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Unit 1
Introduction to Nurse-Family Partnership for Nurse Home Visitors and Nurse Supervisors

Nurse-Family Partnership®
Helping First-Time Parents Succeed

Unit 1- Introduction to Nurse-Family Partnership for Nurse Home Visitors and Nurse Supervisors

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Nurse-Family Partnership
Helping First-Time Parents Succeed

Welcome to Nurse-Family Partnership

Congratulations on your decision to join Nurse-Family Partnership. The members of the Nursing team and all Nurse-Family Partnership staff look forward to meeting you as you embark on your journey to better the lives of mothers, fathers and children.

Nurse-Family Partnership is an evidence-based, nurse home visitation program that positively transforms the lives of vulnerable babies, mothers, and families. The Nurse-Family Partnership National Service Office is a not-for-profit organization that provides service to nurses and their communities in implementing and sustaining this cost-effective program.

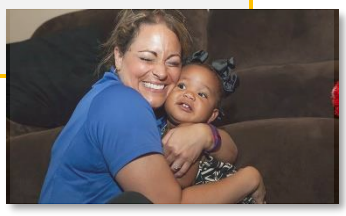
You are joining a stellar team of nurses from around the country, who are making a profound difference in the lives of the nation's most vulnerable individuals. As a Nurse-Family Partnership nurse home visitor or nurse supervisor, your role is vital in the delivery of this client-centered, solution-focused intervention program. Nurse-Family Partnership is one of the few intervention programs guided by empirical evidence. Powerful outcomes across multiple domains of maternal, child health, and development have been demonstrated for over thirty years by David Olds, Ph.D., through randomized controlled trials and subsequent longitudinal follow-ups conducted in rural and urban settings with diverse populations.

This position promises to be one of the most challenging of your career. The National Service Office is here to provide education in the Nurse-Family Partnership intervention and to support you in your professional growth. We're sure you share our vision, "A future where all children are healthy, families thrive, communities prosper, and the cycle of poverty is broken."

Sincerely,

Your Colleagues at the
Nurse-Family Partnership National Service Office

It's with pride that we note that most of the photos in this workbook are of Nurse Family Partnership nurses, clients, and babies.



Introduction to Unit One

Welcome to Nurse-Family Partnership (NFP). As you study Unit 1 over the next several days, you will be introduced to a way of helping new mothers and fathers accomplish some of the most important tasks in human development—to learn how to care well for themselves and their children. You will learn how to help new mothers and fathers envision a life for themselves and their children, and to develop the skills to succeed so that their children can enter the world safely and become healthy, productive members of society.

NFP Program Goals

As an NFP nurse, you have three major goals:

1. To help parents improve the outcomes of pregnancy by helping mothers improve their prenatal health
2. To help parents improve their children's subsequent health and development by helping them care competently for their children
3. To help parents become more economically self-sufficient by helping them complete their education, find rewarding work, and plan subsequent pregnancies in ways that support their aspirations.

The Population We Serve

NFP is designed to serve low-income mothers bearing their first children. It focuses on this segment of the population because low-income mothers have more than their share of stressful living conditions that interfere with their ability to care well for themselves and their children. Poverty is a pervasive condition that undermines maternal and child health. Some of its most damaging components can be mitigated during pregnancy and the early years of the child's life with the application of the NFP program content and methods.

NFP focuses on mothers having their first children for two fundamental reasons. First, women going through their first pregnancies have a heightened sense of vulnerability, both physical and social, that make them more receptive to offers of help—especially offers of help from nurses, as nurses have legitimate skills to address issues of concern to all pregnant women and parents of young children. Engagement in the program around issues of importance to women and their families is crucial for the success of the program. Secondly, to the extent that you are able to help women postpone subsequent pregnancies until they are better positioned to care well for another child, you will help parents focus their scarce resources on the care of the first child, and you will help them position themselves so that they are able to complete their educations and gain traction in the workforce, if they choose to do so.

Learning to be an NFP Nurse

At some level, all of this sounds simple. But, of course, it's not. Accomplishing these goals requires a great deal of effort on your part, to learn effective methods of engaging

clients and of collaborating with them to follow each parent's instinct to protect his or her child. As you go through nurse education, you will learn how to collaborate with mothers, fathers, grandmothers, and other family members in ways that align the goals of the program with their hopes for the future. You will learn how to utilize the *Nurse-Family Partnership Visit-to-Visit Guidelines (or, eGuidelines)*, menus, and facilitators in ways that make sense to parents in light of their most pressing concerns. You will learn methods of eliciting parents' concerns for themselves and their babies, and methods to build their self confidence in taking on larger and larger challenges in their lives, beginning with ensuring a healthy pregnancy and their own safety.

The NFP program is structured and detailed to provide you and the parents you serve with the resources you need to achieve NFP goals. The materials must be implemented with great sensitivity to mothers' and fathers' individual needs and concerns—which requires adaptation of these materials to families' needs on a visit-by-visit, moment-to-moment basis in order for the program to be experienced as relevant to parents' lives, and to achieve the greatest effectiveness. This means that you will thoroughly learn the program structure and content so that you can make needed adaptations to ensure that the program is experienced by your clients as maximally applicable to their needs and aspirations. Your challenge as a nurse is to ensure that the goals of the program are accomplished, and to embrace the fact that in order to accomplish the goals you must make the program resonate to parents' immediate concerns, even if the link between their expressed concerns and the program goals are not completely transparent at first.

Theories that Focus Your Attention on Aspects of Human Health and Development and Supporting Behavioral Change

NFP is grounded in three theories—human ecology, human attachment, and self-efficacy. Dr. Olds valued the importance of the three theories but believed that each one standing alone was insufficient to serve as a basis for an effective preventive intervention. He therefore integrated these theories as a foundation for NFP.

Human Ecology Theory

Human ecology theory orients nurses to the social context in which mothers and fathers are functioning, calling particular attention to the extent to which mother has support from the child's father (or partner), her own mother, or other family members and friends to protect herself and her baby. It calls attention to the mother's larger network of family members and friends and to the degree to which their values and behaviors are congruent with mother's goals and those of the program. These elements of the mother's social context are important as they embody social influences which can have profound effects on the mother's behavior and ability to care well for her child. Human ecology theory orients the nurse to the social contexts in which the mother and family live, but provides little guidance about how to support some of the most essential tasks of early care-giving. To help with this aspect of the intervention, Dr. Olds turned to attachment theory.

Attachment Theory

Attachment theory orients nurses to the fact that human beings are biologically driven to protect their young, and that infants are endowed at birth with signaling behaviors—such as crying and cooing—designed to elicit their parents' care and protection. A baby's sense of trust in the world depends upon the degree to which its parents read his or her communicative signals accurately and respond in ways that relieve distress and create a sense of security. This sense of security is the foundation for all subsequent behavioral and emotional development and is a crucial element in children's communicative, language, and cognitive development. Attachment theory helps nurses orient to parents' central task of helping their babies develop a sense of security through responsive, competent caregiving, but it provides no guidance about how to elicit and promote behavioral change. For this, Dr. Olds turned to self-efficacy theory.

Self-Efficacy Theory

Self-efficacy theory helps us understand individuals' motivations for engaging in behaviors. It is grounded in the observation that individuals make efforts in those areas of their lives that they believe are important and in which they have been successful in the past. They avoid trying those things that they do not believe are important and in which they have been unsuccessful. Positive behavioral change increases to the extent that individuals are able to accomplish small achievable objectives consistent with what they believe is important. Consequently, NFP is designed to help parents gain clarity about what is important to themselves and to set small achievable objectives that increase their confidence in taking on larger and larger challenges in accomplishing what matters to them. NFP nurses focus on helping parents accomplish small changes rather than simply providing encouraging support (although that is helpful). Parents' successes at accomplishing things that are important to them, even if the accomplishment is small, are the most important source of encouragement for developing motivation for change.

More recently, self-efficacy theory has been augmented in the NFP with an approach to promoting behavioral change known as Motivational Interviewing (MI). MI is grounded in self-efficacy theory, but adds these two critical additions: 1) it orients nurses toward clients' readiness for change (how important is changing this behavior to clients); and 2) acknowledges and works with the ambivalence that people feel about change. It guides nurses toward embracing their clients' ambivalence and supporting adaptive behavioral change through the development of a collaborative relationship centered on what clients find most important, while working toward the goals of the program.

MI provides a host of useful approaches to working with clients that are consistent with the NFP approach, such as using open-ended questions for learning more about clients' beliefs and feelings; embracing clients' ambivalence about behavioral change; learning to resist the temptation to try to fix clients' lives; developing a shared agenda with clients for home visits; and learning to use a guiding style that incorporates reflection to help clients accomplish their goals.

You can count on almost every mother and father you serve wanting the best for their babies, but you also can count on their feeling ambivalent about some of the changes in their lives required in order to become more effective parents and providers. And you can expect parents to be ambivalent about having to show up for the scheduled home visits. They want you to help them with their pregnancies and babies, yet they have lots of other priorities in their lives. For teens, it may be going to the mall with their friends after school rather than showing up for their visits with you. Some mothers may have disorganized lives in which it is hard to keep regular appointments. They may have a history of acting impulsively and going with what is most interesting at the moment, leading them to forget that they have appointments scheduled with you. Ambivalence is a part of life.

NFP Visit-to-Visit Guidelines and Domains

NFP is embodied by visit-to-visit guidelines and facilitators designed to help you work with clients to uncover what's important to them and to guide them toward healthier pregnancy outcomes, healthy child development, and self-sufficiency. The guidelines offer structure in two ways: a) Visit Guidance: Descriptions of assessments, topics and guidance appropriate for visits in each developmental phase. b) Facilitators: the handouts and resources for nurses to use as they facilitate conversations with their clients and families. They offer flexibility as the client and nurse make choices about topics to be addressed. There are six content domains encompassed in the guidelines and facilitators.

My Health

This domain focuses on maternal health and addresses factors like obstetric complications, preparing for labor and delivery, sex during and after pregnancy, diet and nutrition, mental health, and planning subsequent pregnancies. Maternal health is important in its own right and is essential for healthy fetal development, uncomplicated labor and delivery, and mothers' having the physical and emotional reserves to care competently for their children. Identifying emerging obstetrical health problems and helping mothers and primary care providers address those problems is a fundamental feature of NFP.

My Child

This domain focuses on such things as fetal growth and development, the impact of prenatal substance exposures on fetal growth and development, and children's stages of growth and development. Some may question why prenatal exposures to substances is included in this domain rather than under My Health. It is included here because the primary motivation for changing these adverse behaviors comes from parents' motivations to protect their children. Knowing about fetal, infant, and toddler health and development and environmental influences on their children is crucial for parents' developing competent care.

Taking Care of My Child

This domain focuses on parents' adjustment to becoming parents and learning how to promote their children's physical health, emotional and behavioral development, and language and cognitive development. The most powerful and alterable influence on children's early health and development is the care parents provide to them. Human beings are endowed with a powerful biological instinct to protect their children, which you can activate and support through your work with young parents. Even the most vulnerable parents who may have experienced traumatic and neglectful upbringing have a desire to protect their children. The NFP materials provided in this domain are designed to help you help parents adjust to their new roles and learn how to become competent caregivers.

My Life

This domain focuses the nurse's and client's attention on the client's personal development, including completing their education, deciding how they can provide materially for themselves and their children, and managing stress. The choices mothers and fathers make about their own lives again are important in their own right, but also shape the environments children will experience throughout their lives. The birth of the first child represents a major life transition for young parents. The choices they make at this critical juncture can have monumental effects on their lives and the lives of their children, and generations that follow.

My Home

As a nurse, you will assess the physical characteristics of the home environment to determine its safety for parents and for children, in part because hazards in the home are a leading cause of injury and death for young children. Parents may not be aware that exposure to environmental lead in chipped paint is an important cause of mental retardation and behavioral dysregulation or that home fires can be reduced with proper installation of smoke detectors. Many toxic exposures and home related injuries can be abated with informed parental action. While parents cannot alter characteristics of their neighborhoods, they set in motion procedures to reduce risk to their families and provide a safe environment.

Family and Friends

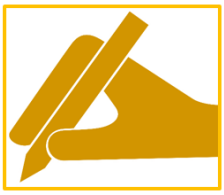
Mothers and fathers are embedded in networks of other family members and friends that can have profound influences on their behaviors, care of their children, and hopes for the future. As a nurse, it is crucial that you understand the influence of the broader network of family members and friends on parents and that you factor that influence into your strategies for guiding parents' adaptive behavior. Grandmothers, aunts, grandfathers, brothers, and other family members can be crucial sources of support for vulnerable young mothers and fathers, and you can play a role in helping parents link with these sources of support. Sometimes, there will be cultural differences in the beliefs and behaviors of family and friends that you must learn to respect even if those behaviors are not in complete alignment with conventional recommendations in

maternal and child health. You must form respectful relationships with those who influence the parents. You can disagree if you need to, but respect is crucial for success. There will be times, of course, in which the behaviors and beliefs of other family members and friends will be clearly damaging to parents and the child. In these cases, you will learn to guide parents toward life decisions that may break from the prevailing patterns of behavior in their family and friend networks in order to create safety for mothers, fathers, and children.

In this workbook we provide information about Nurse-Family Partnership; the three foundational theories underpinning this program; the home visit structure; the *NFP Visit-to-Visit Guidelines*; and the six content domains. You will learn about developing therapeutic relationships and using Motivational Interviewing to support clients interested in making changes in their lives. You will also learn the NFP approach to working with first-time mothers to develop their maternal role. We have delineated how reflective practice in NFP promotes your professional growth. Since you will be recruiting and engaging clients in visits when you return from the face-to-face Unit 2 education session, you will learn strategies to help you be successful. We have also described your responsibilities for record keeping and documentation of your clients' progress in NFP data system throughout the intervention. Following are the materials you will need to complete this part of Unit 1:

- This workbook
- The *NFP Visit-to-Visit Guidelines* (Pregnancy and Infancy required)
- The *NFP Data Collection* manual (found online in NFP Community)

The workbook is designed to address your individual learning needs. We encourage you to explore this information with your peers and supervisor. NFP NSO has requested that your administrator and supervisor allocate dedicated study time for you to complete this independent learning session prior to attending Unit 2. Expect to spend approximately 25 to 30 hours on Unit 1. The graphic on the right, which you'll see throughout the workbook, indicates when you will be asked to reflect on a question and write your response. You can either type directly into the workbook using your PDF reader tools, or write your responses or notes on a piece of paper. We strongly recommend that you *do not* print the entire workbook.



We deliver instruction within the NFP Standards of Professional Development. Each chapter begins with a statement of purpose, the nurse home visitor standards addressed in that chapter, and objectives for your learning. Nurse supervisors and Nurse home visitors are responsible for carrying out the nurse home visitor standards. Standards that apply only to nurse supervisors are addressed in separate educational sessions. The standards serve as a framework for assessing the extent to which nurse home visitors and nurse supervisors perform their specified Nurse-Family Partnership roles as described in standards and proficiency statements.

There are six NFP Nurse Home Visitor Standards:

1. Applies theories and principles integral to implementation of the NFP model.
2. Uses research, ongoing quality improvement and reports from data systems to guide and improve practice.
3. Uses the Nursing Process to deliver individualized client care and set goals across the six domains.
4. Establishes therapeutic relationships with clients.
5. Utilizes reflective processes to improve practice.
6. Adheres to Standards of Nursing Practice.

You are now ready to begin your study of this workbook.
We look forward to seeing you at Unit 2 education!

Chapter 1

David Olds – Baltimore 1977

History, Evidence, and Theories

Nurse-Family Partnership
Helping First-Time Parents Succeed

Chapter 1: History, Evidence, and Theories

Purpose

This chapter will provide background and perspective on Nurse-Family Partnership and the research that supports it. It will also help explain the relevance and value of evidence-based practice and maintaining fidelity to the model.

Chapter Organization

Part 1 introduces the Nurse-Family Partnership National Service Office (Nurse-Family Partnership National Service Office), the Prevention Research Center (PRC), and Invest in Kids (IIK). You will learn about the relationship between Nurse-Family Partnership National Service Office, its partners, and Implementing Agencies, including how each supports fidelity to the research model.

Part 2 defines randomized controlled trials (RCT) and evidence-based practice, including a description of each of the three research studies. Part II connects your nursing practice and that of your colleagues to outcomes of the program.

Part 3 describes the Nurse-Family Partnership *Model Elements* which define effective and consistent program implementation across the United States.

Part 4 introduces the three theories that underpin the Nurse-Family Partnership model: Human Ecology, Attachment, and Self-Efficacy. You will learn more about the theories and find examples of how you can apply these theories in your day-to-day practice in Chapters 3, 4 and 5.

Competencies Covered in this Chapter

Nurse Home Visitor

- Applies theories and principles integral to implementation of the Nurse-Family Partnership Model.
- Uses evidence from randomized trials and the Efforts to Outcomes (ETO) system to guide and improve practice.

Nurse Supervisor

Promotes the home visitor's development of competence to deliver the Nurse-Family Partnership home visiting intervention.

Note: there are several "Think about It…" exercises in this chapter. Be sure to take the time to write down the answers when indicated, but your answers do not need to be submitted to NFP NSO or brought to Unit 2 education. They are to expand your understanding of a complicated topic.

Part 1: Nurse-Family Partnership and Collaborating Partners

Objectives

- Describe the evolution of Nurse-Family Partnership.
- Describe the relationships between Nurse-Family Partnership National Service Office, partners and Implementing Agencies.
- Explain why fidelity to the Nurse-Family Partnership model is required.

What is Nurse-Family Partnership?

Dr. David Olds

Nurse-Family Partnership (Nurse-Family Partnership) is an evidence-based nurse home visiting program that improves the health, well-being, and self-sufficiency of low-income, first-time parents and their children. Built on a strong theoretical foundation, Nurse-Family Partnership is strengths-based, comprehensive, and cost-effective (Isaacs, 2007). Nurse-Family Partnership evolved out of three randomized clinical trials led by Dr. David Olds. As the third trial was ending, there were requests to replicate the research model in the "real world." During those first years, the name of the program was "Pregnancy and Early Childhood Home Visitation Program." Our name changed to Nurse-Family Partnership in 2000.

Originally, Nurse-Family Partnership was part of the Prevention Research Center (PRC), which is directed by Dr. Olds and located in the University of Colorado Health Sciences Center, School of Medicine. In 2003, Nurse-Family Partnership became a separate nonprofit retaining a Memorandum of Understanding with the University and the PRC to continue collaborating on program development and research. The Nurse-Family Partnership National Service Office serves communities that implement the program and helps agencies sustain Nurse-Family Partnership over time. The Nurse-Family Partnership National Service Office is located in Denver, Colorado.

Nurse-Family Partnership National Service Office collaborates with Invest in Kids (IIK) based in Denver. IIK assists with the development of new implementing agencies and continuing support of those programs in Colorado. In addition to direct service to Nurse-Family Partnership Implementing Agencies, the Nurse-Family Partnership National Service Office works with its partners to educate policy makers, clinicians and the public about the impact of Nurse-Family Partnership on maternal and child health and on government spending. These efforts help broaden understanding of the value of the evidence-based program, create a community of support and assist with long-term sustainability.

Agencies Implementing Nurse-Family Partnership

Nurse-Family Partnership has Implementing Agencies in many of the states in the United States. Nurse-Family Partnership Implementing Agencies vary in size and location, some serving hundreds of families in parts of an urban area and other agencies serving few families in many counties in rural, remote areas.

Local, county, or state health departments are the most common locations for Implementing Agencies although some are located in independent non-profit agencies and hospitals. Information on Nurse-Family Partnership locations can be found on the public website at http://www.nursefamilypartnership.org/Locations. .

Service to Implementing Agencies

Nurse-Family Partnership National Service Office provides service to communities in implementing and sustaining this program. These services include:

- Program implementation support
- Education of nurse home visitors, nurse supervisors, administrators, and state nurse consultants
- Ongoing clinical support
- Agency management and operations support
- Evaluation, reporting and quality improvement systems and support designed to ensure quality services and progress toward program goals
- Federal policy and program financing support
- Marketing and community outreach resources

Fidelity to the Nurse-Family Partnership model

Before becoming a Nurse-Family Partnership Implementing Agency, there must be assurance by the agency of its intention to deliver Nurse-Family Partnership with fidelity to the model. Fidelity requires adherence to specific criteria outlined by the Nurse-Family Partnership National Service Office. The specific criteria spell out such things as who is eligible to enroll in the program, delivery of the home visiting intervention, and the relationship between the Implementing Agency, its community, and the Nurse-Family Partnership National Service Office. Part III of this chapter provides further description of these criteria, known as the *Model Elements*.

The Nurse-Family Partnership Model Elements are supported by evidence of effectiveness based on research, expert opinion, field lessons and/or theoretical rationales. When the program is implemented in accordance with these Model Elements, Implementing Agencies can have a reasonably high level of confidence that results will be comparable to those measured in research. Conversely, if implementation does not incorporate these Model Elements, results may be different from research results.

As you work your way through this workbook and participate in the Nurse-Family Partnership Core Education, you will learn how to implement the program to achieve fidelity to the Nurse-Family Partnership model. Achieving fidelity requires a partnership that goes both ways. Best practices from your experience inform the Nurse-Family Partnership National Service Office and help us improve our national program replication efforts.

Review Part 1 Key Points

For your personal review, write your answers to these questions on a piece of paper.

1. What is the name of the partner working with Nurse-Family Partnership National Service Office and what state do they oversee?

2. Write your definition of model fidelity – underline the sentences in the preceding pages that contributed to your definition.

Part 2: Research Trials

Objectives

- Cite two requirements of a randomized, controlled trial
- Describe how the results of the three randomized, controlled trials contributed to Nurse-Family Partnership as it is known today
- Define evidence-based practice
- Relate the importance of evidence-based practice to the sustainability of funding and political support for local Nurse-Family Partnership Implementing Agencies.

Randomized controlled trials

A major strength of Nurse-Family Partnership is its history of randomized, controlled trials (RCTs) to conduct extensive research of the model over the last three decades. RCTs are the most rigorous research method for measuring the effectiveness of an intervention.

RCTs require a study group and a comparison control group with random assignment into either the study group or the control group. The random assignment occurs after individuals consent to participate in the study. The groups must be similar demographically and in other ways. Random group assignment ensures that the effects of the intervention cannot be attributed to some special characteristic of the group. Randomized, controlled trials are the kinds of studies that the Food and Drug Administration (FDA) requires for new drugs or medical devices to determine their effectiveness and safety before they are made available to the public. Because of their cost and complexity, these kinds of trials are not often used to evaluate complex health and human services.

The RCTs began in Elmira, New York, in 1977, and were later replicated in Memphis, Tennessee, and Denver, Colorado. All three trials targeted first-time, low-income mothers. The Prevention Research Center continues long-term follow up research today, assessing and reporting the progress of families who participated in the original three trials.

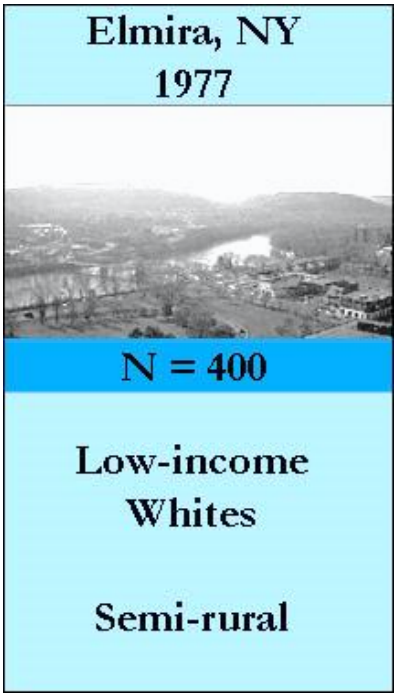
While research studying the effects of the intervention continues via the longitudinal studies of women and children in the Elmira, Memphis, and Denver research trials, clients enrolled by Nurse-Family Partnership replication sites across the United States are *not* participants in this ongoing research.

Results of Three Randomized, Controlled Trials

Elmira, New York

During the 1970s, David Olds realized that trying to assist families after the damage was done, even when children were still young, was "too little and too late." Dr. Olds and colleagues conducted the first randomized controlled trial in Elmira, New York to see if intensive home visits by a nurse from pregnancy through the child's second birthday would achieve the following goals:

- Improve pregnancy outcomes
- Improve child health and development
- Improve parent's economic self sufficiency



The Elmira research trial began in 1977. Four hundred women consented to participate in the study and were randomly assigned to one of two demographically matched groups. This would allow for fair comparisons between the groups. At the time, Elmira had one of the highest child abuse rates in the country.

Nurses began visiting the clients during pregnancy and throughout the child's first two years. A visit schedule and content domains for assessment and teaching were established.

The findings for the Elmira study (Olds, 1986) were very encouraging, including:

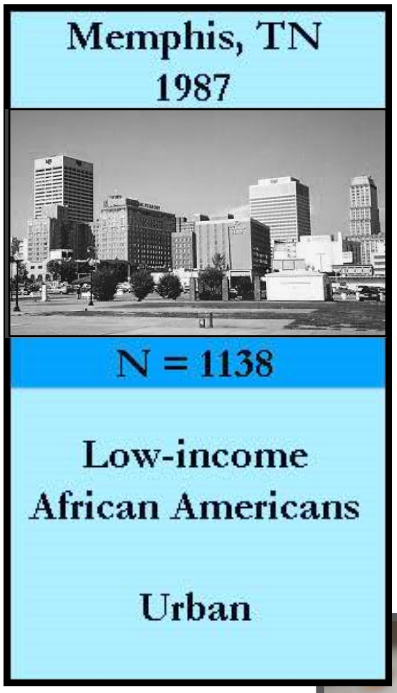
- Reductions in child maltreatment
- Reductions in emergency room visits for child

The Elmira trial was completed in a rural community with predominately Caucasian clients. Dr. Olds asked:

- Would this program work in a big city?
- Would it work in a regular public health department?
- Would it produce similar results with other ethnic groups?

