoln and Guba's (1985) philosophy of naturalistic inquiry provides the underpinnings for this qualitative approach. With naturalistic inquiry, reality is subjective, intimately connected to its context and may have multiple truths. The researcher and the participant influence each other, and separation between the two is not possible.

This study was conducted in two distinct phases. The first phase consisted of a secondary analysis of five focus groups conducted with six public health nurses who delivered the NFP intervention as part of the feasibility and acceptability pilot in Hamilton, Ontario. This analysis identified themes expressed around experiences and challenges experienced by the PHNs in their home visiting practice with vulnerable families. In phase two, individual, semi-structured interviews were conducted with those PHNs in addition to all PHNs who have since delivered the NFP to expand on and conduct a practice, problem and needs analysis (van Meijel et al., 2004).

Theoretical Scaffold

Thorne, Kirkham and O'Flynn-Magee (2004) advise the use of a scaffold, rather than a framework, in the initial stages of the analysis process, and as the true nature of the data emerges a departure from this scaffold is encouraged. The initial scaffold, or structure of the study, was guided by the first phase of van Meijel and colleagues (2004) model for the development of evidence-based nursing interventions. This four stage process consists of 1) defining the problem, 2) building a foundation on which to develop interventions 3) intervention design, and finally 4) evaluation and validation of the intervention. In the first stage, before an intervention can be developed, insights and perspectives of those who are in the situation need to be heard (van Meijel et al., 2004). A literature review is then conducted to establish existing interventions, if any, implementation concerns, and what current theoretical knowledge may contribute to ensure the nature of the problem is clear. Problem analysis delves further into the definition and clarification of the nature of the problem. Therefore, in this specific study, a needs analysis specific to

the problem areas within the context of the NFP were identified by the PHNs. The practice analysis component identified current practices and strategies used by PHNs to, as well as encouraged them to provide perspective on their use and effectiveness. The first two stages of the intervention development model were used to guide the design and analysis of the overall study and the creation of the semi-structured interview questions so that information generated will have future utility in practice. This application dovetails with the goal of interpretive description moving beyond a description to link the research back to a practice goal (Thorne, 2008). This forms a foundation from which future interventions can be created to support PHNs to deliver the NFP to a vulnerable Canadian population.

Phase One: Secondary Analysis of Focus Group Data

Objective

1. To describe PHNs' perceptions and experiences of delivering the NFP program.

Sample

The sample consisted of the total population (N = 6) of PHNs who participated in the pilot NFP in Hamilton, Ontario.

Data collection.

Phase one data consisted of transcripts from previously conducted focus groups (Jack, Busser et al., 2012). Written transcripts were provided by the original study author and were stored on a password-protected computer. By definition, a focus group, a form of group interview, has three defining elements: 1) data collection; 2) interactions between participants that contributes to the co-construction of new data; and 3) the researcher engaging in an active role to stimulate and facilitate group discussion (Morgan, 1996). Focus groups are not only a cost-effective and efficient method of hearing from multiple people in one session, but they are also useful to allow participants to build on their comments in the context of what others bring forward (Patton, 2002). Additional advantages of focus groups include allowing participants to ask questions of each other and to create opportunities for participants to explain their own views (Morgan, 1996). Study participants who already know each other and work together have a shared understanding of their work context and are able to not only relate to each others experiences but also to comment on contradictions between what was expressed and what actually occurred (Kitzinger, 1994).

Focus group data collection.

The focus groups were conducted over a span of 32 months from 2009-2011. Each group was conducted over 90-120 minutes. Prior to the start of the focus groups, informed consent was obtained from each PHN after discussion of study objectives, risks and benefits of study participation. The McMaster University Faculty of Health Sciences-Hamilton Health Sciences Research Ethics Board approved the acceptability and feasibility pilot study. The first focus group focused primarily on acceptability of the NFP program in Hamilton with questions centering on the NFP model, staff training, client recruitment, use of NFP curriculum materials and ability to maintain fidelity to the NFP model. Themes and discussion from the first focus group carried over into the second focus group. The third focus group focused on the evolution of the PHN role in the NFP, ongoing feasibility and acceptability issues as well as the experience of reflective supervision. Focus group four focused on personal growth within the program, strategies to improve family retention in the program, compassion fatigue/burnout and recommendations for new Canadian sites. The final focus group topics centered around challenges and benefits of delivering the NFP with a toddler age group, how participation in the NFP has transformed the PHN's personal practice, the process of disengagement and key lessons learned while delivering the NFP program. Demographic information was collected for each PHN, and field notes were kept following each focus group.

A skilled qualitative nurse researcher (SJ) with extensive interviewing experience and expertise in the NFP program and home visiting and public health nursing facilitated the focus groups. Given this background, the facilitator was able to determine what areas needed further exploration or clarification. A co-facilitator or graduate student was present at each focus group to record observations, manage administrative tasks and ask any questions that required further probing. Each digital recording was transcribed verbatim and any identifying information was removed. A research assistant reviewed all transcripts, a process that entailed correcting spelling errors, removing identifying information and checked for accuracy with the digital recording.

Data Analysis

A secondary data analysis was conducted using retrospective interpretation and a latent content approach. Retrospective interpretation, one of the five distinct types of secondary research identified by

Thorne (1998), addressed research questions that were not proposed during the original data collection (Heaton, 2004). Themes that were identified in an original study but not fully analyzed make up the substance of this type of analysis. Although the primary purpose was not to elicit information around impacts on PHNs working with vulnerable families, these themes emerged naturally during the focus groups. Rew, Koniak-Griffin, Lewis, Miles, and O'Sullivan (2000) suggested that secondary analysis was useful for eliciting latent content of responses versus the original analysis of manifest content. In this case, the latent content refers to the expression of impacts experienced by the PHNs responsible for the delivery of the NFP program, a theme not originally targeted.

Focus group transcripts were uploaded and coded using NVivo9 (QSR International Pty Ltd., 2012). Throughout the study, field notes and a reflective journal were kept to capture changing ideas or personal responses to the ongoing research (Thorne, 2008). The texts of the focus group transcripts were analyzed using content analysis. Hsieh and Shannon (2005) describe three content analysis methods: conventional, directed and summative. Conventional content analysis is used when the goal of the study is description and there is little existing theory or literature to guide the analysis. Directed content analysis draws on existing literature or knowledge base but needs further elaboration or possibly validation. The existing knowledge base guides the formation of the overall research question and targets data collection to pre-established content areas. Analysis is structured by the use of pre-determined coding categories based on what is known in the field. Summative content analysis uses an initial quantitative approach starting with a count of specific words or content in a transcript. Beyond the word count is the analysis of the latent content, or gleaning of insight in how words are used in the context.

Conventional content analysis was used in this study as this allowed the coding categories to come from the text to produce a rich description of a phenomenon grounded in the voices of the participants. As there was limited literature on the selected topic, using predetermined categories would have prematurely limited the analysis. Elo and Kyngäs (2007) provided an approach to the content analysis process consisting of the phases of preparation, organization and reporting. As part of the preparation phase, the unit of analysis must be determined and then the researcher is to become familiar with the data through multiple readings. Graneheim and Lundman (2004) suggested whole interviews, or in this case each individual focus

group, as appropriate units of analysis as they can be considered as a whole, but also not so large as the context for the meaning unit is lost. A meaning unit can be words or statements that centre on the same meaning (Graneheim & Lundman, 2004). Words and statements as meaning units were the basis for open coding for this content analysis. Open coding is a process of inductive content analysis where codes are created from initial impressions from the text to reflect key thoughts (Hsieh & Shannon, 2005). Codes are then grouped into categories and meaning is then abstracted (Elo & Kyngäs, 2007). However, despite the pathway that was provided in this approach, the process of intellectual inquiry and interpretation must remain at the forefront and not just adherence to a set of directions (Thorne et al., 2004). However, as this was a secondary analysis, themes identified through abstraction may only suggest a broad overview and not the depth typically expected in a qualitative study.

One caution with using secondary analysis is that not all questions may have been consistently asked of all participants, as is often the case with individual interviews where questions may change over time (Hinds, Vogel, & Clarke-Steffen, 1997). In this instance, consistency was maintained as all participants were in attendance at each focus group so concerns about missing data were minimized. In secondary analysis there was no opportunity to influence the initial sampling decisions or questions asked and researchers are cautioned to ensure they are open to the data as it stands, and to not look for what they expect to find (Thorne, 1998). A strength of this two-phase study design was that clarification and expansion of content, with the original participants, from the secondary analysis was possible in the second phase, overcoming a limitation of using secondary analysis alone.

Phase Two: Semi-structured Individual Interviews

Objectives

In phase two of this study, themes identified in phase one were shared with the PHNs through a process of semi-structured individual, face-to-face interviews to describe:

1. The in-depth properties and dimensions of themes identified in the secondary analysis of the focus groups;
2. Practices used by PHNs to deliver the NFP;
3. Problems PHNs have encountered in delivering the NFP; and

4. Needs identified by PHNs to be supported in the delivery of the NFP.

Sample and Recruitment

Past and current PHNs who have delivered the NFP in Hamilton (N = 10) were invited to participate. At the time of data collection, four of the original six PHNs from the pilot and two PHNs who had since joined the team, were actively delivering the NFP. The remaining four PHNs (two from the pilot phase and two from subsequent hiring) left the program due to natural attrition. Although the recently hired PHNs did not participate in the focus groups, their experiences and insights on the impact of delivering the NFP provided an important contribution to the study. These PHNs had not yet experienced graduating a cohort and reflected a different perspective on the needs and challenges of a novice as compared to an experienced NFP PHN. As the total population of past and current NFP PHNs were targeted, no further sampling strategy was necessary. To be included in the study, participants must be a past or present NFP PHN.

Publically available workplace e-mail addresses were used to invite eligible participants. Detailed study information and consent form (Appendix B) were attached the to e-mail. Participants were asked to express interest by responding to the e-mail invitation. Interested participants were then contacted by telephone or e-mail to arrange a mutually agreeable time to meet and conduct the informed consent process and interview. Participants who did not respond to the initial e-mail received one follow-up e-mail and if required, one follow-up phone call.

Data Collection

The study information was reviewed and informed written consent was obtained by the student investigator prior to the start of the interview. The Director, Family Health (Hamilton Public Health Services) granted permission to conduct the interview within the PHNs' hours of work. Data collection consisted of a single semi-structured individual interview (Appendix C) and completion of a demographic information form (Appendix D). To gain a deeper appreciation and understanding of the range of PHN experiences, the semi-structured interview guide was developed from, but not limited to, themes identified in the secondary analysis and the first stage of the model for the development of evidence-based nursing interventions proposed by van Meijel and colleagues (2004). However, as data analysis and collection occur

concurrently (Thorne, 2008), there was flexibility to alter or deviate from the interview guide as themes reached saturation. This allowed for more time for an increased depth of discussion to reflect this evolving understanding of the phenomenon.

Participants were reimbursed for any associated parking costs and received a small token of appreciation (\$25 coffee gift card). For those who consented, a brief follow-up phone call was made for clarifying any emerging themes from the interview or to ensure data was accurately captured. The interviews were digitally recorded and ranged from 60-90 minutes. All interviews were conducted at McMaster University.

Data Analysis

Within interpretive description, particular analytic strategies or data collection methods were not prescribed, although it was necessary that strategies used made sense with the overall purpose of the study (Thorne, 2008). Individual interviews were uploaded into NVivo 9 (QSR International Pty. Ltd., 2012) then analyzed using conventional content analysis as previously described. A notable difference in the second phase analysis process was that data collection and analysis occurred concurrently. As such, emerging themes were explored with subsequent participants and there were slight variations in questions asked of later participants. Interviews were transcribed by a transcriptionist and the student investigator reviewed final transcripts for accuracy.

As interpretive description aims to move beyond a description of a phenomenon to an investigation that informs clinical understanding, data was constructed into themes or categories and arranged in a detailed narrative, so that key ideas and new understandings are clearly presented (Thorne et al., 2004).

Rigor

Given the philosophical and methodological differences between qualitative and quantitative research, assessment of rigor also involved different strategies. Compared to quantitative research where rigor was assessed using concepts such as reliability and validity, qualitative research was assessed for trustworthiness (Krefting, 1991), the confidence that the reader has that your findings are deserving of your consideration (Guba, 1981). Trustworthiness in qualitative research acknowledged that the interpretations, conceptualizations, coding decisions and transformation of raw data into “constructed truths” (p. 6) are

driven by the researcher rather than a defined set of procedures (Thorne et al., 2004). As the purpose and methods of qualitative research vary widely, the evaluation of trustworthiness must be appropriate to that given purpose (Krefting, 1991). Rigor for this study was assessed across the dimensions of credibility, dependability, confirmability and transferability (Lincoln & Guba, 1985)

Credibility, a judgment to indicate that the findings are plausible, was enhanced through several strategies. The researcher had previously met several of the PHNs during a clinical placement as part of graduate course work and observed home visits and the day-to-day operation of the office environment. This placement allowed for the building of trust and rapport with the PHNs as well as provided the researcher with a greater understanding of their context. This previously existing relationship allowed the PHNs to be more comfortable sharing their experiences thus enhancing both credibility and confirmability (Krefting, 1991). Credibility was also enhanced through the use of data triangulation with data from focus groups, demographic information and individual interviews. Collectively, data from these three sources added strength to the ability to generate nursing practice knowledge (Thorne, Kirkham, & MacDonald-Emes, 1997). Peer debriefing, in the form of ongoing discussions with both thesis supervisor and committee members allowed for the testing of new ideas and insights throughout the research process (Guba, 1981). Member checking, returning to participants to confirm that the report captured the ideas as told to the researcher (Lincoln & Guba, 1985) is not strictly advocated in interpretive description, however, the synthesis of ideas from multiple participants may be shared with select participants to have them consider if the synthesis has adequately captured their experience (Thorne, 2008). Member checking was conducted by sharing a written synthesis of the study data with the PHNs and an invitation to comment on the accuracy of the findings. Participants were also invited to participate in a follow-up phone call. Including representative quotes from participants further enhanced credibility by showing examples of various coded categories (Graneheim & Lundman, 2004).

Credibility was further enhanced through the use of a reflexive journal kept throughout the duration of the study, which included comments on logistical and methodological issues as well as to allow the researcher to challenge personal biases and reflect on interpretations (Guba, 1981) and new insights or questions brought to the analysis (Krefting, 1991). Understanding why specific interpretations and decisions

were made allowed the reader a better sense of what other factors may have been contributing to the outcome and if the researcher was able to account for their own biases.

Dependability refers to a consistency of findings (Guba, 1981). To allow for a transparency of the research, analytic decisions, how findings were constructed and the role and positioning of the researcher must be made known (Thorne et al., 2004). Dependability was supported as findings from the independent secondary analysis of the focus group data converged with those from the original primary research. Assessing inter-coder reliability was not required in the second phase of this study as only one researcher conducted the coding, however the student researcher's thesis supervisor coded random segments of the transcripts for discussion and comparison of interpretations.

Confirmability speaks to the findings and recommendations of the study that were supported by the data and the research process (Guba, 1981). An audit trail, a record of data, analytic decisions, interpretations and process notes were maintained throughout the process to enhance confirmability (Guba, 1981). In this way, another researcher could follow along the decisions made and if they were to repeat the study in a similar context, similar findings and interpretations would follow (Krefting, 1991). A clear presentation of the analytic decisions enabled the reader to better assess the quality of the study (Thorne et al., 2004). Given the potentially varied interpretations offered by different researchers, it is important to acknowledge and report the rationale for decisions made throughout the process.

Transferability, comparable to the concept of external validity in quantitative research, was supported by providing enough description about the context and process so that readers may make their own decisions about applicability of the findings to their own setting and context (Lincoln & Guba, 1985). In qualitative research, the purpose was not to generalize to a large population so an evaluative concept such as external validity is not appropriate (Krefting, 1991). Avoiding common errors in analysis such as premature closing, attributing a structure to findings prematurely in the process, and of going native, an assumption that you as the researcher understand the phenomenon on the same level as a participant (Thorne et al., 2004) further strengthened the rigor of the study. A process of open coding of main themes, then selective coding for those relevant to the study purpose helped avoid premature closing. A rich

contextual discussion of the participants and the contextual setting allowed readers to assess for themselves the transferability of findings to their context (Krefting, 1991).

Ethical Considerations

Participation was voluntary, and participants were able to withdraw at anytime throughout the study. Interviews took place at a site that allowed for privacy as well as anonymity. The participants' workplace was not informed of employee participation status or specific content of the interviews. Digital audio files and transcripts were labeled using participant numbers and both were encrypted and saved on a password-protected computer. The participant key was also stored in an encrypted file on a password-protected computer. Original audio files were deleted from the digital recorder once transferred to the computer. No names or identifying information were included in the transcripts. Due to the small and specific sample population, caution was used in the description of emerging themes and experiences to avoid identifying specific individuals. Consent forms were stored separately from the transcripts in a locked cabinet. The demographic form was confidentially recycled once the information had been entered using participant codes onto a spreadsheet. Transcripts and digital files will be stored for a period of three years from the completion of the study. Upon conclusion of the study, the consent forms were confidentially recycled.

Chapter 3: Findings

Findings from each phase of this study will be presented as distinct components followed by a synthesis of the two pieces. Phase one consisted of a secondary analysis of focus groups data conducted with the PHNs. Themes generated from this phase, in addition to newly identified content, were further explored within the second phase, an interpretive description of individual interviews conducted with the full population of PHNs oriented to provide the NFP in Hamilton, Ontario.

Phase 1: Qualitative Secondary Data Analysis

A summary of findings from the secondary analysis is presented in Table 1.

Table 1
Summary of Findings from Phase 1 Focus Groups

Category	Sub-category	Codes
PHN Perceptions of the NFP	Evidence of program effectiveness Program structure and guidelines Frequency and intensity of home visits	
Relationships in the NFP	PHN-client relationship	Time, and timing, to build the relationship Barriers to the relationship <ul style="list-style-type: none"> • Trust issues • Client fatigue • Transient/unstable housing • Changes in clients relationship status • Scheduling conflicts/overload • Client withdrawal • Mental health concerns Maintaining the relationship <ul style="list-style-type: none"> • Being there • Consistency PHN transformation in the NFP <ul style="list-style-type: none"> • Client as expert
	Changing relationship with other service providers	
Delivering the NFP: Challenges and Impact on the PHN	Professional and work-related challenges	Challenges <ul style="list-style-type: none"> • Confidentiality of NFP content • Workspace and resource issues • Theoretical differences from other service providers • Demands of a full case load • Sense of overload • Documentation • Time in the car • Accessing satellite offices • Scheduling realities of NFP clients

	Personal impacts	Sense of doubt <ul style="list-style-type: none"> • Impact on life outside of work • Realities of a high risk population • Emotional impact • Graduation • Changing definition of success • Rewards of delivering the NFP
Formal and informal support mechanisms in the NFP	Team meetings and case conferences	
	Reflective Supervision	<ul style="list-style-type: none"> • Supervision focus • Time constraints • Barriers to effective supervision
	Informal peer debriefing	
	Individual stress management practices	
	Need for additional support	
Long term perceptions of delivering the NFP		

Demographics

In 2010, when the series of five focus groups were completed, the average age of the PHNs was 41 years (range 27-64). The PHNs in this sample had worked in nursing for an average of 15.5 (range 1.6 - 38) years and more specifically had an average of 8.9 (range 1.6-23) years of public health home visiting experience. All the PHNs in this study were female with a minimum of a bachelor's degree in nursing.

Nurse-Family Partnership Implementation in Hamilton: PHN Perceptions

All of the PHNs were excited to be a part of the NFP in Hamilton. PHNs hired to deliver the NFP had previous home visiting experience, most notably in the provincial HBHC program. From this perspective they were able to see and appreciate the differences in program design and delivery between the two programs. PHNs related some frustrations with HBHC, including the lack of evidence supporting program outcomes, the lack of defined goal as well as a limited visiting schedule. When comparing the two programs, the most distinct differences reported between the NFP and HBHC were: 1) level of evidence of program effectiveness; 2) program structure and guidelines; and 3) the frequency and intensity of home visits.

The NFP: an Evidence-based Intervention

PHNs stated they felt empowered and excited to embark on delivering the NFP, a program that was evidence-based and had proven outcomes with a population of high-risk clients. They noted that equivalent evidence about the effectiveness of the HBHC program was lacking and left them doubting the efficacy and impact of their efforts with this particularly vulnerable population. One PHN who was a recent nursing graduate and newer to home visiting, expressed that in her nursing education, evidence-based practice was a heavily reinforced concept and almost an expectation for practice. For all PHNs, the concept of an evidence-based program was an essential component to their belief in the NFP. With proven effectiveness, PHNs were secure in the knowledge that over time the program would work to improve the lives of their clients and this was sustaining during more challenging periods. One PHN explained her perception of both HBHC and the NFP:

I personally felt like *finally* we can make a difference because I felt like in Healthy Babies it was you know *here and there*, you don't really know if what you're doing is having a positive effect or if the outcome is going to be the way you wanted...Because the *evidence* is there [with the NFP] so I thought once we start to implement it, then I would feel better about what I was doing. (PHN FG-01)

NFP Program Structure and Guidelines

PHNs commented that with HBHC no actual plan was in place for families, the program lacked specific guidelines or were vague, the monthly visiting schedule was a barrier to connecting with higher-needs clients and navigating the relationship and communication with HBHC lay home visitors was challenging. Some PHNs reported feeling frustrated, “inefficient and ineffective” and acknowledged the very nature of the HBHC program structure was detrimental to retaining high-risk populations. One PHN shared her struggle with maintaining a connection with young clients:

I only probably had *one young, young* 16 year old, 17 year old [in HBHC]... When I did get them it was *hard to keep them* ... so there was only one or two that I *managed* to keep so that I had doubt there too. I'm thinking oh I didn't manage to keep that one very well... she disappeared. I only had one visit a month. I couldn't keep her. There was something missing, I'm not doing a good job here. And so... I had *doubts*. (PHN FG-01)

Although the PHNs were aware that the structure of HBHC prevented, or limited, full engagement with high-risk clients, there was still a sense of personal blame for lack of success. PHNs expressed that the NFP model and approach fit with this population, and a structured visitation schedule with a set curriculum

provided a consistent approach. The PHNs also appreciated the flexibility to adapt the curriculum to meet the needs of their clients, which reflected the reality of forming therapeutic relationships with a population of young, vulnerable, first-time mothers. With the NFP, the PHNs had the benefit of knowing they would be involved with the client over an established time period, different from HBHC. This allowed the relationship to develop at a different pace without the same pressure of time.

Frequency and Intensity of Home Visits

In the initial focus group, PHNs were vocal in their recognition and appreciation of how the NFP allowed them to connect with and support young, vulnerable clients. While many of the NFP program structures were viewed favourably by the PHNs, such as enrollment by the 29th week of gestation and the frequency of visits, the overwhelming strength of the NFP was the importance placed on the therapeutic relationship between PHN and client. This was reflected in the frequency of visits, as often as weekly, and the long-term duration of the program. This importance went beyond a theoretical construct as PHNs were provided one thing that was not in HBHC - time. The time to slowly build relationships with a population of young mothers that had not historically been successful in trusting others, and the permission to be an ongoing presence in their lives. PHNs expressed that within the local HBHC program policies, such as discharging clients after three missed appointments, and a limit of one visit per month, the highest-risk clients were being lost. In comparison, because of the resources available, program focus and the emphasis on client engagement, in the NFP, rather than discharging those clients, PHNs were able to take the time to locate hard-to-find clients, not as an “extra” activity but as an expectation.

