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Public health nursing: a comparison of theoretical and actual practice

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To clarify how nursing practice influences programme outcomes, the purpose of the research reported here was to examine the relationship that exists between client factors, system characteristics, provider actions and client outcomes in a postpartum programme. The programme is a community-based service primarily delivered by public health nurses in a large urban city in Western Canada. Relationships between structure, process and outcome dimensions in the programme were examined from both an explicit programme theory (normative programme) grounded in primary health care principles and philosophy, and an implicit programme condition (implemented programme) reflecting actual programme delivery. Elements of the McGill model of nursing were used as the basis from which to develop the normative programme theory that guided the research. One finding from this descriptive study was that nursing practice in the programme is still very much rooted in a 'traditional' model of health service delivery. There was little evidence of practice consistent with generally accepted health promotion standards.

Key words: effectiveness; evaluation; primary health care; public health nursing; theory

Introduction

The focus on effectiveness, quality and outcomes as key markers of accountability is clearly evident in today's health care environment. To demonstrate accountability for professional practice, it is necessary to delineate the roles and functions of specific providers (Gilchrist, 1997) and to explain why particular interventions are selected when delivering care. Explaining outcomes on the basis of deliberate interventions demands a theoretical approach to practice and measurement (Hinshaw, 1992). Theoretical frameworks make explicit the standards and goals of practice, the nature of the problems addressed and the choice of variables used as indicators of programme structure, process and outcomes (Fawcett, 1992). Thus theory clarifies what criteria are used in making judgements about the effectiveness of practice (Kirkhart and Ruffolo, 1993).

The normative programme theory that underpinned this research was grounded in primary health care principles. Primary health care, first articulated in 1978, embodies expectations for a redefinition and reorientation of the health system. The Declaration on Primary Health Care reaffirmed health as a fundamental right and a social goal whose realization requires that people participate to the fullest extent possible in planning and implementing services that meet both their personal health needs and those of their communities (World Health Organization, 1978). Inherent in that objective is the responsibility of health care personnel to increase people's awareness of the factors that contribute to health, and to plan and deliver services that address such important determinants of health as environment, lifestyle and personal coping skills. Health promotion, defined as the 'process of enabling people to increase control over, and to improve, their health' (World Health Organization, Health and Welfare Canada, and

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Canadian Public Health Association, 1986: 1) is a quintessential strategy for achieving the ideals of primary health care. The commitment to health and social equity embodied in the concept of health promotion is intrinsic to the practice of nursing, and can be traced back to the influence of such leaders of modern nursing as Florence Nightingale (Baly, 1973) and Lillian Wald (Wald, 1915). It is no coincidence that in setting the agenda for attaining *Health for All*, it was acknowledged that nurses would have to play a major role in reaching that goal (Mahler, 1978).

The goal of public health nursing (i.e., the promotion of health and prevention of disease) provides the basis for nursing interventions at the individual, family and community levels (Canadian Public Health Association, 1990). Despite claims that public health nurses have embraced the primary health care notion of health promotion in theory (Chalmers and Gregory, 1995; Cradduck, 1995; Rodger and Gallagher, 1995) there is evidence to suggest that this 'new paradigm' view has yet to become operational in practice (Hagan *et al*., 1995; Benson and Latter, 1998). This may be due in part to a failure to use theoretical frameworks grounded in primary health care philosophy as a guide to practice (Chalmers and Gregory, 1995; Stewart, 1995). The McGill model of nursing, which was developed during the 1970s at the School of Nursing at McGill University in Montreal (Gottlieb and Rowat, 1987), is one nursing model that explicitly focuses on the health-promoting role of nurses (Hagan *et al.*, 1995). It was used as the basis for developing a normative programme theory for the research reported here, because its structure and substance are consistent with current conceptions of the role of public health nurses in today's health care system (Stewart and Langille, 1995). Although the health-promoting function of nurses is acknowledged in many other conceptual models in nursing, the focus is predominantly on individuals seeking care for acute or chronic conditions. The emphasis on accountability as the cornerstone of a reformed health system highlights the need for theory that can help to explain the outcomes of public health nursing interventions and programmes (Clarke, 1995).