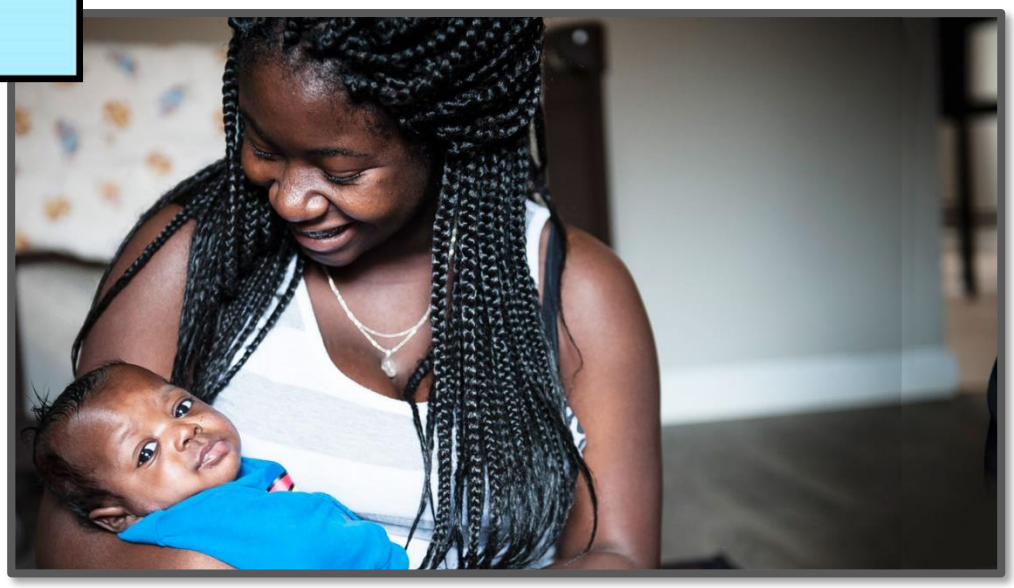
Memphis, Tennessee

Dr. Olds and his colleagues replicated the Elmira study in Memphis, Tennessee in 1987. Again, the study was a randomized controlled trial. Half of the clients received obstetrical care and the other half received intensive home visiting by a nurse in addition to their routine care. The 1,138 women who consented to participate were predominately African-American. There were a larger proportion of teens in the Memphis group than in the Elmira group. An additional finding from the Memphis trial (Kitzman, 1997) included a reduction in child health care encounters for injuries and ingestions.



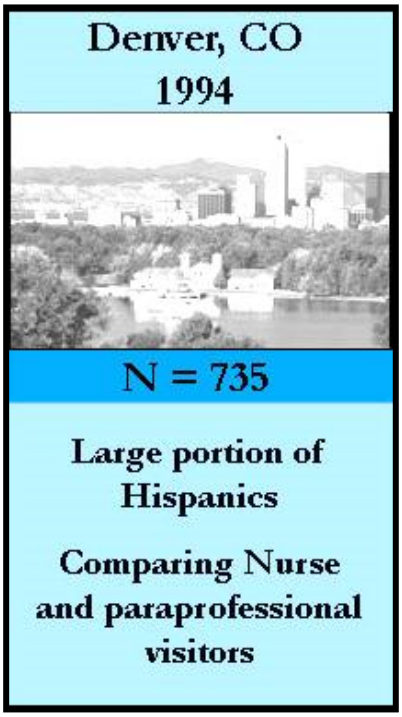
When the health care and early childhood community saw the mounting evidence from the first two trials that supported home visiting, people began to embrace the "Olds Model." They began to attempt to interpret and implement the model in their own settings.

Sometimes they gave in to pressure to produce a less expensive program by delivering the "Olds Model" with paraprofessionals. Because delivery of the intervention by paraprofessionals could be a cost savings, it was important to see if this would have an effect on the outcomes.



Denver, Colorado

The third research study, conducted in Denver, Colorado began in 1994. Of the 735 women who participated in the study, 46% were Hispanic, 35% non-Hispanic white, and 17% African-American. There were three groups: a group receiving standard care, a group receiving the standard OB care plus intensive home visiting by registered nurses, and a group receiving the standard OB care plus intensive home visiting by paraprofessionals. Visit schedules, content domains, and materials were the same for both groups that received home visits.



The findings of this study showed that while the families visited by paraprofessionals had improvements compared to the control subjects, the outcomes were not statistically significant. The families visited by nurses had statistically significant improvement over those in the control group and continued to benefit from the program two years after it ended. Olds (2004) noted that the impact of the nurse-delivered program was concentrated on children born to mothers with low levels of psychological resources.

Research Findings

The following were consistent findings across the three research trials:

- Improvements in women's prenatal health
- Reductions in children's injuries
- Fewer subsequent pregnancies
- Greater intervals between births
- Increases in fathers' involvement
- Increases in employment
- Reductions in welfare and food stamps
- Improvements in school readiness

The findings from the three randomized clinical trials, ongoing research and evaluation, and feedback from nurses delivering the intervention in over twenty states in the US provide an invaluable contribution to the ongoing development of Nurse-Family Partnership. For more information on the research trials, visit www.nursefamilypartnership.org and select **Proven Results**. Selected publications are also available on the website. You can read about new results and publications as they become available by visiting the Nurse-Family Partnership website.

Continuing Research

The Prevention Research Center for Family and Child Health (PRC), directed by Dr. Olds, is committed to improving the health and development of children and their families. A significant focus of the PRC is on the prevention of child abuse and neglect, unintentional injuries to children, welfare dependence and crime. The PRC staff—along with their Elmira and Memphis colleagues—conducts ongoing research with the original families who participated in the Elmira, Memphis, and Denver research trials. Many of the Elmira "babies" are now parents themselves.

Evidence-Based Practice

The Center for the Study and Prevention of Violence recognizes Nurse-Family Partnership as one of 11 programs out of 900 reviewed that meets the standards of Blueprints for a Model Program. Only programs that meet a strict scientific standard of program effectiveness qualify as a Model Program. For more information, visit the Center for the Study and Prevention of Violence at www.colorado.edu/cspv (Blueprints Nurse-Family Partnership page http://www.colorado.edu/cspv/blueprints/modelprograms/Nurse-Family Partnership.html)

Evidence-based practice entails using scientifically designed studies to demonstrate conclusively that an approach is effective. The randomized, controlled trials represent the strict scientific standards of program effectiveness that the Center for the Study and Prevention of Violence required to qualify as a Model Program. The adherence to these standards and the strong, consistent outcomes across the clinical trials led to recognition of Nurse-Family Partnership as a highly effective intervention.

Evidence-based practice is the expectation of politicians and funders that champion programs such as Nurse-Family Partnership at the local, state, and federal levels. The evidence reassures those who champion the program that Nurse-Family Partnership nurses and Implementing Agencies will consistently make positive changes in the lives of families and have a positive impact on their community.

As government commitment to evidence-based practice grows, the demand for Nurse-Family Partnership grows. Likewise, funding and political support grows to create more opportunities for families to participate and benefit from Nurse-Family Partnership. Staff members from Nurse-Family Partnership National Service Office and PRC meet regularly to share insights, plan improvements and plan next steps with new research or best practices. The PRC leads the effort to improve Nurse-Family Partnership implementation by conducting research on such issues as reduction of participant attrition and addressing issues such as mental illness and intimate partner violence.

Communities are inspired to apply to become Nurse-Family Partnership Implementing Agencies for many reasons. Among these reasons are benefits to:

Mothers

- Better pregnancy outcomes
- Improved self-sufficiency
- Less welfare dependency

Children

- Improved health & development
- Reduced abuse, neglect, and accidental injury
- Improved school readiness
- Better community health and economic outcomes
- Assurance that the investment will pay off

Review Part 1 Key Points

For your personal review, write your answers to these questions on a piece of paper.

3. Write the requirements of a randomized, controlled trial.
4. What were the common research findings of the three randomized, controlled trials?
5. Read the definition of evidence-based practice. How do you think adhering to the Nurse-Family Partnership standards can help you and your Implementing Agency come as close as possible to achieving the desired Nurse-Family Partnership outcomes?
6. What is the value of evidence-based practice to the sustainability of funding and political support for local Nurse-Family Partnership Implementing Agencies?

Part 3: Nurse-Family Partnership Model Elements

Objective

Identify the purpose of the Nurse-Family Partnership Model Elements.

What are the Nurse-Family Partnership Model Elements?

A defining characteristic of Nurse-Family Partnership is its focus on fidelity to the model tested in the research trials. As the program moved from academia to the community, new strengths and challenges emerged. The Nurse-Family Partnership National Service Office was established to lead this replication phase, as a national nonprofit organization with strong private sector and foundation support.

Very specific fidelity criteria provided by Nurse-Family Partnership National Service Office to your agency help ensure successful program implementation and give communities the best chance to achieve the same outcomes. These fidelity criteria, known as the Nurse-Family Partnership *Model Elements*, are statements about how to deliver the program. Nurse-Family Partnership recognizes that organizations may want

to make well intended (or sometimes, unintentional) changes to the model. However, it is important to avoid “watering down” the model or making untested changes to the model that may alter the probability of achieving the desired goals.

The combined influence of good community and organizational planning, intensive nurse education, Visit-to-Visit Guidelines, the data collection system, standardized evaluations and reports, and quality improvement processes led by Nurse-Family Partnership National Service Office translate into a predictable and replicable service model. Nurse-Family Partnership National Service Office’s investment in infrastructure to maximize fidelity to the research model helps ensure that Nurse-Family Partnership programs nationwide consistently produce significant community impacts.

A primary purpose of Nurse-Family Partnership National Service Office is to help communities replicate the program with confidence that they will achieve similar outcomes as the randomized, clinical trials:

- Improved Pregnancy Outcomes
- Improved Child Health and Development
- Improved Maternal Life Course Development

Nurse-Family Partnership National Service Office provides education and support services to ensure precise replication of the model in communities. Your Implementing Agency has a formal agreement with Nurse-Family Partnership National Service Office that spells out how to maintain fidelity. Implementing Agencies must adhere to key elements of the Nurse-Family Partnership model, which broadly include:

- Enrolling first-time, low-income mothers early in pregnancy
- Employing specially educated registered nurses who deliver home visits over 2 ½ years
- Establishing support for the program within an implementing organization

Nurse-Family Partnership National Service Office relies on Program Quality department to help communities meet their commitment to maintain fidelity. Program Quality partners with Nurse Consultants and Implementing Agencies to systematically examine data to identify variances in outcomes and set goals for improvement. You will learn more about the Efforts to Outcomes system and your role later in this workbook.

Review Part 1 Key Points

7. Go to the Nurse-Family Partnership website at www.nursefamilypartnership.org and click on Nursing Practice>Model elements to review the 19 Model Elements.

Part 4: Theories

Objectives

- Describe the contribution of each theory to the development of Nurse-Family Partnership.
- Describe how application of the theories contributes to the three outcomes of the program.

Three Theories

The theories that serve as the foundation for Nurse-Family Partnership complement one another and have been a part of the model since the original trials. The theories provided a framework that guided the development of the Nurse-Family Partnership Visit-to-Visit eGuidelines, Nurse Home Visitor and Nurse Supervisor Competencies, and Nurse-Family Partnership education. They are a constant thread throughout the model and Nurse-Family Partnership clinical nursing practice. Applying these theories to your everyday practice helps ensure that you are implementing the model successfully.

There are three theories that provide a framework for practice in the Nurse-Family Partnership:

Human Ecology
Attachment Theory
Social Cognitive Theory and Self-Efficacy

Each of these theories will be explored in more depth in later chapters, but following is a brief synopsis of each theory.

Human Ecology Theory

Bronfenbrenner's Theory of Human Ecology emphasizes the importance of social contexts as influences on human development. Characteristics of families, social networks, neighborhoods, communities, cultures and interrelations among these structures influence parents' care of their infants.

Human ecology focuses the nurse's attention on the social and material context in which mother and child are living. What is the quality of the mother's relationship with her husband or partner, with her own mother and other important people in her life? These social relationships are profound influences on the client's adjustment to her pregnancy and care of the child. Human ecology also focuses on the importance of changes in roles – such as young women becoming parents. The implementation of this theory during this time presents opportunities for significant changes in behavior.

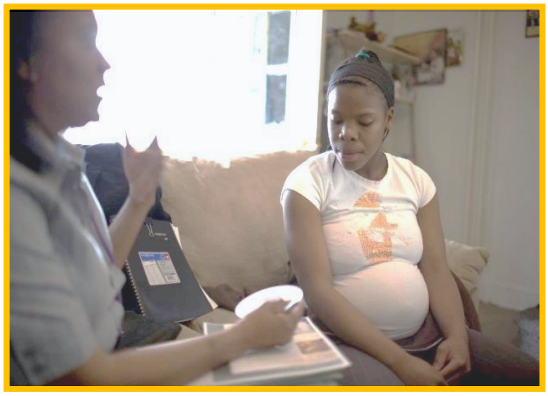
Attachment Theory

Historically, Nurse-Family Partnership also owes much to John Bowlby's Theory of Attachment. This theory holds that human beings have evolved a repertoire of behaviors that promote interaction between caregivers and their children, and that these behaviors tend to keep specific caregivers in proximity to defenseless youngsters, thus promoting their survival, especially in emergencies (Olds, Hill, Mihalic, & O'Brien, 1998).

Attachment theory focuses the nurse's attention on the importance of a mother's awareness and attitudes towards her baby during pregnancy, early infancy and the development of secure attachments between the growing baby and the baby's consistent caregivers.

Self-Efficacy Theory

Self-Efficacy Theory, which is part of Social Cognitive Theory, provides a useful framework for promoting women's health-related behavior during pregnancy, care of their children, and personal development. According to Albert Bandura (1997), differences in motivation, behavior, and persistence in efforts to change a wide range of social behaviors are a function of individuals' beliefs about the connection between their efforts and their desired results. According to this view, cognitive processes play a central role in the acquisition and retention of new behavior patterns. Individuals' perceptions of self-efficacy can influence their choice of activities and settings, and can determine how much effort they will put forth in the face of obstacles (Olds, Hill, Mihalic, & O'Brien, 1998).



The Nurse-Family Partnership intervention will have maximum effect if you are able to interact with women and their families in ways that promote responsiveness, emotional connection, and confidence in their ability to succeed in achieving their goals. In addition, facilitating families' efforts to improve their environment and expand their support network will provide them a healthier world in which to live and thrive.

What is Your Role?

You Are the Core to the Success of this Model!

As a nurse home visitor or nurse supervisor, it is important for you to understand the evidentiary foundations of the program, underlying theories, and how to apply this information in your day-to-day delivery of the home visiting intervention. Over time, we know that our partnership with nurse home visitors and community agencies nationwide will help us refine the home visiting intervention and improve our own efforts to help new communities successfully implement Nurse-Family Partnership.

By adhering to this common commitment to doing the best by the families we serve and using evidence to guide us in all of this in the future, I have a lot of optimism that we're really going to solve some major societal problems that confront us." – David Olds

References

Review Part 1 Key Points

Look back at each of the theories. Print out just the page on the theories (or use the tools in your PDF reader) and highlight the key words describing each theory.

How are the theories applied in Nurse Family Partnership?

Olds, D. L., Robinson, J., O'Brien, R., Luckey, D. W., Pettitt, L. M., Henderson, C. R., Jr., et al. (2002). Home visiting by paraprofessionals and by nurses: A randomized, controlled trial. *Pediatrics, 110*(3), 486-496.

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Chapter 2

Human Ecology Theory

Nurse-Family Partnership
Helping First-Time Parents Succeed

Chapter 3: Human Ecology Theory

Purpose

The purpose of this chapter is to introduce you to the Human Ecology Theory as it applies to the Nurse-Family Partnership model.

Standards Covered in This Chapter

Nurse Home visitor

Applies theories and principles integral to implementation of the Nurse-Family Partnership model

Nurse Supervisor

Promotes the home visitor's development of competence to deliver the Nurse-Family Partnership home visiting intervention

Objectives

- Describe the bidirectional relationship of individuals and the environment within the Human Ecology Theory.
- Describe the four systems of the environment within the Human Ecology Theory.
- Identify ways to apply the Human Ecology Theory to nursing practice.

What is Human Ecology Theory?

Human Ecology Theory, developed by Urie Bronfenbrenner and published in the 1970s, is one of three theories underlying Nurse-Family Partnership. According to Bronfenbrenner, an individual influences the environment and the environment influences the individual. This bidirectional relationship between an individual's development and the environmental context occurs from infancy through adulthood and is central to the theory.

In Human Ecology Theory there are four environmental systems that exert influence within and between each other. The individual is at the center of this theoretical model. The four systems are explained below.

Microsystem

- The immediate contextual environment of the individual (e.g. family, school, neighborhood)
- The individual's own biological make-up

Mesosystem

- The connections between the immediate environmental systems (e.g. connection between parents and child care provider)

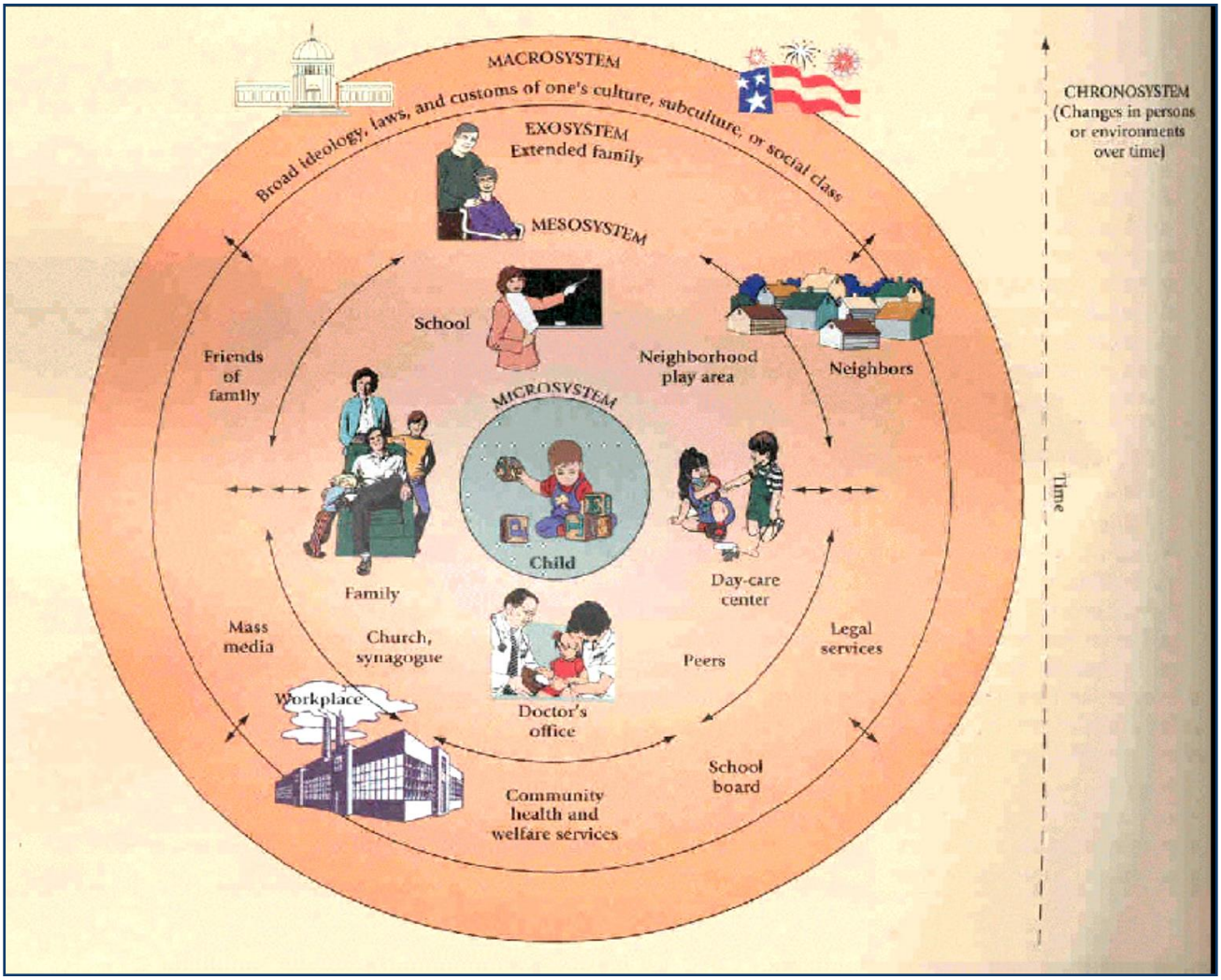
Exosystem

- External systems that have an indirect effect on the individual (e.g. parents' work place schedules)

Macrosystem

- The larger system of cultural context, national or political environment, public policy (e.g. welfare reform)

A diagram of this system is displayed on the next page.



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All environmental factors will influence the individual. Recall for a moment a past work place or school setting in which you were surprised to learn that you and a co-worker or fellow student perceived the same environment and experiences in that environment very differently. Can you think of an example when differing past experiences and perceptions may have affected your behavior and/or professional development?

An example may be nurse home visitors' experiences in the neighborhoods they visit to see clients. One nurse may have had a lot of experience in neighborhoods similar to our clients and feels safe, confident and accepted in these neighborhoods. Another nurse may have not had any experience with low-income neighborhoods and her perceptions are influenced by her family's opinions from when she was a child. These two nurses will have very different experiences in their first visits to the same neighborhood based on past experience and influence. The current experiences in the neighborhoods will continue to influence both nurses' development.

What are Ecological Transitions?

The primary application of human ecology theory during the NFP intervention is to the client's progressive mastery of the parenting role and responsibility for health, well-being, development and economic self-sufficiency. This puts the client in the middle of the concentric circles.

NFP emphasizes parent development ". . . because parents' behavior is the most powerful and potentially alterable influence on the developing child, particularly given the clients' control over their children's prenatal environment, their face-to-face interaction with their children postnatally, and the influence on the home environment" (Olds, et al, 1997, p. 12). This focus on parents does not minimize the important opportunities clients and their families have in their broader contextual environment. Rather, NFP recognizes that many environmental factors are outside the direct influence of NFP intervention.

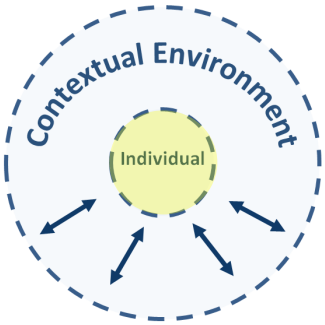
Bronfenbrenner suggests there are windows of opportunity that he calls "ecological transitions" in every individual's life. The windows occur when there are changes in a person's social position resulting from a change in her role or environmental setting. These periods of transition instigate further development or can be consequences of new development. Examples of such transitions include pregnancy and the birth of a child, getting married, or graduating from school. NFP is designed to take advantage of the ecological transition, the window of opportunity, in a first-time pregnant woman's life. At this time of developmental change a woman is feeling vulnerable and more open to support.

Think about it…

Take a moment to reflect on what it was like for you to experience the ecological transition from nursing school into the work force. Did you feel vulnerable and more open to support? If there was someone who was especially supportive, think of some of the specific ways this person helped you to be successful in making the transition from student to nurse.

Which of the Environmental Systems Is Most Important to an Individual's Growth and Development?

The microsystem (inner concentric circle), which is the system closest to the individual, has the most impact on growth and development. Within the microsystem family members provide the greatest influence. The physical nearness of family members and the nature and quality of experiences and interactions are significant to future development.



Positive, healthy growth and development is enhanced by mutual participation in developmentally appropriate activities and interactions among family members. Prevention and protection from physical and psychological harm are ideal characteristics found within the microsystem of the family.

For example, a child in a child-proofed home in a child friendly neighborhood experiences more opportunities to explore her/his surroundings. This leads to a greater sense of security and opportunity to explore the larger world. A safe home where positive, encouraging words are used builds a child's sense of security and self-esteem. A positive, supportive, interactive relationship between children and parents provides a child with the appropriate tools to effectively navigate the other layers of the environment.

An individual raised in a positive, supportive, and child friendly environment has the opportunity to apply those experiences to the other layers of the larger environment.

When the family system is disruptive and interactions and activities are not supportive of healthy growth and development the microsystem can provide a negative influence on the individual's future development.

Human Ecology Theory and Attachment Theory (which you will read about in the next chapter of this workbook) discuss the influence of family members on an individual. In the Human Ecology Theory the context is broad and involves all family members. In Attachment Theory, the context is narrowed to one specific individual attaching to a caregiver.

What about Relationships and Connections?

The quality of the connections that occur within the microsystem and mesosystem are next in importance. For example, are the child's parents and child care provider, the two systems where the child is spending most of her time, in sync with each other regarding behavior, discipline, feeding, and sleeping? Or, does the child consistently have to re-learn the rules moving between the two environments? The parent-child relationship functions effectively as a context for development when the parent has support from other significant relationships.

According to Bronfenbrenner (1979),

- The parent-child relationship is enhanced as a context for development to the extent that each of the other relationships the parent has involves mutual positive feelings and the other parties are supportive of the developmental activities carried on in the parent-child relationship.
- Conversely, the developmental potential of the parent-child relationship is impaired to the extent that each of the other relationships in which the parent is involved consists of mutual antagonism or interference with the developmental activities carried on in the parent-child relationship.

The client's behavior and family patterns are understood in terms of their adaptation to the ecological system. Clients adapt to their environments in an effort to maximize their own well-being and that of their children. Your efforts as a nurse home visitor at providing support must recognize and respect this adaptive quality by building upon individual and family strengths. Clients' success selecting and shaping developmentally enhanced settings are presumed to reflect, in part, their psychological resources such as mental health, coping, knowledge, and attitudes.

You will apply both Human Ecology Theory and Self Efficacy Theory as you assist your client in enhancing her environment through her own resources. For example, in a discussion about exercise you assess a pregnant 17-year-old client's level of activity and learn that she is not exercising and wants to increase her activity. As part of Human Ecology Theory, one step would be to assess her environment. Through that assessment you learn that she attends a charter school two blocks from her home, which is housed in a former warehouse, and does not offer any physical education classes. Other than walking to school and to a corner store located in the next block, she does not walk outdoors due to the drug and gang activity in her neighborhood.

Applying your human ecology lens looking at your client's situation, at least two of the systems are currently affecting her access to physical activity. The microsystem, her neighborhood, is not safe for outdoor activity. The exosystem, the school, does not have physical education. However, tapping into her resources and building self-efficacy you could assist her within the microsystem of her home by brainstorming ways to exercise indoors. One idea that might come up is to exercise to a video or she might want to network with other women in the neighborhood to set up a "safety zone" for walking. Building on self-efficacy through enlisting others to help, she could affect the exosystem by requesting development of an after school exercise group and re-evaluation of the school's policy of no physical education classes.

The bidirectional nature of the impact of the environment on the individual and the individual on the environment is evidenced in all of the systems. An individual might not be directly involved with the system that is being impacted, and vice versa.

Think about it…

Can you think of some examples where a system impacts a child without the child's direct involvement?

Examples of this situation include:

- A client receives a raise in pay that takes her salary over the Child Care Assistance Program maximum criteria. The client cannot afford to pay the full fees for the child care and so the child must be moved to a lower cost child care center.
- Immigration raids when parents are placed in custody and the child in foster care.