Relationships in the NFP

The theme of relationship was a consistent thread woven throughout the focus groups. While the relationship between the PHN and the young client featured most prominently, a changed relationship with other professionals also emerged throughout the focus groups.

PHN-Client relationships in the NFP

NFP PHNs were supported in developing therapeutic relationships with clients due to program elements such as enrollment no later than the 29th week of gestation, a program span of approximately two and a half years, a visitation schedule including weekly, bi-weekly or monthly visits, and the time allowed

to pursue clients who had missed visits. Of the three theoretical frameworks underpinning the NFP program, self-efficacy theory was cited as having the greatest influence on how the PHNs engaged with their clients. Throughout the span of the program, and reflecting on their experiences after graduating their first cohort, the PHNs were continually coming back to this relationship as foundational to the success of their client.

Time, and timing, to build the relationship.

PHNs recognized the importance of having time to build a therapeutic relationship with their clients. The PHNs explained that they believed that for many of their clients, who had often experienced chaotic childhoods, these experiences impacted their ability to form trusting relationships. The timing of program initiation prior to the birth of the child, allowed the PHN and the client to establish a connection prior to the predictably tumultuous period after delivery. Over time the PHNs were able to appreciate the progress in the relationship development as well as gain an in-depth understanding of their clients day-to-day reality. The long-term nature of the relationship, supported by the frequency and duration of visits, allowed for a depth of understanding and connection that was not possible in other programs and contributed to the retention of clients in the program.

Barriers to the relationship.

Maintaining the PHN-client relationship over time was also presented as a challenge. Possible barriers to relationship formation may range from the complex, such as a client's traumatic past and inability to form trusting relationships, to the simple, such as scheduling. Other factors that presented a barrier to the relationship included client fatigue after the birth of the child, transient or unstable housing, changes in the clients' relationship status as well as the client returning to work or school. Clients, particularly those involved with Children's Aid Society (CAS) services, may have four or five appointments in a week in addition to the work of caring for an infant or toddler, and as the NFP was a voluntary program, it may be the first thing to go until life was calmer. Several of the PHNs recounted that early relationship building was essential to "picking up where they had left off" if there were long gaps between visits. Scheduling was not the only reason that clients may miss visits. One reported that on occasion when clients had felt they had made mistakes they did not want the PHN to return until they had resolved their situation, as they did not want to disappoint "their nurse." Several of the PHNs echoed this

experience but also shared the opposite experience of client's excitement to share their successes.

Another challenge to the ongoing relationship that was experienced by all of the PHNs was when the client returned to work or school. With the PHNs working hours very similar to their clients school or work commitments, shortened visits were fit in wherever they could, be it during their clients lunch breaks or after the workday. The child was often not present during daytime meetings, and at the end of the workday, the client, child and often the PHN, were hungry, tired and as a consequence, it was challenging for all involved to engage in a meaningful way. However the efforts that client's exhibit, to make time for their PHN reflected the strength of the relationship and a willingness to remain in the program. One PHN shared an experience of continuing to visit a young mother for six months even though CAS had apprehended her infant. As the young client made improvements in her life, her infant was returned to her care and has remained there since.

The PHN shared that this successful reversal of the apprehension outcome may not have occurred in another home visiting program and that within the HBHC model, the client would have been discharged and her willingness to stay in the program would not have been recognized. Another PHN shared her perceptions of the difference in the home visiting experience around this challenging period:

So you're negotiating ...we'll do ... a few visits without the child, which is actually good because then we can talk about some of the other domains in more *detail* uninterrupted. But... my late home visits don't feel like they're a good experience. It's a *long day* for me. It's a *long day* for them. They have... good intentions. it's actually a visit of a lot of *apologizing* happening on *their part* because ... the *child is tired*, we're getting close to *supper*. It's just *not* the best time of day to do anything and it's just ok we're just *keeping in touch*, ... the actual *visiting* the *quality*, as far as I'm concerned, a *big* difference, a *big* difference. And then you pray for the *PA days* or *vacation time* or whatever you might get a good quality visit, and then it's like *catch up time* and then it's *really long and intense*. So, it's been really, really difficult. (PHN FG-05)

Maintaining the relationship.

Although some clients may "disappear" for several months, the strength of the established relationship in the early period and the proven history of "being there" allowed clients to re-engage with their PHN at a time of their choosing. Although simply "being there," being a consistent and trustworthy presence in the client's life was identified as an important factor, PHNs also described skillfully navigating the relationship within the context of the client's changing circumstances.

This elastic relationship, with a pattern of backing off and waiting for the client to return when

ready, sustained and maintained relationships, and very rarely broke the connection. The coming and going of clients and elastic nature of the PHN-client relationship, was a common experience. As one PHN stated, the program approach itself allowed for this back and forth process to occur:

I just wanted to go back to...the reality of relationships with these girls. I think this program has allowed me to be more *flexible* to the, to the human condition as far as *realistic expectations*... she doesn't want to talk to me. And that's *ok*. I'm giving her that chance to not to talk to me and that doesn't mean I'm going anywhere, ... this program is *allowing* me to ...be respectful...that's what human beings are all about...and it gives you permission maybe to, to *start* a difficult conversation but, but it also is... you can *back off* and it's ok and there's no penalty to *me* and there's no penalty to the client. (PHN FG-04)

Knowing that the program allowed for this flexibility was also supportive to PHNs, in that there was not a punitive element to missed appointments or deviating from program content.

Throughout the NFP, PHNs were the most frequently involved health care or social service provider. They had a consistent and predictable structure of visits, and they were well positioned to assess clients over time, during three unique time periods - pregnancy, postpartum period, and the first two years of motherhood. This was in stark contrast to many other health or social care providers who have a limited role or focus and intervene only during a specific period e.g. during pregnancy. PHNs often reported that they were able to view client strengths and achievements in a way that other service providers often missed and from this understanding were able to advocate for their clients. PHNs stated they were often the “one person” that was consistently there for the client over time to assist them with navigating changing circumstances and transitions. For many of their clients, simply having someone supportive in their lives over time was a novel experience.

PHN transformation in the NFP.

In the formation of this relationship it wasn't only the client who benefited. The PHNs themselves recognized transformations in themselves throughout the program. The concept of the PHN as “expert” and in control of the home visit was not the reality of the PHN-client dynamic, nor was it ever intended to be. With the philosophical underpinnings of the program being driven in part by self-efficacy theory, the PHNs encouraged clients to make their own decisions and take control of their lives. For some PHNs, letting go of this control was challenging yet once this was accomplished, it brought a deeper sense of connection with the client. With control remaining with the client, the PHNs shifted their approach, in the language used by

one PHN as “doing for” rather than “doing to,” in contrast to the approach used by other service providers.

One PHN shared her experience of her evolving approach with clients:

I think it's transformed me in that I can give up that *expert role* ... I would go into a visit and be scared not knowing ...what's the point of going in there *like that*? So let's give up that expert role and *they are the expert* and just using my knowledge to, to facilitate and draw them out. So for *me* I didn't think I had the skills. And as I'm doing this program... I can see we're learning *together*. My *client* is learning the skills and seeing her strength and I'm doing the same thing back. So it, it's a two-way street.... I've made mistakes through this program. And just to not beat myself up for it and say ok let's move on, now I know what I'm going to do differently next time. So I think the program has *definitely* changed *me*. It made me a *stronger* and a more *effective* nurse. (PHN FG-04)

PHNs reflected that they felt more comfortable with acknowledging their own mistakes and discussing them with clients. This had the added benefit of role-modeling with the client that a range of emotions was allowed, mistakes happened, and by working through these issues together, ultimately growth could occur. This mutual growth further strengthened the relationship. Despite best efforts, there were some clients the PHNs stated they just could not connect with and spent the duration of the program trying to “get them.” Possible explanatory factors were client mental health issues, client fatigue, or involvement of a large number of health and social service professionals. Some PHNs, reported that clients were involved with the NFP only to demonstrate to CAS that they were involved in a parenting program:

I've got an ambivalent client that I've been working with, but is keeping me because of the CAS involvement. And I definitely feel that...but she's *ill* as well so, we're dealing with that. And I think that I probably feel more ambivalence than there possibly is and it's part of her mental health. So I struggle with that. So I just have to keep *plodding* and keep *connecting* with her and *trying* different ways. (PHN FG-05)

Regardless of clients' motivations for participating in the program, PHNs tried multiple strategies to connect with and keep their clients engaged.

Changing Relationships with other Service Providers

The PHNs reflected on how their role in the NFP changed how they worked with other health and service providers involved with their clients. However, this changing dynamic was related to how well the other health or social service providers understood the nature and depth of the NFP role. In simple terms, those providers who understood the program were more likely to involve the PHN in discussions and rely on her assessments. Some were less willing to involve the PHN with possible explanations including concerns around their own funding security, a sense of protectiveness or territoriality around the young

mothers, and a lack of understanding of the NFP role and goals. Relationships with physicians also had similar parameters, where an understanding and appreciation of the depth of knowledge and involvement of the PHN seemed to precede any improved relations. PHNs discussed difficulties with contacting and communicating with physicians as an ongoing issue. PHNs expressed a need for ongoing education for other professionals around the program and to tailor this to fit the individual community agencies.

Much of the dialogue in the focus groups revolved around the changing nature of the relationship with CAS agencies. Those CAS workers who understood and valued the role of the PHN would make an effort to keep the PHN informed about any updates. When this ideal situation occurred, the PHNs felt like part of an effective team in a way they were not before. PHNs also changed how they approached CAS workers. Because PHNs viewed their clients from a strength-based lens, they had a different view of their client compared to their CAS colleagues. On many occasions, the PHN shared experiences where they had advocated for their client to highlight progresses made and this ultimately impacted CAS decisions. One PHN reflected that she thought, due to the level of time spent and depth of the relationship, she was more confident about her role and assessments in discussions with CAS workers. In previous programs she felt that the CAS opinion often out-weighed her own, or that they [the CAS worker] “were usually right.” In the NFP she felt she was a stronger voice to advocate for her client:

When I was in Healthy Babies, I always thought the CAS worker knew *best*. I *always* deferred to them. But now ... I think we *see* it differently, not that we maybe know more than they do but... *Something's changed* so that I can go in and I can *challenge* her whereas before, I would be quiet. So I don't know what's happened but... I don't know whether we do know more. We know different things. There's something. (PHN FG-04)

This changing dynamic can be considered from two views – an external perspective of the recognition of the NFP contribution by other agencies or providers as well as an internal one, a change in the professional practice of the individual PHN. As one PHN reflected on her experience in HBHC she reported feeling “inefficient and ineffective” whereas an NFP PHN reported feeling like a “stronger and more effective nurse.”

Delivering the NFP: Challenges and Impact on the PHN

While PHNs shared many challenges relating to delivering the NFP, some can be considered within the professional, or work-related, realm and some within the personal, however the division between

the two is anything but clear. Given that so much of what the NFP has to offer is driven by the unique knowledge base and relationship-forming skills of the individual PHN, the separation of where professional PHN role ends and the person begins was not possible. What was important to acknowledge was that professional work factors impact the PHN both at work and home and the opposite holds true as well.

Professional and Work-related Factors

The PHNs in the NFP pilot were unanimous in their support of the NFP program and it's acceptability in the Hamilton context. From a professional practice perspective, the PHNs felt that they were fundamentally changed and jokingly refer to this as being “brainwashed...in a good way” to the NFP philosophy of care. Beneath this humour though was an uncertainty and even fear about what to do with this professional knowledge beyond the NFP. At the time, the PHNs were acutely aware that the NFP program was only a pilot intervention within Hamilton Public Health Services and they feared that if funding was not secured for ongoing delivery of the program, they would be reassigned to other PHN roles within the division. Some feared moving back to a different nursing role would reduce their ability to use the extensive knowledge and skills accumulated in the NFP program and to work at their full scope of practice.

In other home-visiting roles they enacted prior to delivering the NFP, some PHNs described having doubts of their effectiveness to influence clients outcomes. This left them feeling frustrated which then negatively impacted their expressed level of job satisfaction and their confidence in their own skills. PHNs experienced a growth in professional capacity and stated they were finally doing the work they desired and reaching the clients they had been unable to reach. One PHN, who described herself as “older,” reflected on the state of nursing before and after the NFP:

We've [PHNs] *given up a lot* ... we always take the back seat ... I think we need to grab some of this stuff *back* that we've given up ... Until working in Nurse-Family Partnership I think I really was struggling with the *role* and so now I see my role and I'm saying, 'yes it's a good role and yes the nurse should be in there and yes we have something to offer to the community even though other factions have a different philosophy.' I feel *stronger* and *believe stronger* in my Nurse-Family Partnership philosophies and *theories*. (PHN FG-01)

PHNs reported seeing the outcomes they were hoping to achieve, such as, clients demonstrating healthy attachment behaviours with their babies, quitting smoking, improved breastfeeding rates and many clients

returning to work and school. However, engaging with a high-risk, vulnerable population was not without challenges.

Professional and Work-related Challenges in the NFP.

From a professional perspective there were particular challenges faced by the PHNs: 1) the confidential nature of the NFP content limited PHNs ability to share professional knowledge with colleagues outside of the program; 2) lack of workspace and resources to deliver the NFP; 3) the NFP approach of self-efficacy with clients, of acknowledging strengths and allowing them to be experts of their lives occasionally created friction with other service providers; and 4) the demands of a full caseload were often overwhelming for the PHNs.

Confidentiality of NFP content.

As the NFP curriculum content is copyright protected, PHNs were required to restrict the use of materials to clients formally enrolled in the program. Only PHNs who had completed the full NFP educational requirements had access to the NFP materials and guidelines. PHNs were often faced with the dilemma of knowing other departments or colleagues and their clients would benefit from the resources already prepared but were bound by confidentiality not to disseminate this material.

Workspace and resource issues.

PHNs reported that they did not have some of the resources required by the NFP such as materials to complete lesson guidelines. PHNs revealed they spent time “chasing” incentives, such as food vouchers or bus tickets, and these non-nursing tasks caused further stress and a sense of role overload. PHNs reported that a lack of dedicated administrative support meant tasks such as photocopying, assembling materials for specific guideline elements and data entry fell to them. Space within the office was at a premium resulting in issues of inadequate storage for NFP-related material. PHNs also reported feeling the need to “talk out” some of the program content, an option currently not available due to lack of privacy to conduct confidential discussion with co-workers and clients within the open concept work environment.

Theoretical differences from other service providers.

The working relationship with other service providers also presented challenges to the PHNs.

Often a PHN would refer to having to “undo” damage done by other agencies and professional staff who approached the client from a perspective of everything they had done wrong. This philosophical difference acutely impacted this PHN, as well as her client:

I think I take on what they feel and I, I deal with these other agencies and I thought oh my God, this poor teen no wonder she’s so *angry* and so *upset* when all these professionals are *down* her case and saying well, ‘you can’t ... you haven’t been *parenting*, you don’t *breastfeed* properly, you aren’t putting the baby on the tummy’, and all of this. So *all so negative*, and then I go in. I have a hard time *undoing* all of that damage that was done and so we *go back ten steps*. (PHN FG-03)

Seeing first-hand, and also experiencing that anger herself, the impact of this negative approach helped this PHNs appreciate the challenges imposed by the system but also recognized the strengths of her clients to persevere through them. The PHNs frequently commented on the importance of the philosophy of self-efficacy and the strength-based approach used in the NFP. One PHN reflected that she felt less open to some other service providers due to their problem or risk-based perspectives to care.

Demands of a full caseload.

Within the Canadian NFP, a full caseload consisted of 20 clients. PHNs, who were carrying a caseload of 19 clients, reported the feeling of “tipping over” and feeling overwhelmed at a caseload of 10-13 clients and were fearful of how they would manage a full caseload. Already they reported working through lunch, working overtime, having little preparation time for their visits, taking work home and feeling like they had little energy spared for their families at the end of the day. One PHN even revealed the experience of having to reassure her clients that she was okay and felt she was in “constant apologizing mode” for running late. For these PHNs, however this was still in the pilot phase of the program and learning the program contributed to this sense of overload.

Sense of overload.

Multiple factors contributed to this sense of overload and from a program perspective there were multiple demands on their time. Time was at a premium and documentation, time spent in the car, accessing satellite offices and the scheduling demands of their clients were all in competition for limited hours during the day. The complexity of cases, or emotional challenges relating to interacting with a high-risk population

seemed secondary to the logistical pressures of this role, or perhaps these logistical stresses were easier for the PHNs to express.

Documentation.

PHNs were unanimous in their frustrations around the apparent duplication and inefficiency of their documentation obligations and felt this was a major contributor to their stress. PHNs stated that they found their documentation requirements as “repetitive,” “redundant” and involving too many different systems. They even shared that their mileage per visit was to be recorded in three different places. As one PHN explained, the complexity of the multiple layers of documentation resulted in a duplication of effort for the PHN, the nature of the documentation system as it was during the time of the focus groups required PHNs to satisfy requirements specific to the NFP, the Ontario Ministry of Health and Long-Term Care, as well as the local public health division. With duplication of information required on various formats PHNs revealed that at times they struggled with ensuring that they had documented the right information in all the varied places. As one PHN shared “the problem with that is that in your mind I know I’ve transcribed it somewhere so then I *omit* to transcribe it somewhere else because I’m oh well I’ve written that somewhere” (PHN FG-02). PHNs struggled with setting the priorities of what was to get done with limited time:

Research thinks ... that’s all we need. ISCIS [documentation system] thinks that’s all we need. And then there’s NCAST and PIPE, and we’re all kind of sitting, there’s *seven* different tools on documentation that are *most* important and we kind of pick and choose out of those *what do we feel* is most important. And there’s no consistency between the six of us. (PHN FG-02)

PHNs stated that they often found themselves up to a month behind in documentation and felt that they would never be caught up, and that the volume of documentation was not an achievable expectation. The PHNs also expressed concern about the legal implications of this documentation backlog, and felt that they failed to meet their own standard of nursing practice.

Time in the car.

Time spent in the car was noted to be a factor as the office was not located where the majority of their clients lived, their client population was mobile and often moved to centers further afield. As one PHN commented: “we’ve travelled up to 4 hours a day and that takes away from all the charting time we’re

supposed to be doing” (PHN FG-02). Often PHNs were faced with the dilemma of what to do with time between visits when returning to the office was not feasible. As one PHN lamented:

And there’s also time in that car in between ... when I plan my visits, I give my client an hour and a half ... I have to realistically ... I’m not going to drive from the east-end to [office location] when I have a 30 minute gap so I’m kind of stuck sitting there. I’ll do some of my paper charting... that’s the only reason NFP got laptops originally to say ok we need something a bit remote and the original intent was to have a bit more of an option of going to different offices. But that still proves to be impossible because the other offices don’t have space for us to put our laptop down and connect into a network. (PHN FG-02)

Accessing satellite offices.

PHNs vocalized their desire to have a means to document while out of the office and were frustrated by this wasted time. Portable laptops were not connected to the required network and access to other health unit offices was not feasible. There were multiple barriers to using other offices to complete documentation such as not having required swipe card access, limited availability of computers or workstations and a sense of not feeling welcome.

Scheduling realities of NFP clients.

As part of the challenge of working with a population of high-risk clients, PHNs often needed to reschedule cancelled or missed appointments. No additional time was allotted for this purpose. PHNs must then re-connect with, or find, their clients, who may have suddenly moved or changed their number, book another time to meet and then as time moves on, try to achieve the visits as outlined by the NFP. Gaps in meeting with clients may be weeks or even months. In addition, long weekends add another time pressure as the expected number of visits does not change despite the removal of one working day. A further scheduling issue emerged around the time the child turns one, when the client may be returning to work or attending school. This was previously discussed in the context of a challenge to the maintenance of the PHN-client relationship but also presented as a scheduling issue.

Personal Impacts

The cumulative result of the professional challenges, as well as those related to working with a vulnerable population, results in very real personal impacts on the PHN. PHNs report contending with: 1) a sense of lingering doubt –asking themselves if they have done enough for their client; 2) the impact of work

on their home life; 3) the realities of life for their clients; 4) the emotional impact on themselves; 5) the graduation process; and 6) their changing perception of success.

Sense of doubt.

Although the PHNs work in isolation in clients' homes, this aspect was not mentioned in the focus groups as a contributing factor to work-related stress. One theme that did emerge however, was dealing with unanticipated crises. Although the PHN had access to phone support with colleagues or a supervisor, often situations were addressed by the PHN themselves in the immediate time period when they arose. They then bore the responsibility of any decisions made and are often left wondering if they made the correct decision, or if they have done enough.

The sense of "have I done enough" also surfaced beyond the context of decision-making. Many of the PHNs perceived a gap between what they felt they should be offering their clients of themselves, and what they were actually able to. They felt guilt around client's outcomes, and struggled with taking responsibility for them. One PHN shared her own experience of guilt around what she could offer her clients:

I don't have time to follow up with my clients, I don't have time to do this, or you're kind of doing the minimum, I have felt a lot of *guilt* towards my clients saying if I was a better nurse to you, you would be doing *better*...I'm not doing enough. (PHN FG-03)

Impact on life outside of work.

These lingering doubts and worries about having done enough for their clients are not the only personal impacts experienced by conducting home visiting. Work overload, or work demands that exceeded work time created personal stress that was impacting the PHNs in their time off. This ongoing tension between work expectations and what the PHNs felt they could accomplish left them feeling overwhelmed and ultimately affected their ability to care. In the third focus group, the following discourse occurred, illustrating one PHN's response to work overload and how that carried over into her home life as well as how her response was to stop caring:

PHN 1: So we're going into *coping mechanism mode* and that's where some of the things we've talked about already where *time's cut down*, why we want to know about the *future holds* because you know you feel ... you go home... Every day we leave not feeling accomplished. *Not with clients* but you *never feel* like you're ... you *never feel* you've done what you needed to do.

PHN 2: Or *never* caught up.

PHN 1: And that's a *horrible* feeling right now.

PHN 2: You wake up in the morning thinking of all the work you're *not* going to get done.

PHN 1: Yeah, and you stop caring. You go, oh well.

PHN 2: You know hyperventilating thinking of all the work that I'm not going to get done because I have the four visits or whatever... Sunday night to Monday, I have a terrible sleep. I do because that's what I'm thinking. (FG-03)

When PHNs felt overwhelmed, it was often their personal life and family members who suffered. PHNs would comment that they felt they “had nothing left to give” either to their clients or their families.

Realities of a high-risk population.

In addition to the workplace demands, working with a young, high-risk, vulnerable population brought personal and ethical challenges. Bearing witness to the daily struggles of these young client's challenged the PHNs' own sense of balance between social responsibility and nursing obligations. One PHN expressed her own struggle between professional and personal roles:

How do you leave without giving them some money? And I know I'm not supposed to and I cannot but... am I that horrible a person that I can walk out an apartment building when this young woman has no food and I can just go on my way? I struggle with that. (PHN FG-02)

Emotional impact.

When describing some of the emotional impact of the work, PHNs often used terms such “weighed down,” “drained,” or of needing an outlet to “dump” their emotions. These descriptive terms reflect a physical act of carrying something with them and the PHNs needed an appropriate strategy to manage these feelings and experiences. PHNs identified several challenges that limited their ability to work through and understand the impact that this type of nursing work has on them. They explained that due to standard PHN-client confidentiality agreements that they are limited to discussions within their team. Furthermore, these PHNs perceived that it was difficult for individuals, including family members or friends, who do not do this type of work to fully understand the nature and extent of an intense program of home visiting with a vulnerable population, the workload demands and the emotional impact subsequently experienced by the PHNs. They also related that debriefing with non-NFP PHN colleagues was challenging, as those not in NFP, “just don't get it.”

Graduation.