In this paper, selected results are presented from a study that aimed to increase understanding of the relationship that exists between client needs, nursing actions and client outcomes in a postpartum programme primarily delivered by public health nurses. To guide exploration of nurses' focus and actions in the course of delivering programme services, a theoretical framework (i.e. a programme theory) within which nursing practice could be examined was developed. The programme theory was grounded in primary health care principles, and was derived from current literature about the health-promoting role of nurses practising in Canada (Stewart, 1995). Consequently, it was assumed that nursing practice would be characterized by a 'positive' view of health, meaning that needs assessment would incorporate a determination of clients' sense of control over their day-to-day life situations, and of their perceived capacity to achieve personal and family long-term health goals. It was also assumed that clients would be actively involved with nurses in the process of clarifying mutual purpose and goals with respect to the nurse–client interaction, and in specifying what activities would be undertaken in working towards desired change (Labonte, 1994; Cradduck, 1995). It is the aim in this paper to make explicit the assumptions underlying a primary health care practice framework, and to compare these with what was discerned empirically.

Methods and procedures

The sample for this qualitative, exploratory research consisted of six public health nurses involved in delivery of the postpartum programme in a large urban setting and clients ($n = 25$) from a range of socio-economic strata and family structures. The postpartum programme provides home-based nursing services to women and their newborn infants at the time of hospital discharge, which typically occurs within 24 to 36 hours of normal vaginal delivery. The programme goals reflect an emphasis not only on providing a cost-effective and safe alternative to hospital care, but also on encouraging women to participate more fully in determining and addressing their own health needs (Capital Health Authority, 1996). This latter goal implies a commitment to involving clients in mutual decision-making related to the planning and implementation of health care strategies.

Volunteer sampling was used to recruit public health nurses. The programme, as currently deliv-

ered within the organization in which the study was conducted, did not have an explicit theoretical underpinning. In order to improve understanding of whether and how practising from a particular theoretical perspective would influence programme activities and outcomes, three of the nurses received instruction in the McGill model of nursing at the outset of the study. The other three nurses continued to practise according to their own implicit model. The McGill model was chosen because it had been used in the development of the normative programme theory, and reflected the researcher's beliefs about the role of public health nurses in today's health care system. An assumption was made that if the 'McGill group' of nurses was sufficiently sensitized to this approach to practice, differences between the two groups of nurses should become apparent in their focus and actions during the course of the study.

Once recruited, nurses were asked to inform all new postpartum clients on their caseload of the study, and to request their permission to have the researcher contact them to explain the project in detail and ask for their consent to participation. The desired client profiles had been established a priori to ensure that a broad range of clients would be recruited. All volunteer clients who fulfilled those criteria were invited to participate, until it was determined that no new information would be likely to be obtained by increasing the sample size. The final client sample consisted of 25 women. Signed client consent was obtained during the first interview. Prior ethical approval for the study had been obtained from the researcher's academic institution, as well as from the agency in which the study was conducted.

Most of the data were obtained via face-to-face interviews with nurses and clients. Initial interviews with each nurse elicited overall perceptions about the postpartum programme, and additional interviews were conducted at the time of discharge of each client from the programme. These interviews yielded data about the nurses' goals and aspirations in relation to the programme, their usual approach to clients, perceived constraints in providing services, typical concerns addressed in their interactions with clients enrolled in the study, what types of decisions were taken, and what outcomes they thought were achieved.

Interviews were conducted with participating clients on three occasions: first, within 2 weeks of entry into the programme; secondly, when the infant was about 2 months old (the 'official' time of exit from the programme); and thirdly, when the infant was about 6 to 7 months of age. The latter interview was conducted by telephone. The series of interviews was intended to provide information about perceived client needs and the nature and extent of interaction between clients and public health nurses over time, to elicit perceptions about programme effects of significance to clients, and to ascertain client views about potential areas for programme improvement.