How Does the Larger Environmental Picture Influence the Individual?

In order for an individual to receive all of the experiences and protective factors necessary for quality growth and development it helps if the child is raised in a community that is child-centered. This means beginning with the child's experience of the environment. The community, the exosystem and macrosystem, must be focused on each child being able to experience interesting things, in a safe environment, with people that care about her/him, throughout the day.

A child-centered community will provide access to activities and opportunities that encourage growth and development. A children's section in the local library, playground equipment in local parks and open spaces, and a focus on quality pre-school education for all children are a few examples of a child-centered community.

Think about it…

Parents of children not raised in a child-centered community will have more challenges in obtaining experiences and protective factors for their children. How might you assist your client in developing opportunities for their child when the larger environment is not child friendly?

Assisting your client to navigate the bus route to a community with parks, a children's library or play area at a mall are examples of things that may increase the child's opportunity to experience child-friendly communities.

Conclusion

Human Ecology Theory provides the nurse home visitor with a structured approach to evaluate and address the many layers of environmental context in which clients are living. The theory assists the nurse with explanations for the client in the importance of relationships within and between environmental layers. The theory supports the concept that the involvement of family and friends has an impact on client behavioral change. It provides credence to the belief that the immediate family is the most influential aspect of a growing, developing child.

It is vital that the nurse home visitor recognize and acknowledge the importance of the family role in influencing the client and her choices. In secondary analysis of the Memphis data ". . . the structure of households can play an important role in moderating the influence of the program" (Olds, et al, 1997, p 14). Grandparents, especially grandmothers, often play a significant role in the acceptance of a nurse home visitor into the home and of a favorable reception towards the information she is providing. In situations where the grandmother is the head of household, it is important to acknowledge that she is the gatekeeper to the home and client and it would be wise to engage her from the beginning.

A nurse home visitor applies Human Ecology Theory to her nursing practice when she assesses and teaches about environmental safety, developmentally appropriate toys and play activities, laws regarding maternity leave and/or child support, and family and friend relationships. As you develop relationship with your clients, keep in mind how the entire environment, from immediate family outward, affects your client and how she impacts the environment.

Review Key Points

For your personal review, write your answers to these questions on a piece of paper.

1. In your own words, describe the bi-directional relationship of individuals and the environment within Human Ecology Theory.

2. Look back through the chapter and use your PDF reader tools to highlight any examples of ways to apply Human Ecology Theory to your NFP nursing practice.

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Chapter 3

Attachment Theory

Nurse-Family Partnership

Helping First-Time Parents Succeed

Chapter 3: Attachment Theory

Purpose

The purpose of this chapter is to introduce attachment theory, the four attachment patterns for children, and ways you will apply attachment theory to your Nurse-Family Partnership practice.

Standards in this Chapter

Nurse Home Visitor

Applies theories and principles integral to implementation of the Nurse-Family Partnership model

Supervisor

Promotes the home visitor's development of competence to deliver the Nurse-Family Partnership home visiting intervention

Objectives

- Describe attachment behaviors.
- Describe the four patterns of attachment in children.
- Describe the impact of different attachment patterns.
- Identify ways to apply the Attachment Theory in nursing practice.

Beginnings

Attachment theory evolved in the 1950s. John Bowlby, a psychoanalyst in England, was trying to make sense of the behaviors he saw in boys who were involved in crime and had early maternal separations. He was also studying the behaviors of homeless children. He learned from others studying animal behavior that animals followed or "imprinted" on the first animal they saw, generally their mother (Karen, 1990).

Bowlby (1969) realized that babies are biologically motivated to connect with others when in distress such as when they are hungry or cold. He noted that infants engage in what he called "attachment behaviors" such as clinging, sucking, and following the caregiver with their eyes. He noted that innate behaviors such as smiling, babbling, looking, and listening are strengthened when they are reinforced by a responsive parent. These behaviors signal the parent to respond, to take action, to provide assistance; they are essential for physical and emotional survival. Infants will feel close with almost anyone who is nurturing and responsive. It is when the child gets his needs met with timely, nurturing, and appropriate responses over and over from the same caregiver that the child learns to trust that specific caregiver. He learns "My mother is there for me; I am safe and loved." Bowlby understood that children need this attachment to thrive.

Bowlby (1969) proposed that the infant develops a "blueprint" for how relationships work based on the infant's first relationship experiences. This blueprint, called the "internal working model" gives the child the "rules" for what to expect, what to ask for, when to give up, or how much to expect closeness and responsive care. The internal working model also guides how the individual processes new information so that the model for relationships established in the first years of life is maintained. New relationships tend to fit the beliefs and expectations established in these important first relationships. Subsequent researchers have validated this concept. Although the blueprint from early years is very strong, it can change with major shifts in relationship experiences.

Attachment Theory Development

In the 1930s, Mary Ainsworth (Karen, 1990) began studying "security theory" which posits that children can move out and explore if they feel secure. In the 1950s, she began working with Bowlby and participated in studies to understand more about relationships, attachment, and security. Subsequently, she went to Uganda and observed mothers and children in their natural setting. She identified behaviors that attested to the child's attachment: differentially stopping crying (stopping crying for mother but not as reliably for others), differential smiling and differential vocalizations.

When Ainsworth returned to the United States, she had difficulty identifying these behaviors in mothers and children. The US children were accustomed to mom coming and going and the interactive responses in the home were not as easily identified. Ainsworth developed a laboratory procedure called the “Strange Situation”. This procedure involved putting the mother and 12-14 month old child in a strange room with a strange person and asking the mother to leave briefly and then return a few times. She observed how the toddlers responded when mom left and how they responded to the mom and stranger when mom returned.

Ainsworth identified three specific patterns of response that demonstrated the kind of relationship the mother and toddler had. Subsequently, a student and colleague, Mary Main, assisted with further study, helped refine the description of these patterns, and identified a fourth. The four patterns are: Secure Attachment, Insecure-Avoidant, Insecure-Ambivalent, and Disorganized. (Karen 1990) Children with secure attachments are the most resilient and have the lowest risk for poor social-emotional outcomes. Children with insecure attachments are at risk for social-emotional problems. Children with disorganized attachments are seriously at risk for psychopathology, poor later outcomes, and highly likely to need intervention (Zeanah, 2007).

Next, we will look at the four patterns of attachment identified by Ainsworth and Main.

Attachment Patterns

Secure Attachment Pattern

Secure Attachment is observed in infants who are confident that their caregivers will be emotionally available and appropriately responsive when they signal a need. The infant uses the caregiver as a "secure base" from which to explore and learn. When a caregiver proves to be a "secure base", the infant feels security, love, and self-confidence and is able to move out to explore and try new things.

When the child moves out to explore, eventually the child feels threatened and the caregiver is the "safe haven" to whom the child returns for comfort and support. When the child has a safe base and safe haven the child can go back for comfort and support as needed and then move away again, feeling safe to explore, be playful, and be sociable. Attachment is a relationship quality; it represents the reciprocal behavior and emotional experience between a child and the primary caregiver. Each member of the dyad contributes to the quality of the relationship as they learn what to expect from and how to interact with each other. Securely attached children generally have better social skills and are more empathetic and responsive.

Think about it…

Who is your secure base today? Who was your secure base as a child? How did that affect your ability to explore, to risk, to try new things?

Who was your safe haven? How did that person comfort you and give you support?

Insecure-Avoidant Attachment Pattern

Insecure-Avoidant Attachment is seen when the parent/attachment figure is uncomfortable with a child who is needy and has trouble responding to distress. The parent may be emotionally unavailable or rejecting. Overtime, the infant learns to anticipate that the caregiver will minimize his needs. He may cry because he is hungry, and the caregiver is troubled by his cry. The baby learns that it is not OK to express negative emotions. The child becomes indifferent about separations and reunions; mom leaves and on her return, he hardly notices; he has learned to be a "big boy". This insecure pattern is organized in that the infant learns what to do in response to the caregiver: When distressed, the child will act like everything is OK. The child learns to hide or "stuff" his feelings, and may learn not to recognize them. The child doesn't know how to let people know what his needs are or what would help. As he grows older, he is more likely to ignore others, have few friends, and anticipate that others will not respond to his needs.

Think about it…

If one parent minimizes the child's needs and the other is consistently responsive, what type of attachment pattern do you think the baby might have?

Children will learn the difference and respond differently, responding and eliciting interaction with the parent who is responsive and nurturing and avoiding the minimizing parent. The child could be securely attached with one, and have an avoidant attachment to the other. A secure attachment with one caregiver is a protective factor for children who have an insecure attachment with another caregiver (Zeanah, 2007).

Insecure-Ambivalent Attachment Pattern

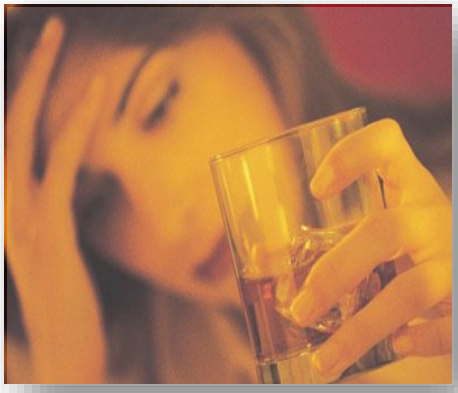
An Insecure-Ambivalent Attachment pattern occurs when a caregiver alternates being attentive and inattentive or sufficiently near and then insufficiently near. The parent may be attentive, but out of sync with the child. The parent/attachment figure may be focused on his/her own fears or look to the infant to validate him or herself. When this pattern occurs, the infant becomes preoccupied with the attachment figure: “Will she smile if I smile? Sometimes she does and she is so fun, but sometimes she doesn’t and I feel sad and embarrassed.” “Will he come if I cry or will he fail to show up?” The baby becomes ambivalent in his/her responses: “Will I get what I need this time or not?” The infant may cling to the parent, cry louder and longer than other babies, whine more, be anxious about separations and avoid exploration. This insecure pattern is also organized in that the infant learns what to do in response to the attachment figure. Since the parent is inconsistent, the child is not sure how to get his needs met, he will “hang on” to ensure the parent is present and available. These children tend to be seen in school as dependent, clingy, immature, and less competent socially.

Think about it…

What are some reasons why a client might alternate in being attentive and then inattentive with the baby?

Some reasons for alternating responsiveness might include inadequate understanding of what babies need or how to relate to them (“all babies do is sleep, eat, and mess”), depression, anxiety, family chaos, and conflicted relationships with their own parents.

Disorganized Attachment Pattern



According to many theorists, Disorganized Attachment occurs when an attachment figure acts fearful or overwhelmed by the infant's needs. The parent may be threatening, fear-producing or hurtful to the child. The parent is more likely to have a major mood disorder with mood swings, have a significant substance abuse problem or be involved in intimate partner violence. The confusing and often frightening behaviors of the parent make it difficult for the infant to know what to do to achieve comfort or to get needs met in times of distress. The person on whom the child is dependent for survival, the person who is supposed to comfort, causes alarm and fear. This parent's actions disorient the child, the child could think, "If I cry for help will she help me or will she get mad and hit me?"

This infant will have difficulties with regulating emotions; perhaps the infant gets upset, but doesn't know how to stop or calm down. These children may calm themselves in odd, contradictory or conflicting ways; they may engage in repetitive behaviors or self harm in the presence of the fearful caregiver but not with other caregivers or strangers. In video samples of children with disorganized patterns, one little girl went to her mother with outstretched arms upon her mother's return, but kept her eyes closed. A little boy began to pull his hair upon mother's return, and another little girl repeatedly banged her head. Actions and responses are difficult to predict in these children and for the parents, there is little satisfaction or delight in their infants. Children with disorganized attachments are likely to exhibit more severe emotional, social and academic problems; they are the most at risk for abuse and neglect (Zeanah, 2007).

Attachment theory – What is our goal?

We are biologically predisposed to seek closeness to specific caregivers under times of stress, illness, or fatigue in order to promote survival. Children normally develop attachment patterns with their caregivers by the end of their first year as they are able to remember who is there for them, who responds to their needs and they can move away and come back to the caregiver. Literature and experts on attachment will speak about being "attached" or "unattached." In fact, all of us attach. The pattern of attachment developed with the caregiver (secure, insecure or disorganized) is dependent on the quality and consistency of the care children get from their primary caregivers. While we recognize that attachment develops even in the face of child maltreatment and severe punishment, we want parents to understand that secure attachment is the goal (Perry, 2004). Secure attachment happens within the context of warm, nurturing, consistent

caregiving. When a parent is able to recognize cues and respond appropriately the child learns to recognize his needs and signal his caregiver. This responsive parenting helps the child feel valued and worthy of being cared for, feel competent in his interactions and relationships. This is the basis of the development of trust.

Attachment theory has affected the design of the Nurse-Family Partnership intervention in three fundamental ways:

- Emphasis on developing an empathic and consistent relationship with clients and other family members so that the nurse becomes a “secure base” for the client
- Promoting sensitive, responsive, nurturing and engaged care giving in the early years of the child’s life
- Helping mothers and other caregivers consider their own childrearing histories so that they can appreciate the impact of their history on their “natural” way of responding and interacting (Olds, 1997).

Let’s look briefly at the nurse-client relationship as it relates to attachment. We will address other aspects of the nurse-client relationships in more detail in Chapter 8.

Nurse-Client Relationship

A key component of the NFP program is the ability of the nurse to establish a long-term, positive relationship with the client. It is believed that the quality of the nurse-client relationship enhances the possibility of change and growth in the client. Many clients in the program have not experienced a consistent, empathic, supportive relationship in their lives and may be cautious in developing a relationship with the nurse. This makes the two-and-a-half year duration of the NFP intervention with the mother and her family an important factor in the development of an empathic relationship. Continuity of the nurse-client relationship, accomplished by having nurses follow the same set of families for the duration of the intervention whenever possible also contributes to the relationship.

The research findings from the Memphis trial supported the importance of continuity in the nurse-family relationship. Those women who had continuous relationships with their nurses made greater advances in several aspects of parental functioning than did their counterparts who had broken relationships. Given that there were no differences in the amount of contact between the two groups, it appears that the severed relationship

interfered with the families' abilities to gain as much in parental care giving as did their counterparts who had continuous relationships (Korfmacher & Olds, 1994).

In general, you'll be building effective relationships by focusing on your clients and their family members' strengths and by addressing issues of concern throughout the intervention in culturally sensitive ways. You'll encourage your clients to assess how your relationship with them is developing at periodic intervals. Conscious reflection of the qualities of the developing relationship can facilitate your efforts to improve interactions with your client and other family members.

Think about it…

Think of a healthy personal relationship you have. How do you and the other person reflect on the status of the relationship? What has helped your relationship to grow deeper and stronger?

You have an opportunity to model characteristics of secure attachment. This gives parents examples of how to become the caregivers their children need in order to develop a secure attachment. Some of the NFP Model Elements and Competencies support you in building a secure base for clients. Examples include: the intensive visit schedule and predictability of the schedule; providing time during each visit to hear about issues and concerns; and negotiating topics for discussion with the client and adapting the visit and content to meet the client's wishes and needs. All of these factors contribute to a predictable and consistent relationship and reliable expectations. They also help the client to feel valued and respected.

Finally, you have the time (60-90 minutes for each visit) to really be present with your clients. NFP nurses nationally share their great enthusiasm for the opportunity to connect with clients in meaningful ways. Your client may, for the first time, experience someone who listens carefully, responds to what is really coming up, and is consistently supportive and caring. This quality of presence is called "emotional availability." This experience of emotional availability between you and the client serves as a model for how the client may relate to the baby.

Think about it…

Sometimes parents make negative attributions or comments about the baby. How might you feel? How will that affect your response? How might it affect your ability to be emotionally available?

On a piece of paper, list some of the ways you've been successful reading and responding to previous clients' emotional signaling. What are some specific ways of modeling how to read and respond to a child's emotional signaling?

Sensitive Response and Responsive Caregiving

Parents develop expectations and beliefs about their children even before they are conceived: they dream, they plan and in some cultures they name the child. When pregnancy is confirmed, the dream becomes more real.

One huge advantage that we have in NFP is promoting the parent-child relationship during the pregnancy. There is time to assess the feelings that the client has towards the coming baby. Does she smile when she speaks about the baby? Does she get upset and say that baby always hurts her when it kicks? Has she given the baby a name; how/why did she choose that name? In Chapter 8: Maternal Role and at the face-to-face education session, we will focus on some ways that you can help the client (and her family) feel emotionally connected to the coming baby.

Tools to Support Sensitive and Responsive Caregiving

There are many ways to promote and support prenatal connection. We will focus more on how to promote this emotional connection later in Chapter 9. During the face-to-face education session, we will talk about many behaviors to consider and possible strategies to employ that support and promote a positive connection to the baby.

The NFP Visit-to-Visit Guidelines have been designed to support your systematic presentation to parents on how infants communicate, giving special attention to nonverbal cues, states, behavior, sleep, crying, and tantrums and how parents can meet their infants' and toddlers' emotional needs. There are many handouts to facilitate discussion and help the parents see their baby as an individual. Some Implementing

Agencies also purchase the book Promoting Maternal Mental Health and the handouts for the series (available from NCAST and written by Joanne Solchany). Nurses use these to supplement the NFP Visit-to-Visit Guidelines.

Several months after attending the face-to-face education session, you will receive training on a tool to help organize your observations and thoughts about caregiving behaviors. These behaviors affect the parent/child relationship as well as the child's long term outcomes. This tool is known as the Dyadic Assessment of Naturalistic Caregiver-Child Experiences or DANCE. You will learn how to use observations of parents caring for their child to help parents understand where they are very strong and where they might shift or improve on some interactions to build the most nurturing and effective relationship with their child.

In addition to learning DANCE, you will find DANCE STEPS (Strategies to Enhance Parenting Skills) very useful. Once you identify caregiving behaviors that you would like to praise or that you would like to strengthen, you may refer to DANCE STEPS. DANCE STEPS links each caregiver behavior to specific materials in the Visit-to-Visit Guidelines and to lessons in the parenting curriculum used by NFP, Partners in Parenting Education (PIPE). This provides you with several options to consider as you work with the parent to build a strong, caring, and supportive relationship with their child.

Partners in Parenting Education (PIPE) (Dolezol & Butterfield, 1994) is an interactive parent-child curriculum also incorporated into the Nurse-Family Partnership program. While many parenting curricula are focused on growth and development, this curriculum focuses on building emotional connectedness between parents and babies. Growth and development are still addressed in PIPE, but the central focus of this curriculum is to assist the new parent with building parenting skill and confidence increasing nurturing, responsive caregiving. The NFP Visit-to-Visit Guidelines will prompt you to use lessons from PIPE regularly. The PIPE curriculum was designed originally for teen mothers in a school system and has been adapted for home visits. In 2005, we developed "PIPE to Go" lessons that are simplified versions. The "PIPE to Go" lessons that were developed were those chosen because NFP nurses listed them as favorites.

Impact of Adult Attachment on Parenting

According to attachment theorists, differences in internal working models have enormous implications for mothers' capacities for developing sensitive and responsive relationships, especially with their own children. Parents with secure attachment relationships with their own caregivers or those who had difficult childrearing histories and have succeeded in integrating their painful experiences are more likely to read and respond sensitively to their own children's emotional signaling.

Those parents who experienced early rejection or lack of nurturance by their own caregiver and either dismisses those experiences or idealizes them are more likely to have children with anxious or avoidant attachment, presumably because the parents are preoccupied with their own attachment needs (Carlson & Sroufe, 1995). Likewise, parents with unresolved disorganized attachments are more likely to have children with insecure or disorganized attachment.

Remember, we are biologically predisposed to seek closeness to specific caregivers under times of stress, illness, or fatigue in order to promote survival. This organization of behavior directed toward the caregiver during times of distress forms the basis of the quality of the attachment relationship. Adults as well as children exhibit attachment behaviors and seek out specific people in times of distress.

Review of Childrearing Histories

During pregnancy, you and your clients (and perhaps their partners) will review their childrearing histories, primarily through a discussion of ways things were done in their home, how events were celebrated, how discipline was handled, who was present and supportive in their lives, etc. They may identify other parents (either their own or others) whom they feel are good role models. They may identify also, behaviors and choices they will want to avoid in parenting their child. Through conscious consideration, they may make different choices about parenting their children, or reinforce some factors that had a significant positive influence in shaping their lives.

For example, nurses sometimes observe that some expectant mothers seem to have negative or hostile attributions about their children even before they are born. By assessing women's beliefs and attitudes toward children and childrearing during pregnancy, you'll be able to help clients and other caregivers develop more accurate perceptions and beliefs about the infant. This assessment also fosters the early identification of clients who may need referrals to address the effects of their own early neglect or maltreatment.

Think about it…

Do you remember where you were on September 11, 2001? People tend to recall a person with whom they feel attached or safe. Who did you want to call as soon as you learned the news?

Parenting, especially for the first time, is stressful. How will a parent respond to a baby with colic or sleepless nights if they believe eliciting support is useless?

If the mother's working model says, "My boyfriend will be there sometimes, but I better hold on tight and do everything I can to keep him close to me," how might she behave?

Handouts in the NFP Visit-to-Visit Guidelines will assist you in helping the client to become more aware of her history. She can begin to choose the models she may want to emulate and those behaviors she might want to avoid. The Life History Calendar and Baby's Family Tree facilitate these discussions.

A powerful effect of your relationship with clients is your ability to model healthy ways of relating. Your willingness to listen, to care, to tolerate the difficult situations as well as to take pride in success and to respond to your client's hopes and dreams demonstrate nurturing, warm behavior. Your interactions serve as a model for how she can relate to her baby. When she experiences qualities of secure attachment and has the encouragement of a caring person to build responsive and nurturing parenting practices, her child is more likely to have a secure attachment. This impacts society, one baby at a time.

Review Key Points

For your personal review, write your answers to these questions on a piece of paper.

1. What are the four patterns of attachment?
2. Pick one pattern of attachment and jot down the behaviors exhibited by children with that attachment pattern.
3. How will you apply Attachment Theory to your NFP nursing practice?

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Chapter 4

Social Cognitive Theory and Self-Efficacy

Nurse-Family Partnership

Helping First-Time Parents Succeed

Chapter 5: Social Cognitive Theory and Self-Efficacy

Purpose

The purpose of this chapter is to provide Nurse-Family Partnership Nurse Home Visitors with an understanding of social cognitive theory and self-efficacy as it relates to the Nurse-Family Partnership model. Skill building will occur during the face-to-face education session.

Standards Covered in This Chapter

Nurse Home Visitor

Applies theories and principles integral to implementation of the Nurse-Family Partnership model

Supervisor

Promotes the home visitor's development of competence to deliver the Nurse-Family Partnership home visiting intervention

Objectives

- Identify the three modes of agency that clients use to function successfully
- Define the role of self-efficacy in the success of clients
- Compare and contrast efficacy expectations with outcome expectations
- Identify four sources of self-efficacy
- Describe practical activities a nurse could use with clients to access each of the four sources of self-efficacy

Social Cognitive Theory and Self-Efficacy

Albert Bandura (1998) conducted research during the 1970's on how humans function, research which continues to the present day. Social cognitive theory grew out of this research. He identified essential factors that contribute to success in life. According to Bandura (1998), individuals proactively engage in their own development and can influence their life-course through their actions. "Most human behavior, of course, is determined by many interacting factors, and so people are contributors to, rather than the sole determiners of, what happens to them" (p. 3).

A Definition of Agency

Agency refers to deliberate, planned actions by a person. Bandura considers the use of agency as essential to successful functioning. There are three different modes of agency:

1. **Personal agency** is observed in individuals when they act on their own to achieve a goal. When an NFP nurse challenges a client to set personal goals and supports her in planning steps to achieve them, she is collaborating with the client to enhance her personal agency.

2. **Proxy agency** refers to an individual achieving her goals through enlisting others to act on her behalf. Every client who voluntarily enrolls in NFP and uses her nurse to help her reach her goals is demonstrating a degree of proxy agency.

3. **Collective agency** occurs when individuals collaborate to impact their future (Bandura, 2002, p.269). One nurse in the Denver trial worked with a client who was experiencing sexual harassment at work. Through thoughtful discussion during numerous visits with the nurse, the client made the decision to approach other females in the workplace who were also experiencing harassment. Eventually they agreed to collectively report their concerns to someone in authority. Their use of collective agency changed that workplace.

In short, this theory addresses how individuals, including NFP clients, develop, adapt and change using three modes of agency.

A Definition of Personal Agency or Self-Efficacy

Bandura also identifies self-efficacy beliefs as essential for experiencing success in life. Self-efficacy is an individual's belief in her ability to accomplish certain tasks (efficacy expectations) and that achieving those tasks will lead to a desired outcome (outcome expectations). Bandura (1986) identifies self-efficacy beliefs as key to an individual's motivation and personal achievement. "What people think, believe, and feel affects how they behave" (p. 25). What may be surprising is that "people's level of motivation, affective states, and actions are based more on what they believe than on what is objectively true" (p. 2).

In your work with clients it is vital that you assess what your clients believe because you are more likely to be able to predict how they will behave based on their beliefs than on your belief about what they are capable of accomplishing. A client's self-efficacy beliefs influence the choices she makes and the actions she takes while she is with you in this program. She is more likely to follow through on information that as a nurse you consider vital for her well-being if she believes it is important, and she is confident that she is capable of making a change.

While a client's sense of self-efficacy is extremely important, her personal beliefs alone do not guarantee success if she does not have the necessary skills and knowledge. Thus while an NFP nurse needs to make certain she is supporting her clients in developing a strong sense of self-efficacy, she also needs to collaborate with clients to assess what knowledge and skills they need to develop in order to act on their sense of self-efficacy regarding a behavior change (Bandura, 1998).

Four sources for the Development of Self-Efficacy Beliefs

Bandura's research identifies four sources for the development of self-efficacy beliefs. These are:

1. Performance accomplishments/enactive mastery experiences: Successfully accomplishing a desired activity. **Doing is believing!**
2. Vicarious experience: Seeing someone model the desired activity. **Seeing is believing!**
3. Verbal persuasion: Hearing positive feedback about the ability to accomplish a desirable activity. **Hearing is believing!**
4. Emotional arousal: Feelings about the behavior. **Feeling is believing!**

The Importance of Performance Accomplishments to Self-Efficacy

NFP calls successful experiences that increase an individual's sense of personal efficacy "performance accomplishments". Bandura uses the term "enactive mastery experiences" (1998, p.80). Bandura's research and the research of others whom he quotes indicates that performance accomplishments/enactive mastery experiences are the most powerful way individuals internalize self-efficacy and gain a sense of control over their lives. If a client has a diminished sense of efficacy and needs evidence that she is competent to perform what is required of her, any victories in accomplishing similar tasks give her the best evidence that she may succeed on a new one.