During the last four months of the NFP program, visits occur monthly and the focus shifted towards preparing for graduation. Within the curriculum guidelines, PHNs started to engage in discussions with clients about the relationship coming to a close and reflecting on the progress made since the start of the program. For many clients, the end of relationships were negative experiences so this was an important component of the guidelines. The PHNs particularly valued having the tools and the vocabulary to discuss a positive ending of the relationship. The switch to monthly visits allows the client to experience a longer time interval without the PHN prior to graduation. For some PHNs, they felt that graduation might be harder on the PHN than the client and described going through a grieving process. Disengaging with the client after they had been actively involved with their client and child for over two years was difficult and they were often left wondering how their clients were doing. One PHN shared her experience around graduation and her own reflection on letting go:

These four visits of saying goodbye has been *hard* in some ways and emotional to say ok I have to say goodbye to this girl who's done amazing work. But to look back and say well we did that or I was able to facilitate that and *now I've grown enough not to hang on*. I can *back away* and say *fly*. (PHN FG-04)

For this PHN, while this graduation may have been emotional, she recognized the client's progress and her role in the relationship was done. However, given the tumultuous nature of some of their clients' lives, crisis was a near constant. PHNs experienced an internal battle between feeling the need to help the client through a crisis and starting to disengage to allow the client to manage on their own with the strengths they have built throughout the program. This PHN described a challenging graduation with a client:

I've really struggled because in those last few months I've had to deal with different types of crises that come up... it's stuff out of the blue, that's totally different than what we've even dealt with, miscarriages of second pregnancies, threatened apprehensions ...You're in crisis. I don't walk out when you're in crisis. ... you've gone through too much. So we never really in a sense have a celebration at the end, it's like whew ok you, made it through the crisis and you're in a better place and now you're moving forward and now I step out. (PHN FG-05)

For some of the PHNs, the challenge around graduation can be captured by their need to "fix things," to send them on their way with all issues resolved. However they acknowledged this was not realistic.

Recognizing that clients were responsible for their decisions was a difficult, but necessary, process and ultimately PHNs needed to make peace with this idea. This PHN shared how she reframed her view of a

client in crisis:

There are going to be issues that are *ongoing* ... my client who just got arrested on Friday night who is being discharged at the end of this month, from where she was, great successes...when I spoke to her Monday morning had *all* these supports *already in place*, which 2 years ago she wouldn't have been able to do. So, although this has occurred she has made progress. And so I have to let go of *fixing* everything by the end and just focusing on those successes. (PHN FG-05)

Some PHNs reported the experience of clients not even being present at graduation. This withdrawal or “fading away” as one PHN described may have been easier for the client rather than facing a goodbye. However, the PHN was then left with a lack of closure and without the opportunity to say goodbye.

Changing definition of success.

One common concept that PHNs embraced and found supportive throughout the program was their changing definition of success. The measure of success needed to be constantly redefined and personalized for each client. A strengths-based approach with clients meant that the PHNs focused on providing something positive with each client, on each visit. On some visits PHNs struggled to do this and for some clients success for that day was simply agreeing to the visit or getting dressed. For other clients success may be liaising with a community program or going back to school or work. Recognizing success that was personalized to the particular client allowed the PHN to see progress in a realistic way.

Rewards of delivering the NFP.

Despite all of the professional and personal challenges, PHNs also described enjoying coming to work, and loving their job and as one stated, the NFP was “so much more than a job” (PHN FG-03). Multiple factors, from the design of the program to client success stories fueled this sense of job satisfaction. PHNs saw positive outcomes with their clients, such as healthy infant attachment, increased rates of breastfeeding, decreased smoking rates and clients returning to work or school. They were in a role with more flexibility and scope compared to existing home visiting programs and they felt they were in a position to actively advocate for their clients.

Forming relationships with individual clients, and then seeing them improve their circumstances over time kept the PHNs motivated and engaged in the program. Even when discussing the many challenges, PHNs were also careful to separate out challenging circumstances as separate from the client.

Often, it was the situations and living circumstances the clients were in as well as workplace pressures, rather than the clients, themselves that PHNs found stressful. One PHN commented that she was very quick to defend her clients when offhand or stereotypical comments were made. Other PHNs echoed this sentiment and came to realize that many of the assumptions they had held themselves about this population were simply not true. This PHN described her sense of gratification both personally and professionally with one client:

It is very *gratifying* when you are *introduced* to their friends... this is *my* nurse. ...This is just a constant thing that sort of warms the heart I guess but to feel that, that you've *elevated* ... the nursing *role* or whatever that this is, that this is truly something *special that's happening* between us, that *the* nurse as far as our *status as a professional is important*. (PHN FG-01)

Formal and Informal Support Mechanisms for PHNS

Within their practice, PHNs identified strategies to manage the stresses and emotional responses arising from their work. Strategies including team meetings, case conferences and reflective supervision, are part of the NFP model elements (Nurse-Family Partnership, 2011) while informal peer debriefing occurs naturally among team members. Although field supervision was a required NFP model element, PHNs in the focus groups did not mention this. PHNs also adopted individual strategies outside of work to manage their stress.

Team Meetings and Case Conferences

Team meeting and case conferences were required model elements of the NFP with the goal of providing PHNs with an opportunity to discuss client cases, and receive support and guidance from their peers and supervisor. As PHNs did not clearly differentiate between case conferences and team meetings in the focus groups, those will be considered together. As health division content was often presented at weekly NFP meetings, PHNs stated that this took time away from NFP content. They felt that while the division content was important it could be disseminated in other ways, such as e-mail, or presented monthly rather than weekly. This PHN expressed her frustration

I have to say half the time not even *relevant to our work* because we're getting these *updates* on *every little thing* that's going on in our division. Updates are great, but when you're getting it on a weekly basis, it's completely overdone. You get by email and then you have to talk about it... and then people get *off on tangents* and *off on topics* and the *stuff* that I *want* to get out of my team

meeting or that case conference ends up being washed out ... just there's *so many* things that are standing items on our agendas that really don't need to be there. (PHN FG-03)

PHNs expressed the need to streamline weekly NFP team meetings, institute a decreased focus on administrative tasks and more discussion around practice issues in the NFP. Meetings that were perceived as inefficient added to the PHNs' frustrations, sense of wasted time and task burden. PHNs reported that they were attempting to modify the meeting structure however the results of this effort were not reported in the focus groups.

Reflective Supervision

Within the structure of the NFP, one of the supervisory mechanisms for providing support was reflective supervision, a one-hour scheduled weekly meeting between the PHN and supervisor (Nurse-Family Partnership, 2011). Reflective supervision allowed the PHN the opportunity to examine her own emotional responses to client encounters and how this influenced future practice decisions. The PHN was assisted in the application of the program foundational theories through discussions in the reflective sessions and this among other mechanisms, such as case conferences, assisted with professional development (Nurse-Family Partnership, 2011).

Supervision focus.

The PHNs suggested that they supported the concept of reflective supervision, and found that supervision was most effective when the sessions did not have an administrative or clinical focus. With the session being scheduled, PHNs had the assurance of knowing that a set time was available to them, however this lacked an immediacy to address issues that arose unexpectedly. One PHN, who was initially reluctant to share her personal life experiences, found that she was able to further understand how stresses in her personal life were impacting her at work through the reflective process. PHNs further reflected that having an understanding of themselves was important when engaging with clients and helped them to understand some of their emotions and relationships. PHNs needed a supportive environment for debriefing, discussion and reflection and recognized the importance of not always having to rely on the team to supply this support. One PHN shared her perspective on her experience of reflective supervision:

We have to *meditate* or we have to *debrief*, we have to *calm* ourselves down because it's *tough out there*. If I didn't have a supervisor that let me *dump it* or, or *share it* or ... Like you almost have to *divest* yourself of it, to *shake it off* to say *I* had a crummy day today and *I* don't know what to do with *this*. And I don't want to always dump it on my colleagues but where do I dump it? ... But I think it's a very necessary process with this emotion to understand *what* is this all about and *how* can I be more effective. (PHN FG-03)

Time constraints.

Time constraints, on both the PHNs' and supervisor's part, often resulted in shorter supervisory sessions forcing the PHN to focus on urgent matters, which shifted the tone to more of advice-seeking rather than an emphasis on reflection. When PHNs were pressed for time, reflective supervision felt like another task to be completed rather than a support. As one PHN shared, she sometimes had the feeling afterwards: "I come out to all the work that I have to do and now I've just lost an hour plus ... and I'm *totally drained*" (PHN, FG-03). When the session did not provide a restorative function, it actually added to the task burden of the PHN.

Barriers to effective supervision.

Despite the perceived benefits of reflective supervision, barriers were noted in its use and acceptability. Taking time for reflective supervision, as well as when the meeting occurred relative to an a difficult visit, surfaced as limiting factors in addition to the individual PHNs comfort level with engaging in personal reflection within the structure of a PHN-supervisor/manager relationship. As the nature of this relationship was vastly different from past experiences, it was suggested that both the PHNs and supervisor needed to adapt from previous patterns and learn the reflective process as practiced in the NFP.

Although reflective supervision was a requirement of NFP, how PHNs approached the sessions and their individual comfort level around engaging in this process with someone in a position of authority differed. Some used the session to seek advice on a particular situation for example, to seek out information on community programs, whereas others were more comfortable sharing personal experiences. For one PHN however, linking personal and professional realms was not supportive to her:

When there's been attempts to bring in what's happening with my own family, I actually feel *uncomfortable* with that because, I'm trying to keep that *separate* from so that I'm *not* prejudice against ... I've really kind of *struggled* with, with how to use the supervisory sessions (PHN FG-03)

The sentiment illustrated by this PHN suggested that a sense of trust must be established and this process

was different for individual PHNs. The relationship between the PHN and the supervisor, just like that of the PHN and the client, needed to be built over time for reflective practice to be effective.

Informal Peer Debriefing

In addition to the require provision of reflective supervision, PHNs also adopted their own informal mechanisms for managing work-related stress. Debriefing with colleagues was a routine, essential and potentially subconscious practice. PHNs commented that working in close physical proximity to their colleagues allowed for timely debriefing. They also had the assurance that their colleagues understood the nature of the work in a way that other public health colleagues or family did not. For some, debriefing with colleagues was a more effective, timely and comfortable way to engage in reflection. One PHN shared her use of reflection with a team member with an emphasis on the importance of the immediate availability of a colleague:

I think we use our team members more for the *reflection*. I think we tend to gravitate toward a team member that we're the most comfortable with to kind of *delve* into that really the emotional reflection side. ... I often do it when I come back with whoever *there* with a *team member*. Because I think that the emotional side to the reflective practice happens more immediately *after* the visit that's affected us versus waiting for whatever. (PHN FG-03)

However, a heavy reliance on the team for support may present a burden to team members who are struggling to manage their own challenges. As one PHN stated, she was well aware of the needs and benefits that debriefing met for her but also at a potential cost to her colleagues:

The intensity of the program *has to be shared*. It's the *only* thing that saves your *sanity* because otherwise you get *totally* drawn into your clients and that's the only way I *get myself out* is to *talk it out* and *distract* the heck out of everybody as I do. (PHN FG-03)

Individual Stress Management Practices

Struggling to maintain work-life balance was a common theme among the PHNs as was the challenge to be present for both clients and those at home. One PHN shared her desire to be more intentional with forgiving herself for choices made at work and to not carry that home with her. Learning to say no to additional tasks or demands, and being realistic about what could be reasonably accomplished in a given time were also helpful strategies. As one PHN reflected, her sense of work-life balance was somewhat more ingrained:

I have a bit more *self-preservation* than some of my colleagues. I will actually just cut a visit short sometimes. I've got to get home. I've got other things to do. And if you were to see my charting it's like you know doctors are recognized for their terrible writing and my charting is *appalling* and the *paper* version it's a not a priority for me. (PHN FG-03)

Expressed Need for Additional Support.

Within the discussion around stress management, PHNs expressed the desire for additional support mechanisms. An annual retreat and occasional team lunches were mentioned, with the caveat that the PHNs are not required to plan them. Continued workshops on compassion fatigue were also stated to be helpful. Further support requested by PHNs came in the form of additional resources for the program, such as funding for graduation to provide cards or some small token of celebration for their clients. From a general workplace perspective, PHNs were aware of the irony of preaching the gospel of self-care but not being able to practice it:

How many times have we said we're not walking the talk when we're telling our clients about self-care and emotional refueling and what the heck do we do to ourselves? And, and our sick time just, just look...I get really upset about this because I'd like somebody to do an analysis of our absenteeism rate that first year because we were, we were *physically ill* we were so stressed. (PHN FG-04)

PHNs recognized that working in the NFP was challenging on many different levels and program supports should be built into the program from the beginning to promote long-term success and sustainability.

Long-term Perceptions of Delivering the NFP

As the focus groups were conducted over the span of the pilot, PHNs' perceptions shifted over time as well. As the PHNs were new to the NFP program, they were simultaneously learning the program and delivering it. However, over time there was a natural evolution as PHNs became more comfortable and familiar with the content as well as the other nuances of the program such as documentation. After the completion of the NFP cycle, and graduating their first cohort, PHNs were asked to reflect on their entirety of their experience delivering the NFP. PHNs shared client success stories, feelings of pride and acknowledgement and appreciation of client's strengths as well as some of the challenges of letting go. Within this discussion there was less emphasis on some of the issues mentioned in earlier focus groups, such as problems with documentation and day-to-day work frustrations.

Elements that stood out for PHNs were the relationship, length of time in the program and consistency of care for their clients. Having the benefit of perspective, and having the experience of clients leave and return, PHNs saw how the strength of the NFP program impacted their clients:

I can think of the two clients that I've had that have been extreme high-risk situations of things that I would never even ... you'd think you'd see in a movie. But *they know* even though ... we haven't always agreed they know there's a *benefit* and eventually when we get through our struggle there's a *benefit to me being with them*...there's going to be *benefit* to coming back to me. So even though they drop off, they do their thing, they'll come back and so it's like two steps forward, one step back but there's always a move forward. (PHN FG-04)

At the start of the program, PHNs were aware of the potential for positive outcomes with young clients based on the research and outcomes produced by the NFP in other locations. Now that PHNs have experienced the theories they initially appreciated on paper, they remained steadfast in their support for the program and their ability to alter the life course of their clients. As one PHN expressed:

This program has really *helped* me to understand what it really means to have a trusting relationship. You know we talk about rapport, we talk about trust but this program you, you only realize that you have to be in there's *so many times and for such a lengthy period of time* for these clients to really take what you say and use it. Because you know *before* we would just talk and I think it would go in one ear and out the other because you didn't have that ... that foundation. But *now* you know you can get to really, really *heavy, core issues* that they're dealing with. So I think that's how it's transformed me and transformed them just that understanding of what that trust really means. (PHN FG-04)

Remaining Questions

While the secondary analysis of the focus group data revealed a wealth of information about PHNs perceptions of delivering the NFP, the depth of analysis was limited to the data previously collected. The nature of the questions in the focus group were intended for a different purpose, which also bounded the scope of the data. To overcome this limitation, individual interviews with all past or current NFP PHNs were subsequently conducted to expand upon the themes identified in the secondary analysis as well as explore new questions that have arisen.

Areas that required further exploration were: 1) further exploration of facilitators and barriers to the PHN-client relationship; 2) how the philosophy of the NFP has altered how PHNs saw their role with clients; 3) how the NFP changed relationships with other service providers; 4) challenges in delivering the NFP at the program and personal level; 5) how challenges varied throughout the different phases of the

NFP program; 6) impacts of the program on the PHN personally and professionally; and 7) nature of the transformation that PHNs have experienced in the NFP.

While many of these themes have already been introduced within the context of the focus groups, the individual interviews allowed for an increased depth of exploration of these topics. The major themes identified formed the basis for the development of the semi-structured interview guide. As not all the PHNs answered each question in the focus groups, this allowed each one the opportunity to express their experience. PHNs that subsequently joined the NFP after the completion of the NFP pilot study, were also invited to participate in the second phase of this study. Further, a practice, problem and needs analysis was conducted by asking PHNs how they were currently practicing, what problems they were facing, and what was needed to overcome them.

Phase 2: Analysis of Semi-Structured Individual Interviews

Demographics

The total population of past and current NFP PHNs in Hamilton (N = 10) consented to participate in semi-structured individual interviews providing a 100% response rate. This population included the six PHNs who participated in the focus groups as part of the feasibility and acceptability pilot, four of whom were still active in the NFP, as well as four additional PHNs who had since been hired to deliver the NFP. At the time of the interviews, PHNs were an average age of 42 years (range 26-66). Participants had an average of 18 years (range 4-41) of nursing and an average of 10 years (range 1.5-30) of nursing in public health. All PHNs had previous home visiting experience with the HBHC program representing an average of 4 years (range 0.2 -12). PHNs had on average enrolled 24 clients (range 9-50) and six PHNs had the experience of graduating an average of 12 clients (range 4-15). The remaining four PHNs had active caseloads but had not yet graduated any clients. PHNs had a minimum of a bachelor's degree in nursing and one PHN was pursuing graduate studies.

Phase 2 Findings

Interview data from the individual interviews are presented in three segments. The first, delivering the NFP, describes organizational or structural requirements of the program. The second, individual experiences of adjusting to working in the NFP are presented in transitioning to the role of NFP PHN while

the third segment summarizes support strategies. Within each segment, a practice, problem and needs analysis as outlined by van Meijel et al. (2004) was done. A summary of major themes within each segment is presented in Table 2.

Table 2
Summary of Practice, Problem and Needs Analysis

Category	Area of Analysis	Sub-categories
Delivering the NFP	Practice	PHN Education Home visiting Documentation Team meetings/case conferences, reflective supervision
	Problem	Lack of community Workload and time demands <ul style="list-style-type: none"> • Scheduling • Driving time • Documentation • Team meetings/case conferences, reflective supervision
	Needs	Time Consistent orientation and formal peer support/mentoring Ongoing professional development and education Increase in workplace efficiency (minimize driving time, efficient documentation system, dedicated administrative support, improved efficiency of team meetings/case conferences, safety in reflective supervision)
Transition to NFP PHN Role	Individual PHN Practice	Building the therapeutic relationship Redefining success Shifting to client as expert Using the NFP education
	Problem	Concern for clients Working up to a visit/Nothing left to give Impact of doubt/Did I do enough? Emotional and physical impact Client Graduation
	Needs	(see support section)

Support in the NFP	Individual PHN - Practice	Satisfaction in the NFP <ul style="list-style-type: none"> • Therapeutic relationship • Making a difference • Learning from clients Individual coping strategies <ul style="list-style-type: none"> • Boundary setting with clients • Reflecting on practice • Managing self-expectations and letting go • NFP evidence as support • Engaging in self-care activities
	NFP Program Support - Practice	Informal peer debriefing
	Problem	Burden of peer debriefing
	Needs	Culture of safety Validation and formal preceptor

Delivering the NFP –Practices

The NFP is a structured nurse-home visitation program. In the program model, there was a suggested schedule of visits for PHNs to consider when planning their work with clients; however the program also provided flexibility to negotiate visits, based on the family’s needs, priorities and availability. PHNs were responsible for scheduling their own home visits, driving to meet with clients as well as completing all required documentation.

NFP Education

PHNs who were part of the initial pilot attended the NFP nurse education program at the National Service Office (NSO) in Denver, Colorado. As this was a program new to Canada, these PHNs also had the opportunity to shadow experienced NFP nurses on their home visits in Pennsylvania, U.S. The initial cohort of six PHNs were all hired and trained together. PHNs who were subsequently employed to work on the NFP team, were hired at different times in the replication phase and reported initial orientation experiences that ranged from attending the nurse education program in Denver, job shadowing local, current PHNs to no formal orientation.

Home Visiting

The NFP model of practice recommended that PHNs home visit clients weekly for the first four visits, then bi-weekly through the remainder of the pregnancy. PHNs visit weekly in the post-partum period, then transition to bi-weekly visits. In the last four months of the program, prior to the child's second birthday, PHNs reduced their visits to monthly although the schedule could be adapted based on client needs and availability. PHNs used their own vehicle to drive to client's homes for visits and reported spending significant amounts of time on the road and away from the office. PHNs had clients at various phases of the program and carried a full caseload consisting of 20 clients. When clients missed or cancelled appointments PHNs attempted to reschedule when possible. Often clients were only available outside working hours and PHNs reported a range of willingness to schedule visits into the early evening. No weekend visits were conducted.

PHNs often faced the challenge of locating clients that had moved or were not home when the PHN arrived for a home visit. PHNs connected primarily with clients through cell phones and text messaging but many clients would lose their phone, change their number or run out of cell minutes. To locate clients, PHNs used a variety of strategies including contacting Children's Aid Society (CAS) social workers, the office of the client's family physician, or other known contacts in the community. If they were unable to locate the client, the file remained open and the PHN waited until the client re-initiated contact.

Documentation

PHNs completed required documentation using both on-line and paper-based formats. As the NFP was a research-based program within an existing structure of the provincial home visiting programs, information was collected for multiple end-users. Documentation was required for the NFP program, the Ontario Ministry of Health and Long-Term Care and the local public health unit. As these systems were designed independently and remained separate, there was significant duplication of charting across the different systems. An infrastructure to chart remotely was not in place and as a consequence PHNs reported frequently being behind with their documentation.

Team Meetings, Case Conferences and Reflective Supervision

Although the actual role of a PHN involved delivering the program as an individual, they were still part of a greater NFP team, consisting of other PHNs and a supervisor. The NFP program required PHNs to attend and participate in regular case conferences, team meetings and weekly reflective supervision sessions to promote program delivery with fidelity to the NFP model as well as a means of support.

PHNs described spending a significant portion of their time in meetings. One morning per week was devoted to either team meetings or case conferences. However, as the monthly Family Health Division meeting, a joint meeting with other home visiting and child/reproductive health teams within the department, coincided with the NFP meeting schedule, this effectively brought the number of exclusively NFP team meetings to a monthly schedule.

When speaking about reflective supervision, PHNs described using the sessions to serve a variety of purposes such as an opportunity to seek advice on community resources, to ask questions around policies or procedures or to update the supervisor on the status of clients. There was consensus among the PHNs that the reflective practice sessions involved limited discussion of, or reflection on, the emotional experience of delivering the NFP. While some PHNs desired the opportunity to reflect on how personal histories or experiences were influencing current relationships with or responses to clients other PHNs were not comfortable engaging in this type of discussion with a supervisor. PHNs disclosed that often support was received from fellow NFP team members first, partially as a result of their immediate availability, physical proximity in the office and their intimate familiarity with the nature of the front-line experience. If issues were not adequately resolved within the team, those issues were then brought up in reflective supervision. PHNs had a tendency to carefully filter or select what issues to discuss in supervision depending on what they needed out of the session.

Delivering the NFP – Problems

Lack of Community

Compared to new PHNs starting in an established home visiting program, PHNs and the supervisor in the pilot NFP learned the program without the benefit of on-site, experienced colleagues. Given the value of support and validation that an experienced colleague provides, PHNs had to navigate learning the

program without this. While PHNs who have joined the team since the pilot have experienced PHNs to rely on, they did not have the benefit of a consistent or formalized orientation program. Even with the experienced PHNs fulfilling a preceptorship role to their new NFP colleagues, this was still a very small community of support. One PHN described that she felt that the support available to the US NFP sites, such as an on-line community, was not available or offered to the Canadian site. She shared one example of how this virtual community could have provided validation and alleviated some of the pressures PHNs placed on themselves with respect to a particular clinical situation:

We perceived there's a *huge* surge in [clients] getting pregnant for a second time while you're involved and *really* feeling like that was *our fault*...And then we learned some of the *statistics* ...it would've been part of being on the online community...Our rate was almost the exact same as the *average* across the US. So even though we felt like we had this huge surge and we are doing something that we shouldn't be doing and not following the program because if we were this wouldn't be happening, well the *reality* was we were doing the *exact same*. We weren't the island. But we weren't *offered* that or *given* that, and I don't know *why*. (PHN 006)

PHNs also discussed a willingness to act as support to the PHNs in the NFP RCT that was starting in British Columbia, as they recognized the benefit of creating this community, however there has been little communication between the programs.