The data were collected between February and November 1997. Interviews with clients were conducted in their homes, and nurses were interviewed at their place of work. All interviews were tape-recorded and transcribed verbatim. Transcribed data were organized and analysed using the NUD*IST programme, which is a computer package designed for qualitative data storage, indexing and theorizing (Qualitative Solutions and Research, 1996). The data were initially categorized according to the main components of the interviews (client needs, programme structure, nurse and client actions, and outcomes), and were then coded for sub-themes that emerged in each major category (see example shown in Appendix 1).

Findings

Biographical details

Maternal age at the time of delivery ranged from 17 to 41 years. About one-third (8/25) of the clients had family incomes below $20 000 (Canadian dollars), and almost as many (7/25) had incomes over $50 000 annually. It should be noted that average annual incomes for Canadian two-parent families with children ranged between $46 308 (one earner) and $66 998 (two earners) in 1997. The average family income of female lone-parent families during the same period was $25 445. The majority of clients were married ($n = 17$) or living in stable common-law relationships ($n = 2$). A quarter ($n = 6$) were single and either living alone or with the baby's father. More than half ($n = 14$) of the clients were first-time mothers.

All six of the nurse participants had baccalaureate degrees in nursing and were Certified Lactation Consultants. The length of time they had spent in public health nursing ranged from 1 to

20 years (mean 10.2 years), and all of them were experienced in the provision of services to postpartum families. The three nurses assigned to the McGill group had expressed interest in learning about this model of practice. They attended two half-day orientation sessions, were provided with reading materials as a reference, and were offered the opportunity to consult with a research assistant should they so desire at any time during the course of the study. The research assistant was a graduate student in nursing who had developed expertise with the McGill model of nursing. As the study progressed, it became obvious that the practice of the McGill group of nurses had not been substantially transformed by their introduction to this model of nursing. In retrospect, it became clear that the nurses' orientation to the McGill model was of insufficient strength, duration and intensity to alter their practice. The findings are therefore reported for the total nurse/client sample as a homogeneous group.

The research questions were stated as follows.

1) What is the relationship between client needs, organizational structure, nursing interventions and client outcomes in the postpartum programme (the *implemented programme*)?
2) How does holding an explicit theoretical perspective when examining nursing practice influence interpretation of the relationship that exists (or should exist) between client needs, organizational structure, nursing interventions and client outcomes (the *normative programme*)?

Only the latter research question is discussed in this paper. In describing the findings, the focus and actions *that would have been expected* had nursing practice been congruent with the normative programme theory were contrasted with what was actually discerned empirically. The findings of the study are presented by systematically reviewing the theoretical assumptions of primary health care within each component of a conceptual model of practice (e.g. standards and goals of practice, nature of the problems, structure/process/outcome variables). Theoretical or 'ideal' practice is then compared with the 'actual' data obtained in this research (see examples shown in Table 1).

Standards and goals of practice

In the McGill model, health promotion is viewed as a process of enabling individuals to overcome problems or difficulties in coping with or adjusting to events of daily living, crisis situations or medical conditions (Gottlieb and Allen, 1997). The role of nursing is considered to be complementary to that of other health professionals, and is depicted as aiding clients in exploring their potential for healthy living (Allen, 1997a). The International Council of Nurses (1996) also notes that effectiveness in nursing practice involves demonstrating that nursing is more than an activity supporting medicine, in that it makes a significant contribution to health in its own right.