NFP recommends nurse home visitors make it a high priority to collaborate with clients in planning opportunities to experience success in new activities. You will collaborate with your clients to set small, achievable, "can't fail" steps toward their goals and share with them the importance of persevering in spite of obstacles. At each visit you must seek feedback from your clients on how things are going with the small steps. You'll want to acknowledge your client's successes on the Home Visit Form, and once a goal has been achieved, you'll want to work with your clients to set new ones. When you engage a client in role-play and participant modeling, you are enhancing a client's performance accomplishment.

Focus on building your client's confidence regarding her ability to engage in new behaviors. Knowledge of rules and strategies is not enough if the client does not feel competent. "Improvements in functioning are also more likely to endure if skill development emphasizes the personal power to produce results through the exercise of the skills" (Bandura, 1998, p. 81). When a client masters a desired outcome, her success can be convincing enough to lead her to take other steps and to persevere, even when there are difficulties to overcome!

Caveat!

Nurse home visitors work with clients on action steps that are readily attainable while at the same time preparing them to persevere in the face of obstacles and to recognize not all performance accomplishments will happen without a struggle. According to Bandura, easy successes have an inherent danger in them. Individuals can grow to believe they will always have quick, effortless results. "A resilient sense of efficacy requires experience in overcoming obstacles through perseverant effort. Some difficulties and setbacks in human pursuits serve a beneficial purpose in teaching that success usually requires sustained effort"(1998, p. 80).

The Role of Perception in a Sense of Self-Efficacy

While successful performance tends to enhance an individual's sense of efficacy; success or failure at performance accomplishments does not guarantee a change in perceived efficacy. How a client evaluates and interprets her successful or unsuccessful experiences influences her more. It is important to explore with clients how they view their experiences. A nurse home visitor may be able to support a client in reframing a present or previous experience so that her sense of efficacy is enhanced.

Because a client's perception of her experience contributes to her sense of self-efficacy, the NFP Visit-to-Visit Infancy Guidelines prompt a nurse on the first postpartum visit to ask her client what she experienced in labor and delivery. Some clients have expressed feeling like a failure as a mother because they had to have a C-section and/or they needed pain medications when they had planned not to use them. A nurse can enhance her client's sense of self-efficacy by normalizing her experience and feelings and by reframing what it means to be a good mother.

The Importance of Vicarious Experiences to Self-Efficacy

When individuals see others who they perceive are similar to themselves succeeding in specific arenas and tasks, they are benefiting from vicarious experiences. The research indicates that perceived similarities in the role models are very important (Bandura, 1998). While this form of developing personal efficacy is not as powerful as performance accomplishments, it does have potential for enhancing confidence regarding competence to attempt new activities.

Here are some examples of models of vicarious experiences:

- Nurse home visitors who were teen mothers often find they have enhanced credibility with their clients. Nurses without that advantage still have the opportunity to explore with clients who they would perceive as positive role models similar to themselves.
- Use of role models from inspirational media venues can spark lively dialogue and reflection by clients.
- In some communities, nurses are able to refer clients to support groups with guest speakers similar to their clients who provide role modeling.
- At times nurses are so skillful at building the therapeutic relationship and emphasizing similarities, that clients verbalize wanting to be like them. NFP clients have gone on to nursing school to become NFP nurses.

The Importance of Verbal Persuasion to Self-Efficacy

Verbal persuasion is feedback from others who express their confidence in an individual's capabilities to perform an activity. "People who are persuaded verbally that they possess the capabilities to master given tasks are likely to mobilize greater effort and sustain it than if they harbor self-doubts and dwell on personal deficiencies when

difficulties arise" (Bandura, 1997, p. 101). However, this form of feedback may not support actual change unless the persuasion is based on reality.

Think about it…

Nurse home visitors always need to have their eyes open for opportunities to provide specific, realistic, verbal and/or written affirmations of their clients and expressions of confidence in their clients' capabilities.

How might you give verbal feedback to enhance the self-efficacy of a client who is struggling in seemingly many areas of her life yet keeps all of her home visit appointments with you?

Verbal feedback can take many forms. Here is one example, "I've noticed that you keep your appointments for home visits with me, which means you have some great skills that will help you at school and work! You keep track of the day and time of our appointments, and you show up even if there might be something else you'd like to do."

Caveat!

Be careful not to provide unrealistic or grandiose feedback that gives clients the perception they can accomplish an activity they don't have the skills or knowledge to tackle. If a nurse encourages her client to believe she can make a change that she is not yet ready to attempt, then the client is likely to fail; she is less likely to believe the nurse the next time, and the client will experience a diminished sense of self-efficacy.

The Importance of Emotional Arousal to Self-Efficacy

Emotional arousal refers to a phenomenon in which an individual experiences negative emotions, such as anxiety, fear of failure or feeling threatened, which diminishes self-efficacy. Nurses can support clients in developing their sense of self-efficacy by working with them on managing stress and reducing physical and emotional symptoms of stress involved in emotional arousal. Individuals who experience symptoms of stress such as increased heart rate, hyperventilating, perspiring, and insomnia, and focus on these physiological sensations, are likely to feel a heightened sense of vulnerability and less capable of managing a situation.

In addition, an individual's mood can influence their sense of self-efficacy. Depression has a negative effect on a person's perceived self-efficacy. A nurse who works with a client to develop a healthy sense of self-efficacy and to manage her mood states can make a difference in the outcomes for that client. "By raising efficacy beliefs that

heighten motivation and performance accomplishments, good mood can set in motion an affirmative reciprocal process" (Bandura, 1997, p.113).

On the other hand, by not addressing issues surrounding emotional and physiological arousal, clients are likely to "inhibit their efforts to cope, which can lead to a vicious cycle in which individuals do not allow themselves to be put in situations where they have the opportunity to develop coping skills" (Olds, Kitzman, Cole & Robinson, 1997, p.16). Two ways NFP nurses address management of emotional arousal and mood states is through the PIPE parenting curriculum and through facilitators and handouts from the NFP Visit-to-Visit Guidelines. "Emotional Refueling" is a parenting lesson that nurses find useful for discussing a client's level of stress and finding ways to manage it.

Use of Self-Efficacy Theory in the Research Trials

In the trials, the primary emphasis was on the use of personal and proxy agency. In the Elmira trial, nurses worked with clients to plan and take small, achievable steps which, when reached, increased clients' confidence and built evidence of success for further goal setting and action. The most important outcomes in Elmira were observed in women who had a low sense of control over their lives at the time they enrolled. For this reason, the Memphis and Denver trials emphasized building self-efficacy to an even greater degree than the Elmira trial (Olds, Kitzman, Cole & Robinson, 1997).

The Cultural Relevance of Social Cognitive Theory

Since the term "self-efficacy" may seem to apply only to individually oriented cultures, it's important to keep in mind that Bandura's (2002) more recent research indicates a healthy sense of self-efficacy is important for individuals to achieve success in both individually oriented and collective societies. Bandura (2002) stated, "People do not live their lives autonomously. Many of the things they seek are achievable only through socially interdependent effort. Hence, they have to pool their knowledge, skills and resources, provide mutual support, form alliances, and work together to secure what they cannot accomplish on their own" (p. 270). Personal, proxy and collective agency are found in every culture, though the degree to which each is used varies from culture to culture.

The Importance of Addressing Clients' Personal Beliefs of Efficacy

Self-efficacy beliefs regulate human functioning through cognitive, motivational, affective, and decisional processes. They affect whether individuals think in self-enhancing or self-debilitating ways... (Bandura, 2002, p. 271).

The degree to which a client believes that an action will lead to a desired outcome and that she is capable of taking that step affects the probability that she will attempt a behavior change and the persistence with which she will pursue it.

In conclusion, self-efficacy theory played a role in the design of the Elmira, Memphis, and Denver trials and continues to be used in the replication of the NFP model. This theory, "has a number of direct implications for the methods that the home-visitors use to promote mothers' healthy behavior, optimal caregiving, family planning, and economic self-sufficiency." (Olds, Kitzman, Cole & Robinson, 1997, p.17)

If clients in NFP believe they are capable of taking action at a personal, proxy, or collective level, and that their actions can produce the outcomes they would like to achieve, they will be motivated to act or to persevere even when they face obstacles in their paths. When clients agree to be in the program, they open the door to the support of a NFP nurse who can work with them to develop their support network and their sense of self-efficacy in order to achieve their goals.

Review Key Points

For your personal review, write your answers to these questions on a piece of paper.

1. Fill in the blanks: Bandura identifies _____ beliefs as _____ for experiencing success in life.

2. Fill in the blanks: A person's belief in her ability to accomplish certain tasks equals _____ expectations. A person's belief that accomplishing those tasks will lead to a desired outcome equals _____ expectations.

3. What are the four sources of self-efficacy?

4. What are two practical activities mentioned in this chapter that a nurse can use with clients to access each of the four sources of self-efficacy?

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Chapter 5

Content Domains

Nurse-Family Partnership
Helping First-Time Parents Succeed

Chapter 5: Content Domains

Purpose

This chapter introduces you to the content domains, which provide a systematic comprehensive nursing approach. The domains guide your clinical practice to help achieve client goals and program outcomes.

Standards Covered in this Chapter

Nurse Home Visitor

Uses the Nursing Process to deliver individualized client care and set goals across the six domains.

Nurse Supervisor

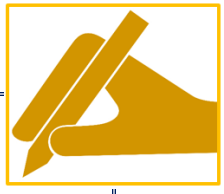
- Promotes the home visitor's development of competence to deliver the Nurse-Family Partnership home visiting intervention.
- Implements the Nurse-Family Partnership program with fidelity to the model.

Objectives

- List the six content domains.
- Identify the areas addressed by each content domain.
- Identify ways to implement each content domain.

Introduction to Content Domains

Before we look at the domains, think of yourself as a nurse in the first clinical trial. You and your team want to improve pregnancy outcomes (particularly prematurity and low birth weight), improve child health and development (particularly injury prevention and language development), and improve maternal life course development and economic self-sufficiency. What topics do you think it would be important to address with moms in order to impact these key outcomes? Make a list below



Think About It…

On a piece of paper, write down as many topics as you can think of.

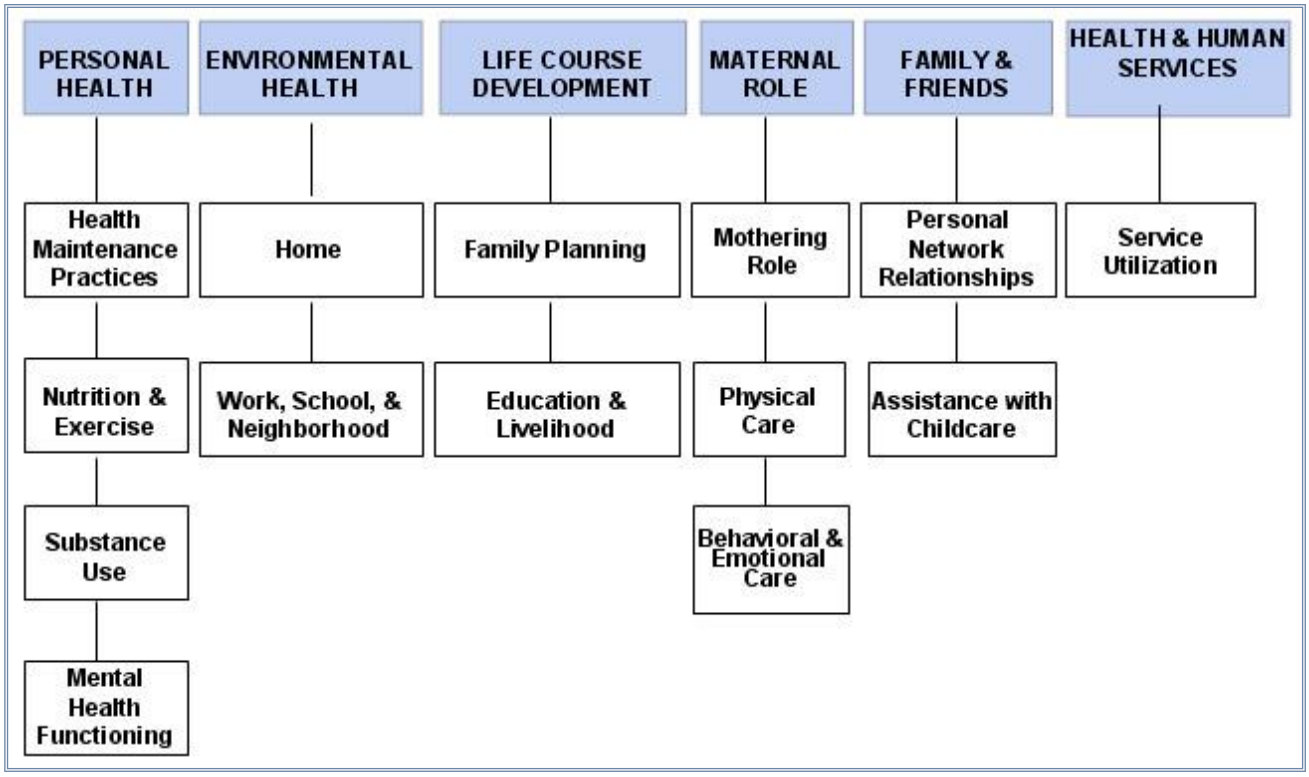
This very question was asked by Dr. David Olds and his team of nurses and researchers. The desire to link the outcomes with the core theories of NFP led to the development of what we call Content Domains: Personal Health, Life Course Development, Maternal Role, and Family and Friends. In order to support a comprehensive community health approach, Environmental Health was added. Health and Human Services is the domain that captures referrals for issues and concerns that are identified in all the other domains.

During the research trials, the nurses and research staff organized all the topics into the six content areas or domains, which helped to ensure that each nurse was comprehensive in her approach with every client. The domains and sub-domains formed the foundation for nurse assessment in NFP, the first step in the nursing process. The domains were also useful in observing the changing emphasis in content areas during the pregnancy, infancy, and toddler phases of the intervention. For example, the researchers noted that during the trials, nurses tended to spend more time in the Personal Health domain during the pregnancy phase, and more time in the Maternal Role domain during the infancy phase.

On the Visit-to-Visit eGuidelines web site you will find **Visit Guidance** which assists each nurse in knowing what specific topics are important during specific phases in each domain. This helps the nurse avoid bias and choosing topics those in which she feels more comfortable or more interested. The Strengths and Risk Framework (STAR) provides the framing needed to assess and plan interventions and is based on the domains.

Domains and Sub-Domains

In NFP – Domains are how we assess each client's progress toward personal goals and program outcomes. The following graphic lists the domains, and the sub-domains under each domain.



Note: Remember that in order to make the content more accessible to clients, more user-friendly domain names have been introduced in the NFP Visit-to-Visit eGuidelines. The correlation is as follows:

Personal Health	My Health
Maternal Role	My Child Taking Care of My Child
Environmental Health	My Home
Family & Friends	My Family & Friends
Life Course Development Health & Human Services	My Life

Personal Health Domain

The Personal Health domain addresses clients' health maintenance practices, nutrition and exercise, substance use involving cigarettes, alcohol or drugs, and mental health functioning. Initially, you will spend much of your time in this domain discussing pregnancy issues with your client; however after the baby is born, the amount of time spent in this domain will depend upon the client's health issues during the duration of the program.

Examples of topics in each of the sub-domains are:

- **Health Maintenance Practices**: Access to medical care, consistency in seeking care, pregnancy discomforts and danger signs, personal hygiene, safe sex practices
- **Nutrition and Exercise**: Access to food resources, balanced meals, adequate food/fluid intake, appropriate weight for height, weight gain during pregnancy, adequate rest, relaxation, activity level, pregnancy exercises, posture
- **Substance Use**: Tobacco, alcohol, marijuana, illegal substances, prescription drugs, and caffeine
- **Mental Health**: Baby blues, depression, anxiety, affect, and mental illness

Let's practice finding facilitators in the Personal Health Domain

Think About It…

Go to the vtov.nursefamilypartnership.org website.

1. Enter "mental health" –be sure to use the double quotes!

   How many results did you find?

2. Use the STAR filter and check #4 Depression, Anxiety etc.

   How many results are left?

3. Click on the link "An Emotional Roller Coaster". How might this facilitator be helpful for a client?

4. What might you want to do as a follow-up to this facilitator?

Click here to check your answers

Environmental Health Domain

Environmental Health addresses adequacy and safety of maternal and child health in the home, work, school and neighborhood settings. Low-income families often have difficulty finding adequate housing in safe neighborhoods. Frequently there are many health hazards. Unintentional Injury is currently the #1 leading cause of death in children under age 4 in the United States. Children are at greater risk to air pollutants, toxicants/pesticides vapors in dust, soil and carpets and to toxic chemicals on the floor, grass or ground. NFP families are at high risk for environmental health problems.

Throughout the program, you will be given reminders to assess for safety in the home, work place, school, and neighborhood. You will focus on environmental health in all phases of the program, with increasing emphasis after the baby is born.

Examples of topics in each of the sub-domains would include:

Home: Adequate and safe housing, access to basic living necessities such as water, electric, heat, gas, phone, absence of rodents and insects, presence of unsafe pets, lack of childproofing, fire and gun safety, secondary smoke, injury prevention measures, lead exposure, etc.

Work, School & Neighborhood: Safe neighborhood, car seats, gang/drug influence, transportation, crime rate, chemicals, pesticides, air pollution, internet safety, etc.

Let's Practice Finding A Facilitator in the Environmental Health Domain

Think About It…

Go to the vtov.nursefamilypartnership.org website.

1. Enter "pets" Be sure to use the double quotes.
2. Click on "Babies and Pets". How does this facilitator help you as the nurse address pets?

The types of safety issues change as the baby ages. Reminding the client of new hazards related to development and preparing for the upcoming hazards as baby begins to crawl will make a big difference in the incidence of accidental injuries. In the Elmira and Memphis trials, the comparison of the rate and seriousness of injuries between the control group and the research group was striking (Olds D, et al. 1986; Kitzman H, et al. 1997). Nurse visited babies had significantly fewer and less serious injuries.

Look at the facilitator "Have you crawled around the house?" You can use the concept presented in the facilitator even without using this paper. Simply take a walk through the rooms in your client's living space to determine what objects pose a danger to baby and have your client write them down. Discuss with your client what she could do to mitigate the risk to her infant or toddler. This is a great discussion to do before baby crawls or walks.

Some NFP agencies invest in thermometers that test the water temperature and give one to each client. You can run the water and check the temperature together. Some local children's hospitals and fire departments have great handouts that supplement the NFP material. Remember that your best discussion may not be around a facilitator but a safety pamphlet from the fire department or health agency or even watching a video together on home safety on YouTube.

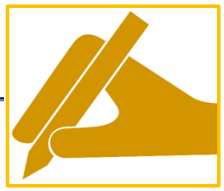
Life Course Development Domain

Life Course Development focuses on clients' goals related to their future. There are so many topics in this domain that it is almost endless. When we are focused on listening and hearing our clients heart's desires – we will be surprised as the wealth of dreams they have. Often for our clients it is not the lack of dreams but the skills to put those dreams into reality that hampers them from moving forward.

This domain can include everything from education, employment, family planning, setting and achieving goals, developing communication skills, learning how to write a resume, or learning a number of life skills like time management, check writing, applying and studying for a driver's license or library card. The list is as endless as the imagination.

A main program outcome goal is to promote economic self-sufficiency. Self-sufficiency looks different for every client but it can include obtaining insurance, housing, and income. In the research trials, nurse visited clients had a reduction in the use of welfare (Olds, et al. 1997; Olds, et al. 2004).

Let's Practice Addressing Life Course Development



Think About It…

As a personal review, write the answers to these questions on a piece of paper.

1. As a teenager, what is one skill you wanted to learn? It might have been driving a car, applying for your first job, or trying to imagine your career.

   Pick one goal you wanted to reach.

   What were the steps it took for you to attain that goal? What or who helped you reach that goal? What resources did you need to reach that goal?

2. What might be challenges your client has reaching this same type of goal?

3. Go to the Guidelines website and search for the goal facilitator and for instructions for "Potholes that block my path." How might this facilitator be helpful in the situation you identified above?

Maternal Role Domain

Maternal Role Domain addresses clients' development of the maternal role and their acquisition of the knowledge and skills needed to promote the health and development of infants and toddlers.

The sub-domains include the physical, behavioral and emotional care of the child. Nurse-Family Partnership is a mediated model, so the child's outcomes will be achieved by working with the mother to refine her ability to care for the child. It is in this domain that you will document your clinical notes about the child.

Examples of topics in each of the sub-domains would include:

- **Mothering Role**: Client's adjustment to her mothering activities and role attainment
- **Physical Care of the Child**: How the mother manages medical/dental appointments, immunizations, bathing, feeding, sleep/wake cycles, growth and development stages, etc.

- **Behavioral and Emotional Care**: Development of bonding and attachment behaviors, responding to cues in a nurturing and timely way, promotion of social-emotional growth, etc.

Implementing the Maternal Role Domain

As part of the Maternal Role domain, you will find many facilitators that can be used to engage your client in connecting well with her baby. The facilitators will help mothers reflect on how they are developing as a mother and what they think a good mother does.

In the last weeks of the pregnancy, you may use *NCAST Keys to Caregiving* booklets to explain infant cues, states, and behaviors. These give parents skill and confidence in understanding and responding well to the baby. Your Implementing Agency will order the booklets from NCAST.

When you are working with infants and toddlers, you will observe and assess the caregiver-child relationship. Currently NFP uses DANCE as a dyadic assessment. You will learn more from your agency about when you will attend DANCE education. In the meantime, a colleague who is certified in DANCE can help you when a screening is due on one of your clients.

During the Infancy and Toddler phases, you will find numerous facilitators that address care of the child such as sleep safety, dental care, feeding and nutrition, behavior management, signs of illness, teething, second-hand smoke, toilet learning, etc.

Use of Assessment Tools

- **Child Weight/Length**: Most implementing agencies use child length/weight grids to track growth and provide teaching about the child's growth. These are standardized forms that may be accessed from numerous sources. Some agencies rely on client report of feedback from the pediatric provider.
- **Child Health Status**: Some Implementing Agencies use agency forms to routinely screen for child health, feeding, behavior, etc. Some data on Infant Health will be routinely gathered and reported through the NFP data collection form *Infant Health Care* form. This data will become part of your reports and useful in looking at your success in impacting infant care.
- **Guidance for Developmental Screening**: In the Appendix of your Data Collection Manual, you will find a useful guide titled Guidance for Developmental

Screening. The guide introduces you to screening, monitoring, and referral. Frequently asked questions are addressed on the first few pages. Guidance for use and implementation of the screening tools is provided. Finally, there are suggestions for interventions that promote improvement for the children you are monitoring or have referred. Take a minute to find the Guide.

Friends and Family Domain

The Family and Friends domain focuses on helping clients deal with relationship issues and find support for their own goals. You will be assessing how clients' friends and family members promote her self-efficacy and independence. You will initiate and maintain therapeutic relationship and appropriate boundaries with the client as well as with those friends and family who participate in visits. Over time, you will help clients build a stronger and healthier support network.

Examples of topics in each of the sub-domains would include:

- **Personal Network Relationships**: Your client's relationships may be limited when you initially meet her, but by the end of the program, hopefully she will have supportive positive people that are good role models in her life. Referring clients to services in the community will also increase her supports and hopefully provide additional networks that will promote her self-sufficiency.
  Some agencies also offer client networking events and many clients find friendships in these events.

  Assistance with Childcare: This is a national concern because of variance in and lack of quality and affordable providers in low-income communities. You will help your client evaluate the pros and cons of various childcare options.

Let's Practice Addressing Friends and Family Domain

Think About It…

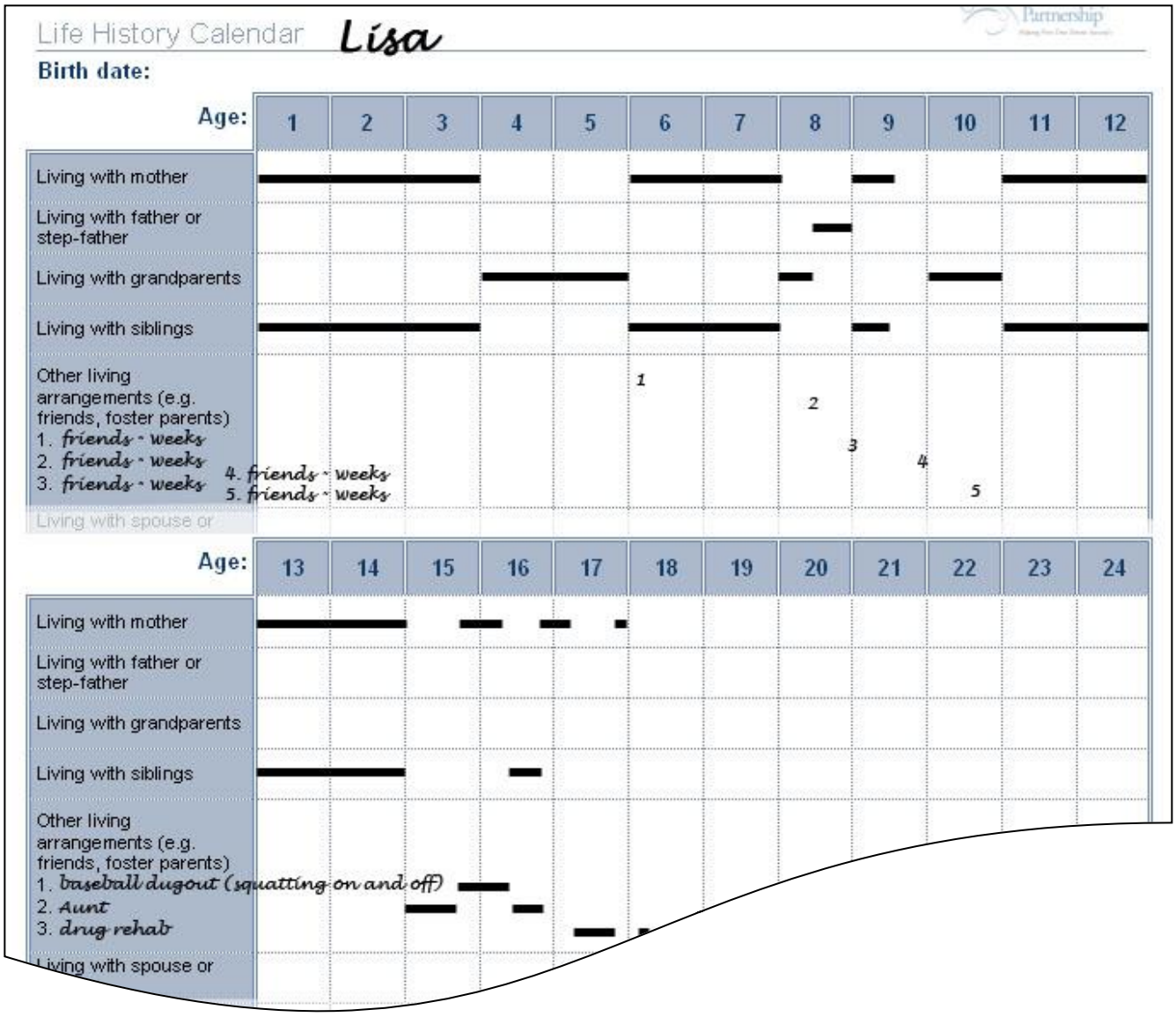
The Life History Calendar is a wonderful way to find out more about your clients network of support and what created or diminished that network of support.