Workload and Time Demands

Workload and time pressures were the most commonly cited sources of stress among the PHNs. Particular contributing factors were scheduling and rescheduling of home visits, a large geographical coverage area resulting in high driving times, documentation, coordinating a full case-load, and inefficient team meetings. For PHNs who did not find reflective supervision supportive, this added to their sense of time pressure.

Scheduling.

With home visits being the main purpose of the NFP, PHNs prioritized these over other workplace demands. However when clients cancelled or missed appointments, rescheduling created an additional time burden. PHNs were under constant pressure to deliver the program with fidelity to the evidence-based model elements and program guidelines. PHNs were conflicted by a gap between delivering the program and what was achievable with competing demands on their time. One PHN shared her perspective on this:

We're expected to see these clients on this *guideline* or this *timeline* and yet still have 20 clients. Supposed to be *flexible*. Supposed to see them *all*. Can't work weekends. Don't work evenings, which I wouldn't want to anyway. But sometimes we *do*. I mean we work out in the community sometimes until 5:30, 6:00 where other programs wouldn't do that. So that's a *huge* barrier. That's a *huge challenge*. And then it goes into your home life. (PHN 002)

The clients' changing schedules throughout the program, such as when they return to work or school, presented an additional challenge. With some clients only available in late afternoons or evenings PHNs had to choose how to navigate this. For some, the end result may be shorter, or possibly missed, visits while still maintaining their standard work hours. This PHN, however, found that she was frequently conducting home visits in the evening and despite the option of taking that time off elsewhere, that did not happen:

I think that it needs to be noted somewhere the ongoing challenge of the *work-life balance* because the expectation of the program is we meet the client where they are. The *where* they are and also the *when* they are...that was never an expectation of previous home visiting programs, there was definitely boundaries about time... the flexing of your days and you're doing evening visits ...definitely is an issue around work-life balance. And in theory you take that time *back* you know and flex it or whatever, reality is *there is no time* because there's not enough hours in the day as it is to get what you need done, done. (PHN 007)

PHNs expressed feeling torn between balancing their own time and the expectations of the program. A few PHNs shared that they felt pressured to extend home visiting hours beyond the standard business day to ensure they were following the visit guidelines, unlike expectations of other home visiting programs. Communication with clients was a time consuming task, and PHNs reported the clients frequently moved or ran out of money or time on their phones.

Driving time.

Adding to the time demands of locating and visiting clients was the large geographical area covered by the program. The main office was located in an area removed from the majority of NFP clients. PHNs reported long driving times and periods of 'wasted' time between visits that were not long enough to return to the office but could not be used effectively for completing tasks such as documentation as this could not be done remotely. At the time of writing, a move was pending to an office location that was closer to areas where clients typically live.

Documentation.

PHNs stated that the documentation process was inefficient, time-consuming and resulted in multiple entries for similar information, yet there was also the recognition of the complexities of capturing

or measuring program outcomes. One PHN described her perspective on the challenge of capturing elements beyond tangible outcomes, particularly during the time frame of the program:

*We still see that pressure that the success of the program can only be qualified and quantified if you check off, for lack of a better word, boxes on a page which is service plan goals. If you haven't said that you have met X, Y, and Z on this online documentation essentially to funders, the ministry, it hasn't *happened* ...But the fact that if you can't put it on paper, and to some extent that's true because how do you describe the feelings you get out of the long-term relationship in seeing numbers and cents and dollars and providing funding for a program if you can't have really concrete *outcomes*. (PHN 006)*

She further pointed out that follow-up in the US RCTs extended many years after the NFP was completed. Her concern was that some of the benefits of the program may not be observable or measurable during the program delivery phase of the NFP and that further evidence for program effectiveness or positive outcomes over time would not be tracked. Documentation was a combination of paper and on-line-based programs so PHNs were limited in what they were able to complete when off-site or in their car in between visits.

Team meetings and case conferences.

PHNs reported that team meetings and case conferences were often a frustrating experience due to unclear meeting objectives and varying expectations among team members. Some PHNs shared reflections that on occasion, meetings were used as a venting opportunity and this had the effect of decreasing team morale. Although PHNs still wanted to be part of the greater public health department there was the challenge of how to present department-specific information that was not directly applicable to the NFP PHNs. This information was reported to occupy a disproportionate amount of time at meetings, which further frustrated the already time-limited PHNs and limited their opportunity to address program-specific concerns.

Reflective supervision.

Given the time demands and pressures of both roles, the supervisor and PHNs scheduled reflective supervision in advance, which may not coincide with when support was actually needed. As one PHN shared, there were occurrences when she did not feel it was the right time to engage in reflection, but as the session was scheduled, attendance was required:

Because situations are not consistent I would say that the reflections are not consistent. I mean sometimes, I'm thinking I'm not *ready to reflect* but I still have this appointment so I have to reflect on something. Because it takes *time to process* some of these things ... So you book the appointment. You're committed. (PHN 007)

As this PHN alluded to, situations were constantly evolving in the clinical world and thus the need for support also varied. The pressures and challenges of scheduling made reflective supervision less flexible to meet PHNs support needs during times of crisis. PHNs also expressed a range of comfort with disclosing personal information with the supervisor in reflective supervision. This PHN explained her view on this issue:

I think a part of it was it's very difficult to have a person you consult on cases with be your direct supervisor, the person that's going to fill out your performance appraisal...I'm thinking a sane person shouldn't be telling the supervisor some of the *struggles* that you might be feeling because it is a direct person you report to... So having somebody that you can go into a meeting with that *doesn't* have that hat on so you can honestly have a good cry and say this is what I did, I'm pretty sure it wasn't the right thing to do, or I said this and now in hindsight I wish I had said that. (PHN 003)

For those PHNs who were comfortable with this, they desired an increased focus on the emotional, rather than the policy or clinical, aspect of delivering the NFP.

Delivering the NFP – Needs

Time

In addition to having a structured orientation or initial education program, one of the most commonly expressed needs for PHNs was time – time to practice and integrate new skills, as well as time to become familiar with new or changing program content. One PHN reflected on her initial experience and what she found useful:

So *time* needs to be dedicated to *practice* these skills, to review the material. It needs to be formal training. It can't just be read a textbook...The time we spent in Denver was *invaluable* because we had 3 days of practicing how to do that and listening to people that have been doing the program for awhile and hearing their experiences. So I think that's a *real* huge thing that really needs to stay. Time to *train*, time to *observe*, time to *debrief*, and time to *practice* cannot be done instantly. It needs to be there. (PHN 003)

Regardless of the initial education received, there may be a long gap between when guidelines and program content were reviewed and when they were actually used in practice. PHNs, particularly those newer to the program, expressed the need for time to become more familiar with program content as the program carried on, especially in light of program changes. This was expressed among some of the newer PHNs who for

their first cohort of clients were essentially learning the program guidelines and content as they went in addition to ongoing application of newly learned skills. As this PHN related:

Some of those PIPE [instructional tool for parents] kits, doing examples and demos in your team meeting on it worked because we would get instructions but I'm not a creative person, what do I do with these popsicle sticks? You had to problem solve on your own. There was no support for that. All of it, you grabbed your kit and in the car as you were driving you were looking through it because there was no time to prep. You were trying to look through to say ok well what can I do with this to go deliver it? So having more *time* instead of just running from visit to visit and then run back to the office to *chart*. Give me time to actually practice it and learn it and get *comfortable* with it. The stuff is constantly *changing* so I need constant time to keep up with the constant change. (PHN 003)

Other PHNs also echoed this sentiment, that having more time to prepare for and review specific aspects of the guidelines and activities would improve their ability to deliver the NFP.

Consistent Orientation and Formal Peer Support

PHNs stated a need for a consistent orientation program for new staff. Assigning an experienced colleague as a preceptor was also suggested as a possible source of support to new staff.

Ongoing Professional Development and Education

Ongoing education and professional development was identified as a further need. PHNs had recently received education on intimate partner violence (IPV) and described this as a useful endeavor. Opportunities to practice and refine skills such as motivational interviewing would also be welcomed. PHNs identified mental health assessment, screening and local referral options as well as increased knowledge on substance use as areas for further education. PHNs also expressed a desire to offer the NFP to multicultural clients however the current curriculum is limited to English. One caution however was that the volume of additional or ongoing education be carefully balanced within the context of the PHNs existing workplace demands and should serve a supportive function rather than an overwhelming one.

As PHNs hone their knowledge and skills over time through practice and experience, PHNs who worked part-time were at a disadvantage. Not only were there fewer opportunities to conduct each specific home visit to become well versed in the program content, part-time PHNs also had less contact time with their peers and reduced opportunity for support. The consensus among many of the PHNs was that working full-time was recommended.

Increase in Workplace Efficiency

Minimize driving time.

While workload and time pressures were not exclusive to working in the NFP, PHNs offered suggestions to improve efficiency such as an office located closer to where their clients were. A move to a more central location was pending at the time of writing.

Efficient documentation system.

PHNs needed to spend less time documenting on multiple systems and desired one integrated, streamlined system reflective of the program they were delivering. To optimize efficient use of time while out of the office, PHNs would benefit from the ability to document remotely.

Dedicated administrative support.

PHNs reported spending large periods of time photocopying and preparing paperwork for home visits. PHNs recommended dedicated administrative support to assist with these tasks and to assemble the activity packages used in some visits. Lack of supplies for these activities added to PHNs frustrations and ensuring adequate supplies would resolve this.

Improved efficiency of meetings.

PHNs recognized the potential of team meetings and case conferences to provide both an educational and support function, however in practice this varied. At the time of the interviews, PHNs had identified that improvements needed to be made and were actively trying to brainstorm strategies to address this. This PHN recognized the potential for meetings as a platform to bring forward the skills and strengths of other team members:

I like the fact that there's opportunity to have weekly meetings as a team. I'm not convinced that those meetings are as productive maybe as they could be...There's some really smart women on that team with a lot of valuable experience and I think that that's *underutilized* in the team setting. (PHN 009)

PHNs needed to feel that meetings were focused on NFP content and provided opportunity to seek feedback related to challenging cases from experienced colleagues and the supervisor. While material related to the Public Health department was required to be disseminated at meetings, PHNs stated that keeping this to a minimum or utilizing other distribution methods should be considered.

While team meetings and case conferences allowed for a group discussion of a particular issue, reflective supervision was designed for an individual focus with discussion and exploration of emotional responses to difficult work. All of the PHNs stated that they faced challenges and felt an emotional impact of working in the NFP however not all were comfortable discussing those issues in reflective supervision. PHNs needed to feel safe sharing their concerns about emotional responses or doubts about nursing practice without fear that it would impact their performance evaluation. Suggestions were made to conduct the reflective supervision process with someone removed from the management hierarchy. Several of the PHNs stated that they were aware that some US-based NFP programs hired a psychologist to provide support and they felt this would be beneficial to them.

Transitioning to the Role of NFP PHN – Individual PHN Practices

Beyond learning program content and meeting logistical requirements of delivering the NFP, PHNs altered or adjusted their nursing practice to fit within the theoretical perspective of the program. While all of the PHNs had HBHC home visiting experience, the range of other previous nursing experience varied from the hospital setting to other public health positions. Some PHNs' home visiting experiences involved delivering single postpartum home visits whereas others had many years with a generalist focus (e.g. mental health, home care). Despite variations in individual personalities and previous work experience, PHNs described common practices in transitioning to the role of a NFP PHN. Fundamental to the successful individual transition to this role of was the embodiment of the philosophical framework, or the spirit of the NFP, most notably that of self-efficacy. While the concept of self-efficacy is not unique to the NFP, it is the foundation of the education and the structure of the program. PHNs reported they were constantly evaluating their own nursing practice to ensure that interactions with clients stemmed from this philosophy.

Reflecting on their experiences delivering the NFP, PHNs discussed overt and subtle shifts in their individual professional nursing practice. To effectively deliver the NFP, PHNs were 1) building a therapeutic relationship; 2) redefining success; 3) shifting to client as expert; and 4) using the NFP education.

Building the Therapeutic Nurse-client Relationship

PHNs were unanimous in the recognition of the therapeutic focus of the nurse-client relationship was the foundation of the NFP program. They acknowledged that building and maintaining relationships with this population of young mothers was inherently challenging and appreciated the NFP program elements that allowed for this relationship to build over time. In particular, PHNs commented that the schedule of visits, enrolment early in the pregnancy and long-term involvement allowed for the relationship to form at a pace that fit with each individual client. A common theme noted among the PHNs was the variability in their clients' willingness and ability to form trusting relationships. The consistent presence of the PHN over time was in itself, a relationship-building strategy. As this PHN shared, a client's ability to engage in a relationship at all, was in her mind, a success:

For them to be able to have a positive experience, a relationship with someone, where they were opening the door for you week after week, that in itself was a huge, personal goal for them to be able to let somebody in. Because there's no reason these women should really trust people when ... you look at their histories. So I felt *privileged* to be allowed in and I valued the relationship and I know they did too. (PHN 009)

There was consensus among all of the PHNs that the relationship with their clients was intensely valued and was a key contributor to their work satisfaction.

While the PHNs consistently described the value they placed on the nurse-client relationship, they also readily acknowledged these relationships were often difficult to maintain. The education and approach of the NFP helped one PHN navigate the potentially volatile relationship:

I know there was a couple of clients that when I became involved clung to me at the beginning and they loved me and then they would hate me and then they would love me and then they would hate me ... I think the big difference in that trust and the reasons some of the relationships evolved was again because of the *training* that we received. I was never enforcing my views of what I wanted them to be. It was more so *guiding them through* whatever their goals were. (PHN 003)

The ability to be a consistent, non-judgmental presence in their clients' lives was essential to the formation and maintenance of the nurse-client relationship.

Graduation from the program was the logical end step of the NFP program. For the last four months of the program visits were extended to a monthly schedule to allow the client a longer phase between visits without losing contact all together. Program content during this time was also geared towards preparation for the termination of the relationship. PHNs described being careful about the timing of how

they talk about graduation. For some clients, if they discussed graduation too early the client may stop participating in the program and if the discussion was held too late, the PHNs perceived that clients might feel like they were being abandoned. Some PHNs readily internalized the principle that they would not be there for the long term so were cautious about maintaining some distance between themselves and their clients throughout the program.

Redefining Success

While the idea of remaining non-judgmental was part of the program, PHNs still needed a way of making sense of clients' behaviours. Whether it was a conscious process or not, PHNs were unanimous in their experience of redefining the meaning of success for their clients. For many of their clients, change was slow and rarely steady. The ability of PHNs to look for and see small changes, a skill that developed over time, was not only fulfilling but also a necessary indication that their work was having an impact. As one PHN expressed: "without *those* [small changes], the burnout would've probably happened years [ago]...there's so much high-risk ... you're dealing with that if you don't have a spark that, 'oh my God am I making a difference?' you can't continue" (PHN 003). While reflecting on and sharing observations of change and success with clients was a fundamental component of the NFP framework of self-efficacy, this approach also helped PHNs reframe their approach with clients. As one PHN related: "I think I had to *learn* to do that as far as breaking things into *smaller pieces* so that you *could* have *some* success even when you're feeling like you're not moving" (PHN 007).

Given the variety of clients' circumstances and histories, success had to be carefully considered for each client and her individual context. As part of this process of redefining success, PHNs challenged their own assumptions or expectations about what to expect from their clients. As this PHN stated, "We *expect* them to be able to do so much more like what you and I could do and they *can't*" (PHN 002). PHNs no longer took for granted an assumed ability of their clients' to complete everyday tasks such as make appointments, return phone calls or go to the grocery store. This understanding was essential for PHNs to establish where to start – at what point individual clients were at to take their first small step. One experienced PHN summarized her changed view of success and realistic expectations over time:

Experience ... makes a difference... [now] I don't go in expecting things to change as quickly as probably I once did. So changing those realistic expectations and looking at ... remembering that and thinking *small steps* are steps in themselves. A client not even *cancelling* the next visit is a step in itself ... it's not *lowering* expectations for what they can do it's being realistic about what *change is* for each client, especially the ones that have *bigger* obstacles and *higher* risk factors than most. (PHN 006)

A few PHNs commented that this practice of looking for and seeing success permeated other personal and professional endeavors as well.

Shifting to Client as Expert

For several of the nurses, approaching their clients from a foundation of self-efficacy was a fundamental shift in their nursing practice requiring them to let go of several long-held ideas of what nursing was. PHNs were required to let go of the idea of being the expert. Not only did PHNs have to undergo this shifting of expectations, they also needed to internalize and accept the idea that the client was the expert of her own life and was responsible for her own decisions. Some PHNs related experiences of wanting to do things for their client, such as making phone calls on their behalf or registering them for a program, however they realized that ultimately this was in opposition to the principles of self-efficacy. PHNs learned to step away and accept the timeline and agenda of their clients rather than imposing their own. Many PHNs, had to let go of the internalized idea of 'nurse-as-fixer.' As one PHN related, the struggle with letting go and sitting back was not always easy:

With the NFP Program that was *such* a core theme self-efficacy, and I had great struggles with that, especially at the beginning. I think I was *just* getting to the point at 6 months where I was *literally* in the midst of a visit and I would hear myself starting to go... where my comfort zone was and realizing I was *not* doing that client *any favours* by *fixing it* for her, that I needed to let *her* discover how to do that. Give her the *skills* to solve the problem but not to solve the problem myself...let her fall if she had to and then be there to pick up the pieces...And have to *live* with that as well and *sit* in that ambiguity where I like to jump right to ok we fixed it, tick. And NFP is not about that...I found some of that difficult and it was difficult work to do that, *but the payoff huge. Huge.* (PHN 009)

Although this idea was fundamental to the NFP model, PHNs acknowledged an ongoing struggle with both letting go of their need to be the expert and allowing clients to take control of their decision-making. However, with time and experience, they appreciated the freedom that this allowed from the pressure of their own expectation of having to know everything.

The ability to not only shift the responsibility for decision-making to the client, but to also truly allow them to make their own decisions, helped ease some of the pressures of working with this population

of vulnerable mothers. PHNs would worry about how their clients were doing, how they were maintaining safety in abusive relationships or what was going on with them during long periods of absences and wanted to actively intervene. However, accepting that decisions belonged to their clients was helpful to many PHNs in letting go of their sense of personal responsibility. One PHN described how she navigated the experience of a client's absence:

So it's just letting go and hoping that nothing happens ... you worry about how they're doing and how their baby is doing, or curious as to what's happening. But to take a step back and say well they're in charge, they're the mother, they are doing what's *best* for them and their baby, and probably it's safer. I might not have *known* all the *dynamics* that were going on at the time. So just to be more gentle to myself and it wasn't *about me*, it ... And I was just so happy when they came back. (PHN 010)

Using the NFP Education

Although strategies such as motivational interviewing and active listening were not exclusive to the NFP, PHNs commented that the education they received was instrumental in facilitating the use of these strategies in practice. Several PHNs commented that in previous roles, motivational interviewing was an expectation but they were not confident in their skills or were given limited opportunity to develop them.

Coming from HBHC to NFP, this PHN shared her perspective on the NFP nurse education:

The big eye opener ... like the big transition for me was to actually get the *tools on how to do it*. Because we were told even when we were doing HBHC you should be doing motivational interviewing, listening to the client, what does active listening mean? That's all great in theory...But what does that *mean*? And what does that mean when you're actually interacting with a 16 year old that's going off on tangents in 16 different directions and you're trying to do active listening yet narrow her down to actually complete some goals...what I really appreciate ...was the training was a bit more *intense* than what we would normally receive about MI [motivational interviewing]. (PHN 003)

In addition, PHNs were impacted by seeing first-hand the nature of the struggles and hardships their clients faced on a daily basis. This nurse reflected on both of these components:

The training in itself, I can speak endlessly ... about how that's [nursing practice] changed, how I interact with clients and how I speak to clients and how I listen to clients. But seeing what I saw, seeing the dark side, speaks *volumes* on how *that's* changed my practice. Seeing how some clients have to *live* makes you want to be a stronger advocate. (PHN 002)

As this PHN alluded to, the education that she received as part of the NFP orientation allowed her to change how she engaged with her clients, but that experience with clients also advanced her practice.

Transitioning to the role of NFP PHN - Problems

Concern for Clients

While PHNs describe that forming relationships and engaging with clients was the most rewarding and sustaining aspect of working in the NFP, this intimate connection also carried a significant emotional burden. The most commonly described emotion experienced by the PHNs was of worry or concern for their clients. Concern was often regarding their living circumstances, including lack of food security or adequate housing, and safety with their significant partner. PHNs frequently reported wanting to take the client or their child home with them. Many PHNs reported worrying about their clients outside of work hours and this was particularly noted during times of crisis. Even when PHNs attempted to create a boundary between work and home, they found it difficult to disengage from what they faced during the day. This PHN described her experience with this:

Even though I'm able to turn my phone off or not look at the phone when I'm at home after hours I do struggle with turning my *mind off*. *Thinking* about them, *worrying* about them, I even *dream* about my clients sometimes. I'm like oh my God, this is a sign ... And I think it's definitely *situational* depending on the client issues that they're dealing with that I'll be going home and I'll be thinking about it... I came at the height of the crisis. So I left and I was ... *exhausted* and I couldn't stop thinking about her and just worrying about her and her going back into that home. (PHN 005)

Working Up to a Visit/Nothing Left to Give

PHNs also described that home visits following crises can be emotionally draining and reported needing to actively 'work themselves up' as they felt they had 'nothing left to give'. Even though the actual crisis may have passed or resolved for that particular client, the emotional memory of traumatic visits frequently remained. Often the relationship needed to be rebuilt with the client, which does take considerable emotional energy. For this PHN, she was concerned with both preparing herself emotionally for subsequent visits and also struggling with the sense of being emotionally present for her client:

Every time I see this client ... I have to work myself up to go see her, just to feel good, and feel like I'm giving her, what I would want to give any other client...have that emotional capacity too, to be able to give back to her, so that she feels like we had a good visit. I don't even know what to call that... we're not robots...We give of ourselves too, in order to do this work. (PHN 001)

With several home visits scheduled in a day, PHNs were also faced with the challenge of leaving a difficult home visit and proceeding to the next one with little time in between to decompress or process the content

and events of the previous home visit. Several PHNs expressed a sense of guilt for not being able to be fully present for subsequent clients and the emotional impact from one situation carried over into another.

While the completion of additional education on IPV gave PHNs much needed guidance and skills to engage with clients on this difficult topic, it also meant an increase in the amount of disclosures. For this PHN, once she started discussing IPV with clients, she was overwhelmed with the response:

Three people in one week disclosed *so much*. I was just like whoa, and I felt like the one girl I thought I can't even leave here... I just want to put her in my car. I'm really *worried* for her, *worried*... and then I went into the parking lot at Canadian Tire ...had a little *cry*. It's a cry for humanity... it's just ...this is awful. This is awful. I feel bad for these girls that live like this and somehow this passes for love. It's pretty sad...(PHN 008)

While the increase in disclosures of IPV was actually a sign of a trusting relationship with a client, PHNs then had to manage the aftermath of a disclosure. After the fact, PHNs often questioned how they responded to such disclosures and if they had done enough for their client. This experience of doubt in their ability that they had done enough to meet the needs of the client was commonly expressed by a majority of the nurses.

Impact of Doubt/Did I do Enough?