The nurses in this study appeared to function in the role which Allen (1997b) describes as 'replacement of the physician' (p. 164). Some nurses believed that physicians were 'involved more than they needed to be' in the provision of postnatal services, resulting in perceived duplication and waste of professional resources. As one nurse noted:

> Public health nurses need to be [given more] responsibility for monitoring these babies, for looking after them. A lot of the family physicians and paediatricians are involved with these babies. Rather than just leaving them to us, I think there are many reasons why physicians remain involved, or get involved, more than they need to. They don't understand who we are, what our qualifications are, or how closely we monitor these babies, and so that's the motivation for some of them.

There was substantial evidence that clients viewed the public health nurse as an adjunct to the physician. In some cases, they noted that the nurse was the preferred provider for assistance with breast-feeding concerns and 'to answer questions about mothers and babies, because they see so many . . . and have all the answers at their fingertips.' The direct care and teaching role of nurses is relevant to primary health care practice, but of itself does not adequately address the goal of health promotion – that is, to assist individuals to 'understand and achieve their highest possible level of health' (Canadian Nurses Association, 1992). To attain that goal, nurses must openly discuss health and well-being with clients (Canadian Nurses Association, 1988). This implies that they must

Table 1 Assumptions of normative programme theory compared to actual findings

	Normative programme	Actual programme
Nurse's role	Facilitator, enabler, resource person	Expert. Focus on provision of information and support
Client's role	Actively engaged in identification of needs, concerns and goals	Often passive recipient of services. Not fully engaged
Focus	Development of skills, knowledge and resources to promote self-reliance in managing current and future problems or concerns. Understanding of root causes of problems and situations. Long-term involvement with client when indicated by client's unique situation (e.g. teenage parent)	Problem-focused. Termination of nurse–client relationship when immediate postpartum problems are resolved
Processes	Client meaningfully involved in determining plan of action, including discussion of mutual roles and responsibilities. Emphasis is placed on personal and family development within the context of social and environmental determinants of health	Nurses 'diagnose' the problem. Plan of action often standardized, not specifically tailored to unique client situation (e.g. termination of relationship when breast-feeding is well established)
Outcomes	Focus on client's capacity to manage current challenges and prevent future problems, or address them more effectively	'Diagnosed' problem resolved

explore individuals' perceptions about themselves and their health-influencing behaviours. These public health nurses did not appear to inquire into clients' beliefs and values about health, or to deal in depth with the challenges faced by some of the clients, particularly single and/or teenage mothers. Although they were generally aware of the clients' social situation, they appeared to avoid openly addressing emotional matters. Opportunities to engage clients in working towards the development of improved coping skills were either inadvertently missed or consciously evaded, as exemplified by the following comments:

> She talked about friends and . . . I take that at her word . . . but over time [I thought] I don't think she really does have that much support. I think we zeroed in more on the depression. I was mostly concerned about that, thinking about the baby. Was the baby safe? And overall, I got that impression. . . . Well, I guess too, she talked about being depressed [for a long time], and I wondered 'Has there been anything that she's found helpful? Like, is she thinking this is hopeless?'. . . . '*Did you talk to her about that?*' No, not really. The first couple of visits she kept saying everything was fine. It was after that [our contact] just kind of got cut off.

The nurses in this study perceived their primary function in the programme as being to provide information and support to postpartum mothers and their babies ('my aspirations in relation to the program? To make mothers feel comfortable going home from hospital, to know they aren't alone, that they can call on us. It's satisfying to know you've provided them with a lot of reassurance, a bit of advice'). None of the nurse participants seemed to regard the postpartum contact as an opportune time to foster examination of child and family development within the broad context of social and environmental determinants of health. It was acknowledged by some of the nurses that time and

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resource constraints were such that greater attention was usually given to dealing with the physiological concerns of mothers and babies.

Interactions with clients centred primarily on giving situation-specific information and support. Professional relationships tended to be somewhat didactic, with the nurse as expert and the client as the very grateful beneficiary of her vast knowledge of, and experience with, mothers and babies ('the nurse can help me be the mom I want to be'). This is consistent with what Gottlieb (1997) describes as the 'teaching' framework underpinning practice.