1. Go to the VtoV Guidelines website and look up the "Life History Calendar" Read the instructions carefully. Take a look at the example of the next page of how the calendar looks when completed. Clients will give you lots of background and information while talking about something as simple as where they lived during the ages of 1 to 15 years old. If you were filling out this calendar on yourself – what would be some of the interesting facts you could share about your life?

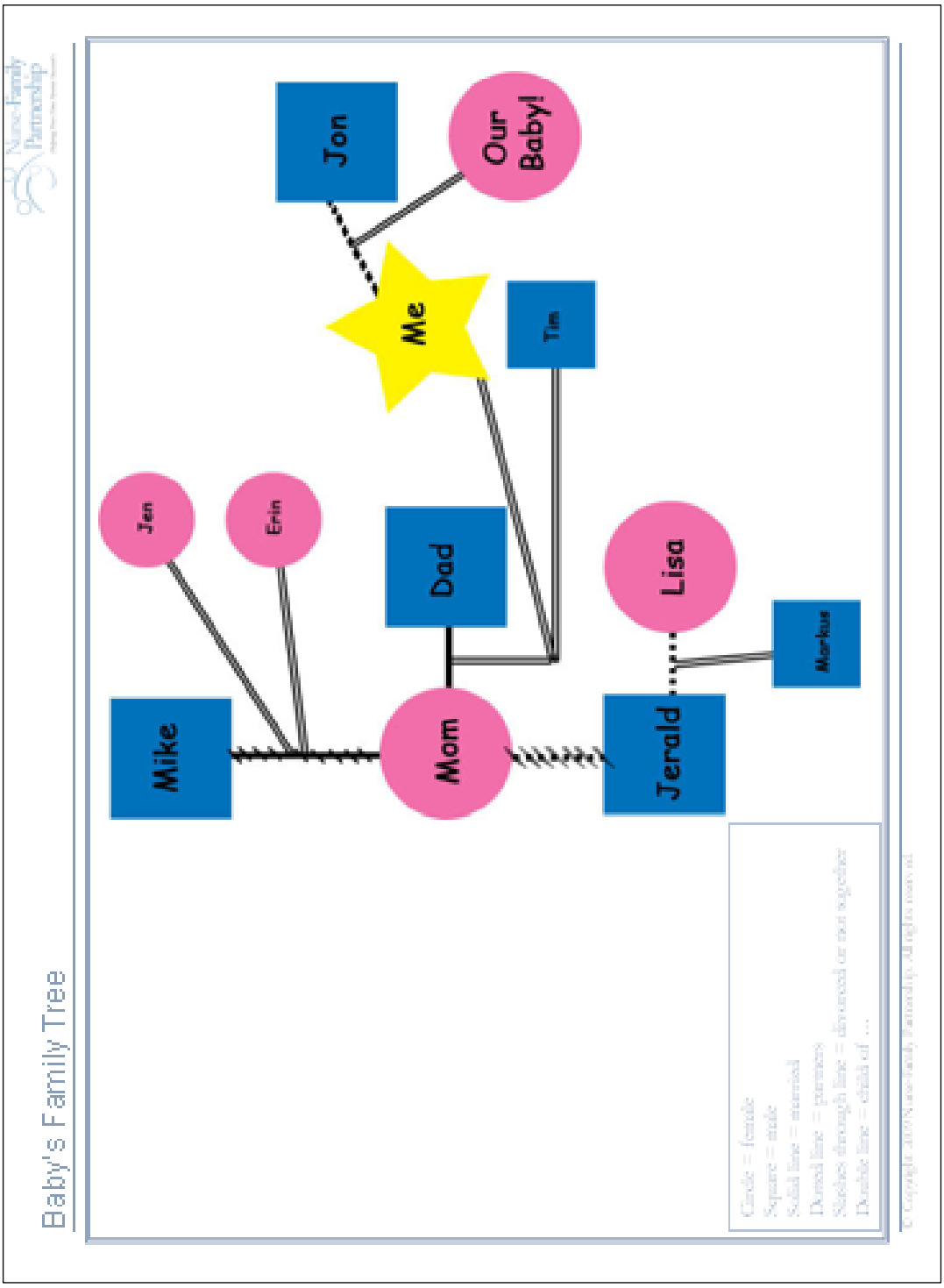
2. Look up "Baby's Family Tree" and read the instructions for how this facilitator can be used. What are two benefits of doing this facilitator with clients?

Samples of both the Life History Calendar and Baby's Family Tree follow this activity.

Sample Life History Calendar



Sample Baby's Family Tree



Health and Human Services Domain

The Health and Human Services domain addresses linking families with community services for which current family resources are not adequate. This domain serves as a regular reminder to consider options for better care.

Implementing the Health and Human Services Domain

Time spent in health and human services relates back to the affected domain. For example, when referring a client for mental health services, the assessment, teaching, intervention, and referral fall under the Personal Health domain and the Mental Health sub-domain.

Documentation

The domains guide your practice, organize your assessment and intervention, and organize your documentation. In some agencies nurses write narrative nurse's notes organized according to each domain, while in other agencies nurses address the client domains by using checklists and then complete the nursing planning and evaluation with brief narrative notes. Because funding streams and political stakeholders require different information, agencies generally modify agency documentation forms to meet their unique needs.

In their book, Home Visiting, Wasik and Bryant (2001) note that while documentation tends to be the least favorite task, it is of course essential – to document needs, individualize care, evaluate progress, monitor program delivery, replicate successful programs, and comply with legal obligations. They include the overview below.

Client Assessment

	Collection of Initial Data	Collection of Outcome Data	Ongoing Program Documentation
Types	Intake data Demographic data Client needs	Client functioning Attitudes/behavior Home environment Client satisfaction	Home visit procedures Program content Referral contacts Client behavior
When	Early visits	Typically yearly, biannually, or end of program	Daily or weekly
Examples	Interviews Checklists	Questionnaires Observations	Home Visit Forms Case Notes
Goals	Document client needs Individualize care	Show client progress and program effectiveness	Monitor program delivery and client progress Replicate successful programs

Ultimately, you will want to ensure that your documentation meets nursing standards, your Implementing Agency policy and contributes to successful replication of the program within your agency.

Professional Development in the Content Domains

How much experience do you have in assessing and teaching in each of the domains with pregnant and parenting women? How confident are you that you can explain the concepts, give examples, and answer questions? Look at the visit by visit guidelines for pregnancy and review the content topics in the first visits. Do you need to learn more?

Look at the "Possible Continuing Education Topics" at the end of this chapter, and determine which topics are the most important for you to master first. Think about your learning style, the time you have to master this, and the most effective, efficient, and useful way to acquire this understanding. Discuss your learning needs with your supervisor. *(You completed a sample Skills/Experience Assessment Form at the end of Chapter 2; you can use this if you need a place to start.)*

Possible Continuing Education Topics by Domain

Core Instruction for NFP consists of education sessions carefully designed to provide nurses with a strong base of knowledge regarding the program model. Core NFP education sessions are not able to cover clinical practice issues specific to maternal child nursing and community health. Additional continuing education at each implementing agency (beginning during the early months of program start-up) is required.

Circle topics you want to study in order to feel prepared and confident in delivering the NFP model, then discuss with your supervisor how you will obtain this additional professional development.

Personal Health

- Pregnancy Wellness (Nutrition and Exercise)
- Pregnancy Complications (Preterm Labor, PIH, Gestational Diabetes)
- Fetal Development
- Genetic Testing/Counseling
- Preparation for Labor and Delivery
- Doula Care
- Mental Health/Community Resources (Perinatal Depression, Mood Disorders)
- Stress Management/Emotional Refueling
- Personal Safety/Self-Defense
- Substance Abuse
- Smoking Cessation

Environmental Health

- Baby/Child Safety
- Safety of Housing (Appliances, Furnishings)
- Safety of Neighborhood (Assaults, Gang Issues)
- Smoking by Others
- Communicable Disease Control (Epidemiology, Prevention, Universal Precautions)

Life Course Development

- Cognitive/Learning Problems/Barriers to Education
- GED (Testing, Education Completion Programs)
- Strategies for Assessing and Building Job Skills
- Job Training Programs (Financial Aid and Other Support)

Maternal Role

- NCAST Keys Study Guides - All Classes
- Breastfeeding/Community Resources
- Infant Massage
- Infant/Toddler Nutrition
- Infant Safety Issues (SIDS, Back to Sleep, Shaken Baby)
- Immunizations
- Infants and Children with Special Needs
- Early Childhood Development
- Discipline
- Relinquishment/Loss of Custody

Family and Friends

- Intimate Partner Violence/Community Resources
- Role of Fathers/Adult Male Role Models

Health and Human Services/Miscellaneous

- Emergency Services (Food Banks, Transportation, Shelters)
- Mandatory Reporting Issues (Child Abuse, Maternal Substance Use, Intimate Partner Violence)
- Other Community Services and Resources (WIC, TANF, Medicaid)
- Vital Statistics (Birth Certificates, Immigration, Establishing Paternity)
- Legal Assistance/ Issues and Resources
- Foreign/Sign Language/Use of Interpreters
- Introduction to Public Health for Nurses New to Home Visitation
- Case Load Management
- Serving Adolescent Clients (Developmental Differences, Adapting Ways of Relating/Teaching)
- Grief and Loss/Community Resources

- Child Health Assessment
- Child Abuse/Neglect (Prevention, Assessment, Intervention)

Possible Resources for Finding Presenters:

- Within your NFP nursing team
- Within your implementing agency
- Within your region or state agencies
- Local universities (schools of public health, nursing, medicine, education, language)
- Local high schools
- Police Department/Legal Aid Services
- Local OB providers
- State/local public health agencies
- Local agencies (e.g., WIC, clinics, etc.)
- Agencies identified as sources of NFP referrals
- Local hospitals
- March of Dimes Nursing Modules: Some nurses have used the March of Dimes modules to gain knowledge about pregnancy. These modules are excellent, up to date, and inexpensive. They are designed for independent or small group self-study. You can find them under nursing education at www.marchofdimes.com.

Conclusion

The content domains serve to help you organize and deliver a comprehensive intervention with high-risk clients. In NFP we assess through the domains and the STAR Framework is based on these domains. All facilitators in the guidelines are tied to one or more domains. Everything you do with a client is based in a domain. And each domain is created to help clients reach the three overarching goals of NFP, improved pregnancy outcomes, improved child health and development and economic self-sufficiency.

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Olds, D.L., Henderson, C., Tatelbaum, R., & Chamberlin, R. (1986). Preventing child abuse and neglect: A randomized trial of nurse home visitation. Pediatrics, 78(1), 65-78.

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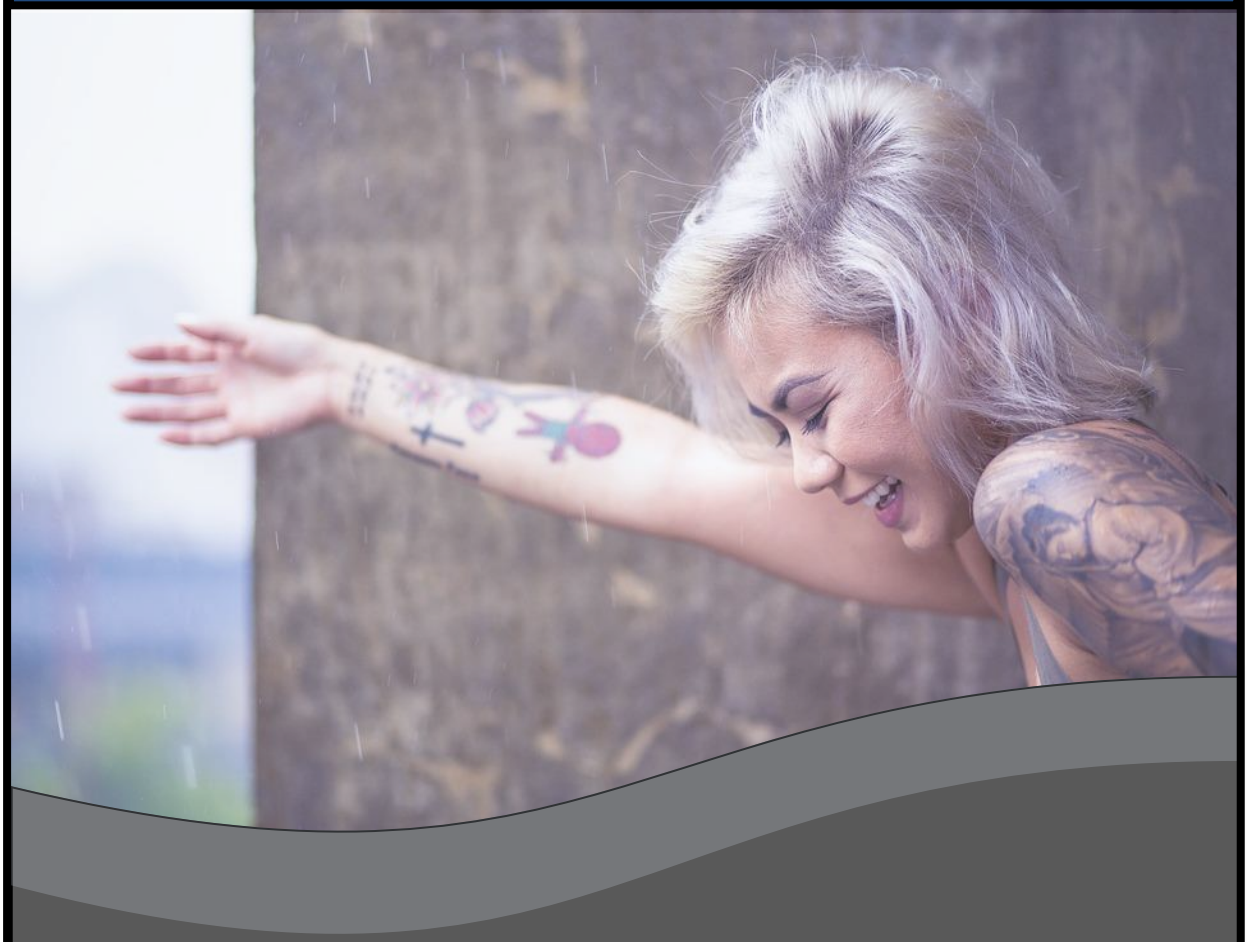
Answers to Personal Health Domain "Think About It" Questions

1. 17, 2. 12, 3. Helps the client identify the different feelings she is experiencing, might normalize those feelings for her, will be a start in identifying postpartum depression or anxiety, 4. Do assessments like PHQ-O and/or a GAD -7

Chapter 6



Client Centered Principles

Nurse-Family Partnership
Helping First-Time Parents Succeed

Chapter 6: Client-Centered Principles

Purpose

The purpose of this chapter is to introduce the Client-Centered Principles.

Standards Covered in this Chapter

Nurse Home Visitor

- Applies theories and principles integral to implementation of the Nurse-Family Partnership Model.
- Establishes therapeutic relationships with clients.

Nurse Supervisor

- Application of principles of supervision that promote the clinical and professional development of all team members.
- Promotes the home visitor's development of competence to deliver the Nurse-Family Partnership home visiting intervention.

Objectives

- Identify the five Client-Centered Principles.
- Describe uses of the Client-Centered Principles in practice.

Client-Centered Principles in the Nurse-Family Partnership

There are five Client-Centered Principles foundational to the Nurse-Family Partnership program.

The client is the expert on her life.	A nurse focuses on what the client knows will work in her particular life, culture and environment. While the client may need information and support, the nurse needs to hear from the client how that information and support can be individualized to facilitate success.
Follow the client's heart's desire.	A client's energy, time and attention will be devoted to changes in her life based on what she desires deep in her heart. When a nurse discovers what matters most to her client, she and her client will experience momentum in the behavior change process.
Only a small change is necessary.	This principle reminds the nurse and client that small steps in a purposeful direction are valuable. Behavior change is fundamental to the NFP Model. Life-transforming changes are often begun with the smallest of steps.
Focus on strengths.	This principle demonstrates respect of the individual and the spirit of motivational interviewing. It encourages the nurse to reframe challenging situations by pointing out what a client is doing well.
Focus on solutions.	This principle requires a paradigm shift away from focus on the problem toward collaborating with the client to envision success. It's a focus on how she wants to move forward rather than remaining stuck in the difficulties of the past and the present.

Think about it…

Think about each of the Client-Centered Principles. On a piece of paper, write down in what ways might you find this Client-Centered Principle easy to implement in practice? In what ways might this Client-Centered Principle be challenging for you? What can you do to address the challenges?

The client is the expert on her life.

Easy	Challenging

Follow the client's heart's desire.

Easy	Challenging

Only a small change is necessary.

Easy	Challenging

Focus on strengths.

Easy	Challenging

Focus on solutions.

Easy	Challenging

Think about it…

Practice recognizing the Client-Centered Principles in the following scenarios. Review the photos that follow and assume these are pictures of clients. Based on what you observe, deduce how you might approach the client and answer the questions below each photo.

Thinking of the client-centered principles, what strengths do you see in this client?	Thinking of the client-centered principles, what might be challenging about working with this client?	What are some open-ended questions you might ask this client?

Thinking of the client-centered principles, what strengths do you see in this client?	Thinking of the client-centered principles, what might be challenging about working with this client?	What are some open-ended questions you might ask this client?

Thinking of the client-centered principles, what strengths do you see in this client?	Thinking of the client-centered principles, what might be challenging about working with this client?	What are some open-ended questions you might ask this client?

Review Key Points

1. NFP Client-Centered Principles define your work with your client within a nursing framework.
2. Use the NFP Client-Centered Principles to build rapport and experience collaboration with your clients.
3. Which principles do you want to discuss with your supervisor during reflection?

Chapter 7

Therapeutic Relationships

Nurse-Family Partnership
Helping First-Time Parents Succeed

Chapter 7: Therapeutic Relationships

Purpose

The purpose of this chapter is to address the therapeutic use of self in Nurse-Family Partnership and appreciate the importance of establishing boundaries.

Standards Covered in this Chapter

Nurse Home Visitor

Establishes therapeutic relationships with clients.

Nurse Supervisor

Applies principles of supervision that promote the clinical and professional development of all team members.

Objectives

- Describe the purpose of therapeutic relationships
- List areas of knowledge deemed essential to professional therapeutic relationships by the RNAO
- Describe the phases of the therapeutic relationship
- Identify characteristics of professional therapeutic relationships
- Define the Zone of Helpfulness as part of the Continuum of Professional Behavior

Why Are We Studying Therapeutic Relationships? As Nurses, We Are Already Pretty Good at This

Nurses are typically good at therapeutic relationships. Successful nurse/client relationships are part of who we are. This characteristic of nurses is one of the great motivators in using nurses for NFP. Nurses come with some great relational skills that they have already refined and use well. In this model, those skills are highly important, so important in fact that we sometimes refer to the relationship and your ability to use yourself in a therapeutic way as the "secret ingredient!" In this program we are looking for long-term outcomes that require first-time mothers to make significant change. The nursing intervention to achieve this is not through dispensing medications or doing treatments, it is through YOU and your relationship with each client.

Therapeutic use of self is the contribution a nurse makes as an individual to the process and outcome of the relationship. It requires self-awareness, understanding, skill, persistence, and self-evaluation. Establishing and maintaining therapeutic relationships can be a curious, challenging and refining art. Not only is the client a "work in progress," but so are you. It takes reflection, insight, and adaptability to maintain a positive and professional therapeutic relationship with complex clients in crisis. We will review information that you already know, invite you to expand your view, introduce you to materials in Nurse-Family Partnership that support you, and invite you to consider common challenges to the therapeutic relationship, particularly as they pertain to working with Nurse-Family Partnership clients.

Nurse-Family Partnership Commitment to Best Practice

Whenever possible, Nurse-Family Partnership education will use study materials, theory, and standards that are based on evidence (replicated research trials) and if that is not available, we will use "best practice" models. The Registered Nurses Association of Ontario (RNAO) has done an excellent job of reviewing the concept of therapeutic relationships in nursing. They did not find replicated research trials, so they did an extensive literature search, established 14 recommendations that support healthy and professional therapeutic relationships, established practice standards, and field tested the standards in several agencies. The feedback from the field testing was used to refine the standards. We will use the standards in this section and provide some activities and thought questions so you may apply the standards with common challenges we see in NFP.

Definition of Therapeutic Relationship

"An interpersonal process that occurs between the nurse and the client(s). It is a purposeful, goal directed relationship that is directed at advancing the best interest and outcome of the client" (Registered Nurses Association of Ontario, 2002). Thus, the purpose of a therapeutic relationship is to promote the client's best interests.

Essential Knowledge for Professional Therapeutic Relationships

The first recommendation from RNAO (2002) is that the nurse needs knowledge to participate effectively in therapeutic relationships. You can be more effective with Nurse-Family Partnership clients when you know about poverty; about the cultures you work with; and about health promotion and maternal child care. Knowing about safe home visiting, health care systems, and access to care and resources will help you stay engaged and fluid in the relationship.

Think about it…

What areas will you want to learn more about so that you can feel confident and comfortable in your home visits?

The second recommendation is to know yourself. The RNAO describes self-awareness as the "ability to reflect on one's subjective thoughts, feeling, and actions." In her article Philosophical Basis and Practice of Self-Awareness in Psychiatric Nursing, Echroth-Bucher (2001) states that nurses are more likely to give clear messages to clients when the nurses are able to understand their own feelings, even if the feelings are negative. She notes that when nurses lack self-awareness, their anxiety or strong emotions may interfere with seeing the client clearly and understanding the client's true perspective. Without self-awareness, you may project your own issues on the client or interpret her comments through your filters versus her worldview.

Example

A client opened the door and welcomed the nurse. The client had a bruise on her cheek. Immediately, the nurse felt nervous and angry. She looked around for the boyfriend and in her head began to make a list of things to do regarding a safety plan and getting the client moved out. She was about to introduce the topic when the client's mother came in and gave the client an ice pack saying, "Boy we were clumsy getting out of the car, I backed into her, knocked her into the door, and I fell down too!" The client's mother had scraped knees.

As she saw the client and mother smile and support each other, the nurse realized that she had raced to a conclusion based on her own history with an abusive partner.

Think about it…

Do you remember a time when you made a wrong assumption about someone based on your own experiences? Did anything or anyone make it easier for you to notice where your assumption came from?

Echroth-Bucher (2001) notes that to be effective, it is important to understand our biases and prejudices. We grow up learning from others, and we tend to align with the values of those people who are important to us, some of which may not be useful representations. She says, “Practicing self-awareness will help bring into focus the irrational, preconceived ideas that generate prejudices regarding the way other people behave, think and believe. This helps nurses put clients’ needs first.”

Echroth-Bucher (2001) remarks that while we tend to think of prejudice related to racial, sexual, religious, and national groups, it takes many forms and may be subtle. All of us have prejudices and it is useful instead of creating a façade of tolerance, or denying our feelings, to be constructive by being aware and being open to testing out our beliefs, values, and feelings.

Example

A nurse visited her client. Last week the client didn’t have money for diapers and lost her rented furniture due to late payment. This week the client bought front row tickets for 4 adults and 6 children to go to the circus. The nurse has tickets—for two—in one of the “affordable” rows way back. She thought, “No wonder she’s poor; she’s just like the rest of them.”

Her frustration and thoughts got in the way of being present with the client until she decided that although she was concerned and frustrated about the client’s choice, she could acknowledge her feelings to herself and still be engaged and enjoy the client for who she is versus what she does. The nurse also resolved to learn more about understanding poverty and brought the issue up in her reflective supervision time.

Confronting difficult feelings, especially ones where you feel judgmental takes reflection and courage. It isn’t easy to look at our assumptions and beliefs and it isn’t easy to change. Remember though, that is exactly what we are asking of our clients.

Phases of the Therapeutic Relationship

The third RNAO recommendation is to understand the three phases of the therapeutic relationship. The three phases of therapeutic relationship as described by Hildegard Peplau, a nursing theorist, are:

Orientation—getting to know you
Working—getting to the nitty-gritty
Resolution or "termination" phase

Orientation Phase

This is the time where you and the client are building a relationship, dealing with preconceptions and establishing expectations of each other. A main goal is to build trust. Some strategies that support this phase are creating a safe emotional context, being reliable, keeping your commitments, being accepting, respectful, and empathetic. In NFP, we recruit and enroll clients. This is a new experience for many nurses, however, it is also the beginning of the relationship, and requires that we establish trust, provide realistic expectations, offer options and are empathetic to their decision making process while considering the pros and cons of enrolling in the program.

Working Phase

Once the "groundwork" is laid, you and clients are ready to explore issues and concerns. This is a time for learning. It is also a time where you will see forward progress, then stopping the progress, or perhaps moving back to old behaviors. It is tempting in this phase to be a "fixer" to help the client along and relieve your discomfort with slow or no progress. It is also easy in this phase to be directive, to "be the expert" about what is important for the client.

Strategies that support this phase are to facilitate versus push or prod, to work on client's priorities, and to use client motivation to guide the direction of the work. You will learn specific strategies about how to achieve this as we proceed through the workbook. Sometimes the client vacillates in her commitment or energy for the visits and during this phase you may be challenged with missed visits or other signs of disengagement. As we observe the practice of NFP nurses around the country and their rates of client retention we are more convinced that, when clients lead the way on what they need and want regarding content and visit frequency, they are more engaged and stay longer.