When PHNs were sharing their concerns and worries about clients, they often reflected on their feelings of doubt within this relationship. For many, this was in the form of the question 'did I do enough?' Some PHNs even suggested that had their client had another PHN, perhaps one with more experience or skill, then a client outcome would have been different. As the role of the PHN in home visiting was in isolation in client's homes, they were solely responsible for making decisions in often rapidly changing situations. While NFP guidelines and health unit policies served to guide decision-making, ultimately situations did not fit within an established rubric. PHNs were charged with not only making decisions in the field, but also then having to live with the burden of that experience and responsibility. This PHN shared her experience of the difference between a 'textbook' response and the often messy and painful reality of working in challenging and emotionally charged situations:

There were many times where I walked out of a supervision meeting or walked out of a home visit and I would sit in my car and cry. Because although you *have the knowledge*, although you *know* this is what the textbook *says*, ... when the woman tells you that her husband is beating her you need to call CAS or this is what you do. It is very different when you're actually *in the middle of observing* the violence or you're in the middle of observing the woman telling you this is what happened to her

or talk to you about... so according to this ... I'm supposed to say this now and so I'm going to ask her this question because that's what the *tool tells me to ask her*. So you ask but you don't always see a response from her in the way that the tool tells you they're supposed to respond. They don't respond that way. So you end up walking out of that visit and you bang your head against the steering wheel and you think oh my God did I say enough, did I say the right thing, did I do the right thing?... in my gut I just want to kidnap this baby, like I don't know how to protect the baby. I don't think I'm doing enough. I'm not good enough at this. (PHN 003)

While this narrative demonstrated a particularly powerful experience, the concept of doubt was an added element to an already difficult situation and PHNs described struggling with this long after a visit ended.

Another situation that PHNs reported as difficult and a source of anxiety was when there was uncertainty about the need to contact CAS regarding a client or family. Some situations were clear, and there was no question of initiating a report, however where PHNs struggled were the grey areas, such as possible cases of child neglect. PHNs were aware that reporting their client, or the family, would have repercussions to the relationship yet they also had a professional responsibility for the safety of the children. PHNs reported that in situations where they were uncertain about contacting CAS, they would contact colleagues or the supervisor for guidance. In addition, they could make an anonymous phone call to CAS to describe the situation and receive guidance as to their responsibilities. If the PHN determined that a call to CAS was necessary, they were open and honest with their clients about why they were going to call. Often clients were angry or fearful, however many understood the need for CAS involvement. In some cases, clients were appreciative of the extra support that CAS provided. Although PHNs recognized the client as expert, they continually navigated the balance between PHN and client responsibility. This balancing act added to their sense of uncertainty and made the availability of support mechanisms all the more important.

Emotional and Physical Impact

PHNs reported a wide variety of emotional and physical impacts of working in the NFP. Fatigue and exhaustion, both physical and emotional, were common descriptors however these were sometimes periodic experiences. When working with a population that faced near-constant challenges, some PHNs struggled with maintaining their energy in the PHN-client relationship:

There's like a *constant flow* of bad stuff happening and it does, it does wear you down because you're trying to be the *positive force* in these girls' *lives*. That's *really hard* to maintain that *intensity* and it takes... its *toll* itself physically, for myself emotionally. (PHN 007)

Maintaining the intensity and positivity through home visits was often difficult and most support strategies were aimed at supporting PHNs through these despairing times. One PHN even shared her experience of a client asking if she was okay. For her, this was an important indicator that she was operating on overload and needed to take steps to manage her stress.

Exposure to clients who live in poverty also had an impact. For one PHN, this strengthened her conviction to be an anti-poverty advocate in her personal life and for others this had the effect of causing them to re-evaluate their own sense of need versus want. However for some, appreciation of their own financial advantages trickled over to a feeling of guilt that resulted in an inability to enjoy them. This PHN shared how the NFP has impacted her financial decision making in her personal life:

Just reflecting on things that I would normally do, I think twice about it, like a *big purchase*. ... you see a whole new light of how people are living and what they're living in and I don't know why it just can make you feel a little *guilty* for maybe a big purchase I probably don't really *need*. And even at home it's... like oh we don't need and I never used to be like that. (PHN 002)

For some PHNs, this changed perspective may be challenging for others in their home lives to understand.

Client Graduation

Although graduation was an expected, and hopefully celebrated part of the program, it still marked the termination of a therapeutic relationship spanning over two years. The ending of this relationship had the potential to add to the emotional toll and PHNs reported a wide range of graduation experiences, ranging from a sense of pride at the 'launching' of their client to grief to its' end. As the therapeutic relationship was in essence the main intervention of the NFP, it was not surprising that the end of this relationship had an impact on both the PHN and the client. Upon graduation, PHNs appreciated the opportunity to reflect with clients on progress made throughout the span of the program, however with crisis a near constant in the lives of some clients, PHNs struggled with how to navigate graduation within this context. As the NFP program had a defined time span, PHNs faced pressure to graduate clients even during challenging times. Although PHNs were helping clients learn to manage crisis throughout the span of the NFP, graduating a client in the midst of turmoil did not allow for closure. This PHN compared her extremes of graduation experiences:

As that client kept going on that cycle, that rollercoaster of up and down and up and down was *really tough to plan anything*, and to have any kind of a systematic way of *closing off* things because there

was always something, you're not *finished* ...I was ... feeling *pushed* to try and end it. We're still doing the graduation talk and yet we were still dealing with the grief process *separate* from the program ... So those are the kind of special circumstances where graduation can be quite messy feeling. There's others where the graduation process is a true kind of wrapping up of *loose ends* with the client and where all of a sudden it's like this is when *they* reflect and make *clear* all of those little things you wondered about and suddenly this is like as you are wrapping it up ... they're pulling it altogether and it all makes sense. (PHN 007)

While on occasion graduation may have been delayed due to a particularly serious event, many clients did graduate as planned. Although PHNs wished to graduate their clients with all their issues resolved, this simply was not reality. With the approach of self-efficacy built into the NFP, PHNs were building the problem-solving skills of their clients. At the time of graduation, no matter what the current state of their client's lives, PHNs had to have faith in the NFP and in the knowledge and skills gained by their clients in order to let go. This PHN shared her perspective reflecting back the work done with her clients:

There'll always be issues at play. But the ones that I graduated they ... I trusted their judgment. They knew everything that I could teach them and they'll do well. Yeah they may slip up and yeah CAS is still in the background there, but 5 years down the line I think they will be better off looking back at their foundation with their toddler. I thought I've done everything I can do, said my goodbyes, and that's it....I always wonder what, what the girls are doing and what are their kids doing and that. So you leave a bit of your heart behind. (PHN 010)

In some cases, PHNs reported that rather than face the goodbye or graduation process, some clients simply faded away by missing final appointments. While PHNs accepted that they could not alter their clients' behavior, in some ways this removed the opportunity for them to say their goodbyes. Some clients provided occasional updates after graduation and these were appreciated by the PHNs.

In contrast to the expected end of the relationship through graduation, there were occasional unexpected departures such as when a client moved out of the city prior to the programs completion. One PHN reported her experience with this as a particularly emotional, and tearful, as she only had one visit to say goodbye. Alternately, the client may move in between visits thus leaving the PHN with no opportunity for this closure.

Not all PHNs have yet to have the experience of graduating clients. For this PHN, she has already started to consider what the process might be like for her:

I can imagine when it's time to graduate and there's *some*...that really avail themselves of your *services* ... it's really enjoyable ... I think I'll be fairly sentimental about the whole thing, but that's ok. ... you knew that coming in, that that's, how that was going to go. ... I don't know what that all looks like and maybe they don't try to necessarily stay in touch but I think a few *do* ... occasional

updates and things would be lovely and I sure would love to know if it's 8 years down the line they end up going to college or something. I'd like to think that this'll be like a nice, little block of time that they *remember* and it was like a positive time in their *life* and because of *this* they did *this* or *that*. It was a platform. It was a springing board. (PHN 008)

Although PHNs understood the necessity of the termination of the relationship, they still had an emotional investment in their clients and hoped that clients appreciated their efforts.

Transition to role of NFP PHN– Needs

When asked about what PHNs need to feel supported while delivering out the NFP, many participants struggled with their answers. As there was variation in PHN personalities, support needs also varied. One particular challenge expressed by this PHN related to how even engaging in supporting practices can add to their time burden:

It's hard just to talk about ways of addressing the issues at this stage ...because it's been going on for a significant amount of time and so you ... get into sort of a *survivalist* kind of way of thinking. Because a lot of the ideas that, that we have to *address* some of the issues take time and energy in themselves, and we've now put ourselves in a place in the program where there is no *space to absorb that extra time*. I mean even something like additional *training* or whatever that is absorbing *time* with no real allowance for a pause in the visit schedule, meetings scheduled. Everything else is still expected to *carry on* and yet we're ... we also are required to do additional *training*...we have ideas. *We know* that it would ultimately make our life easier around documentation on the road, use of technology, stuff like that. But that all takes time and we don't have that right now. (PHN 007)

Clearly time was a key element of the stress experienced by the PHNs and support strategies must take this into consideration. As the concept of support itself was a large topic, the following section is dedicated to those results.

Support in the NFP - Practices

PHNs in the NFP were unanimous that this type of nursing was inherently satisfying but also very difficult. Although there were many rewards from engaging with clients and satisfaction with seeing their growth and successes, PHNs had either directly experienced negative consequences or were keenly aware of that potential. To mitigate the negative effects of this work, various coping strategies or practices were in place. These varied from those practiced at the individual to the program level.

Satisfaction in the NFP

Although PHNs stated that this role was at times difficult and stressful, they were also quick to discuss the satisfaction they experienced working in the NFP. The main sources of satisfaction were 1) the PHN-client therapeutic relationship; 2) making a difference; and 3) learning from clients.

The PHN-client therapeutic relationship.

The therapeutic relationship was the foundation of the NFP. PHNs reported feeling privileged to be allowed into the lives of their clients and to help guide them from pregnancy through to their child's second birthday. PHNs devoted countless hours to fostering and nurturing the development of this relationship, which made it all the more satisfying when they were successful. For many clients, trust was often difficult to establish and PHNs found clients willingness to continue in the program rewarding. As this PHN explained, she found small gestures particularly rewarding:

I find that rewarding just being allowed into their homes, getting back in, them letting me back in is a reward in itself I feel...some other things are... a client saying that they look forward to me visiting...it's just the *small* things, it makes my day when those kinds of things happen. (PHN 005)

Some clients had not had the experience of engaging in a positive relationship of any kind and particularly not with a service provider and PHNs recognized the privilege and satisfaction coming from being a positive example:

I have now run into former clients and they've come running up and wanting to tell me that they're *back in school*, that they've *graduated*, they're planning on getting *married*. Like it's their perception and my perception of the relationship is *intimate* and at times *intense, quality*. And its relationships that very often they haven't *had* anywhere else in their life ...The relationship you get to establish is like *no other* that they will almost ever have in service provision in their life potentially and a lot of times unlike anything they've ever had in their personal life so it makes it extremely satisfying to *be* one of their care providers ... getting to make that kind of *connection* with somebody on a professional level as a client I think is rare. (PHN 006)

While PHNs reported that they appreciated the relationship from their own perspective, they also recognized the importance of the role they played in their client's lives.

Making a difference.

PHNs reported the opportunity to make a difference in the lives of their clients that was a key retention element. In times of frustration, PHNs frequently asked themselves "why do I keep doing this?" In addition to the rewards of the PHN-client relationship, PHNs were motivated and rewarded by seeing

clients progress and make positive decisions in their lives. This PHN described the personal value and importance of seeing the impact of her work:

Seeing the improvements of these children that were exposed to extremely high-risk situations that I had personally never dealt with even in previous clients, and these children were sometimes turning out better – having better verbal skills, having better cognitive [skills]. They're just *developing* at a much better rate than children that weren't exposed to such high-risk situations. You knew that there were little things you were doing that were making a difference. So again those little reward moments I can't say came very frequently because there was a lot of *lulls* and a lot of *bad* things that happened in between, but there was always at the right time when you felt like I can't do this anymore, there was this *wow*, ok, she's doing ok (PHN 003)

Other PHNs reported they felt they were making a difference when their clients would use them as a resource or put into practice something they had talked about.

Learning from clients.

For many of the PHNs, their role in the NFP exposed them to levels of poverty that they were not previously familiar with. Through this exposure they developed a deeper sense of the day-to-day challenges and difficulties faced by clients. Despite these challenges, or perhaps because of them, PHNs reported being continually amazed and impressed by the resilience and strength of their clients. Several PHNs even reported that their clients were better mothers than they were. PHNs used words like 'survivors' or 'fighters' to describe the tenacity that clients exhibited towards their circumstances and were often amazed by their accomplishments. This PHN described her changed appreciation of how difficult it was to live as young mother in poverty and this has influenced her perspective:

How incredible some of the *things* that the clients are able to accomplish given their circumstance, their obstacles. That for sure has, has *shifted* because I think before I worked in the program I didn't really realize how much work it took to be either a young mom or a single mom or a mom in general, or a mom who lives on literally no income or in some of the housing that they live in never mind a lot of the clients that are doing *all* those things at once. ... how difficult and the skill set just to *survive* it is something that has completely changed me. (PHN 006)

Having a better sense of the struggles faced by their young clients allowed PHNs to further appreciate their gains. For this PHN, she was pleasantly surprised that her own expectations were surpassed:

Looking back seeing where they *started*, they were living in a car, to where they are now...*who would've known* some of them would just be *such* good parents... not me. So for me this is such an incredible learning experience because I have a lot of experience in nursing but apparently not so much in *life* outside of what mine was (PHN 008)

This appreciation of their clients' journey and the PHNs role in it was instrumental in retention of PHNs.

Individual Coping Strategies

At the individual level, PHNs shared a variety of strategies they employed to manage the stressful nature of their work. PHNs were: 1) setting boundaries with clients; 2) managing self-expectations; 3) reflecting on practice; 4) using the evidence of the NFP; and 5) engaging in self-care activities. PHNs also cited informal peer debriefing as an essential supportive practice.

Boundary setting with clients.

As the main form of communication between the PHN and client was through text messaging, there was the temptation to be overly available between home visits. Several PHNs reported establishing a clear time frame for responding to text messages such as establishing that clients may text at any time, however responses would only be provided during normal working hours. Despite this, several PHNs shared that they often checked their phone during off-hours, but maintained their boundary by not responding until the next business day. Many of the PHNs struggled with how to manage their phones and that maintaining a division between work and personal time was an ongoing challenge, especially with the easily accessible medium of text messaging.

Beyond phone contact, PHNs were also adjusting to how they made themselves available to clients in person. One PHN reflected how, over time, she grew more comfortable enforcing boundaries around her time:

In the beginning we were so willing to compromise our own working behaviour, professional behaviour. We would jump at rescheduling a visit at every ... any time the client could make it you could stay long past which you normally would've stayed with the length of the visit just to try and ensure you're making that connection. And now having been almost 6 years later we can trust that because of the length of time that we visit that relationship will establish itself. You don't have to compromise your own self to get it there. (PHN 006)

For this PHN, the experience of working in the program over time allowed her a broader perspective and experience of seeing the relationship develop over time. One PHN shared that she maintained her personal boundaries by limiting the amount of personal information shared with clients, whereas another would use anecdotes about personal experiences as a means to connect with their client. Some PHNs newer to the program were still struggling with the sense of where and how to define their personal boundaries. As the relationship between PHN and client had the potential to become very intense, the necessity of clear

boundaries became even more important however this may be interpreted differently by each individual PHNs.

Reflecting on practice.

While a formal, scheduled, weekly reflective supervision session was part of the NFP model elements, PHNs also engaged in informal, independent reflection on their nursing practice. While some PHNs had some previous experience with reflective practice, the majority noted that this was beneficial. Common themes for reflection were the nature of the relationship formed with clients, as well as the PHN's response to clients. PHNs stated that reflecting on practice helped them understand their own response to a given situation and also provided them with strategies or ideas about how to respond in future. As one example, this PHN uses reflection to ensure she is remaining open to her client: "I think about my *reaction* and so...*careful* to not pass *judgment* or make it *seem like you are*... I think I do it [reflection] more now...I think about everything I say" (PHN 008). PHNs expressed the ability and willingness to engage in reflection independently but also desired a forum to explore issues they struggled with. One PHN did share however, that on occasion she was over-reflecting and thinking about a given situation too much but overall appreciated the benefit of reflecting on and improving her nursing practice. PHNs were able to identify when additional support was needed and NFP colleagues were consistently mentioned as the most effective form of support. Reflective supervision was also cited as another possible form of support.

Managing self-expectations and letting go.

One example of changing expectations of self was related to the volume of documentation required. One newer PHN stated that she had finally accepted that she would never be caught up with charting. For her, letting go of this expectation allowed her to leave work on time and accept what was possible for her to achieve in any given day.

One practice that PHNs found supportive, and was a part of the reflective process, was to re-evaluate expectations of themselves. PHNs, and many nurses in general, see themselves as "fixers" and want to make things better. While PHNs had to change expectations of their clients, this process also needed to occur for them. PHNs, whether consciously or not, often felt some responsibility for clients' decisions. One PHN, upon learning her client was pregnant again, then quickly re-examined past

documentation and questioned if she had adequately discussed birth control options. Her initial reaction suggested that she felt responsible for her client's pregnancy due to a failure to deliver information, a perception that was ultimately challenged and overcome through reflection. Because of this identity as fixer or problem-solver, PHNs sometimes related a sense of failure when clients wanted to leave the program. As one PHN related, learning not to take clients' decisions personally was a necessary skill that developed over time:

Not every single, eligible mom is going to need or want this program and we *have* to be ok with that because there's a lot of times that we're not and if somebody says no or declines or wants to be discharged early, we all take that *personally* and we feel like it's a real sign of *failure* when it's *not...* So because I'm much more comfortable and confident with saying that and knowing that I'm *living* that, I don't feel *that* pressure at all when I'm approaching a potential discharge client early. That's the *biggest* change is I don't feel that pressure because I don't take that on anymore. (PHN 006)

For this PHN, learning to let go of that pressure allowed her to cope with the reality that, despite best efforts, not all clients stayed in the program. As the NFP program targeted vulnerable clients, those who remained in the NFP were more likely to move often, miss appointments, disappear for periods of time and make decisions that may not seem in their best interest. The difficulty for the PHNs was to continue delivering the NFP program despite the surface appearance that the program was not working and maintain the sense that the ownership and responsibility for decisions remained with the client. Those who were able to do this found that supportive.

NFP evidence.

A further support to PHNs when struggling to see progress or positive changes in their clients was the rigorous research evidence in support of the NFP. Rather than a blind faith or hope in the program, PHNs were able to refer to the existing NFP body of research to know that positive change will occur, even if it is beyond the time frame of the program. In this way, the evidence was a form of validation of their efforts. This PHN described how the evidence supporting the NFP was a constant thought:

Even if you haven't had any of those small successes at any given time – week, day, hour – knowing *that*, knowing that the *larger picture* is that this program is able to do all of these outcomes that it has shown to do is something that *always* is in the back of my head. (PHN 006)

PHNs also appreciated evidence supporting client's value of the program. Several PHNs related that they received little validation directly from clients and for many, had little sense of the client's

perceptions of the NFP. Other PHNs reported that the only positive feedback they would hear from clients came indirectly through interactions with other health care professionals. One nurse shared her surprise when a client she was having a difficult time forming a relationship expressed the following:

I didn't feel like I was really forming a relationship. I didn't feel that they *liked me*. I just felt they always were very *argumentative* with me. Didn't want to listen to what I was saying. But then when talking to other health professionals they would mention my name to them – oh I have a public health nurse – and they would say good things about me, coming from *other* people, not from *them*. I've never once heard them say thank you or I really appreciate you coming, nothing like that. But from *other people*, oh they told me as a public health nurse they really *respect you*. I'm like, *really?* I'm *shocked*, I'm really shocked. (PHN 002)

Although over time some clients became more vocal of their appreciation of the PHN and the program, PHNs had to contend with the reality that not all clients were capable of expressing this. Validation and support often needed to come from other sources.

Engaging in self-care activities.

While PHNs appreciated support provided through the workplace, all were aware that activities within their personal lives contributed to their well being. PHNs described a range of activities they adopted to promote their own self-care including: volunteering in their communities, participating in social advocacy activities, striving to engage in regular exercise, and engaging in activities that bring them joy. Within the workday, PHNs tried to take regular breaks, occasionally meet for lunch, go for a walk and attempted to steer break conversation away from work-related topics. One PHN described that after difficult visits she would make time to grab a coffee or a treat of some kind. For another, she was acutely aware of the necessity for her to participate in activities that enabled her to continue working in her role: “With the stress, I had to go to the gym and I had to do things for *me* to build myself up because if I didn't I'd be half empty rather than half full” (PHN 010). While the PHNs were aware of the importance of self-care activities they also acknowledged that making them a priority was a continual challenge. Several PHNs also felt an increased awareness and appreciation of their family, friends and social advantages.

NFP Program Support - Practices

Supports at the program level existed at both the informal and formal level. Informal peer debriefing was a common practice that all PHNs engaged in. Formal practices such as team meetings, case conferences and reflective supervision were previously reported.

Informal Peer Debriefing

Informal debriefing with peers was an essential support to all of PHNs. Whether it be to discuss a challenging scenario, seek advice about a client or to vent frustrations, PHNs engaged in this practice on a daily basis. Part of what was valuable to PHNs was the sense that their colleagues really understood the nature of this work, that they “got it.” Many of the PHNs related that they could not debrief with other non-NFP colleagues or with partners at home as they do not “get it.” One PHN described this very experience:

I think the *best* support that we have is with our [NFP] *team*...because they’re the only really people that *know* what it’s like. I can’t go home and vent about it to my husband because he doesn’t even really know what I do ... so going back to the office or calling a colleague ... whether it be venting or discussing kind of what you did and getting some assurance that yeah you did everything you can do ... That’s really the only way we *deal with it* is talking to one another. (PHN 002)

One advantage of this informal debriefing process was the immediacy and availability of the process. There was no requirement for this to be scheduled and issues were addressed as they came up. For many PHNs, nagging issues or questions were often dealt with through discussion with team members and then only if needed, further support was sought through the reflective supervision session. For many of the PHNs, debriefing with colleagues provided an important function of validation, as well as providing a learning opportunity for how to address a similar issue in the future. When working in isolation, there was little opportunity for feedback on nursing practice and many of the situations experienced by clients were not amenable to existing guidelines or policies. PHNs were often questioning their own decisions and debriefing with colleagues as a way to validate their own decision-making in the context of uncertainty. Both new and experienced PHNs expressed the need for this validation. This PHN shared her process of managing challenging situations and when she would seek further support:

I usually talk about my cases with the team first, individuals, and then it makes it to supervision. So I kind of do that first just as a ... because sometimes I might be satisfied with the support I get from the team and the perspective or direction to go with it, or even just the peer validation that you know what, I think what you did was right, that, that’s enough. And then I’m like ok, I don’t know that I need to bring this up at supervision because it’s kind of *solved* and I feel good about it now. (PHN 005)

A team comprised of new and experienced NFP PHNs allowed for a mutual sharing of strengths.

Experienced PHNs provided insight and the benefit of their program knowledge whereas newer PHNs provided different perspectives and energy to the team dynamic.