Problems addressed

In assessing effectiveness, the 'problem' which gives the programme its *raison d'être* determines the appropriateness of selected interventions (Sidani and Braden, 1998). The 'negative' conceptualization of health evident in interviews with both public health nurses and their clients reflects a strong orientation toward the biomedical model, in which health tends to be viewed as the absence of disease or risk factors. This is captured in the following comment made by one of the nurses:

> It's really important for these moms to nurse these babies . . . that seems to be the main goal of the [postpartum] visit . . . when we first started the program, we thought that we'd have postpartum haemorrhages, perineal infections and all kinds of other problems, you know. We're checking for this, and we're checking for that, and really, our yield is almost zero, in terms of all the things we're checking for. Our time is spent assisting with breast-feeding, and if we can get those babies nursing well, we're happy and the mother's happy. It turns out to be 95% of the work, and the challenges for the mother and the nurse, in most cases.

It was very evident that clients also had a negative view of health, and were not challenged to consider it as a positive concept that encompasses the creation of a satisfying and fulfilling life. 'If we were having trouble breast-feeding, it would be good to have someone who could help with it, but since we're not, I can't really think of anything' [that the nurse could do]. Since public health nurses interact with virtually all young families either during the postpartum period or through the provision of early childhood services, they are ideally positioned to promote the participation of individuals and families in their own 'health' development (Canadian Nurses Association, 1988). To do so would none the less require a reorientation of practice and a reconceptualization of the meaning of health.

Programme structure

The documented goal of the postpartum programme is 'to enhance, maintain, and restore the health and well-being of mothers and newborns within the context of family and community.' One stated means of achieving this is 'by providing an opportunity for women to participate in and determine their own health care' (Capital Health Authority, 1996: 7). Active participation of clients in problem identification and decision making and 'positive' health is thus an apparent ideal for the programme.

However, in order to strengthen client participation, it is important not just to address the specific concerns which clients identify. *Health* should also be promoted by placing those concerns within the broader context of individual or family functioning, and gauging clients' interest in establishing long-term plans for health (Gottlieb, 1997). There was no evidence in this study that expectations and goals of care were discussed by nurses in a manner that could be described as truly health-promoting. In those circumstances where nurses were aware of client goals, these were largely restricted to intentions related to postpartum adjustment, rather than longer-term plans for family development.

> Her main concern was just coping with the frustrations that she had, like suddenly this new schedule, this baby that I don't know what to do with, so we explored the different resources that she had, because she was crying that first visit. We talked about the importance of looking after herself, and using those different resources, and then just answering her questions.

Clients expected nurses to help them to cope with their fears and concerns about postpartum recovery and child care. They were not predisposed to viewing the nurse as a resource for the acquisition of knowledge and skills related to managing

life's broader challenges, such as dealing with relationship conflict, inadequate finances or lack of education. Unless clients are invited to discuss these issues openly with the nurse, they are not likely to surface during interactions, even when clients are encouraged to ask questions and to identify their concerns or worries. This is exemplified in the case of one adolescent mother who thought the programme was all about 'probably making sure that we're OK and seeing if we need help with anything, or have any questions.'

The content of interactions with clients in the postpartum programme appears to be strongly influenced by recording tools and guidelines. As one of the nurses in the McGill group noted:

> Although you may initially or inherently have a certain approach, given the tools that you're working with, sometimes you can stray very easily from that approach. In your whole assessment, you're geared to following this tool which is very medically oriented . . . and the family focus gets lost. The tool is a handicap, not an enhancement to practice.