Resolution Phase

The ending of the relationship is based on mutual understanding, is planned (not a surprise) and incorporates a celebration of goals that were met. With some clients it is fairly matter of fact, and others, there is loss and sadness for the client and/or the nurse. Some clients have histories of abandonment and traumatic loss; this may be a time for them to learn how to do a "good goodbye". Strategies that support this phase are preparing the client from the beginning, planning a celebration together, discussing feelings, and sharing successes.

Qualities for Successful Therapeutic Relationships

The College of Nurses of Ontario (2006) produced Practice Standards for Therapeutic Relationships. The article titled *Practice Standard: Therapeutic Nurse-Client Relationship, Revised 2006* can be read online and is also in the Appendix of this workbook. Read the section "Introduction" and the "Components of the nurse-client relationship" on pages three and four, then return to the workbook to learn how to apply what you read in the article to your NFP clients.

Read pages 3 and 4 of the *Practice Standard* article, "Introduction" and "Components," on the College of Nurses' of Ontario (CNO) website then return to the workbook. You can also find the article in the *Unit 1 Workbook Appendix*. (When you have the opportunity, you might want to browse other resources on therapeutic relationships available on CNO's site.)

The characteristics of therapeutic relationships discussed in the article include trust, respect, professional intimacy, empathy, and, appropriate use of power.

Think about it…

Think of some specific ways that you might demonstrate the characteristics of a healthy and successful therapeutic relationship.

Trust: Being reliable, being genuine, validating, setting appropriate boundaries

Respect: Using active listening, paraphrasing, reciprocating

Professional intimacy: Maintaining confidentiality, having appropriate expectations, establishing and maintaining appropriate boundaries

Empathy: Listening, normalizing, understanding, putting self into another's shoes

Appropriate use of power: Personal awareness about power differential, care about dress and other external signs of financial, educational or other advantage, awareness of use of language, sensitivity to client's vulnerability to an authority figure

For your personal review, write down your answers to these questions on a piece of paper.

1. How have you responded when you experienced a power differential and you were in the "lower" position?
2. If a client felt embarrassed about her clothes or home, what could you do?
3. How might a client respond if she was intimidated by her nurse's education?

Now we will move on to the specific practice standards about therapeutic communication. As you read the indicators for therapeutic communication, label each indicator with one or two of the above qualities that you would need to be successful.

For example, for Indicator A, "introducing self," you might use respect and begin building trust.

Read article page 5, "Standard Statements, 1) Therapeutic communication" then return to the workbook.

NFP provides materials and guidance to address these indicators for therapeutic communication.

Indicator A) describes useful behaviors for the first visit. The NFP Visit-to-Visit Guidelines provide you with a great description for how to set expectations, boundaries, and so forth in your first visit with each client.

Indicator C) describes giving the client time, opportunity and ability to explain herself. The home visit structure and the Home Visit Form have built in time for addressing issues and concerns. The 60-90 minute visit time allows the client time to really discuss issues.

Indicator D) describes the information that you will share; you are guided by the NFP Visit Guidelines on the first visit and you will also want to add your local requirements regarding mandated reporting (these vary by state).

Indicator G) addresses the client's needs and choices. The NFP Visit-to-Visit Guidelines prompt you with possible topics and the client makes choices about what is useful to her.

Indicator I) addresses information and informed decisions. The NFP Visit-to-Visit Guidelines provide you with prompts for each visit for assessment or screening and possible teaching topics.

Indicator L) relates to concerns of family and significant others. Families and Friends is a domain in the NFP Visit-to-Visit Guidelines and plans relationship topics into the visit.

Indicator N) relates to awareness and support. Self-awareness and reflection are built into the program through case conferencing and 1:1 reflective supervision.

You probably noticed that many of the indicators for therapeutic communications needed the following components: trust, respect, and empathy. As you read about client-centered care and boundaries, you will probably note an increased emphasis on the use professional intimacy and appropriate use of power.

Behaviors Demonstrating Client-Centered Care

Client-centered care has been a standard for Nurse-Family Partnership during and since the research trials. The indicators in the CNO *Practice Standards* are a good description of client-centered care.

Read page 6 of the article; "Standard Statements, 2) Client-centred care," then return to the workbook.

Let's look at the indicators of client-centered care for a minute. Indicator I "requesting a therapeutic transfer of care" is an option that would take courage, self-awareness, and reflection with the supervisor. A change of provider happens with Nurse-Family Partnership, though it is rare.

Indicator K is facilitated in a couple of ways. In the NFP Visit-to-Visit Guidelines the facilitator "How is it Going Between Us?" will prompt an open discussion. It may be new for you to ask what people think about your relationship and how it is working. Another way of evaluating care in NFP is by phone surveys done by your agency. This feedback guides your intervention and assures that clients are getting what they need.

Client-centered care is very rewarding and more likely to keep the client engaged as an active and interested partner in the visits. It is also very rewarding for you; it makes your job easier when the client is the expert on her life and you are the facilitator.

Behaviors Supporting Appropriate Boundaries

Boundaries get especially difficult in NFP. Why? The same thing that makes this program so rewarding for clients and nurses - that great relationship and all that continuity - sometimes results in closeness that is confusing. We know that it gets confusing because we hear about it from nurses, supervisors, clients, and administrators. Here's the tough part: the nurse is always responsible for maintaining the appropriate boundary, not the client or family or friend. Read the indicators for maintaining boundaries including giving and accepting gifts. Then we will give you some examples of boundary challenges that we have heard about and look at a way to approach the issues.

Read pages 7 and of the article; "Standard Statements, 3) Maintaining boundaries," of the article; then return to the workbook.

There are some boundaries that are just absolute, like abuse (physical, sexual, emotional, and financial). Some boundaries are set by your agency because of legal implications or to protect your team from having to decide about difficult situations such as not allowing nurses to loan money or sign a loan, or not allowing transportation of clients (some NFP Implementing Agencies have an agency car and legal coverage but many don't).

Many boundaries are contextual – that is they might be the wrong decision in some situations and the right one in others. Remember from our definition, that a therapeutic relationship is "directed at advancing the best interest and outcome of the client." So how do you determine which is which? Scan over the indicators for protecting clients from abuse, and then pay special attention to the "Decision Tree".

Read pages 9 to 11 of the article; "Standard Statements, 3) Protecting the client from abuse,"of the article; then return to the workbook.

Think about it…

Imagine yourself in a situation where you are uncertain about appropriate boundaries. Walk through the decision tree. What did you discover?

One useful way to look at boundaries in Therapeutic Relationships is to consider the following graphic:

Continuum of Professional Behavior

Non-professional	**Professional**	Non-professional
Under-involved	**Zone of Helpfulness**	Over-involved
Non-therapeutic	**Therapeutic**	Non-therapeutic

Adapted from National Council (1996). Professional boundaries: A nurse's guide to the importance of appropriate professional boundaries. National Council of State Boards of Nurse, Inc.: Chicago.

"A zone of helpfulness is in the center of this professional behavior continuum. This zone is where the majority of client interactions should occur for effectiveness and client safety. Over-involvement with a client, which includes boundary crossings, boundary violations and professional sexual misconduct, is on the right side of the continuum. Under-involvement, which includes distancing, disinterest and neglect, can also be detrimental to the client and nurse, and lies on the left side. There are no definite lines separating the zone of helpfulness from the ends of the continuum; instead, it is a gradual transition or melding" (National Council of State Boards of Nursing, Inc., p. 2).

Examples of Under-Involved and Over-Involved

Example: Under-Involved

Most of the time, your interactions with Sara are therapeutic. Today you have a "fender bender" on the way to Sara's house. You know you need to call the insurance company, you need to tell your partner (who will be upset), and you are worried about the time and money to fix it. Face it—today you are distracted and not so attentive to Sara.

You have not crossed the line of unprofessional, but you aren't quite up to par today and not as therapeutic as usual. You would fall somewhere on the "under-involved" side. If under-involvement is a pattern, that would be nonprofessional and non-therapeutic.

Example: Over-Involved

Your client, Marcie, is so engaging and so fun! Together you have shared some wonderful discoveries about her perceptions and beliefs that have resulted in her making significant change. You are both fond of each other, and she states she, "couldn't make it without you." A few times she has called you and needed "immediate help" on the weekend. You have gone over to help out twice on the weekend and you take her calls after hours.

Echroth-Bucher (2001) notes that we all come into nursing with our own motivations, values and needs. The wish to help others is a strong theme among nurses, one that is useful. However, when it is a main source of affection, connection, or personal worth, it can make the client feel dependent while the nurse feels indispensable. If one's self esteem is tied up in how well they take care of and meet the needs of others, it would be easy to become over-involved.

Think about it…

Where would each of the following issues fall on the continuum? Mark each issue below with either **O** = over-involved, **H** = helpful, or **U** = under-involved. Jot down your answers on a piece of paper.

1. ___Being a friend
2. ___Accepting a gift that is expensive for the client
3. ___Chastising the client for her misbehavior
4. ___Avoiding rescheduling the client so she will appreciate what happens when she skips a visit
5. ___Giving money
6. ___Hurrying through the visit
7. ___Rejecting the client because she swore at you
8. ___Self disclosure that made you feel better and caused the client concern for you
9. ___Keeping secrets with the client that you would not share with your supervisor or team

Tip! Generally speaking, when there are boundary challenges in NFP, it is related to being over involved. It is important to distinguish between being in a friendship and being in a therapeutic relationship. Being friendly is one thing; being in a friendship is another. Compare the differences between a friendship and a therapeutic relationship.

Characteristics of Therapeutic Relationships	Characteristics of Friendships
• A specified timeframe • A specified purpose • The nurse home visitor supports the client in achieving her goals • The client's ultimate goal is to attain independence	• An unspecified timeframe, frequently long-term • Reciprocity • Friends are interdependent and engage in mutual give-and-take

Think about it…

How would you know if you are moving towards being over-involved?

What would it mean to a client's self-efficacy to have an over-involved nurse?

How might the client feel when an over-involved nurse pulls back, burns out, leaves, or terminates?

Therapeutic relationships in NFP are very rewarding. They promote client growth, but they also promote personal growth of the nurse. With visiting in the home, with family and friends, and with visiting over a long period of time, boundaries become more difficult to sort out because the nurse and client become so connected.

It's important to remember that you will need your peers and supervisors at times to work through these challenges. You (and how you relate to clients) are the reason for the great changes and long-term outcomes that we see with clients. Take care of yourself and know that navigating these relationships will be an interesting adventure that will at times require support.

Review Key Points

For your personal review, write your answers to these questions on a piece of paper.

1. Define the purpose of therapeutic relationships.
2. Name the three phases of a therapeutic relationship.
3. Write the characteristics of a successful therapeutic relationship as identified by the College of Nurses of Ontario.

References

College of Nurses of Ontario. (2006). Practice standard: Therapeutic nurse-client relationship. Retrieved from http://www.cno.org/docs/prac/41033_Therapeutic.pdf

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Chapter 8

Motivational Interviewing

Nurse-Family Partnership
Helping First-Time Parents Succeed

Chapter 8: Motivational Interviewing

Purpose

The purpose of this chapter is to provide you with a theoretical and practical foundation in the spirit and strategies of Motivational Interviewing (MI) and how Motivational Interviewing is interwoven into the core values of Nurse-Family Partnership. You will also learn the strategies that are part of MI. Skill building in the use of Motivational Interviewing will occur during the Nurse-Family Partnership Unit 2 educational session.

Standards Covered in this Chapter

Nurse Home Visitor

- Applies theories and principles integral to implementation of the Nurse-Family Partnership model
- Uses the Nursing Process to deliver individualized care and set goals across the six domains

Nurse Supervisor

- Applies principles of supervision that promote the clinical and professional development of all team members
- Provides administrative leadership for operations and sustainability of the program

Objectives

- Identify the purpose and use of motivational interviewing (MI) in the Nurse-Family Partnership intervention
- Recognize the correlation between the Nurse-Family Partnership model and spirit, method, and strategies of MI.
- Describe the key components of MI.
- Employ through written exercises the spirit, strategies, and method of MI in preparation to use these components in practice during Unit 2 education.

Note: There are several “Think about It…” exercises in this chapter. Be sure to take the time to write down the answers when indicated, but your answers do not need to be submitted to NFP NSO or brought to Unit 2 education. They are to expand your understanding of a complicated topic.

Introduction

Have you ever encountered anyone who said, “yes, I will change . . .” You walk away excited because you know they’ve committed to the best course. All your conversations, arguments, and confrontations have paid off. They are going to make a change that will improve their life. Yet, next time you see them—NOTHING HAS CHANGED!

Maybe you’ve been that person. When thinking of change you have said:

- “It might be good—but it might not.” (Ambivalence talk)
- “If only everyone would stop telling me to change might do it.” (Discord talk)
- “Is this change worth the hard work it will take? Is the payoff worth it?” (Sustain talk)

You’ve expressed a need to change, have identified reasons to change, have excellent information about the benefits of change, and all the right resources to support the change. In spite of this you have never taken any steps to implement change.

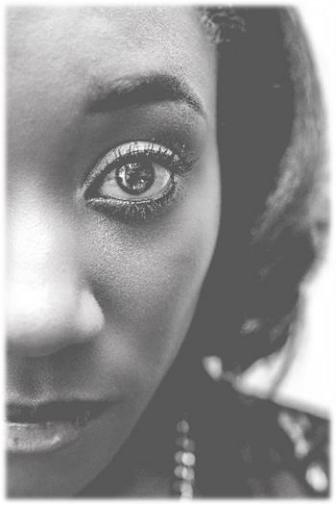
Why isn’t all of this enough? What more is needed to facilitate change? Why are we so ambivalent about change? Because . . .

CHANGE can be difficult!

Think About It…

Think about a change you’ve determined to make in your own life. Write it down.

If someone else pointed out that you should change, how did you feel about the change? In what ways did you resist making the change?



Think About It…

Consider some of the changes we hope our clients will make such as returning to school (Life Course Development), making a change in a relationship (Family & Friends), postponing a second pregnancy, or discontinuing substance use (Life Course Development or Personal Health).

What might the client be experiencing as the two of you talk about change?

What if…

> You could find a way to resolve ambivalence, create movement towards change instead of ambivalence about change, and create an environment where change is embraced?
>
> There was an attitude—would you adopt it?
>
> There was a method—would you use it?

If there was a strategy that would do all this—would you want it?

Motivational Interviewing is that attitude, that method, that tool.

The Alignment between Motivational Interviewing and Nurse-Family Partnership

Before we delve into the mechanics of motivational interviewing, it is beneficial to know why MI and Nurse-Family Partnership are so effective together. Motivational interviewing as defined by Miller and Rollnick (2013), "…is a collaborative conversation style for strengthening a person's own motivation and commitment to change."

When we enroll clients in Nurse-Family Partnership, we hope they will make changes that will improve their lives and the lives of their children.

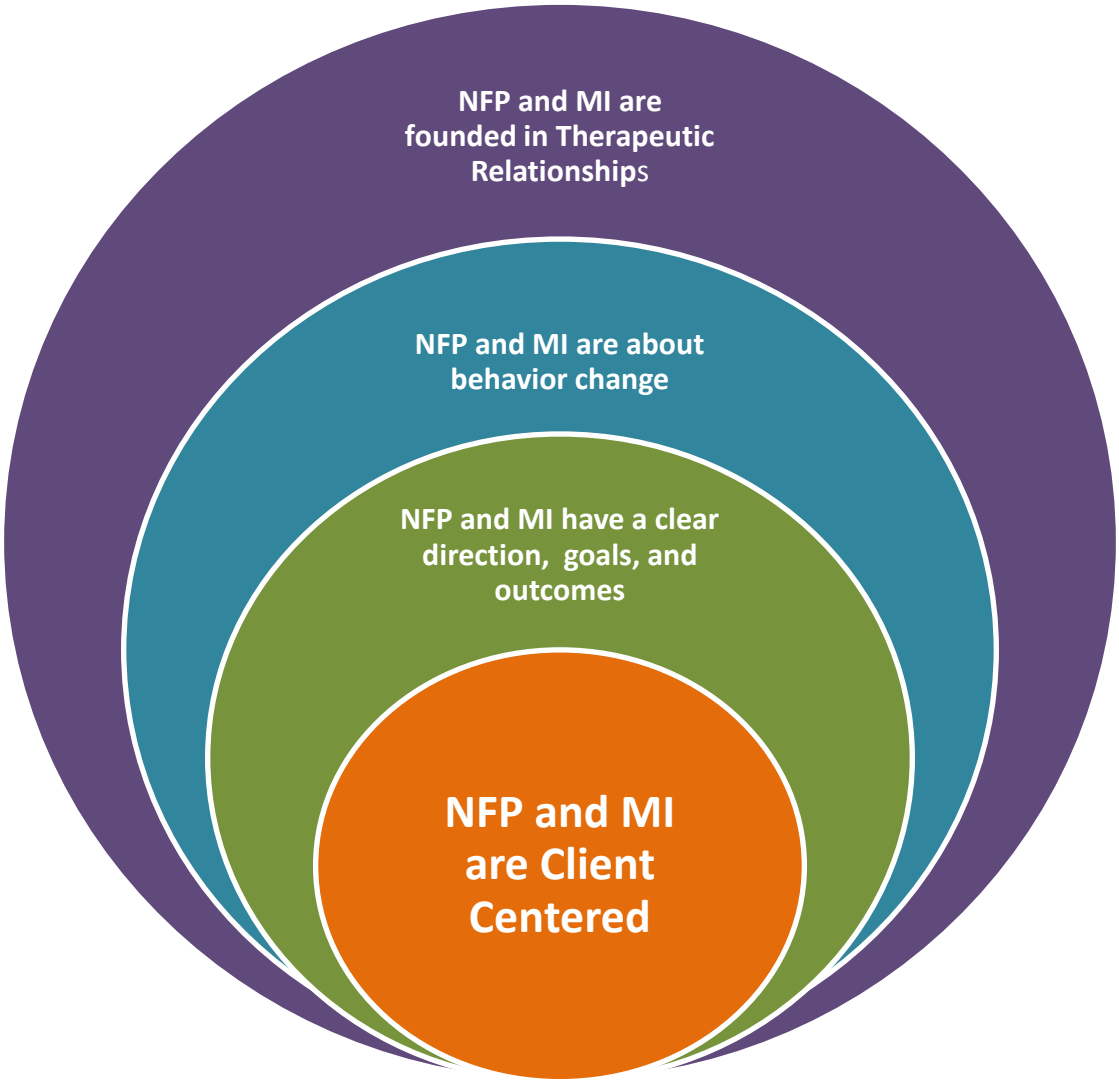
Nurse-Family Partnership has an agenda, a clear direction where we are headed.

- Our outcomes are the big picture agenda.
- Our Visit-to-Visit eGuidelines provide direction at a visit level.

Nurse-Family Partnership has also established a clear client-centric approach to reach our goals.

- The Client Centered Principles establish a spirit and foundation for how we partner with our clients to reach program goals.
- The Visit-to-Visit eGuidelines are formatted so that clients have clear choices about what topics they want to discuss and when they want to discuss those topics.

Like Nurse-Family Partnership, MI has an agenda for change implemented within a spirit that is client centered, client focused and client led.



The Effectiveness of Motivational Interviewing

MI has been extensively researched and proven effective in addressing different health behaviors including smoking cessation (Borrelli, Novak, Hecht, Emmons, Papandonatos & Abrams, 2005), HIV risk reduction (Carey, Braaten, Maisto, et al. 2000), alcohol use (Allsop, Saunders, Phillips, & Carr, 1997), and drug use (Saunders, Wilkinson, & Phillips, 1997). It has also been proven effective in cases of hypertension (Woollard, Beilin, Lord, Puddey, MacAdam, Rouse, 1995), nutritional changes regarding fruit and vegetable intake (Resnicow, Jackson, Wang, et al, 2001), diabetes control (Smith, Heckenmeyer, Kratt, & Mason, 1997), and obesity (DiLillo, Siegfried & West, 2003).

A client retention study conducted by the Prevention Research Center at the University of Colorado, Denver, with Nurse-Family Partnership nurse home visitors and clients

indicated that MI strategies assist Nurse-Family Partnership nurses to better retain their clients as they collaborate with them in the change process.

For all of these reasons, MI has become an integral part of the Nurse-Family Partnership implementation for nurse home visitors and nurse supervisors who desire to learn communication principles and strategies for working with high-risk clients in the change process. In the rest of this chapter, discussion will center on the spirit, methods, and strategies of MI. During sessions at Unit 2 education, you will have the opportunity to build skills in using MI strategies.

Motivational Interviewing strengthens a person's own motivation to change by helping the person discover and reinforce their own good reasons to change.

Think About It…

If you were to explain in a few sentences to a colleague why motivational interviewing is used in the Nurse-Family Partnership model, what would you say?

What is MI?

Motivational Interviewing has four essential components:

The Spirit of MI,
The Method of MI (4 Step Process),
The Strategies of MI, and
You and Your Client.

The relationship you and your client develop allows change to flourish because of the safe, trusting, and therapeutic nature of that relationship. Within that relationship, you can utilize specific communication strategies to motivate and support the client reaching personal and program goals.

Behavior Change is a process of desiring something different and believing you can reach that something different. The role of the nurse is first to support and, if possible, increase the client's desire to change. Once that process is under way, the nurse may provide information or skills so the client can make that change a reality.

In this chapter, we'll explore how the spirit, process, and strategies of MI are utilized to impact behavior change. You will learn why change talk is the essential element to behavior change. You will learn how OARS (**O**pen-ended questions, **A**ffirmations, **R**eflection/Reflective Listening, **S**ummaries) stimulates client change talk and see how the Nurse-Family Partnership Visit-to-Visit eGuidelines facilitators can assist in setting and reaching goals.

Think About It…

Take a minute to reflect on what you know about motivational interviewing. Jot down your thoughts.

What are some feelings of concern you have in learning or using MI?

What are some feelings of excitement you have in learning or using MI?

Ambivalence is a Natural Part of the Change Process

In the introduction to this chapter you may have experienced some amvibilence about MI and making a change to incorporate MI into your practice.

According to Miller and Rollnick, ambivalence is a natural part of the change process. At its simplest level, ambivalence can be understood as the recognition that there are both good reasons to change and good reasons to stay the same. All these reasons seem to have equal weight, and this makes it difficult for us to move forward.

Most of us are aware of the downside of our behaviors. If we've had a heart attack we can describe all the reasons why we should eat better, exercise more, and quit smoking. We can also describe some of the benefits we'd experience if we made those changes. But as we know: **CHANGE IS HARD**.

Ambivalence is the simultaneous expression of all those good reasons to change—and all those difficult reasons why we shouldn't try.

Our goal is to help the client begin expressing more good reasons to change until they believe and embrace their ability to make that change. We support change conversation until their desire to change overcomes their desire to stay the same.

Think About It…

Think back to a time in your life when you have felt conflicting emotions and thoughts about making a change.

You knew there were reasons why you should change, but you also had valid reasons for not changing. You were not yet ready, willing, and able to make the change.

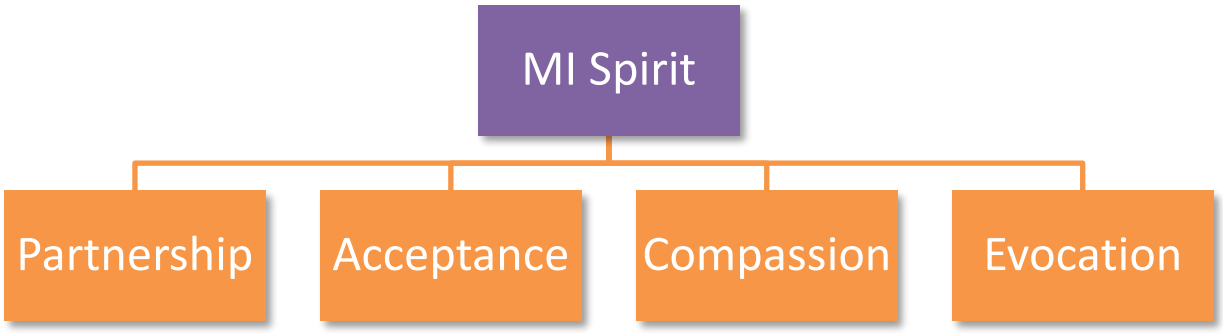
Write your thoughts about why you've gone back and forth about this change? What helped you to work through your ambivalence?

The Spirit of Motivational Interviewing—PACE

Motivational Interviewing offers an opportunity to create a climate for change that is client-focused and reflective, while still maintaining the ability to share information in a way that develops a partnership, is based in acceptance of who the client is and where they are at any given moment in time, is compassionate (not sympathetic), and evocative (of the client's hearts desires).

Like nursing itself, MI is more than skill development. It is founded in the whole person. If we learn and apply only the skills of MI, it can become a manipulative process where we steer our clients to the "right" choice--our choice.

In an earlier chapter of Unit 1, you read about the client-centered principles. The spirit of MI is like the Nurse-Family Partnership client-centered principles. The spirit of MI assures that we have the mind-set and heart-set to apply the skills with care. So let's first explore the key principles in the Spirit of MI: **P**artnership, **A**cceptance, **C**ompassion and **E**vocation, or the PACE of MI.



Partnership

Partnership eliminates the expert/novice, teacher/student, master/disciple models. MI is not done to, for, or on someone. It is done "with" or in partnership. It is an active collaboration between experts—you the nurse, and the client as the expert in her own life. Because of this, your conversations with your clients may involve more listening than talking, more exploration than exhortation, and more interest and support than argument and persuasion (Miller & Rollnick, 2013). MI has been described as dancing, not wrestling!

Think About It…

Consider some reasons why developing partnership may be important in the change process?

Why is allowing the client the opportunity to apply their expertise about themselves and their life important in this process?

Acceptance

Acceptance involves four key components:

1. Absolute worth (prizing the inherent worth and potential of every person)
2. Accurate empathy (seeing the world through the clients eyes and having an active interest in, and effort to understand their world)
3. Autonomy (a person's right and capacity for choosing their direction and decisions)
4. Affirmation (a desire and action to seek out and acknowledge out loud a person's strengths and efforts)

Think About It…

What client centered principles are present in acceptance?

How would you portray acceptance to a client who expressed a desire for something that conflicted with your own values?