Support Strategies – Problems

Burden of Peer Debriefing

While PHNs were adamant about the importance of the team and the informal debriefing process, there was an acknowledgment that there was the potential for frequent discussions to be disruptive and time-consuming. To attempt to create boundaries with their colleagues, PHNs were trialing a system of ‘stop-light’ stickers, (red – unavailable, yellow – important issues only, green - available) on their desks as an indication of how available they were, to help them manage and protect their limited time. At the time of data collection, this was a very new practice. The requirement for such an intervention suggested that PHNs needed a strategy to provide a non-verbal cue to indicate when they were available or needed to focus on a task. PHNs had to balance the willingness to be a support to their colleagues with their own obligations and time demands. Despite this, all of the PHNs stated that without the team, they would not be able to function in the NFP. This PHN related how close-knit the relationships with her colleagues have become and the role that plays in keeping her working in the NFP:

I think if I had a different team, if I didn’t have the relationships that were formed on this team, I couldn’t continue to do ...*this*. I’ve said at times too it feels like family. The support that you get from your team ...I think has helped me to continue to do the work. (PHN 001)

Despite the importance on the team, support practices need to be built into the structure of the program.

Support Practices – Needs

Culture of Safety

Regardless of what form support takes, PHNs needed to have a safe space to discuss what was concerning to them, including elements of their personal life. As this PHN expressed:

We need to feel okay about discussing these things, we need to do things that are more social as a team and in our own...lives to make us feel good, because realistically if you’re going through a hard time in your life as well, because we’re not robots, you know that impacts the work that you do as well. You know, whether you want to acknowledge it or not, it does. (PHN 001)

PHNs expressed that annual retreats and occasional inservices on topics such as compassion fatigue were supportive, as long as they did not have to organize it themselves.

Validation and Formal Preceptor

To counteract the impact of the role of doubt, PHNs were in need of validation. This need for validation was expressed in two ways – one as the need for the validation or normalization of feelings or reactions and the other was for support, or validation of decision-making. The nurses recommended that having a formal preceptor would assist with providing support for both.

Synthesis of Results

Building the second phase of the study upon the first afforded the opportunity to further explore findings from the first. Although many of the findings were further supported in the interviews, others were expressed in greater depth in the interviews. The following provides a summary of major findings that were consistent between phases (Table 3) and those explored to greater depth (Table 4).

Table 3
Findings Consistent Between Phase 1 and Phase 2

Category	Summary
NFP Program	<p>PHNs valued the program structure (visit schedule, frequency, duration, enrolment prior to 29th week gestation and extending to the child 2nd birthday) and have embraced the underlying principle of self- efficacy. For those who received it, training at the NSO and the opportunity to shadow experienced PHNs was regarded as beneficial.</p> <p>The program structure allowed PHNs to establish and maintain relationships with young, vulnerable mothers in ways other programs did not. Program policies that maintained enrolment for clients who missed appointments or ‘disappeared’ as well as allowed PHNs to take time to ‘chase’ clients also supported this relationship and assisted clients to successfully complete the program.</p> <p>PHNs found the evidence supporting the NFP to be motivating during challenging times.</p>
PHN-Client Therapeutic Relationship	<p>The PHN-client relationship was described by PHNs as immensely rewarding but also challenging. This relationship was supported by consistent, predictable PHN involvement. Time to allow the relationship to develop at a pace appropriate to each client was essential.</p> <p>PHNs reported feeling emotionally drained at times, particularly with clients in crisis, or when they perceived that they were not making any gains with a client. PHNs experienced worry and concern for clients however this was often offset by knowing they were making a difference in clients’ lives and seeing the positive impact of their work. These positive outcomes were critical to PHNs satisfaction with their role.</p> <p>Challenges to the relationship included client factors such as unstable housing/frequent moves, lack of experience forming trusting relationships,</p>

	<p>overload of service providers and scheduling conflicts when returning to work or school.</p> <p>For PHNs that had graduated clients, this was a mixed experience. For some PHNs it was a launching, whereas for others graduation was still a time of chaos and crisis for their clients. PHNs had to grapple with how to accept that not all issues will be solved but that clients had learned necessary skills to cope through the NFP.</p>
PHN Transformation	<p>PHNs reported that working in the NFP has been transformative and many stated they felt like a “stronger and more effective nurse.” Specifically the philosophy of self-efficacy has allowed PHNs to relinquish the role of ‘expert’ and allow clients to be experts in their own lives. PHNs redefined how they saw success in their clients and this tendency to look for small gains permeated their personal lives as well.</p>
Workplace	<p>A sense of overload or lack of time to complete organizationally required tasks was universally expressed.</p> <p>PHNs stated that specific workplace inefficiencies added to their stress and sense of overload was commonly expressed. Specific elements that contributed to overload were long driving times, inefficient team meetings, lack of resources to support NFP guidelines, inadequate storage for NFP materials, inefficient documentation system and the lack of capacity to document remotely.</p>
Support practices	<p>Informal peer debriefing and their colleagues were overwhelmingly the most effective form of support to PHNs. The immediate availability and proximity of colleagues was important factors as well as the knowledge that their peers understand what they are going through, they “get it.”</p> <p>PHNs had mixed experiences with reflective supervision as a supportive mechanism. PHNs agreed that an increased focus on emotional content would be beneficial however there was variation in individuals’ comfort levels with engaging in this form of reflection with a supervisor.</p> <p>Annual retreats, timely continuing education/professional development, and opportunities for PHNs to engage socially, such as team lunches, were suggested as supportive activities.</p>

Table 4
Focus Group Themes Examined in Further Detail in Interviews

Category	Summary
PHN-Client relationship	<p>PHNs expressed a sense of doubt around the adequacy of their nursing interventions – the question of “did I do enough” was frequently asked.</p> <p>The idea of “letting go” of the PHN-client relationship was an ongoing theme. This most often presented during graduation but was present throughout the time of the program as well. PHNs also had to let go of expectations they held for their clients and themselves.</p>
NFP Community	<p>PHNs acknowledged the potential for a formal preceptorship or mentoring program between new and experienced NFP staff, both within and beyond the local site to be beneficial. PHNs desired to connect with the on-line community of established NFP program in the US as well as offer their experience to the new program in BC.</p>
NFP education	<p>New staff joined the program at irregular intervals and received different orientation/education from their peers. PHNs desired a standardized education program for all new staff.</p>
Personal support strategies	<p>PHNs expressed a range of strategies and comfort level with boundary setting with clients. Those with more experience tended to be more comfortable establishing firmer boundaries.</p> <p>PHNs reported that the engaging in reflective practice, whether through supervision, informal peer debriefing or on their own, was helpful to the development of their nursing practice and to understanding their reactions to a given situation.</p>

Chapter 4: Discussion

The perceptions and experiences shared by PHNs indicated that the PHN-client relationship is at the core of home visiting. They identified that there are both positive and negative outcomes for PHNs as a result of engaging in this relationship. The positive outcomes included connecting with and learning from their clients, knowing they were making a difference and seeing positive changes. The perceived negative components of this type of therapeutic relationship were that nurses invested heavily in their clients at personal and emotional levels, and as a result, worried about clients, worried they had not done enough, felt guilt, and sometimes found it difficult to say good-bye. Workplace factors also played a significant role in their experiences with inefficient and time-intensive work demands adding to their sense of overload and stress. Support from colleagues, predominantly other nurses working in the NFP program, was deemed essential in helping them navigate and manage the challenges of long-term home visiting with young, socially disadvantaged families.

Zeanah and colleagues (2006), in their study of an American NFP program, and one of the few studies examining NFP nurse home visitors' experiences, challenges and rewards of home visiting, reported findings similar to the Canadian experience. They identified that nurses described the relationship with clients satisfying but struggled with a sense of helplessness in the face of complex social issues. Nurses reported that the support of colleagues along with regular case conference participation were valuable in meeting their needs to debrief with others who understood their experiences. Frustrations with administrative work such as documentation as well as the demands of scheduling and rescheduling to meet visitation expectations were common. However, in their study Zeanah and colleagues (2006) maintained a specific focus on understanding the impact of clients' mental health needs on the nurses' experiences of delivering the NFP program. While client mental health issues were common in the Canadian context, this did not dominate the account of their experience and a broader view of personal and professional issues was provided.

This is the first in-depth qualitative study to focus specifically on the professional and personal impacts that home visiting vulnerable families, within the Canadian NFP context, has on PHNs. The PHNs in this study valued the NFP program from a philosophical and program design perspective, particularly its

establishment as an evidence-based nursing intervention; they also recognized the fundamental importance and necessity of establishing positive therapeutic relationships with their clients to achieve positive maternal and child outcomes. PHNs highly valued the opportunity to make a difference in the lives of their young clients yet they also acknowledged the emotional impact that this work had on their personal selves. PHNs struggled to balance the seemingly competing demands of direct client care with other workplace responsibilities and reported operating on overload.

The PHNs' experience of delivering the NFP was influenced by a complex interplay of individual nurse characteristics, client characteristics and the informal and formal work environment. Overall, the rewards and challenges associated with home visiting vulnerable families, as described by the PHNs, were rooted fundamentally in two main categories: 1) the relationships formed over time with clients and their families; and 2) the workplace culture, and the level and quality of available supports. Prior to a discussion of these elements, a brief synthesis of findings which focused on the emotional impact on PHNs is provided in the next section in order to frame the following discussion to our understanding of the issues of burnout, compassion fatigue secondary traumatic stress/vicarious trauma and compassion satisfaction.

Emotional Impact

PHNs described that the relationship with clients was a mixed experience – one of great satisfaction as well as a source of frustration and stress. A satisfying relationship may consist of active client engagement or participation in home visits, positive mother-child interactions or seeing the impact of their efforts –that they altered the life path in a positive way for this young mother and child. PHNs shared many stories where they were amazed and inspired by the tenacity and strength of their clients to overcome challenges in their path. However, PHNs also shared stories where they described their own worry and doubt of the effectiveness of their interventions in the face of multiple challenges. While a focus on the negative impacts of this work was not meant to downplay the positive rewards that kept PHNs actively engaged and involved, it was not when things were going well that PHNs needed support.

PHNs were unanimous that they experienced tremendous personal and professional growth and rewards in being part of the NFP program, however they simultaneously experienced stress and an increased emotional burden as a result of engaging in work of this nature. The passion and commitment

with which the PHNs embraced the program and engaged with their clients also left them vulnerable to negative consequences of working with a vulnerable population, such as compassion fatigue, vicarious trauma/secondary traumatic stress, or burnout. As the increased intensity and duration of the relationships formed with clients were much different compared to their experiences in other home visiting programs, the nature of the supports for, and awareness of, the impacts on PHNs must reflect the increased intensity of these relationships.

Within this study, PHNs have described symptoms of burnout, compassion fatigue and vicarious trauma/secondary traumatic stress such as feeling overwhelmed by their workload, having to talk themselves up for a visit, crying in the car, dreaming about their client and feeling like they have nothing left to give. The experience of compassion fatigue, vicarious trauma and burnout has been documented in other nursing practice settings (Hooper et al., 2010) but it has not been well documented in home visiting. Further, there is not a clear understanding of how this experience may change over time or if there are predictable points at which PHNs may need additional support.

Burnout

As the essential components of burnout are emotional exhaustion, depersonalization and a sense of inefficacy (Maslach, 1982) this not only has a personal cost to the PHN but also impacts their ability to engage in a relationship with their clients. As these relationships may be difficult to form and are an essential component of the delivery of a home visiting program, factors that decrease the PHNs ability to devote energy to cultivating this fragile relationship will ultimately negatively influence program outcomes. Within the organizational context, there are six factors that have been identified as antecedents that contribute to the development of burnout: workload, lack of control, lack of reward, lack of community, lack of fairness, and incongruency of values between the employee and the workplace (Maslach & Leiter, 1997). It is these workplace factors, rather than the emotional burden of engaging with a vulnerable population that contributes to the development of burnout. Strategies to mitigate these factors are discussed in the next section.

Beyond the impact on the PHN- client relationship, burnout also contributes to negative work-related responses ranging from job dissatisfaction and decreased commitment, to staff turnover (Conrad &

Kellar-Guenther, 2006; Schaufeli & Enzmann, 1998). Although the PHNs cited risk for burnout, they remained committed to their clients and the program. Burnout was not cited as a reason for any PHN leaving the program.

Compassion Fatigue

Compassion fatigue, the final stage of a progressive and cumulative process resulting in physical and emotional symptoms such as lack of energy, apathy, poor judgment and indifference may result in a desire to quit and an inability to care (Coetzee & Kloppe, 2010). Risk factors of compassion fatigue are intense and prolonged contact with patients, the use of self, and exposure to stress (Coetzee & Kloppe, 2010). In contrast, Boyle (2011), suggested that rather than withdraw, as was often the case with burnout, those experiencing compassion fatigue responded by attempting to give even more of themselves to assist their clients until they are at the point at which they can no longer function. Those who were empathetic were at higher risk for compassion fatigue (Slatten et al., 2011) and PHNs in this study were more likely to describe wanting to do more for their client than their role allowed rather than withdrawing from the relationship. It is important for PHNs and those who support them to be aware that both withdrawal and giving too much of one's self are indicators of negative responses to their work and intervention or support may be necessary.

Vicarious Trauma/Secondary Traumatic Stress

Disclosures of current or past physical or sexual abuse, intimate partner violence or even exposure to the systematic impacts of poverty on their clients are examples of situations that place the PHN at high risk for vicarious trauma or secondary traumatic stress. PHNs who are experiencing nightmares, intrusive images based on client's stories, or a sense that the world is no longer a safe place are experiencing vicarious trauma/secondary traumatic stress. While vicarious trauma or secondary traumatic stress has not been evaluated in PHN home visiting, it has been described by emergency room nurses caring for survivors of intimate partner violence (van Wyk & Neltjie, 2013), measured in hospital nurses (Komachi, Kamibeppu, Nishi, & Matsuoka, 2012) and in domestic violence advocates (Slattery & Goodman, 2009). While all of these roles and contexts vary, there was the common element of exposure to a patient/client

with a trauma history. Clients in the NFP often had past or current issues with trauma so the potential for NFP PHNs to experience secondary traumatic stress or vicarious trauma is high.

Compassion Satisfaction

While PHNs described the many and varied challenges of working in the NFP, they also spoke of their experience of compassion satisfaction. They found the intense, long-term relationship formed with clients, the experience of transformation and personal growth, learning from clients and seeing their progress over time were intensely rewarding. The relationship with clients, personal growth and seeing the impact of their efforts were also reported as satisfying elements in a study of US PHNs (Zeanah et al., 2006). There is limited research on factors contributing to compassion satisfaction among PHNs in home visiting, however in a study of domestic violence service providers, organizational value alignment and length of time in the field were associated with compassion satisfaction (Kulkarni, Bell, Hartman, & Herman-Smith, 2013). Applying their finding to this study, PHNs reported a value alignment with the NFP program, however discrepancies or inconsistencies between the NFP model and expectations of the public health unit may potentially have an impact on the PHNs' compassion satisfaction. Increased experience may also be a factor in compassion satisfaction however further study is required to explore this.

In an American study of child protection workers (N = 363), 50% of the participants reported 'high' or 'extremely high' risk for compassion fatigue yet 75% reported 'extremely high' 'high' or 'good' potential for compassion satisfaction (Conrad & Kellar-Guenther, 2006). Rates of 'high' or 'extremely high' burnout rates were low among participants (7.7%) and the authors hypothesized that workers suffering from burnout may have already identified this and quit their job. While the population of child protection workers in this study had a different role than NFP PHNs, they were both engaged with home visiting families with young children in challenging circumstances. Rather than suggest that compassion satisfaction and fatigue were opposing points on a spectrum, this study suggested that they occur in tandem. Compassion satisfaction reflects the practitioner's satisfaction from being effective in their role (Stamm, 2010). In part, this satisfaction relied on openness to the relationship experience, which then also left them vulnerable to experience compassion fatigue.

Although these concepts have been described as discrete entities, PHNs may experience one or all at any given time, and how this was experienced may also fluctuate over time and affect individuals differently. Stresses within personal life and individual characteristics also contributed to a PHN's ability to manage work roles, however the interplay of these factors was beyond the scope of this study.

Worry and Doubt

PHNs unanimously and commonly described the experience of worry for their clients, such as passing thoughts of how they are doing to not being able to 'let go' of their workday. Worry was often linked to a sense of doubt of their effectiveness, particularly when client change was not observable. A sense of inefficacy is a contributor to burnout (Maslach & Leiter, 1997) and this needs to be openly acknowledged and discussed. Doubt was expressed by all PHNs in the study, most commonly by questioning responses to a given situation, asking themselves 'what did I do wrong' and taking client decisions personally. SmithBattle, Diekemper and Leander (2004a) in their study of the development of PHN clinical expertise noted that the tendency to want to 'fix' client problems was common particularly among less-experienced practitioners. This desire to fix leads to the inevitable realization that they cannot. PHNs in this study reported an ongoing struggle with letting go of the 'nurse-as-fixer' concept, and then shifted to embracing the idea of the client as the expert in her own life easing some of the pressure they put on themselves about 'doing enough.' The link between worry, doubt and compassion fatigue has not been well described in the literature although Kanter (2007) suggested that creating realistic expectations serves a protective function. PHNs described this practice, in addition to a shift in how they defined success, as strategies to mitigate the uncertainties within their role. If a PHN set an unreasonable expectation for her client, whether consciously or not, she may be disappointed in the client and often herself when it is not met. It is important for the PHN to be able to be conscious of these expectations and the fit with their client, a process that may be assisted through reflective practice and clinical supervision.

PHNs described mitigating their sense of worry through debriefing with colleagues, reflective supervision and recognizing that clients are responsible for their own decisions -it is not the PHN's role to 'fix.' PHNs in the initial pilot cohort had the experience of delivering the entirety of the NFP and graduating clients whereas the newer PHNs have not. With this experience, PHNs were able to reflect on

the journey their clients had taken over time. This ability to see the broader perspective was indicative of gains in the PHN's relational and perceptual skills (SmithBattle et al., 2004b) allowing them to see past the day-to-day challenges to what was achieved over time. This broader perspective helped mitigate the sense of doubt as often change was not perceptible until seen from a distance. Discussion with more experienced colleagues to assist newer PHNs to develop their sense of perspective or to identify over-involvement has been well supported (SmithBattle et al., 2004a; Zerwekh, 1992).

As the impact of worry and doubt may stem from the gap between theory, or program guidelines, and the unpredictability of the practice environment, this is a significant area where supervisors need to focus their reflective supervision goals (SmithBattle et al., 2004b).

Role of experience.

The theory of transition shock has been proposed to describe the role transition from student to registered nurse and included responses such as anxiety, insecurity, inadequacy and instability (Duchscher, 2009). This model proposed that as experience was gained, these anxieties dissipated and to a certain degree this was seen in this study. All of the PHNs expressed a sense of worry for their clients, although how this was described and managed varied among the participants. It was possible that experience was protective as over time as PHNs may have established their own coping mechanisms (Burtson & Stichler, 2010) however there may be a limit to this protective capability. While the PHNs were not experiencing the same level of transition shock as a new graduate, it is reasonable to suggest some parallels to the role transition experience. Despite previous home visiting experiences, learning a new program involves a period of role transition. PHNs were learning new course materials, delivery model and documentation system while simultaneously working with a new and vulnerable population and a new approach for engaging with clients.

PHNs in this study represented a wide and varied range of nursing experience and career stage. The interaction between PHNs adaptation to the NFP and previous experience in the NFP within this small population was not clear. Some PHNs had many years of home visiting but were new to the NFP, whereas others had significantly fewer years of nursing but were experienced NFP PHNs. The development of expertise in home visiting has been described through the aspects of clinical knowledge development of

grappling with the unfamiliar and learning relational skills (SmithBattle et al., 2004a) then gaining a situated understanding of practice, grasping the big picture and learning the community through the eyes of clients (SmithBattle et al., 2004b). Although PHNs with years of previous home visiting experience may have mastered these skills, they still reported feeling like a novice when starting the NFP. Even with previous home visiting experience, PHNs new to the NFP needed support that specifically recognized the challenges of new knowledge and skill acquisition. Access to experienced colleagues and clinical supervision has been shown to be important strategies for support during the expected challenges of role transition (Sharrock, Javen, & McDonald, 2013), an experience confirmed by the PHNs.

In addition to learning the NFP guidelines and the documentation system, PHNs were managing a caseload of higher-risk clients as compared to previous roles and experiences. A caseload of clients facing similar challenges can be a source of compassion fatigue and trigger a sense of helplessness in the PHN due to the cumulative nature of these challenges (Kanter, 2007). Although attempts were made to balance the caseload by having clients at different stages of pregnancy and motherhood, the commonality of their collective challenges, such as poverty and early childrearing, had a cumulative impact. Adding to the emotional challenges and complexity of these experiences, PHNs worked in isolation in clients' homes unlike nurses in a hospital or clinic environment. While colleagues or a manager were accessible by phone, decisions were often made in the moment and upon later reflection PHNs questioned or doubted them.

PHN-Client Relationship

As the establishment and maintenance of the therapeutic relationship was fundamental to achieving successful maternal and child outcomes, the entire purpose of the NFP, supporting PHNs to engage with clients needs to be a priority. From an organizational perspective, the knowledge that PHNs and supervisors will be personally impacted by the work that they do prioritizes the need for supports to mitigate this impact, as “the expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water and not get wet” (Remen, 1996, p.52).

Development of the PHN-Client Relationship

In this study, it was strongly evident that the PHN-client relationship was both a key source of satisfaction for PHNs and a source of personal stress. The development of a positive nurse-client relationship has been recognized as foundational to nursing (Registered Nurses Association of Ontario, 2002), home visiting (Chalmers & Luker, 1991; Heaman, Chalmers, Woodgate, & Brown, 2007; Zerwekh, 1992) and was identified as the most important outcome by vulnerable mothers (Jack et al., 2005). In a Canadian study of 87 PHNs that evaluated the applicability of a standardized questionnaire to assess PHN job satisfaction, nurses identified that providing direct client care and making a difference were the aspects of work life that were the most satisfying (Best & Thurston, 2006). To-date, most of the literature published about the PHN-client relationship in home visiting focused primarily on the process of engaging and maintaining therapeutic relationships; there has been little account of how engaging in these relationships impacts the individual PHN. While the focus of this study was not to examine the process of relationship development, analysis of the data revealed that the strategies NFP PHNs used to establish new relationships were consistent with published findings.

From the PHNs' perspectives, the development of this relationship has been described in phases such as: locating the family, building trust and building strength (Zerwekh, 1992); establishing, maintaining and terminating (Heaman et al., 2007), giving and receiving behaviours through the phases of entry, health promotion and termination (Chalmers & Luker, 1991) and from the mothers perspective: limiting vulnerability by overcoming fear, building trust and seeking mutuality (Jack et al., 2005). What was common to these studies, and to the PHNs, was the recognition that forming this relationship was a complex process, subject to many influences and yet was the most important factor to home visiting programs (Chalmers & Luker, 1991; Heaman et al., 2007; Jack et al., 2005).

In an examination of how expert PHNs created relationships with vulnerable clients in a home visiting context, Zerwekh (1992) suggested that novice PHNs, and the organizations they practiced in, tended to minimize the importance of the essential, and time-consuming process of building and establishing the relationship and that the 'real work' was achieving change. This was not the case in the NFP program as PHNs found the structure and philosophy of the NFP supportive to the enactment of these

essential competencies. Because of the structure and emphasis on the PHN-client relationship and the long-term involvement, PHNs were afforded the time to locate clients, thus allowing for the potential to build a trusting relationship over time and build strength in clients by recognizing and celebrating small successes.

When examining the process of engagement from the mothers' perspectives, these competencies were further supported. In a study by Jack and colleagues (2005), maternal engagement in a home visiting program was mediated by limiting vulnerability, consisting of the phases of overcoming fear, building trust and seeking mutuality. These phases may be revisited within each home visit and were a dynamic and constant process. The 'client as expert' approach, instilled by the NFP, allowed clients to control the focus of home visits and to engage with topics or content that was meaningful or of interest to them. As the relationship progressed and trust developed, clients were more comfortable sharing information, however PHNs also had to determine when they needed to 'back off.' PHNs were keenly aware that nothing would be gained, and in fact the relationship would be harmed, by pushing too far.