One of the fundamental principles of primary health care is accessibility of continuing and organized care that is sufficient in content and amount to satisfy the perceived health needs of clients, and provided in a manner that is acceptable to them (Canadian Nurses Association, 1988). Nurses were generally unaware whether services exceeded or fell short of what was expected or desired by clients. It would therefore be difficult for them to advocate system changes that would bring services more in line with what clients told the researcher they would have liked. All the single, teenage clients commented that they would have benefited from more contact with the public health nurse. A few clients noted that although the nurses made it very clear that additional visits could be made, there was unease about requesting such a visit because of the manner in which it was offered. 'Perhaps it's the way that you ask, "do you *need* another visit?" Well, no, I don't *need* another visit . . . but one more would have been really nice.' An empowering approach to practice would require that clients be given more opportunity to negotiate the nature and frequency of the follow-up contacts they have with public health nurses (Stewart and Langille, 1995).

Programme processes

Nursing practice grounded in health promotion philosophy is distinctive in its orientation. Since its focus is *health*, the actual problem that brings the client into contact with the health system, although certainly not discounted, is seen as an opportunity to generate client interest in pursuing a broader health agenda. Interactions involve either the entire family or individuals as they are influenced by and affect the family. When health is defined as a feeling of being in control over life's circumstances, it follows that its assessment must necessarily actively involve the client. An exploratory stance is thus taken when assessing client needs and interests, and client participation is sought in developing and implementing plans for achievement of desired ends. Evaluation consists of a determination of the extent to which proximal goals have been achieved, and further elaboration of plans for ongoing development. The process is cyclical and continuous, rather than episodic (Cradduck, 1995; Gottlieb, 1997; Benson and Latter, 1998).

In this study, nursing practice consistent with this health promotion paradigm was minimal. Given the biomedical conceptualization of health held by these practitioners and clients alike, it is not surprising that clients viewed the nurse as an 'expert' who was valued for her ability to promote confidence in managing concerns related to postpartum adjustment and infant care. Nursing assessment was characterized by a health maintenance and risk reduction approach (Neufeld and Harrison, 1995), as exemplified by the following comment:

> Well, I guess [I did] the same as I do for most clients that I see. I evaluate their home situation, their social situation, their coping skills . . . as you can see when you're talking to the mom, and by the questions you're asking . . . to see if there would be any potential problem.

Although it was apparent that nurses made a genuine effort to be sensitive and responsive to client needs, their interaction style tended to be instructive and supportive rather than truly participatory. Consequently, the depth and breadth of concerns that surfaced during nurse–client interactions seemed to be largely predetermined by somewhat 'routine' approaches to assessment.

> She just asked how he was doing, how the baby was doing, and any concerns . . . providing information. If I needed any information, she would re-direct me to wherever I could get it from. Of course, they asked if I wanted a physical, did the work-up on him. When I had a concern about breast-feeding, she went more in depth. When I had requested some information, she really was thorough about providing it. She was really friendly, and very easygoing, and she checked out the crib in the bedroom and we found it wasn't up to standards . . . and then she just looked around to see if there was any safety hazard.

There was little evidence that clients were actively involved in discussion of concerns that were contextually relevant to their unique social circumstances. Whilst single, teenage mothers frequently (although not always) received more follow-up than did other clients, the focus of these contacts was pretty much restricted to seeing 'how things are . . . how the baby's doing and things like that.' There was nothing to suggest that nurses overtly addressed the unique developmental characteristics of adolescents (Gillis, 1994) or the challenges faced when adjusting to premature parenting (Van Dover and Mitchell-DiCenso, 1995) in their interactions with teenage or single mothers. Specific client problems and goals were circumscribed within the realm of the 'usual' concerns of first-time or multiparous mothers, and there was little variation in the type of needs identified across clients. The concept of 'social determinants of health,' where differences in clients influence differences in approach (Purkis, 1997), was not overtly characteristic of the practice of these nurses.

Since the nurses' role in the programme was identified primarily with the provision of postpartum care, rather than with the overall *health* of families, their involvement with clients was relatively short in duration. To a large extent, the tendency to disengage from families as soon as immediate postpartum needs have been met is dictated by programme protocol and workload pressures.

> That [10 to 14 days] is the usual termination of the nurse–client relationship, because that has been devised in the program – boom – we send out the package and that's it, but at that call I tend to encourage them to call after that, opening doors to the clinic.