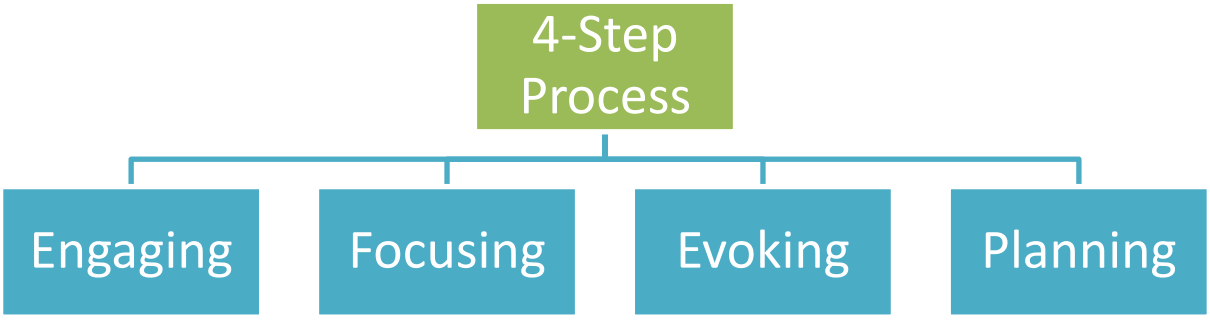
Compassion

Compassion is described by Miller and Rollnick (2012) as "the deliberate commitment to pursue the welfare of the other" (pg. 20). How does compassion differ from sympathy? How does it differ from identifying with another?

Evocation

Evocation is a strength based approach that rests in the belief that the person you are talking with has the capacity and skills to change. Much of what they need – they already possess. They may require help accessing that knowledge. They may need additional skills in applying that knowledge. You will offer to work together to assess and apply that knowledge. But it is their inherent desire and ability that is in play. Evocation is the process of drawing out what a client already knows, offering assistance with continued knowledge and application and partnering or collaborating with them as they apply that knowledge.

The Method of MI—Using the 4-Step Process



Engaging

Engaging is the foundation step in MI. It involves establishing a collaborative working relationship between the nurse and the client. It goes both ways—the way you feel about your client carries equal weight to the way your client feels about you. Trust and mutual respect are integral to engaging clients in order to reach individual and program goals.

Think About It…

How do the Spirit of MI and the Client Centered Principles assist in the engagement process?

During the engagement process the goal is to establish a trust foundation and accurately assess client values, goals and concerns. The hardest part of engagement is to stay neutral and listen. Avoid trying to solve the problem before you've spent adequate time exploring the problem**.**

Rollnick and Miller (2013) describe engagement as, "…the process of establishing a mutually trusting and respectful helping relationship."

Focusing

MI is goal-directed and intended to help our clients find if, why, how and when they might make a change. To do this, a conversation needs to find its focus.

Sometimes the focus is clear, but often our clients have so much on their mind it's difficult to know where to begin. Many of our clients have not had solution-focused conversations about change. They have been told to change or coerced to change, but not guided toward change.

Focus involves setting the agenda, establishing the direction and exchanging information. The menu and choice sheets in your Visit-to-Visit eGuidelines are extremely helpful in establishing focus for client visits. Focus happens throughout the conversation and works like a funnel. It takes the general and ends with the most specific.

Evoking

While engaging and focusing are common to many therapeutic conversations, evocation is unique to MI. Skills necessary to great evoking conversations are:

- Recognizing change talk (desire, ability, reason and need to change)
- Pulling out more change talk from your client
- Responding appropriately to change talk
- Recognizing and responding to ambivalence, sustain, and discord talk
- Evoking and strengthening hope
- Remaining neutral and minimizing your influence toward a choice you think the client *should* make
- Understanding how Stages of Change impact ability and speed of change. If a client is pre-contemplative, she is not ready for a referral or for ideas and solutions!

If you looked at this list and thought, "That will take a lifetime, and I'll never learn it," in one sense, you are right! It will take time and it will take practice. There are two pieces of good news that might be helpful right now.

1. Many of the items on this list you already know and practice instinctively. The terms used in MI might be unfamiliar, but you are probably already using the concepts.
2. You are not expected to be an expert practitioner of MI at the end of Unit 1 or Unit 2.

What you are trying to "evoke" is client change talk – so they hear themselves speak their own good reasons to change. Hearing our own reasons to change supports our desire to make the change.

Change talk is summed up in the acronym DARN CAT. DARN stands for **D**esire, **A**bility, **R**eason, and **N**eed for change and is known as preparatory change talk. **CAT** stands for **C**ommitment, **A**ctivation, and **T**aking steps and is known as mobilizing change talk.

As mentioned earlier, ambivalence is a part of all change. Ambivalence can sound like someone arguing with you about why they don't want to change. When conversation gets heated, it's a good indicator that you are doing one of two things.

- Pushing too hard or too fast
- Offering your ideas for change instead of evoking the clients reasons for change.

Remember that if you argue FOR change, there is only option for your client—argue AGAINST change!

Planning

The final phase of MI is the planning phase. The reason we work to develop someone's motivation to change, is to make a change. Gollwitzer (1999) found that, "People are more likely to follow through with a change when they have a specific plan and express to another person their intention to carry it out."

The Visit-to-Visit eGuidelines have many tools and strategies that can help in this process, including special facilitators on goal setting. Once a goal is established and a plan created to reach the goal, the biggest job for the nurse home visitor is to support the change through affirmation of commitment, persistence, and hope. Remember—only a small change is necessary!

Think About It…

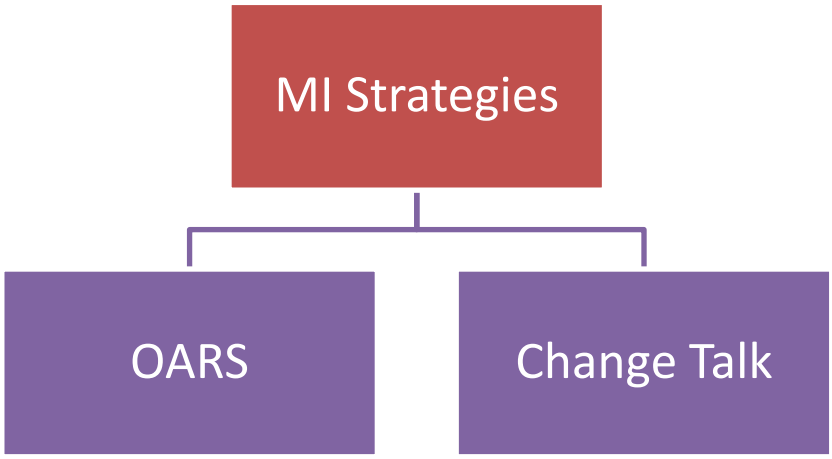
What are you thinking and feeling right now about MI? Focus on your strengths and focus on solutions as you think through what might be most helpful for you in order to move forward in learning MI.

Some ideas (information sharing) that could be helpful right now:

- Talk with a colleague, supervisor, friend, or family member about what you're feeling
- Talk with a colleague, supervisor, friend, or family member about what you've learned in order to reinforce the information
- Put what you've learned so far into your own words or, if you're a visual learner, make a picture or diagram of what you've learned so far
- Take a break from this chapter—do something that feeds your soul!

The Strategies of MI

There are many strategies of MI—more than we can cover in this chapter. The key strategies we cover in Unit 1 are illustrated below.



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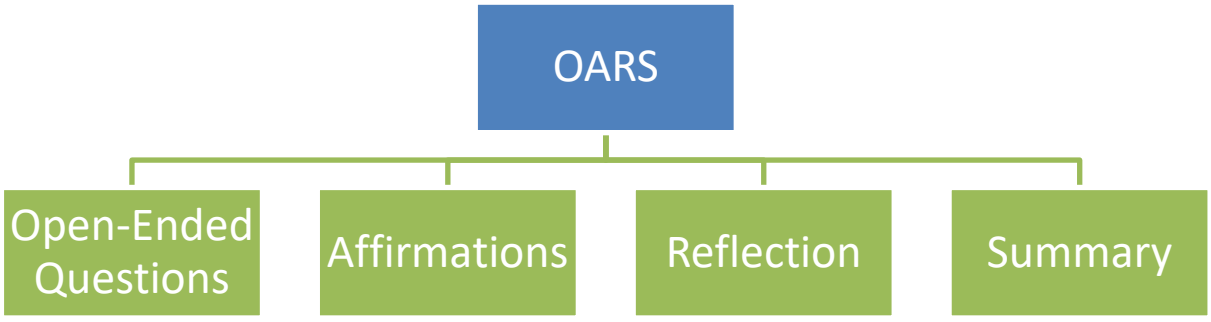
OARS

This acronym is a helpful way to remember the strategies that assist you in each phase of the MI process: **O**pened-ended questions, **A**ffirmations, **R**eflection/Reflective Listening, and **S**ummaries. Without oars, a row boat wouldn't stand much chance of reaching its destination. In MI, OARS helps you evoke from the client their own good motivation to change and establish the direction to reach their goals. OARS gets you to your destination.



Open-Ended Questions

Opened-ended questions typically result in a fuller response, while closed ended questions can be answered with short or one-word responses. An open-ended question invites a person to think a bit about what they'd like to share. It's an invitation that says, "I'm interested in you and what you have to say."

Think About It…

Pay attention to your own questions. Do you usually ask open or closed ones?

Pay attention to the people around you at home, at work, or while traveling. What kinds of questions do they ask? How does the type of question encourage conversation or cut it short?

How might you phrase the questions listed below to obtain more open ended responses?

1. Did you have a good week since we met last? (Closed answer: "yes")
2. How is school going? (Closed answer: "fine")
3. What have you been doing lately? (Closed answer: "nothing")

Affirmations

Affirmations may be the most under-utilized skill in building self-efficacy, yet have the potential to be the most powerful tool in MI.

Affirmation is not the same as praise. It is a comment about a strength observed in the person receiving the affirmation. It involves recognizing and acknowledging this positive aspect. It also points out how the client has used that strength to overcome a challenge. It may sound something like,

> "You have kept all your appointments over the last two months even though you've had lots of challenges with your schedule (strength=constancy, challenge=crazy schedule).
>
> or
>
> "You overcame the transportation obstacles you have and still managed to get your paperwork to enroll in the GED program – Wow!" (strength=persistence, challenge=no transportation).

An affirmation can also include reframing. For instance, your client who was drinking every day believes she failed in her goal to stop drinking because she drank twice since your last visit.

An affirmation might sound like,

> "You feel really bad that you drank twice during the last two weeks, but it strikes me that you didn't drink 12 out of the last 14 days. Two months ago, you were drinking every day. In the last two weeks you were able to stick to your plan 12 out of 14 days. That's amazing progress." (strength = tuck to your plan 85% of time; challenge = you wanted to drink every day).

An affirmation doesn't negate that you will still want to address how to keep working toward the goal. It does acknowledge hard work and progress.

The final type of affirmation is the one the client gives herself. MI works because clients hear themselves talk about their own reasons and ability to change. Hearing themselves speak change provides the motivation to implement change. When one hears her own voice speaking affirmation, it can be a powerful motivator for continued change and growing self-efficacy.

Think About It…

What client centered principles are most apparent in affirmation?

On a piece of paper, write an affirmation statement for the following scenarios:

1. Your client breaks up with her boyfriend and is sad and confused.
2. Your client is angry at her mother for correcting her parenting style even though, in your opinion, the mom's advice was probably right.

Reflection

Reflection provides a beautiful rhythm to an MI conversation that typically begins with an open-ended question followed by some response by the client. You reflect back what you hear as the client shares. Reflection has two parts; listening and reflective statements. Of the two, the listening may be the most difficult!

Think About It…

Non-verbal reflection involves exhibiting undivided attention. Think about someone you consider an excellent listener. What type of behaviors do they exhibit when listening? Write a few down on a piece of paper.

You may have noted attributes like:

- They don't try to do other things like text, paperwork, or check their watch.
- They make eye contact with me.
- Their facial expressions encourage me to keep talking.

There are big differences in what various cultures are comfortable with in reflective listening. Be sensitive to your client's non-verbal indicators to make sure you are reflecting in culturally sensitive ways. A common belief supported keeping your face totally flat while listening. Research, though, shows that it's best to appropriately mirror the client's expression (Miller, 2012). The exception would be when client anger is being expressed. This is a good time to respond with concern and calmness.

Verbal Reflections

Verbal reflections are intended to clarify what you have heard your client say. They are also powerful in the change process because the client hears her own words reframed and can verify that is really what she meant to say. It also assures her you are hearing her accurately and with understanding.

Summaries

Summaries are groups of reflection that you have heard throughout the conversation. It helps both the client and you hear and visualize through words the big picture of the conversation. A summary often starts with a statement like, "Let me share what I've heard you say," and ends with the question, "What would you add or change?" If the client has nothing to add, follow up with an open-ended question that continues to move the conversation forward.

A summary can:

- Collect (series of interrelated items).
- Link (collect what the client says and link it to something else you remember from earlier in the conversation or a different visit).
- Transition (wrap up a session and move on to some other part of the visit or move forward in the change conversation).

The summary is always used to repeat any change language you heard the client speak, so it reinforces her motivations to change. Even if the conversation appears fairly negative, it can be stated in positive change language. We'll practice this during Unit 2.

Think about it…

Below are examples of collecting, linking, and transition summaries. Match up the summaries (A, B, and C) to the type of summary (1, 2, and 3).

A. You were hurt when your friend didn't call you back when she said she was going to. You felt disrespected. I remember you shared another time when you felt ignored by a friend. It's really important to you that people do what they say they are going to do, especially when they say they're your friend.

1. Collecting Summary

B. You have been frustrated with the behavior of some of your friends. They have not followed through on some of their commitments to you. Because of this you're considering making some changes in who you let close to you.

2. Transitional Summary

C. Before we move on to our other topic, I want to make sure I understand everything you've shared so far. You have been frustrated with the behavior of some of your close friends. You believe it's time to make changes in how you choose friends. When we meet next you want to talk about trust and how this changes relationships. What else would you add before we move on?

3. Linking Summary

Click here to check how you did in matching the summaries.

Exploration

The third tool in an MI conversation is intended to explore the client's hopes, values, and goals and to elicit change talk that will move toward those goals. The most important attribute you have for this is genuine curiosity based in the Nurse-Family Partnership client centered principles and PACE (Spirit of MI).

The use of OARS is intended to assist the exploration process. The goals of exploration are:

- Understand the core values and beliefs of your client
- Frame program and personal goals
- Surface ambivalence about reaching those goals
- Surface discrepancy; i.e., the client expresses a value of, "being there for her child," but uses substances that limit her availability to be there emotionally, cognitively, or physically.
- Convey acceptance and respect of the person—even if you disagree with her values and goals

Many of our clients haven't given much thought to the topics we present to them. They might feel intimidated by a question such as, "Tell me what you value in life?" However, they might respond to a question like, "Tell me what matters to you most right now?"

Think About It…

Think about the questions below and jot down on a piece of paper how you would rephrase the questions to be more client-centric.

1. What goals do you have in life?
2. What are your 5 most important values?
3. If you were to write a mission statement, what would it be?

Remember, too many questions can feel intimidating. Reflect more than you ask. The same words can be a question or a reflection simply by changing inflection at the end of the sentence.

A good provider is someone who has a job? (voice inflection goes up)
A good provider is someone who has a job. (voice inflection goes down)

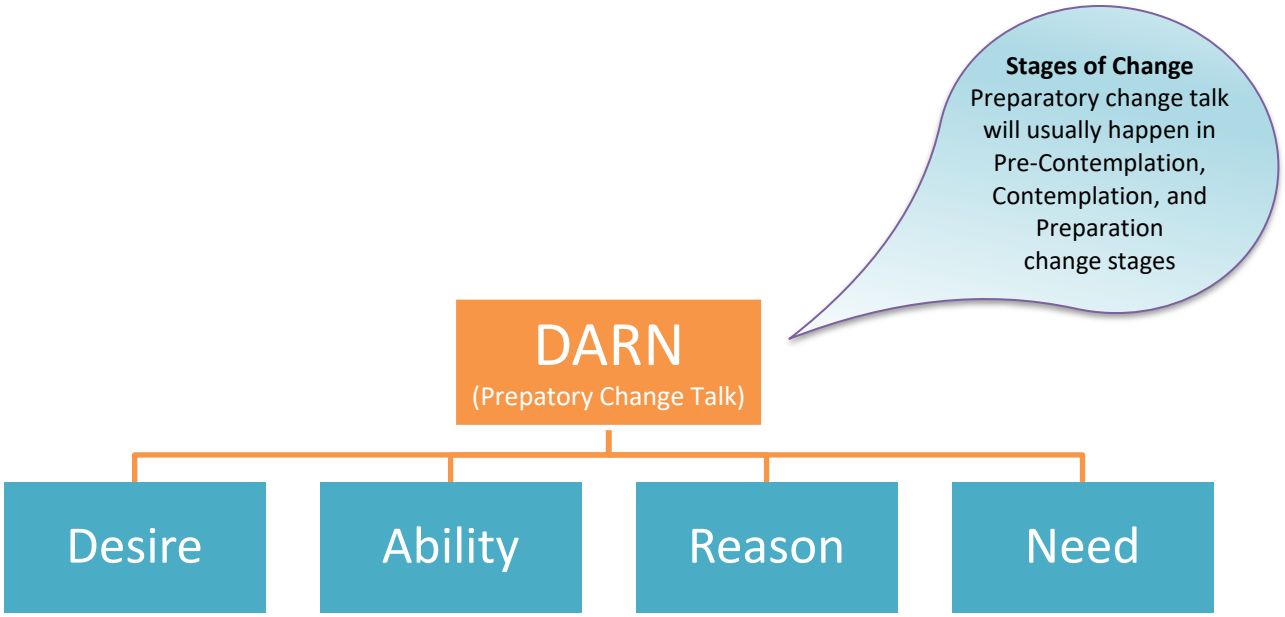
It is immaterial whether your reflection hits the mark! If it's off base, the client will take the opportunity to clarify. If it's spot on, the client will know that you are listening and understand. Either way, a reflection offers the client more opportunity to direct the conversation rather than your questions directing the conversation in a way the client didn't choose.

It is important through reflection to acknowledge your client's ambivalence and explore with her what would help resolve her uncertainty. Respect her expertise on her own life and empower her to find solutions that will work for her.

Change Talk

We've explored OARS which is used by the nurse to evoke change talk. Now it's time to dig deeper into the types of Change Talk we're trying to evoke.

DARN or Preparatory Change Talk



Desire: "I want" statements—"I want to have fun, and smoking is stopping me from doing that."

Ability: "I can" statements—"I've done it before so I know I can do it again."

Reason: "I should" statements—"If I don't quit, my Mom will be so mad at me."

Need: "I must" statements—"I have to quit because I can't afford it any longer."

Think About It…

A client begins to talk about quitting smoking. What might she might say expressing why she might consider this change? On a piece of paper, write a sentence for each element of DARN.

D (I want)

A (I can)

R (I should)

N (I must)

Preparatory change talk can last for one visit or for months. Sometimes the client may move back and forth between sounding ready to take action and then sound like she has never even mentioned this change. When this occurs, remember that ambivalence is part of all change. Staying as we are feels safe because it's known. Our need for safety can outweigh our need for change.

Action Change Talk: CAT

The next type of change language is typically an indication that the client is ready to move toward the plan phase of the MI conversation. CAT stands for **C**ommitment, **A**ctivation and **T**aking Steps.

Commitment

- "I want to"
- "I could"

Activation:

- "I am willing to"
- "I am ready to"

Taking Steps (notice these sentences include past tense action verbs):

- "I did"
- "I went"
- I have"

Think About It…

Your client begins to indicate readiness to make a change about her smoking. On a piece of paper, write a sentence that she might say expressing mobilizing change language for each element of CAT.

C (I could)

A (I want to)

T (I have to)

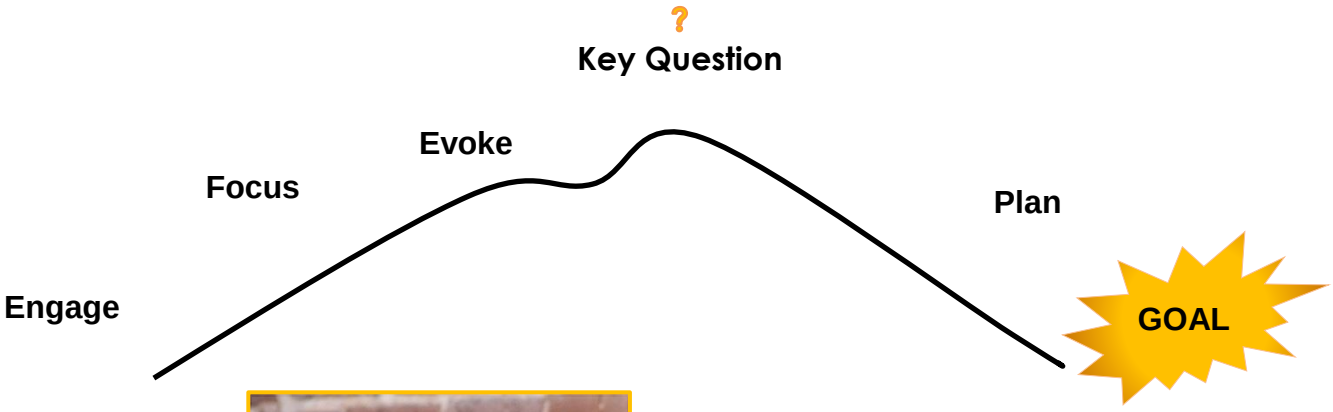
Key Question

There are indicators the practitioner can listen for that show the client is ready to move from preparatory change talk (DARN) to action change talk (CAT). There will be an increase in change talk and a decrease in sustain or resistance talk.

The client might begin to ask some questions about change; i.e., “Do you know anyone who has used this treatment center . . . taken this med . . . quit smoking with this method?”

When you hear this, its time to offer a summary of all the change talk you’ve heard and use a key question to move toward doing.

If you think about an MI conversation as climbing a hill, everything up to now is climbing up the hill. The key question is the summit and intended to move us downhill into the planning phase and toward the goal.



Think About It…

Think about our pregnant mom who is still smoking. She has indicated her desire, ability, reasons, and need to quit. You have heard:

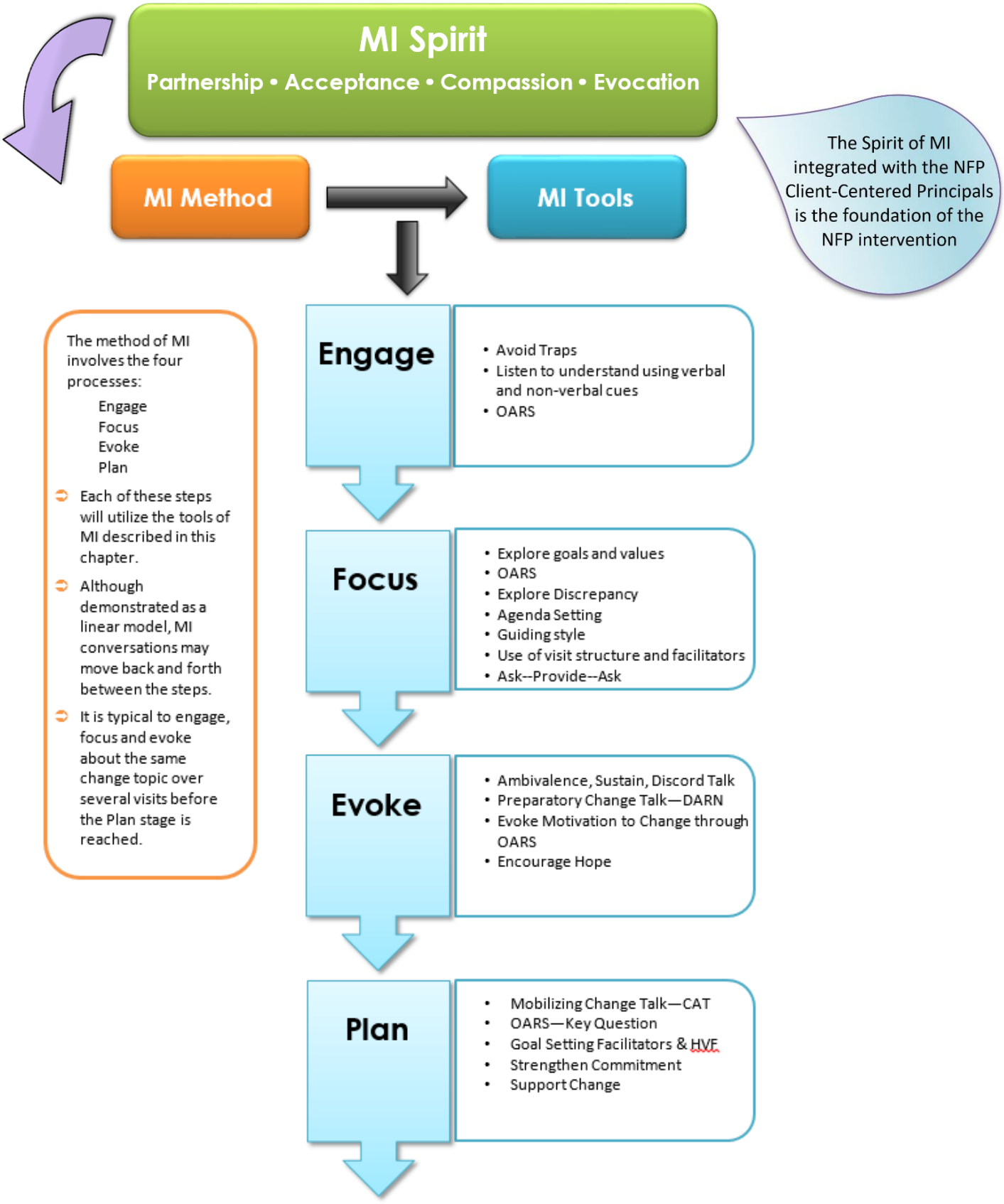
- I really want to quit (desire).
- I hate how it smells up everything and it's really expensive (reasons).
- I've tried quitting before, and one time I even quit for two years (ability).
- So I think I can do it 'cause, now that I'm pregnant, it would be better for me and the baby (need).

For your personal review, write a summary for this client of what you've heard (using your own words) and think about including an affirmation in that summary.

Then write one key question you could use to help move her toward the planning phase, for example, "Did you have a good week since we met last?" (Closed answer: "yes")

MI: The Big Picture

Following is a "Big Picture" diagram of all the elements of MI and a brief summary of what we've talked about in this chapter. Following the diagram, is a scenario that demonstrates how an MI conversation flows. All the elements of the process work together, each skill building on another, and all woven together.



MI Flow Scenario

The following scenario is provided as a way to see the flow of an MI conversation. At the end of each sentence the tool the nurse is using and what type of change talk the client is using is included, as well as some tips for taking MI deeper.

Nurse Home Visitor (NHV)*:* Jen, at our last visit you indicated your desire to start on your GED. I brought some items with me we can look at but before we do that, I wanted to make sure I remember everything you've shared with me over the last few visits about why you want your GED and where you hope this will take you. How does that sound to you? (**Permission** question)

Client (Jen)*:* Well, OK I guess. (Client **consent/readiness** to delve into topic.)