Chalmers (1992) conceptualized the PHN-client relationship as one where both parties managed this relationship by controlling what they 'give' and 'receive' from the other, essentially, the need of the PHN to provide a service of health promotion and the clients need to address or fulfill their own needs or goals. The success of this relationship was thought to be the PHNs' skill in identifying what the client may be 'needing' and then offering something to meet that. Within the NFP, rather than rely on individual 'skill' in determining what may be of value to a client, PHNs provided ample opportunity for clients to identify what focus was important to them. This shift still allowed for a giving and receiving approach, but increased the likelihood that what was offered by the PHN would be received by the client. Like much of the relationship literature, Chalmers's conceptualization does not acknowledge what the nurse gives or receives beyond the professional role, including both fulfilling and emotionally draining experiences. In this study, participating PHNs often referred to giving of themselves, or having 'nothing left to give.' These PHNs were expressing the emotional impact, or the exhaustion, of working in a relationship-based role in which they themselves were a critical component.

When PHNs were asked to describe challenges of delivering the NFP, initial responses were almost universally about office or task-related issues such as driving time or documentation. It was only

through further probing that PHNs shared the challenges around the relationship. The fact that these relationships were potentially difficult to establish was well known among the PHNs, and even expected. They described that their clients were slower to trust, often deservedly so, given their histories of trauma or lack of connected, trusting relationships with others in their lives, so PHNs were cautious with the depth of engagement they offered and expected from clients. How the PHN navigated the progression and development of this relationship was a combination of past experiences, personal temperament, client characteristics, trial and error, and facility in using the NFP home visiting guidelines and facilitators. All of these PHNs had previous home visiting experience in other programs, and most had worked previously in another nursing field, so all had experience of forming relationships with clients or patients. Yet in the context of the NFP, they stated that the depth and intensity of the relationships formed in the NFP were unlike those they had developed in any previous role. The frequency and duration of the home visiting schedule also contributed to the depth of this relationship. PHNs stated that the use of self-efficacy theory (Bandura, 1977) and strategies such as motivational interviewing helped advance their relationship-forming skills.

Termination of the PHN-Client Relationship

Termination, as a concept, is embedded within the literature of other relationship-based disciplines such as social work (Fortune, 1985) and psychology (Vasquez, Bingham, & Barnett, 2008) while nursing literature has devoted little attention to this stage of the interpersonal nurse-client relationship. Peplau, one of few nursing theorists to discuss termination and the impact on nurse and patient, developed a theory of the interpersonal relationship between nurse and patient consisting of four sequential phases: orientation, identification, exploitation and resolution (Peplau, 1952). In her theory, the resolution phase refers to the termination of the nurse-patient relationship after needs have been met or goals achieved through the combined effort of nurse and patient and this was acknowledged to be a potentially difficult process for both nurse and patient. Different terms have been used to describe the end of the interpersonal relationship: termination, resolution and within the NFP, graduation. Variations of terms may be indicative of who (nurse, program guidelines or client) initiated the end of the encounter or reflect the specific context. NFP

clients who completed the program were said to have graduated, so that term will be used when referring to the end of the relationship within the NFP program.

Within the nurse home visitor literature, termination was described as playing a “fairly minor role” (Chalmers, 1992) for both the PHN and client and the focus has largely been on the establishment and maintenance phases (Chalmers & Luker, 1991; Chalmers, 1992; Heaman et al., 2007; Jack et al., 2005). However, the concept of termination provided by Sundeen, Stuart, Rankin and Cohen (1998) in their textbook on nurse-client interaction was consistent with what PHNs described. Sundeen et al. (1998) suggested that termination was an ambivalent and emotionally painful experience due to the simultaneous and conflicting emotions of satisfaction of progress made with knowing the relationship will soon be coming to an end.

When there was uncertainty about the effectiveness of the relationship, as some of the PHNs had shared, this added further challenge to the graduation process. The conclusion of the relationship may be an experience of growth and celebration but also created the potential for loss for both the PHN and client. The experience leaves both with a sense of anger, anxiety, sadness or fear and may cause a reliving of past lost relationships. Clients may typically respond to the end of the relationship with regression to previous maladaptive behaviours, withdrawal or by attempting to negotiate further involvement (Sene, 1969), all behaviours that negatively impact the PHN. Attempting to conclude the relationship amidst a crisis was one situation that was particularly difficult for PHNs to navigate. Reviewing achievements within the relationship, openly discussing and normalizing responses to termination as well as discussing future plans were all important components of the termination process with the client (Sundeen et al., 1998) and the discussion of termination is most effective when conducted over the span of several visits (Heaman et al., 2007; Sundeen et al., 1998), all strategies reported by the NFP PHNs.

Termination of the therapeutic relationship can be considered as either negotiated or non-negotiated (Chalmers & Luker, 1991) or in other words, planned or unplanned. If the client completed the program within the NFP program’s established timeline, graduation could be planned for and acknowledged. However, in many instances, clients would ‘disappear’ for extended periods of time leaving the PHN unsure if this was in essence a termination, rather than graduation, or if they would be returning to

the program. Files remained open and clients could return to the program at any time. These uncertain endings did not allow the PHN to engage in the graduation process.

Given that PHNs spent over two years forming a therapeutic relationship with their client and their child, it is not unexpected for the PHN to experience a feeling of loss although their experience of this varied. A sense of loss was a normal response to a successful and engaged therapeutic relationship with a client (Sundeen et al., 1998) and what was essential for colleagues, the supervisor and the individual PHN to recognize was when such a response was disruptive to their personal and professional lives. PHNs reported that maintaining professional boundaries with their client and ensuring a focus on the client as expert facilitated the process of letting go. Maintaining the focus on the client ensured that clients were building the skills needed to navigate the system on their own once they left the program. Reflective supervision, debriefing with colleagues as well as the individual's own assessment and self-reflection assisted the PHN in determining if other supports were necessary.

PHN-Client Boundaries

Challenges to maintenance of the PHN-client boundary specific to the context of home visiting were the relaxation of the traditional professional-client role due to the less structured home environment (Walker & Clark, 1999) and the client's view of the PHN as a 'friend' figure (Heaman et al., 2007; Kurtz Landy et al., 2012). Within the RNAO (Registered Nurses Association of Ontario) Best Practice Guideline (BPG) on Establishing Therapeutic Relationships (2002), awareness of boundaries and limits of the professional role is listed as an essential competency in the formation of an effective relationship. In this guideline, behaviours that do not have the client's best interest at the forefront, having favourite clients, extending visits, or keeping secrets with clients may be indicative of a boundary violation. From the mental health literature, Walker and Clark (1999) also stated off-hours communication, doing too much and inappropriate use of self-disclosure were boundary violations. While limiting availability to clients to within established working hours was a clear strategy, determining what was 'too much', 'inappropriate' or 'in the clients best interest' was not always as clear given the complex nature of the client's social dynamics. Simply stating ethical guidelines was inadequate to the navigation of the complex and developing relationship (Walker & Clark, 1999) and required the PHNs to interpret guidelines to fit the situation.

Further, the over-reliance on external guidelines, a struggle with the differences in social worlds between themselves and clients and the tendency to want to ‘fix’ problems (SmithBattle et al., 2004a) were experiences noted by novice PHNs that may challenge the maintenance of appropriate boundaries. Specific challenging situations reported by PHNs included seeing clients with very little resources, such as no food in the cupboard or few possessions, and then leaving with a sense of “how do I do nothing?” Effective clinical supervision has been well supported as a valuable mechanism to identify and explore sources of boundary problems in the PHN-client relationship (Pernelj & Yonge, 2003; Registered Nurses Association of Ontario, 2002; Walker & Clark, 1999) in addition to the support of experienced colleagues (SmithBattle et al., 2004a). Participants in the study successfully created boundaries through discussion with peers and reflective practice and supervision.

A further challenge to the PHN-client relationship arose from the PHN’s responsibility as a mandated reporter to CAS. As trust was often difficult to establish and maintain in relationships with clients, PHNs had to navigate the complexity of simultaneously serving both a supportive and surveillance function in the client’s home (Marcellus, 2005). As CAS had the authority to remove children from the home, clients were often fearful about their involvement, which may in turn limit their engagement with the PHN (Davidov, Jack, Frost, & Cohen, 2012). Although there were no simple solutions to solve the balance between these potentially competing roles, there are strategies to support the PHN as well as the client. To address client’s fears and to assist with building a trusting relationship, PHNs can reinforce the supportive purpose of home visits, the client as expert in their lives and the confidentiality between the PHN and client. However limits to confidentiality, such as when the PHN is required by law to contact CAS, should be clearly stated early in the relationship building process (Davidov et al., 2012). Open and direct communication with clients, an understanding of local reporting policies and procedures, ongoing education about abuse and neglect, and accessibility to experts on ethical and practical issues around child maltreatment and reporting is recommended (Davidov et al., 2012; Marcellus, 2005; Mitchell, Turbiville, & Rutherford Turnbull, 1999). Despite the inherent risk to the PHN-client relationship, PHNs reported that being honest with clients about why and when a report was to be made to CAS was an effective strategy to maintain trust with clients.

Contributing Factors to Workplace Stress

Workload is a major contributor to burnout (Maslach & Leiter, 1997) and PHNs reported that workload was a major contributor to their stress. PHNs stated that factors contributing to their workload were a complex caseload, long driving times, inefficient documentation systems, inability to document remotely, maintaining the required home visits and inefficient team meetings. They described feeling constantly behind, never caught up, working late and some reported completing work on their own time.

One element contributing to burnout was lack of control (Maslach & Leiter, 1997). When PHNs have little control over their workload, the impact of this was even greater. Documentation was a key example of this. PHNs were adamant and vocal over the duplication and inefficiency of the current documentation requirements – a combination of systems reporting to several end-users. Despite their voices, the system was slow to change. In this case the lack of control in combination with doing what appeared to be a duplication of work was frustrating. As well, PHNs often had periods of time between clients in which they were unable to complete required work because of driving distance to the office and documentation systems that were not accessible remotely, which only added to their frustrations. NFP PHNs in an American study also confirmed that documentation was a significant burden (Zeanah et al., 2006).

Strategies for prioritizing home visits and managing complex caseloads is an area for significant development in the NFP model. The complexity of client situations, combined with other administrative tasks, added to the workload burden of NFP nurses, even with a reduced caseload in Canada. In the US NFP model elements, nurse home visitors were required to carry a caseload of 25 active clients. However, in Canada, the adapted NFP model required nurses to carry a caseload of 20 clients (Jack, Busser et al., 2012). While this change was instituted to reflect differences in hours worked per week and annual number of vacation days, this reduction in caseload may also assist nurses in providing the level of care and support they want to give as required by the program to their Canadian clients. Yet, despite this reduction, PHNs still reported that workload was a major issue. These findings substantiate the work being done in the US to enhance the NFP model of care through the development of a risk/strength assessment framework allowing

nurses to independently prioritize and adjust home visit frequency to support higher-risk families (Olds et al., 2013).

Existing Supports for PHNs

Informal Peer Debriefing

PHNs stated peer debriefing, reflective supervision, case conferences and team meetings were all supports available to them in their workplace. Of these supports, peer debriefing was perceived as the most valued and supportive strategy as well as the activity most consistently used by PHNs. Peers, or other nurses employed in the NFP program, provided a safe, immediate and non-judgmental environment to express concerns, doubts, and emotions with others who were working under the same pressures and in the same environment. This debriefing with others who ‘get it’ was critically important as it provided PHNs validation for their actions and reactions from someone who understood their context. Maslach and Leiter (1997) proposed that a lack of community was a necessary contributor to burnout, however the high level of functioning and support among this NFP team provided the PHNs with a strong sense of community in their workplace. This served a protective function against burnout and in turn fostered a sense of work engagement, thought to be the opposite of burnout (Freeney & Tiernan, 2009).

Despite the benefits and necessity of peer debriefing, PHNs acknowledged that it was also a potential drain on their emotional resources. The sharing of traumatic details between colleagues added to the risk of vicarious trauma for the listener (Pearlman & Saakvitne, 1995) so the freedom to express frustrations needed to be balanced by the potential impact. Establishing parameters around peer debriefing limits the amount of trauma exposure for peers and would also assist with focusing on what the speaker needs. The process of a low-impact disclosure involves four steps: increased self-awareness, fair warning, consent and limited disclosure (Mathieu, 2012). When debriefing, PHNs need to understand what is effective for them: a formal or an informal process, what level of detail is required, and what level of detail is comfortable to hear. Providing the listener with fair warning that a story may have graphic details prior to sharing them, followed by seeking consent to continue, ensures that both parties are amenable to the discussion. This also encourages the listener to pause and consider his or her own capacity, at that moment,

to take in more traumatic content. Finally, the level of detail provided would be determined by the PHN based on what they needed from the debriefing.

The concept of the NFP team should be considered from a broader scope. At any given time only five or six PHNs were active in the program and for the initial cohort, they were the first and only PHNs delivering the NFP in Canada. The community of support for Canadian PHNs was very small compared to the US, where the NFP is well established and an on-line community of NFP PHNs was available. PHNs in Canada expressed a desire to connect with a broader community to have additional resources and a forum to share experiences and ask questions and PHNs identified the benefits of the creation and fostering of a broader NFP community that would contribute to their work engagement (Freeney & Tiernan, 2009).

Case Conferences/Team Meetings

Within the PHN interviews, meetings were discussed generically although they participated in three distinct formats: case conferences, NFP team meetings and meetings specific to the Family Health team. As per the Canadian adaptation and implementation recommendations, case conferences provided the opportunity for PHNs to discuss successes and challenges with a case and solicit feedback from peers and the supervisor (Jack, Busser et al., 2012). NFP team meetings were a forum to present NFP content related to day-to-day operation, program delivery and concerns such as vacation coverage. Due to time constraints, every other NFP team meeting was joined with the Family Health team, which resulted in a 50% decrease of NFP-specific meeting time compared to the adaptation and implementation recommendations.

PHNs reflected on the challenge of being ‘a program within a program,’ a small home visiting program within the larger context of the Family Health team. PHNs still wanted to be a part of the greater unit, yet their perception was a disproportionate amount of time was spent on non-NFP content. When the meetings did not serve a restorative or motivating function, the perception was they were simply another task to complete and added to the PHNs workload. As these meetings were required and routinely scheduled, PHNs were unable to control how they spent their time during these meetings. As workload and lack of control were contributors to burnout (Maslach & Leiter, 1997), organizations need to consider the harm of inefficient processes. As the NFP team had identified problems with the current structure and

format of their various meetings, at the time of writing they were actively attempting to integrate new practices to improve focus and efficiency.

Reflective Supervision

While the term “reflective supervision” was used by the PHNs in this study, they were referring to the use of reflective practice within the context of clinical supervision. Clinical supervision, a meeting between the PHN and the supervisor, served three functions: education, support and management (Fisher, 1996). Reflective practice is “an active and deliberate process when an individual is challenged and enabled to undertake the process of self-enquiry to empower the practitioner to realize desirable and effective practice within a reflexive spiral of personal transformation” (Duffy, 2007, p. 1405). The incorporation of reflective practice supported the functions of clinical supervision (Fowler & Chevannes, 1998) and provided the context for the PHN to develop their own skills of reflection with the guidance of the supervisor (Beam, O'Brien, & Neal, 2010). The RNAO BPG on Establishing Therapeutic Relationships (2002) stated that through reflection, nurses can assess what attitudes or possible bias from past or personal experiences may be influencing how she/he engages with a client. In this study, reflection played an important role to allow nurses to clarify and define the boundaries of the PHN-client relationship. Reflective practice is a critically important tool for the PHN to examine her own responses engaging with clients who have challenging and often chronic issues. As this may be a new practice, the incorporation of reflective practice into supervision taught PHNs how to use this skill and incorporated motivational interviewing thereby modeling how to use this with their own clients (Beam et al., 2010).

The provision of clinical supervision by the NFP supervisor is a model element of the NFP program and serves the purposes of providing the opportunity for reflection, to model the integration of theories into practice and to promote professional development (Nurse-Family Partnership, 2011). Reflective supervision was initially added to the American NFP program in the 1970's as a mechanism to address PHNs doubts or concerns about their own proficiency or lack of perceived progress with a client (Beam et al., 2010), the same issues that current PHNs reported grappling with.

The process of reflective supervision begins with PHNs bringing forward a clinical situation in which they have concerns or are questioning how they responded. The NFP model of reflection has six non-

linear phases based on Gibbs' (1988) reflective cycle: description of the event, exploration of feelings associated with the event, evaluation of challenges and successes, analysis of learning from the event, conclusion of other actions the PHN could have taken and the process concludes with the formation of a plan of action for the future (Beam et al., 2010). Theoretically, the process of reflective supervision furthered PHNs' learning through experience, improved NFP program implementations and provided a supportive function (Beam et al., 2010) however, the benefit to program outcomes or to the PHNs has not been formally evaluated.

Multi-disciplinary literature supported the use of clinical supervision with reflection as a recommendation for a multitude of issues. It is used: to enhance program implementation and reduce nurse turnover (Beam et al., 2010); as a BPG to establishing therapeutic relationships (Registered Nurses Association of Ontario, 2002); to support role transition (Sharrock et al., 2013); as a risk management strategy (Walker & Clark, 1999); as a mechanism to mitigate compassion fatigue (Kanter, 2007) and identify problematic relationships with clients (Gill, Greenberg, Moon, & Margraf, 2007). While supervisors may bring a wealth of experience this does not mean they have had adequate training in the specialized role of providing clinical supervision (Rodriguez-Keyes, Gossart-Walker, & Rowland, 2012). Given the importance of clinical supervision in the management of the complex issues facing PHNs, ongoing professional development of the supervisor is important.

Despite all of these perceived advantages of clinical supervision, PHNs in this study reported a gap between the potential and actual gains of this process, particularly with respect to managing emotional responses. Engaging in this process with a manager, the same person responsible for their performance evaluations, was a challenge for PHNs and served as a barrier to full engagement. Moving through the reflective process was a potentially vulnerable experience where the PHN was required to express doubt, uncertainty or present a situation where they felt they did something 'wrong.' PHNs expressed a desire for reflective supervision sessions to be a safe place to express emotional reactions to their work without fear of reprisal. PHNs shared that they carefully selected what experiences to present in the supervision sessions and as a result were more likely to discuss scenarios that were more flattering to them rather than ones where they needed support. PHNs were not unique in this and filtering out certain experiences lessens the

potential benefits of the supervision process, resulting in a superficial experience (Gardner, McCutcheon, & Fedoruk, 2010). PHNs reported that reflective supervision had an overemphasis on a clinical rather than reflective discussions of client updates and procedural content tended to dominate the sessions. The challenge and difficulty was to balance the need of the supervisor to fulfill administrative or managerial obligations, such as client updates, with the opportunity of the PHN to have an open forum to discuss salient issues. The opportunity to discuss stressful cases within supervision was shown to improve depressive symptoms and result in a higher sense of personal accomplishment in a study of 41 home visiting home visitors (Gill et al., 2007). This should be interpreted with caution, as the home visitors were not PHNs, however there is limited research available evaluating the impact of clinical supervision on PHN home visitors.

The pre-scheduled nature of supervision sessions limited its' use to respond to urgent issues. The disconnect between arising needs and scheduling of supervision has been reported by PHNs in other NFP programs (Beam et al., 2010). This in itself may not be an issue as long as other alternatives were in place to respond to more immediate needs. PHNs reported that colleagues and the supervisor were supportive in managing urgent issues although this process only allowed for limited reflection. The benefit of routine scheduling of supervision ensured that there was at a set time for PHNs to examine their own practice, even in the absence of a problem (Gardner et al., 2010), and have the dedicated attention of their supervisor.

This process may also be challenging from the perspective of the supervisor who must balance their multiple roles, responsibilities and information requirements within and beyond the session. As a supervisor hears from multiple PHNs every week about their most challenging events, supervisors are at high risk for vicarious trauma or secondary traumatic stress and may avoid emotional content as a means of self-preservation. Defaulting to a focus on procedural issues or clinical updates may feel safe or more comfortable for both parties. This type of interaction provided the PHN with some answers to questions, but did not serve the purpose of reflective supervision, to the extent that PHNs had reduced opportunity to explore their own emotional reaction to their clients.

The importance of the supervisory role to the support of the PHN, the main intervention of the program, cannot be understated. Organizations should ensure that support is routinely scheduled for

supervisors, much as it is for PHNs. The NFP NSO has developed online resources for supervisors as they have recognized the challenge of developing and maintaining supervisory skills in the reflective process (Beam et al., 2010). In addition to increasing support around the development of reflective supervision competencies, having the supervisor carry a small case-load would also ensure that they are grounded in the same experience as the front-line PHNs. First-hand experience allows the supervisor to better understand the unique challenges of delivering the NFP. With front-line expertise, and increased knowledge and skill in the process of reflection, supervisors can better support the PHNs.

The NFP Program

PHNs often stated that they believed in the NFP program, indicative of program and personal values alignment. A necessary condition for the development of burnout is a conflict between organizational and personal values (Maslach & Leiter, 1997) so this alignment of values, what drew many PHNs to the program initially, actually served a protective function for the participants in this study. PHNs stated that they appreciated developing new skills, such as motivational interviewing, that assisted them to engage with their clients. However, the acquisition of these skills and the rate at which they felt they became comfortable delivering the NFP was in part influenced by the initial training or orientation they received.

PHNs described that the NFP program itself was supportive to their engagement with clients and their ability to implement behaviours to achieve a positive outcome. The theoretical foundation of self-efficacy had a profound effect on how PHNs engaged with their clients resulting in a shift to recognizing small successes and empowering clients to be experts in their lives thus increasing the clients' belief in their own capabilities to achieve their goals. Heaman, Chalmers, Woodgate and Brown (2006) asked participants in another Canadian early childhood home visiting program (*BabyFirst*) what factors they found contributed to the program's success and these were nearly identical to what NFP PHNs stated: strength-based, early intervention, a voluntary and ongoing and structured service delivery. PHNs and home visitors within this program highly-valued the strength-based focus with their clients and felt this was instrumental in achieving positive child and maternal outcomes such as positive parent-child relationships and healthy child development (Heaman, Chalmers, Woodgate, & Brown, 2006).

One challenge that PHNs reported was of conflict between the NFP and other demands required by the Family Health unit. They reported the sense of answering to “multiple masters” such as completing documentation that did not reflect the delivery of NFP content but rather of health ministry requirements. PHNs found these additional tasks did not take into account the focus or purpose of the NFP but were reflective of the needs and philosophies of other programs. This conflict may be further exacerbated as the visitation guidelines of the NFP were evidence-based yet conflicted with ministry-required visitation content. A review and evaluation of conflicting requirements between the NFP and the health ministry would highlight potential avenues to streamline the program and deliver the NFP as it was designed.

Self-Care

Within the health care literature, self-care was often suggested as a strategy to prevent or mitigate the negative impacts of work (Radey & Figley, 2007; Slatten et al., 2011). Although PHNs reported the use of self-care, such as engaging in activities they enjoyed outside of work, as a strategy to manage work place stress much of this discussion centered around issues and supports specific to the workplace. This was not meant to downplay the critical importance of engaging in self-care activities or striving for work-life balance however the context for the practice, problem and needs analysis was the workplace which may have unduly limited the scope of the self-care discussion. Although PHNs stated the importance of self-care, they also expressed some guilt that they were not better at it. Encouraging PHNs to prioritize self-care, or work-life balance is important as health care workers tend to place the needs of others before their own (Boyle, 2011). Although ongoing professional education on topics such as stress management and compassion fatigue may be beneficial, they should not be in place of improving workplace factors where possible.