One of the nurses expressed frustration about the fact that a specified number of client contacts was expected to be completed within a certain time period, restricting the amount of time that could be invested in conducting holistic client and family assessments.

Although all the nurses appeared to have considered their clients' bio-psychosocial situation, there was evidence that intuition or observation, rather than active client involvement, sometimes played a role in assessment. For example, commitment to breast-feeding was questioned, but did not appear to have been openly discussed with the client in at least three instances, involving different nurses. In other cases, problems were identified, but nurses seemed to be reluctant to offer specific interventions. As one nurse noted:

> I had [another] nurse going in because I was worried about her health. . . . We got [community resource] to go in, but she didn't want them. . . . It concerned me that she didn't call us, didn't want us. We had a sense it was because she was coping OK.

As the nurse–client interactions in this study appeared to be primarily problem-focused rather than truly client-centred, planning for ongoing involvement beyond what is prescribed by protocol was contingent on the presence of physiological concerns, and the client's perceived or expressed level of confidence about managing on her own. When nurses sensed that they were no longer needed, the relationship was terminated, although clients were encouraged to telephone or drop into the clinic at any time if concerns arose. The majority of nursing interventions consisted of giving information and breast-feeding support, building mothers' skills and confidence in child care, and 'being there' for the client when needed. However, as Allen (1997b) notes, health-promoting nursing interventions should add a dimension to health care that goes beyond the mere provision of information and support in response to health care problems that are narrowly defined within a biomedical model of service delivery.

Outcomes

Nurses expressed satisfaction with the outcome of interactions if they perceived that the client had gained some knowledge, was coping well with child care and breast-feeding, and felt comfortable contacting the health centre for help as needed ('She's nursing her baby, and I think she's really pleased about that. She's getting a lot of positive encouragement from us, and I think she'll manage well. We didn't have to call her . . . she called us'). In the absence of major concerns, nurses usually left it up to clients to initiate contact with them if further assistance was required. 'If everything has gone well on the three basic contacts that we do, we disengage by telling the mom that she can call us if she has any further concerns or wishes to have any further information.' A formal evaluation of outcomes was seldom conducted, and in some cases nurses could not easily articulate what they thought had been achieved with particular clients.

Clients generally expressed a high degree of satisfaction with the services provided, and almost always noted that the greatest benefit of the programme was the sense of security they gained from having ready access to a professional, knowledgeable and supportive source of help.

> This is such an overwhelming period. It's hard to explain unless you're a new mom yourself, but just to have somebody come in and say 'OK. Your baby looks just fine. She's looking healthy. This is our number, please call it.' Just reminding you that somebody's there to help.

Increased perceptions of confidence in ability to care for the newborn infant effectively were frequently noted. In general, however, clients did not feel that the programme had contributed to the health and well-being of the family, except to the extent that nurses helped the mother to 'sort things out, and therefore I was a better family member.' Postpartum issues were the focal point around which most nurse–client interactions occurred, and there appeared to be little interest in broadening the discussion to include the family's overall goal for health. Assessment tools, agency protocols and workload pressures all played a part in narrowing the focus of interactions to the resolution of short-term problems, thus blinding nurses to the possibilities that might have existed for engaging clients in addressing long-term and possibly more complex health issues.

Conclusions

The findings of this small study suggest that nurse participants did not practise from an explicit theoretical perspective, nor was their practice when interacting with individual clients in the postpartum programme consistent with generally accepted health promotion standards (Stewart and Langille, 1995). This research supports the results of other studies that have demonstrated incongruity between 'theoretical' health-promoting practice and its actual implementation by nurses (Kendall, 1993; Lauri, 1994; Benson and Latter, 1998).

The McGill model of nursing was used as the conceptual nursing framework to underpin the development of programme theory in this research, for two reasons. First, a conceptual practice model provides the framework for assessment of the effectiveness of nursing programmes by making explicit the interaction between structural elements (e.g., nurses' skill base), the process of care (e.g., enhancing problem-solving) and intended outcomes (e.g., goal attainment). Secondly, the McGill model evolved from concern about the predominance of the 'medical model' in health care delivery (Allen, 1982). It positions nursing within a health care environment in which individuals and families are encouraged to 'assume greater responsibility for their health, and become increasingly involved in healthier lifestyles' (Gottlieb and Rowat, 1987: 52). It is therefore consistent with currently held conceptions of the role of public health nurses in today's climate of health care reform (Cradduck, 1995; Rodger and Gallagher, 1995).

In this study, many elements of public health nurses' practice were congruent with the McGill model. Nurses focused on helping clients to develop problem-solving strategies that increased their confidence as parents and their feelings of self-sufficiency in managing postpartum concerns. Nurses often sought input from clients in identifying areas of concern, carefully assessed clients' coping ability, listened attentively to their questions, provided reassurance and validation of parental competence, gave relevant information and instruction, and offered a great deal of needed support to their clients (Frasure-Smith *et al*., 1997).

What was not evident in this research was the expected focus on assessment of broad health-related needs of individuals and families. In all cases, client goals were described in terms that clearly reflected a narrow focus on physiological or emotional concerns associated with postpartum adjustment. That focus restricted client involvement in prioritization of issues to the identification of immediate postnatal needs. There was little opportunity to explore broader family health issues, because nurses were singularly intent on risk reduction and health maintenance, rather than also helping clients to visualize and achieve overall health goals that were unique to them. A stronger focus on mutual goal-setting with clients could have directed nurses to individualize their interventions to clients' unique needs, and would probably have influenced the evaluation of outcomes in each particular instance of care. Instead, the presence or absence of immediate postpartum problems narrowly defined the content of interactions, and the duration of involvement with families was limited to managing those concerns. The 'negative' definition of health was reinforced in assessment tools and practice guidelines that place emphasis on early detection of physical and psychological problems associated with the postpartum period. It was also reflected in the expectations (of clients and programme personnel) that nurses demonstrate a high degree of technical skill in managing infant feeding and other postpartum needs. Because the programme structure is so heavily steeped in the biomedical model, there are few rewards for adopting a health-promoting style of practice.

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Appendix 1 Project nodes tree structure (NUD*IST)

(1) /Biographic data
(1 1) /Biographic data/Client
(1 2) /Biographic data/PHN

(2) /Needs-Issues
(2 1) /Needs-Issues – Health
(2 2) /Needs-Issues – Skill
(2 3) /Needs-Issues – Support
(2 4) /Needs-Issues – Information
(2 5) /Needs-Issues – Continuity of care – consistency of information
(2 6) /Needs-Issues – Professional expertise

(3) /Organization
(3 1) /Organization/Client
(3 1 1) /Organization/Client/Preferences
(3 1 2) /Organisation/Client/Goals and expectations
(3 2) /Organization/Provider/

(3 2 2) /Organisation/Provider/Accessibility
(3 2 3) /Organisation/Provider/Policies

(4) /Relationships
(4 1) /Relationships/Nurse–client
(4 1 1) /Relationships/Nurse–client – attentive
(4 1 2) /Relationships/Nurse–client – supportive
(4 1 3) /Relationships/Nurse–client – comfortable

(5) /Interventions
(5 1) /Interventions/Assessment
(5 2) /Interventions/Being there – being with
(5 3) /Interventions/Resolving concerns
(5 4) /Interventions/Giving support
(5 5) /Interventions/Giving information

(6) /Outcomes
(6 1) /Outcomes/Knowledge
(6 2) /Outcomes/Trust
(6 3) /Outcomes/Coping
(6 4) /Outcomes/Well-being
(6 5) /Outcomes/Confidence
(6 6) /Outcomes/Breast-feeding duration