Study Strengths and Limitations

Multiple strategies were implemented in the conduct of this two-phase qualitative study to address frequent critiques of both qualitative secondary analyses and small descriptive studies, as well as to promote overall trustworthiness of the data. First, the implementation of a two-phase study design addressed the common critique that secondary analyses are limited in their ability to address a specific phenomenon in depth, if that issue was not the primary focus of the data (Rew et al., 2000). In this study, the focus group

data were purposefully analyzed to identify key themes that guided the development of the interview guide. This created a foundation for the second stage of the study, where original themes were explored in depth with a larger sample, including the original participants.

Although the sample size was small, this was the complete population of Ontario PHNs experienced in delivering the NFP and allowed for the in-depth exploration of multiple perspectives. However, this small pool within the specific context of a pilot site is a limitation. Within this group, over half were involved in the pilot project and were exposed to many challenges and difficulties that come from being the first cohort. Considerable time and energy was spent adapting and learning program content, without the benefit of on-site expertise, and educating community partners about their role. Conversely, the remainder of the sample joined the NFP at different points reducing their access to the education or support offered during the pilot study. New PHNs joined one at a time benefiting from the support of experienced colleagues but not from orienting with a peer group. These additional factors may have influenced the individual PHNs experience of work-related stress and may not be comparable to other settings. A study including a broader sample of PHNs across varying contexts is warranted. As new NFP sites are developed across Canada, they will face similar issues of lack of local expertise and adapting content to fit their context.

Overall trustworthiness of the data was enhanced by the application of multiple strategies to address credibility, dependability, confirmability and transferability. Confidence in the credibility of this data as an accurate reflection of Canadian PHNs' experiences and impact of home visiting vulnerable NFP clients on their personal and professional selves was achieved through application of data triangulation, researcher credibility and member checking. To promote overall researcher credibility, the researcher was immersed in the public health PHN environment through an advanced clinical placement. This daily interaction with PHNs, along with observation of home visits and attendance at team meetings, helped establish rapport as well as understand the context of the program. While this experience did not imply an understanding of experiences as the PHNs did, it did allow for an appreciation of their day-to-day professional life.

Implications for Practice, Education and Research

Overall implications of this study relating to practice, education and research as well as recommendations for the enhancement of the Canadian NFP model will be highlighted in this section. A summary of recommendations is provided in Table 5.

Table 5
Summary of Recommendations
Practice recommendations
<ul style="list-style-type: none"> Recognize that PHNs will be impacted by their work
<ul style="list-style-type: none"> Ongoing monitoring for compassion fatigue, burnout and vicarious trauma using self-evaluation tools
<ul style="list-style-type: none"> Recognize the contribution of inefficient or time-consuming tasks, such as documentation, to the overall workload of staff and reduce or eliminate where possible. Provide adequate administrative support for non-nursing tasks
<ul style="list-style-type: none"> Clearly define the goals and purpose of team meetings and case conferences
<ul style="list-style-type: none"> Develop workload/caseload assessment tools to allow PHNs to alter the home visiting schedule to meet client needs
<ul style="list-style-type: none"> Make time for team building
<ul style="list-style-type: none"> Adopt low-impact disclosure for formal and informal team debriefing
<ul style="list-style-type: none"> Allow time and space for informal and confidential team discussions
<ul style="list-style-type: none"> Foster the creation of a Canadian NFP community of practice
<ul style="list-style-type: none"> Establish support procedures for the NFP supervisor
<ul style="list-style-type: none"> Maintain a focus on the emotional experience of the PHN in reflective supervision
<ul style="list-style-type: none"> Establish a standardized orientation program for new NFP PHNs
Education recommendations
<ul style="list-style-type: none"> Consider the experience of compassion fatigue, burnout and vicarious trauma as an ongoing professional practice issue.
<ul style="list-style-type: none"> Incorporate compassion satisfaction, compassion fatigue, burnout and vicarious trauma into undergraduate nursing education.
Research recommendations
<ul style="list-style-type: none"> Investigate factors that promote engagement in the workplace
<ul style="list-style-type: none"> Conduct a process evaluation measuring the experience of compassion satisfaction, compassion fatigue, burnout and vicarious trauma over time
<ul style="list-style-type: none"> Evaluation of clinical/reflective practice to determine what elements are supportive to PHNs

Awareness of the Impact on PHNs

Of fundamental importance to any organization delivering the NFP is the recognition that PHNs will be impacted by their work. This impact will be a complex interaction of satisfaction and stress and varies over time. Experiences of burnout, compassion fatigue and vicarious trauma/secondary traumatic stress not only affects the individual but also influences how the PHN is able to engage with her client. Awareness and understanding that the experience of worry, doubt and a sense of ineffectiveness were universally experienced is also important and assessing for these emotions or reactions should be part of ongoing reflection. The use of self-evaluation tools measuring the risk for the emotional impacts on the PHN, such as the ProQOL –RV (Stamm, 2010), should be incorporated into routine practice to provide additional insight and early identification of risk and periods of increased stress. Recognizing and

minimizing workplace contributors to stress and ensuring adequate supports are in place for PHNs is essential for the continued health and well-being of the PHNs and ultimately of their clients. Given the high level skill required in relationship formation, clinical decision-making and high level of vulnerability of the NFP clients, the suitability of newly graduated nurses for a role in the NFP should be carefully considered.

Organizational Contributions to Work Stress

While each organization and workplace has limits to what they can control, the impact of workload as a major contributor to burnout must be acknowledged and limited where possible. Workload that overwhelms PHNs not only impacts them personally but also impairs their ability to form effective therapeutic relationships with their clients (Heaman et al., 2007; Registered Nurses Association of Ontario, 2002). Fidelity to the NFP model, a requirement of NFP programs, cannot be maintained without the appropriate human and material resources (Heaman et al., 2007). Administrative support to undertake non-nursing tasks such as photocopying or gathering of supplies for visits, would allow more time to fulfill other nursing obligations. While issues such as driving distances and documentation requirements/software will vary with each site, these processes should be reviewed to be as streamlined as possible. The purpose and goals of team meetings and case conferences should be clarified among participants and team processes evaluated to ensure that these goals are met.

The PHN's caseload of no more than 20 clients was established by the Canadian NFP implementation guidelines (Jack, Busser et al., 2012), although at present there is no mechanism to assess individual client needs or provide a measure of workload to provide an overview of a given caseload. The development of client assessment tools would allow PHNs to critically assess the state of their caseload and based on client strengths, risks or presenting crises, use their assessment skills and critical thinking skills to independently alter the schedule of home visits to meet changing client needs. Allowing flexibility with the visitation schedule of the NFP program has positively influenced client retention (Ingoldsby et al., 2013; O'Brien et al., 2012) however the corresponding impact of increased decision-making capacity on the PHNs has not yet been evaluated.

In the Canadian trial to evaluate the effectiveness of the NFP, starting in Fall 2013 in British Columbia, it will be important for researchers to integrate questions about the impact of this reduced

caseload on nurse burden and responsibility within the planned process evaluation. An evaluation to identify what particular component of workload (client specific, case load, documentation, driving time) was problematic would allow resources to be prioritized to improving it.

Workplace Supports

All of the PHNs stated that the NFP was the most supportive team they had ever worked with and without it they would not be able to do their job. While this NFP team was fortunate to have a very supportive team, this may not be the reality in all work places. As a supportive team is essential to the success of the program, interventions to engage and increase support merit investigation. Organizations must ensure that they allow the time and space for formal and informal gatherings and set aside time for team building activities. Utilizing the strategy of low-impact disclosure (Mathieu, 2012) may minimize colleague's exposure to additional traumatizing content and lessen the emotional burden of supporting each other.

Organizations that have team members that are physically isolated from each other need to consider creative alternatives to allow for this essential interaction between peers such as the creation of a virtual community. To promote the community of NFP PHNs within the Canadian context, creating a forum for NFP programs to connect with each other would be beneficial, particularly within the context of program expansion. Experienced PHNs can share their knowledge and new PHNs have the opportunity to connect with others who 'get it.' Some PHNs discussed the concept of mentoring within the interview however the utility of a formalized mentoring program compared to fostering connections within the greater NFP community should be evaluated. New NFP implementation sites must consider the value and importance of community to PHNs and ensure creating an NFP community is a priority.

While PHNs relied heavily on informal support from colleagues, the use of formal processes as avenues of support varied. The role of clinical supervision in the nursing context is not as well known compared to other disciplines such as social work or psychology, so both PHNs and supervisors need to learn how to best use this opportunity. Much like learning any new skill, developing skill and ease with the supervision process requires an investment of time and energy. As the supervisors are guiding the supervision process, adequate supports for them is essential to foster success. Of particular importance is

for supervisors to understand the fundamental difference between clinical and reflective supervision and to review strategies to create safe environments for participants. Supervisors require opportunities to receive feedback on their reflective supervisory skills as well as to receive support to mitigate the cumulative impact of exposure to emotional content.

Fowler and Chevannes (1998) reported a wide variation in practitioners' acceptance of the reflective process and its imposition may yield minimal outcomes. Clinical supervision will not be effective if PHNs endure, rather than engage, in the process so the use of alternate supports should be identified for those who do not find the practice supportive.

Professional Development

As the NFP is an evidence-based program based on consistent delivery across sites and contexts, a standard orientation for all new PHNs should be provided to ensure fidelity to the program model. While fundamental competencies, such as motivational interviewing, are introduced within the orientation, ongoing education should allow for the reinforcement of these skills as well as reflect the evolving learning needs of the NFP team. Additional learning areas include identification of child abuse and neglect, recognition and management of compassion fatigue and burnout and issues relating to client mental health.

Education

As there is high potential for compassion fatigue, burnout and vicarious trauma/secondary traumatic stress with significant impacts on PHNs and their ability to form relationships with clients, this should be considered as an ongoing professional practice issue. The development of on-going workplace education and support strategies would ensure that this issue remains at the forefront and part of a larger discussion on program delivery. As well, education on compassion satisfaction, compassion fatigue, burnout and vicarious trauma should have an increased focus within the undergraduate nursing education programs to prepare new entrants to the profession for the potential emotional impacts.

Future Research

Rather than focus on problematic workplace factors, research into factors promoting a positive work environment that supports work engagement: feeling energized, committed and effective in the work role (Schaufeli & Bakker, 2003) would be in keeping with the strength-based approach of the NFP.

However, before supportive interventions can be implemented, the nature and scope of the problem needs to be better understood. The administration of the ProQOL R-V (Stamm, 2010) to all NFP PHNs in Canada and the US would provide information on the prevalence of compassion satisfaction and risk of compassion fatigue (reported as burnout and secondary traumatic stress subscales) and provide insight into where interventions should be targeted. Repeating this measure over time would provide insight into if there are predictable points of early identification and opportunity to intervene and prevent or mitigate the development of burnout or secondary traumatic stress.

The findings from the study reported here, as well as data from the survey, could be used to guide the development of NFP-specific interventions to support work engagement among NFP PHNs. Any intervention to support PHNs should encompass an understanding that PHNs will be affected by the work that they do and seek to mitigate the negative emotional consequences. Qualitative interviews would be used to identify barriers and promoters of work engagement. Possible avenues of exploration on which to base an intervention include the incorporation of a mindfulness practice (Cohen-Katz, Wiley, Capuano, Baker, & Shapiro, 2005) in the workplace, the addition of a clinical psychologist to team meetings or the use of external personnel with expertise in facilitating reflective supervision. Further exploration into what factors influence PHNs satisfaction and engagement with the reflective supervision process would also inform how this practice is used in the NFP. Once the intervention was further defined, a pilot study would be conducted to trial its feasibility.

Upon successful completion of the pilot, the intervention would be evaluated using a RCT. Randomly selected agencies would implement the intervention and outcomes compared to the control group. Specific outcome measures may include the ProQOL or an alternate measure of work life satisfaction.

Conclusion

The fundamental component, and requirement, of the NFP is the PHN's ability to form an empathic, therapeutic relationship with their client, yet it is this very relationship that also places the PHN at high risk for negative consequences. Workplace and organizational challenges contribute to the potential for PHNs to experience burnout. As the negative impact on the PHN increases, their ability to empathically

connect with their client is impaired. Not only does this have potential repercussions for program outcomes and staff retention but for professional and personal outcomes. To support PHNs, and the NFP program, a mitigation approach to compassion fatigue, vicarious trauma/secondary traumatic stress and burnout should be adopted, as prevention is not realistic. Appropriate supports and interventions are important to mitigate the impact on PHNs. However, limits to the effectiveness of workplace interventions must be acknowledged. PHNs and supervisors require additional training for early recognition of situations where additional professional support is required.

Throughout the interviews, nearly all of the PHNs commented jokingly that they routinely asked themselves why they stay in this job when they could be doing something much less stressful. The unanimous answer was that they stayed as an NFP PHN because they loved the program, and felt transformed by it. The therapeutic relationship with their clients, feeling ‘like a nurse’ and making a difference in the lives of these young families were factors that kept them motivated and engaged. As the first step to the creation of an organizational culture that supports PHNs, the essence of the NFP intervention, an awareness of the impact on the PHN is essential. The NFP has transformed the lives of not only the clients but the PHN as well. As implementing NFP agencies, such as Hamilton Public Health Services, are required to deliver the NFP program with fidelity to the program model elements, the experiences of the Canadian PHNs documented in this study will be of high relevance to other NFP nurse home visitors working with clients in urban settings.

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Appendix A
Literature Search Strategy and Results

Database	Search terms	Articles identified by electronic search
CINAHL Limit by: years 1992 to current, English	nurs*, home visit*, stress, community health nurs*, home health, maternal child nurs*, public health nurs*, home nurs*, professional impact*, effect*, burnout, compassion fatigue, compassion satisfaction, secondary traumatic stress, vicarious trauma, occupational psychology	88
PsycInfo Limit by: years 1992 to current, English	nurs*, home visit*, stress, community health nurs*, home health, maternal child nurs*, public health nurs*, home nurs*, professional impact*, effect*, burnout, compassion fatigue, compassion satisfaction, secondary traumatic stress, vicarious trauma, occupational psychology	98
Social Sciences Abstracts Limit by: years 1992 to current, English	nurs*, home visit*, stress, community health nurs*, home health, maternal child nurs*, public health nurs*, home nurs*, professional impact*, effect*, burnout, compassion fatigue, compassion satisfaction, secondary traumatic stress, vicarious trauma, occupational psychology	26
Web of Science Limit by: years 1992 to current, English	nurs*, home visit*, stress, community health nurs*, home health, maternal child nurs*, public health nurs*, home nurs*, professional impact*, effect*, burnout, compassion fatigue, compassion satisfaction, secondary traumatic stress, vicarious trauma, occupational psychology	32
Canadian Health Research Collection Limit by: years 1992 to current, English	nurs*, home visit*, compassion fatigue, burnout, secondary traumatic stress, vicarious trauma, compassion satisfaction	1
Exclusion criteria	Veterinary Literature War/post disaster Trauma Palliative Care Physician specific literature Veteran issues Specific disease process (e.g. HIV)	

Appendix B:
Letter of Information and Consent



LETTER OF INFORMATION / CONSENT

Long-term Home Visiting with Vulnerable, Young Mothers:
Impacts on Public Health Nurses

Investigators

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Purpose of the Study

The purpose of the study is to explore both the challenges and rewards experienced by public health nurses who do long-term home visiting with a vulnerable population of high-risk, young mothers in the Nurse-Family Partnership program offered by Hamilton Public Health Services. I want to understand how this work affects you on both professional and personal levels. As there is little published information about nurses in your position, you are invited to take part in this study to share your experiences.

I am doing this research as part of my Masters of Nursing thesis at McMaster University.

What will happen during the study?

You will be asked to participate in an audio-taped individual interview lasting 60-90 minutes. I will be asking you questions about:

- Challenges and rewards delivering an evidence-based home visiting program to young, high-risk mothers.
- How delivering this program has impacted you both at work and in your personal life.
- Recommendations for supporting nurses involved in delivering this maternal-child health promotion intervention.

I will also ask you to complete a brief demographic questionnaire.

After the interview, I will be e-mailing a summary of key ideas emerging from across the interviews to you. If you consent, I would like to follow-up with a brief telephone phone call (30 minutes) to ensure your ideas were captured accurately and to seek clarification if required.

Are there any risks to doing study?

The risks involved in participating in this study are minimal. You may feel uncomfortable with sharing personal information, however you do not need to answer questions that you do not want to. You can withdraw (stop taking part) at any time. I describe below the steps I am taking to protect your privacy.



Are there any benefits to doing this study?

The research will not benefit you directly, although some people do find the experience of sharing their stories to be beneficial. I hope that what is learned as a result of this study will help us to better understand what problems nurses face, what is working well to address them and what areas need further support.

Compensation

As an acknowledgement of your participation in this study you will receive a \$25 coffee gift card. All costs associated with data collection (e.g. parking) will be covered by the study.

Confidentiality

You are participating in this study confidentially. I will not use your name or any information that would allow you to be identified. No one else will know whether you participated unless you choose to tell them. As your group is small, a total of ten possible participants, general themes rather than specific stories with identifying information will be included in the final write-up. With your permission I will digitally record the interview.

Encrypted transcripts and audio files will be password protected and stored on a computer or external server. Transcripts and audio files will be labelled with a study number rather than a name. All identifying information will be removed from the transcripts. A key linking your study number with your name will be stored securely and separately from the data. Once the study has been completed, the data will be securely stored for a period of three years.

b) Legally Required Disclosure

Although I will protect your privacy as outlined above, if the law requires it, I will have to report it. This may include suspecting, but not reporting, incidents of child abuse.

What if I change my mind about being in the study?

Your participation in this study is voluntary. If you decide to be part of the study, you can decide to stop (withdraw), at any time, even after signing the consent form or part-way through the study. If you decide to withdraw, there will be no consequences to you. You have the option of removing your data from the study, but please let me know this within 30 days of the interview. If you do not want to answer some of the questions you do not have to, but you can still be in the study. Your decision whether or not to be part of the study will not affect your employment status.

How do I find out what was learned in this study?

I expect to have this study completed by approximately December 2013. If you would like a brief summary of the results, please let me know how you would like it sent to you.

Questions about the Study

If you have questions or need more information about the study itself, please contact me at: dmytryal@mcmaster.ca.

This study has been reviewed by the Hamilton Health Sciences/McMaster Faculty of Health Sciences Research Ethics Board (HHS/FHS REB). The REB is responsible for ensuring that participants are informed of the risks associated with the research, and that participants are free to decide if participation is right for them. If you have any questions about your rights as a research participant, please call The Office of the Chair, HHS/FHS REB at 905.521.2100 x 42013.

CONSENT

I have read the information presented in the information letter about a study being conducted by Anne Dmytryshyn of McMaster University.

I have had the opportunity to ask questions about my involvement in this study and to receive additional details I requested.

I understand that if I agree to participate in this study, I may withdraw from the study at any time. I have been given a copy of this form. I agree to participate in the study.

1. I agree that the interview can be digitally recorded. Yes No

2. I would like to receive a summary of the study's results. Yes No

If yes, where would you like the results sent:

Email: _____

Mailing address: _____

3. I consent to a brief follow-up telephone call after receiving an e-mail summary of the main themes from my interview. Yes No

4. I agree to be contacted about future research and I understand that I can always decline the request. Yes No

Please contact me at: _____

Name of Participant (Printed)

Signature

Date

Consent form explained in person by:

Name and Role (Printed)

Signature

Date



Appendix C:
Semi-structured Interview Guide



ID# _____

DATE ____ / ____ / ____
dd mm yy

Semi-Structured Interview Guide for In-depth Interviews with Public Health Nurses

Thank you for agreeing to take some time out of your busy schedule to meet with me to discuss your experiences delivering the Nurse Family Partnership (NFP). I am also interested in learning more about how this has impacted you as a nurse and also how your organization seeks to address your needs.

1. **The focus group discussions provided a picture of the challenges of working in the NFP but also a love for the work. What is it about delivering the NFP that you find personally rewarding?**
 - a. The strength and value of the relationship between PHNs and young mothers was a theme that clearly surfaced in the focus groups. What has been your experience of this relationship? Why is this relationship important?
 - b. NFP nurses have shifted away from a perspective of “doing to” their clients, recognizing that the client is the expert of her own life. How would you describe this new perspective? How does this compare with other health care/social service providers approach?
 - c. What specifically about the NFP program facilitated the development of this relationship? What are the benefits of developing such a powerful relationship with your clients? What are the potential difficulties?
 - d. What are the barriers to the formation of this relationship? What are the impacts if this relationship does not develop? (probe for impact on self as well as on program goals)
 - e. Compared to other PHN roles, NFP PHNs have developed a different type of relationship with other professionals, such as the Children’s Aid Society. How have these relationships changed? What do you think influenced these changes?
2. **“What are the most significant challenges you experience in delivering the NFP program with fidelity to the model elements?”**
 - a. Probe for challenges at different levels: client issues (such as IPV, mental health, homelessness), interpersonal (nurse-client relationship), NFP team/within the organization (supervision, time, meetings, working with HBHC colleagues), community.
 - b. How do the challenges change throughout the phase of the program? Why? (For those who have graduated a cohort: Does seeing the program run a full cycle ease any of these challenges?)

- c. How do you find these challenges affect you? How do you respond to these challenges? Are your current strategies effective? Why or why not? How do you reconcile the passion for the program with the personal toll?
 - d. What do you need from your workplace to support you in this role? What could be improved? If not mentioned, probe for feedback around clinical supervision (comment on frequency, duration, effectiveness), weekly team meetings, core NFP education, ongoing education/professional development opportunities, technology support. Probe for other informal workplace practices that are supportive.
 - 1) Do you feel reflection is an important component of your nursing practice? Why/Why not? Have you had the opportunity to do this in any other nursing work?
 - e. How does (take responses from questions above) influence your professional nursing practice and your ability to deliver the NFP?
- 3. Throughout the focus groups, nurses commented that delivering the NFP has been ‘transformative.’ Can you tell me if this has been your experience and if so, what has been transformed?**
- a. What elements of the NFP program have assisted you in becoming a “stronger” and more “effective” nurse? Those terms came from the focus groups – what does “stronger” and “effective” mean to you? How important are these concepts to your work satisfaction? Any negative aspects to this evolution? Do you feel more like a nurse? How?
 - b. What is the nature of the connection between your job satisfaction and knowing the NFP is evidence-based? Why does this matter?
 - c. Probe for any changes in the idea of ‘success’ since starting in this role (client or PHN success).
 - d. How does (take positive/rewarding elements from above) influence your professional nursing practice and your ability to deliver the NFP?
4. We have had a very rich conversation today, before we end, is there any additional information that you would like to share with me about the impact that home visiting in the NFP program has on you, at either a personal or professional level.

Thank you very much for your willingness to participate and share your stories and experiences. You have very valuable insights and it was a pleasure to be here with you.

Appendix D
Demographic Data Collection Form



Long-term Home Visiting with Vulnerable, Young Mothers:

Impacts on Public Health Nurses

Demographic Data Collection Form

Date: _____

Study ID: _____

Age (in years) _____

Highest level of education (completed or in progress) _____

Numbers of years as a Registered Nurse _____

Number of years as a public health nurse: _____

Years delivering the NFP program _____

Previous Healthy Babies Healthy Children experience? _____

If so, number of years _____

Any other home visiting experience?

How many clients did you enroll into NFP the program? _____

How many (if any) clients have you graduated from the NFP program? _____