NHV*:* I remember you saying money was tight because you were working part-time and your job didn't pay very much. You like computers and social media and want to use that interest to build toward a career in that field. You hoped that getting your GED might be a way to begin progress toward some type of technology degree, and it seemed like the first step in the plan. What did I miss? (**Summary** of past conversations and **Open-ended question** to evoke further information.)

Jen*:* That's still what I'd like to do. But right now I don't have any money. I haven't paid my rent this month and I'm afraid I'll lose my housing (**Need**: I have to keep my home.) If that happens, and we're out on the streets, I'm afraid I'll lose Sadie. (**Need**: I have to keep my home to keep my child.)

Do you have a way to help me pay my rent? (**Ambivalence:** the problem of rent is pressing and makes it difficult to focus on anything else. Jen might also be deflecting rather than working out how to solve this problem because it feels so overwhelming. However, it's not your job to solve the rent situation. Avoid this trap!)

NHV*:* The money situation has you really concerned right now. You want to move forward but the money is a block. It seems like all you can focus on is the immediate need rather than looking ahead. (**Complex Reflection:** the nurse has also included Jen's question in the reflection rather than responding directly to the question. It would be easy to get side tracked, at this point in time, into the rent money and budget situation. The conversation about education could keep getting postponed by every new emergency.)

Jen*:* Yeah, I don't know how I'm going to support us this month. I'm really scared. It's never been this bad before and it's getting worse each month. Sadie needs more things now that she's getting older, and childcare is really expensive. (**Desire:** I want to provide for my child. **Need:** my child needs more than I can give her right now.)

NHV*:* Before you had Sadie, you could make different decisions about your life. Now that you're a mom, you want to be the best mom you can be and provide for the two of you. Having Sadie has really changed the way you think about your future as well as your current needs. You need a short-term and a long-term solution. (**Amplified Reflection:** the nurse is getting to Jen's heart's desire in this reflection and using that as reinforcement of change talk.)

Tip: When providing an amplified reflection, it involves intuition. The client didn't say this out loud, but you've seen something not said. You may be wrong in your intuition. That's OK—it allows the client to correct or modify her statements until you fully understand what she is getting at. If you get it right, it often provides the client with insight she may not have had and helps her move toward change.

Jen*:* Yeah. (Jen is teary eyed and can't talk; she is expressing some shame body language. Jen is feeling like she hasn't made any progress in any area of her life.)

NHV*:* Jen, you have come such a long way. In our first few months together you didn't express any desires for your future at all. Now you've identified a subject you're interested in, a career that would be exciting for you, and a first step toward reaching that goal—your GED. You've shown amazing persistence even though it's been difficult. You know you want to be a great mom and provide a future for you and Sadie. (**Affirmation** and reinforcement of change talk; the nurse wants to focus Jen on progress and take the focus away from shame, which is counterproductive to Jen moving forward.)

Jen*:* It just feels really hard and I'm not sure I can do this. (**Sustain talk:** directed toward ability.)

NHV*:* Right now it feels overwhelming. It's hard to focus on progress and make decisions about what you really want for your future. (**Simple Reflection**)

Jen*:* Exactly!

NHV*:* Let's step back a sec and review what we've talked about. You have no doubt that you want be a great mom. You want to provide a home for both of you. Your current job is not providing enough for your monthly needs and it won't get you where you want to go. So, you want to pursue education to help you get a better job and you also need a better way to provide for your needs today. You want to make a change but you're not sure if you can make a change. (**Summary and recognition of ambivalence using double sided reflection;** i.e., reflecting the good and not so good about the situation, as well as the change. The NHV is also building partnership and empathy.)

Jen*:* Yeah, but the stress is really getting to me. It would be so much easier to just get on aid and let it all go. (**Desire:** I want to be relieved from this stress.)

NHV*:* When you feel stressed, a short term solution is aid. But when you think about your dreams of where you'd like to be, aid doesn't seem like the best answer. (**Double Sided Reflection:** aid helps in the short term but doesn't change the future.)

Jen*:* Yeah.

NHV*:* Jen, we can go a couple of different directions right now. I hear three concerns, and there may be more. So let me state the three I've heard, and you can add to that, too.

One, your current job doesn't pay all your bills, and money is tight—so tight you're worried about paying your rent this month; two, you feel a lot of stress right now and need a solution to de-stress; and, three, you have dreams and want to move toward fulfilling those dreams. What else should I add to that list? *Jen shakes her head, "No."* (Nurse is establishing Jen's autonomy to choose and setting up for Ask-Provide-Ask.)

What area would you like to focus on first? (**Ask**)

Jen*:* Well, I really can't think about anything else right now 'cause I have to find the money for rent.

NHV*:* So resolving the rent situation will help you focus on the other two items. *Jen nods, "Yes."*(NHV is still in Ask mode.)

I'm sure you've been thinking about what to do. What have you thought of or tried so far to find the rent money? (NHV is still in Ask mode; she doesn't want to provide ideas that Jen has already tried or is resistant too. This could create a discord situation where Jen doesn't feel helped and starts arguing back instead of embracing the desire to change.)

Jen*:* Well, I know I could probably ask my mom for help and I could ask Sadie's daddy. My boyfriend isn't working so he can't help pay the rent. But my mom and Sadie's daddy won't just give me money unless I have a plan for next month too. **(Commitment** and **Activation**)

NHV*:* So you could ask your mom or Sadie's daddy, but to do that, they'll want to know that you can make it long term, not just month to month? So, you'll need to think through how you're going to pay rent next month and the next month, and show them a doable plan for your future before you can ask for the money. (**Amplified Reflection:** Jen's focus is on this month but there is a way to combine her desire and her need into a larger action plan.)

Jen*:* Yeah, so I guess I need a plan—not just talk about this month's rent in order to go to my mom. (**Activation**)

Tip: Jen has a network of support, but her pressing need has caused an inability to focus on her dreams and develop a plan that feels doable. She sees the solution as either A or B and can't see that there could be other options. If Jen is unable to focus on more options, this conversation could go back to square one. The nurse home visitor has taken Jen through Engaging (Partnership, Autonomy, Collaboration and Evoking), Focusing (rent and her current dead-end job are harming her budget as well as her ability to move forward), and some Evoking (what Jen wants, which is to provide for Sadie and be a good mom).

What we don't know yet is: what is Jen willing to do to get what she wants? Choices she could make:

1. Ask her mom or Sadie's' father for the rent money and put up with their resistance if she doesn't have a long term plan.
2. Ask them for on-going help and present them with her plan to move toward self-sufficiency.
3. Go on aid. This might be a solution if it allows her time to pursue school and still care for Sadie without the added expense of childcare.
4. Find a different job or more hours knowing that she'd have to solve childcare and still find time for her GED course.
5. Some combination of any of these.

Jen is stuck between Evoke and Plan because she doesn't see a solution yet. She has acknowledged she's reached the end of her resources and will need to widen her network and make some changes in order to move forward.

MI Flow Scenario Continued

The role of the nurse home visitor is to see if Jen is ready to move toward a Plan and evoking Jen's change talk is the best way to do that.

NHV*:* Jen, I've heard you say how important Sadie is to you and that you want to provide a future for both of you. You see a life that is different and better than life now. You realize your current job won't get you to where you want to go. You shared with me that an education is the best way to improve your life. You think you can ask your mom and Sadie's daddy for help if you have a plan for your future that seems doable. (**Summary**)

What do you think you need to do in order to make sure Sadie and you are provided for right now, and you can provide for your future? (**Open-Ended**

Question and **Key Question:** opens the door to "provide" portion of conversation.)

Jen*:* I think I need to get a different job. I could go on aid but I'm worried that's a dead-end for me. I'm scared I'll lose everything. I've worked really hard to have custody of Sadie and take care of us and I don't want to go backwards. I have to ask my mom for help, but I think she'll understand that I'm working on things. She might be a bit nosey in my life if she's giving me money, but that could be ok if it helps me get what I want.

NHV*:* Asking your mom for help has some upsides and some downsides. But overall the good outweighs the bad. (**Summary**) One thing that has helped some of my other moms in the past is to make a list of steps to take and then work out which one needs to be done first. Then we can talk about how to make that step work for you. This could become a plan that you share with your mom and Sadie's' daddy when you ask for help. Would you like to start on that? (**Provide**)

Jen nods: "Yes."

Tip: Notice that Jen has moved off just paying the rent or asking the nurse to come up with the money. She is back on track.

This would be a great time for the nurse home visitor to introduce Jen to the goal planning facilitators in the eGuidelines. They are designed around the client centered principle of "only a small step is necessary" and are great at breaking down goals into manageable tasks. In discussing the plan you can also address how to have this conversation with her support system.

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How Did You Do on Matching Summary Types?

A = 3. Linking Summary
B = 1. Collecting Summary
C = 2. Transitional Summary

Chapter 9

Reflection in Practice

Nurse-Family Partnership
Helping First-Time Parents Succeed

Chapter 9: Reflection in Practice

Purpose

The purpose of this chapter is to help you recognize and appreciate the value of reflection in nursing practice in Nurse-Family Partnership. You will review useful forms implemented in reflective practice. Nurse supervisors will receive additional instruction on their role in reflective practice in supervisor education sessions.

Standards Covered in this Chapter

Nurse Home Visitor

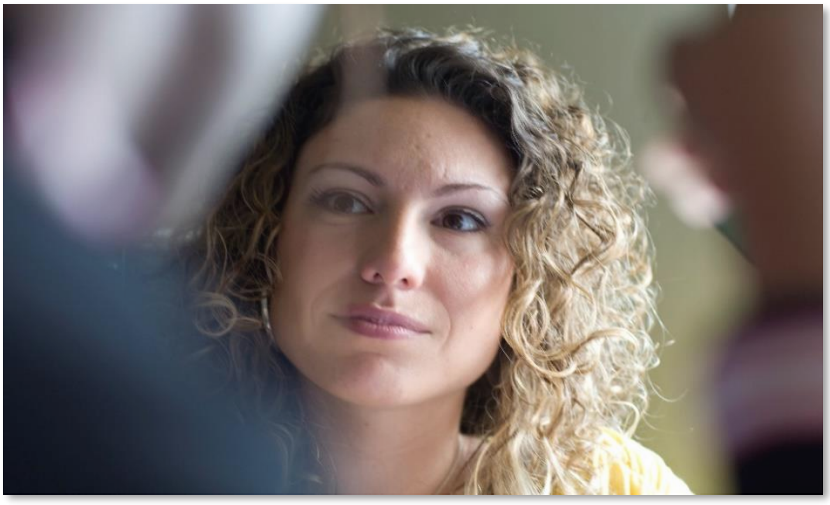
Utilizes reflective processes to improve practice

Nurse Supervisor

Application of principles of supervision that promote the clinical and professional development of all team members

Objectives

- Describe the history of reflection in practice during the three trials.
- Describe use of reflection in Nurse-Family Partnership practice.
- Describe the expectations for reflection in one-to-one clinical supervision, case conferences and joint home visits.
- Identify the steps structured reflection.
- Identify the Nurse-Family Partnership forms used in reflective practice and their purpose.
- List ways to create a therapeutic environment for reflection.



Introduction

Reflection is regarded as essential to professional practice, not only in the field of nursing, but also in medicine, social work, and teaching (McDonald, J. & Glover, D., 2000; Ottesen, 2007; Plack & Greenberg, 2005; Wilson, Walsh & Kirby, 2007). There are many definitions of reflection and reflective practice. This chapter will provide a foundation for understanding reflective practice in Nurse-Family Partnership.

History of Reflective Practice in Nurse-Family Partnership

Formal reflection on one's work was not an established practice of professionals in the seventies. However, Dr. Olds recognized that structured reflection occurred on a regular basis in the Elmira trial and, in fact, all three trials (D. Olds, personal communication, December 19, 2006). During the Elmira trial, Dr. Olds led weekly case conferences, "I saw my primary role as really helping them [the nurses] think through the cases that were problematic in light of the underlying theoretical model of the program….One of the things we would talk about a lot is the nurses' feelings of frustration and inadequacy in their ability to really bring about the kind of changes they all envisioned and were committed to seeing occur" (D. Olds, personal communication, December 19, 2006). By addressing their feelings in a safe and supportive environment, nurses were able to be more therapeutic in their interactions with clients.

In addition to the weekly case conferences, the supervisors supported nurse home visitors' reflective practice through clinical supervision. Supervisors made joint visits with nurse home visitors and team members made joint visits with each other, to "provide another pair of eyes and ears and to provide support to one another" (D. Olds, personal communication, December 19, 2006).

As in Elmira, the supervisors of the subsequent trials were responsible for providing clinical supervision with reflection. Dr. Olds and researcher Harriet Kitzman flew to Memphis once a month for case conferences with the nurses in the second trial. In Denver, Dr. Olds no longer had time to meet with the team for case conferences. His associate joined Pilar Baca, the supervisor, for case conferences (P. Baca, personal communication, December 7, 2006).

Think about it…

If a nurse colleague from another organization were to ask you what reflection looked like in the clinical trials preceding Nurse-Family Partnership, how would you respond?

Your answer might include these points: Structured reflection on nursing practice occurred in the trials through the venues of case conferences, one-to-one clinical supervision, and joint home visits. This reflection addressed how the nurses' practice related to the theoretical foundations of the program design and supported them in processing their feelings so they could be therapeutic with clients.

Defining Reflection in Practice

Numerous definitions of reflection in practice provide helpful understanding on the depth and breadth of this structured process. "Reflective practice is about getting into the habit of consciously and deliberately examining situations, actions, and responses, and changing your practice as a result. Clinical supervision can provide a supportive and safe framework for reflection, helping nurses develop their professional skills" (McDonald & Glover, 2000, p.49). In other words, reflection is a process for learning, professional growth and change.

Reflection is also about exploration for the purpose of understanding a situation and identifying where there are gaps between theory and practice (O'Callaghan, 2005). Reflection in the midst of a situation or after it has occurred is not sufficient. "Rather reflecting-for-action is also crucial to professional development and quality care" (Plack & Greenberg, 2005). Reflecting-for-action is described by one nurse as "pre-stage anticipation (reflection before action)" (Cassidy, 2005). As a nurse home visitor you will need to reflect on action *after* a challenging incident. You will also need to reflect prior to the visit on how your theoretical knowledge and ideals will best be actualized in the "real" world. Lastly, you will want to pause during visits to reflect before responding.

Clinical Application

As a Nurse-Family Partnership nurse who understands the foundational theories in the Nurse-Family Partnership model of Human Ecology, Attachment, and Self-Efficacy, you will want to reflect before, during, and after your visits on how you're using the theories in your practice to promote a client's self-efficacy and secure attachment in a child. You will need to be aware of how the environment is influencing the family with whom you are working.

If you have already studied the chapters on Human Ecology, on Attachment, and on Social Cognitive Theory and Self-Efficacy, please go to the Visit-to-Visit eGuidelines and locate the *Life History Calendar* facilitator. Reflect on how you might use your understanding of Attachment, Human Ecology, and Self-Efficacy theories to support your nursing practice with a client who has never lived with her biological father and moved from one living arrangement to another during her childhood. Some questions you might choose to reflect upon include:

- How has the absence of her biological father affected this client's sense of self-efficacy regarding establishing and maintaining a relationship with the father of her baby? Has she had any influential male role models in her life?
- With whom did this client attach as a child, and what did that attachment look like?
- How have the multiple moves and this client's changing environment affected her education and sense of self-efficacy regarding success in school?
- How will I best explore with this client what she needs to have happen in order to develop an enhanced sense of self-efficacy regarding her relationship with the father of the baby? Regarding school?
- How do my client's childhood experiences influence how she perceives and relates to me?

Reflection is exploration of the, "content, process, and premise underlying the experience in an attempt to make meaning or better understand the experience." This, in turn, will lead to changes in your, "behavior that reflect changes in underlying values, attitudes, and beliefs" (Plack & Greenberg, 2005, p. 1547).

- Reflection on *content* involves analysis of a challenging situation or problem.
- Reflection on *process* leads to analysis of the interventions you have attempted and their effectiveness.
- Reflection on *premises* refers to analysis of your underlying beliefs and assumptions in a given situation.

Assumptions can be dangerous and detrimental to effective nursing practice. Reflecting on premises is much riskier than on content and process. This type of reflection requires the ability to look at your assumptions and beliefs and to think deeply about things that may feel uncomfortable. Through reflection, you can become more self-aware and therapeutic in your relationships with clients.

Since reflection means taking risks, you need a safe place in which to reflect on premises and safe team members. Creating safety for reflection on your team will be discussed later in this chapter.

Wilkinson (1999) argues in favor of reflective practice not only for novice nurses but also for experienced, expert nurses. He notes that expert nurses can benefit from developing greater self-awareness through reflection. What stands in the way of effective reflection? "Many practitioners will argue that they reflect on their practice….However, this is often done in a haphazard, unstructured way….If you do not reflect in a structured way, you cannot explore and understand the meaning of practice, nor explore the contradictions between aim and achievement" (McDonald & Glover, 2000, p. 50).

Think about it…

Nurses sometimes believe they are reflecting effectively when in actuality they are venting. Based on the previous definitions of reflection, what do you consider similarities and differences between venting and reflecting? List as many as you can and then compare your answers with those of other supervisors and nurse home visitors.

If you have come up with more differences and similarities than those listed on the next page, celebrate by taking a break and doing something fun for a few minutes!

Nurse-Family Partnership nurses have noticed the following similarities between venting and reflecting. Both can occur informally, and they involve:

- Communication
- Expression of emotions
- At least two people (except when journaling is used for the purpose of reflecting and/or venting)

Differences between Reflecting and Venting

Reflecting	Venting
Usually takes place formally with structure	Usually occurs spontaneously and without structure
Focuses on learning for the purpose of professional growth and development in one's nursing practice	Focuses on releasing emotions for the purpose of feeling better
Can require more skills from the listener/coach (e.g. supporting and challenging the reflector to enhance critical thinking through use of effective open-ended questions and reflective listening)	Mainly requires that the listener empathize and show support for the person venting
Results in greater self-awareness	May or may not result in greater self-awareness

The Value of Reflection in the Nurse-Family Partnership

Reflecting on practice is a valuable process for Nurse-Family Partnership nurses, who soon discover their work with clients is challenging, complex and emotionally demanding. Even nurses with public health and nurse home visiting experience at times report feeling uncertain, confused and overwhelmed. Nurse-client relationships in this program are affected by the intense visit schedule extending over two-and-a-half years.

Working with twenty-five high-risk clients, their infants, and other family members is never easy. It is even less so for Nurse-Family Partnership nurses who experience emotional closeness with clients they visit frequently (i.e., according to the Nurse-Family Partnership visit schedule). Establishing healthy boundaries and maintaining them throughout the intervention is essential and requires reflective practice. Furthermore, clients often live in difficult situations with tremendous obstacles to overcome. Nurses express the frustration of seeking to support clients in finding solutions and achieving goals when there are no simple answers.

The more intense the work, the more you need reflection in your practice. Reflection helps you:

- Assess where you are with a client, what you have experienced and felt, how you have responded and how you would like to respond.
- Apply the three foundational theories of the Nurse-Family Partnership model as you plan, implement and evaluate interventions and clients' responses using the Nurse-Family Partnership Visit Guidelines and other program materials.
- Develop self-awareness of your strengths, limitations and vulnerabilities.
- Self-correct your behavior and performance.
- Live with ambiguity.
- Be responsive rather than reactive.

According to Pilar Baca, clinical supervisor of the Denver trial nurses (personal interview, December 7, 2006):

Nurses need to build quality therapeutic relationships when working with a vulnerable population. This is emotionally exhausting and takes its toll on caregivers. Nurses trying to facilitate behavior change, as a means of altering the life trajectory of women living in poverty, are in need of support and the opportunity to process their feelings in order to maintain therapeutic client relationships.

Reflective practice provides an opportunity for you to explore the dynamics of your relationships with clients. You need reflection to understand your experiences at the conscious level and to surface those that are unconscious. The emotions that tend to occur at the unconscious level must be processed for professionals to be therapeutic. (Ooijen, 2003) During one-to-one supervision using reflection, a supervisor may notice parallel process occurring. "Parallel process is an extremely interesting phenomenon where the supervisee somehow behaves like her client, without being aware that she is doing so….and probably happens because something about the client has not yet been processed" (Ooijen, 2003, p.137). When you or one of your team members behaves in a way that seems different from your usual manner or exhibits a change in emotional level, your supervisor may want to draw attention to the change in order for collaborative exploration of the meaning behind your behavior. This kind of exploration can also help you and your supervisor gain insight and understanding of your client's behavior.

Other phenomena which can occur between nurses and their clients are transference and counter-transference. Transference occurs when a client views her nurse through the filter of a previous relationship. A nurse can experience counter-transference when she responds to the client's views of the nurse or when the nurse views a client through her filter based on past experiences. If a client and nurse remain trapped in these phenomena, neither will be able to see the other for who she actually is (Ooijen, 2003). Their work together will be hindered and the outcomes of the program are less likely to be achieved. For example, if counter-transference has occurred and you are acting out of the role of mother and your client is acting out of the role of daughter it will be very easy for boundary violations to occur without either of you being cognitively aware that it is happening. For this reason, formal reflection is essential for you and other nurse home visitors on a frequent basis.

Mini Case Study

Please read the following mini case study. If you are a nurse supervisor, reflect on what observational and reflective listening skills you will need to hone in order to support nurse home visitors. If you are a nurse home visitor, consider how the reflection demonstrated in this case study might be useful in your work with clients.

> **Supervisor:** Just now as you were sharing with me about your last visit with Anna, I noticed your tone of voice and body language changed quite a bit.
>
> **Nurse:** Really? I didn't notice.
>
> **Supervisor:** Your voice is usually animated. It suddenly became monotone, your face had flat affect, and you slumped in your chair (supervisor demonstrates).
>
> **Nurse:** Wow! That's exactly how Anna looked and sounded yesterday. I'm really concerned about her. You know she attempted suicide when she was thirteen, and every member of her family has needed services from the mental health center. She seemed to be handling pregnancy so well, but now that her baby is here, I'm not sure that she is ok. I don't know what to do….

If this nurse home visitor does not gain an understanding of what is happening, she may feel overly responsible for Anna's emotional state. By reflecting on challenging situations, like this nurse, you can grow in your understanding of what is happening with you and your client. You will be able to explore how therapeutic and helpful your responses are. Over time you will become increasingly skilled in your use of self in the therapeutic relationship and your use of the theories and tools in the Nurse-Family Partnership model.

Think about it…

Identify a time in your nursing practice when you faced a challenging situation, which could have undermined your therapeutic relationship with a client. What helped you during the incident or after to be therapeutic?

Reflection in Nurse-Family Partnership Nursing Practice

In Nurse-Family Partnership, formal reflection occurs in three venues. These venues are clinical supervision, case conferences/team meetings, and joint home visits:

1. Clinical supervision occurs between a nurse and supervisor in one-to-one weekly, one hour sessions for the purpose of reflecting on a nurse's work including management of her caseload and quality assurance. The supervisor and nurse commit to supporting each other in this process and making it safe to be open and vulnerable. An "Overview of One-to-One Reflection Supervision and Structure" is located near the end of this chapter before a review of the forms you will be using.
2. Case conferences and team meetings are group gatherings to review cases, NFP data including quarterly and annual reports, and program operations. Ideally, these meetings are scheduled weekly for one-and-a-half to two hours with time devoted to case conferences every other week. Some implementing agencies have negotiated an alternate schedule when nurses are housed at different locations or to accommodate other needs unique to that team. In order for reflective practice to be successful in a group setting like case conferences and team meetings, the supervisor "must believe in the concept of professional development" (McDonald & Glover, 2000), and every member must be committed to making it a safe place for openness and vulnerability to be expressed.
3. Joint home visits are made by the supervisor and nurse every four months, and by the nurse and a peer on an as needed basis. After joint home visits with a supervisor and nurse, MAP 1 (Mastery Assessment and Play) is completed and discussed. The number of clients seen during these visits is negotiable depending on schedules and travel time. The time recommended per nurse every four months is approximately two to four hours. One supervisor has found that she can best support her newer nurses by spending an entire day with them.

In this manner they can reflect not only on the visits but also on time and caseload management.

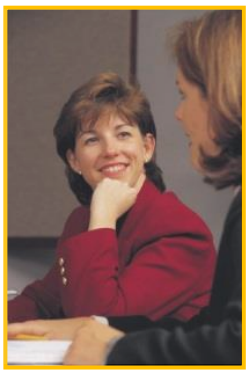
In addition to reflection, regularity, and collaboration are essential features of reflective practice (Parlakian, 2001). Regularity refers to scheduled, uninterrupted time for your supervisor to meet individually with each nurse and for the team to meet together. Developing an environment of acceptance, trust and support requires time and a commitment to protect that time. A commitment to be prepared and open for learning through reflection is also essential.

Collaboration refers to "sharing the responsibility and control of power" (Parlakian, 2001, p.2). When a spirit of collaboration is present, there is an opportunity for open and constructive dialogue to occur regarding issues affecting nurses, the team, and the agency.

A Useful Tool for Reflection in Nurse-Family Partnership Practice

A tool for reflection in the Nurse-Family Partnership is the Reflective Cycle. The Reflective Cycle can be used to structure reflection in clinical supervision and case conferences. Some Nurse-Family Partnership nurses have used the cycle in home visits with clients who are developmentally ready to work on their critical thinking skills and process events in order to learn from their experiences and develop plans of action.

Use of the Reflective Cycle



By Clients with Nurses

The purpose is to identify one's own actions, thoughts and feelings to gain new insight, ideas and understanding.

By Nurses with Supervisors

The purpose is to develop self-awareness, learn and improve nursing practice and expertise. Another purpose is to be therapeutic with clients.

By Supervisors with a Trusted Person

The purpose is to develop self-awareness, learn and improve supervisory practice, expertise and skill in reflecting with staff.

Definitions

A **reflector** and a **coach** play roles in the Reflective Cycle. The reflector is the one reflecting on a critical incident to develop solutions. The coach is the one who guides the process using reflective listening, open ended questions and affirmations. The coach needs to demonstrate interest in what the reflector is sharing and respect for that

person's inner wisdom and expertise regarding her life and work. Just like the client is the expert on the context of her life the nurse home visitor is the expert on the context of her practice.

Using the Reflective Cycle *does not* guarantee that all issues will be solved. It is ok not to have all the answers. The Reflective Cycle is helpful to nurses and clients to develop greater clarity on what they experienced, how they responded and how they would like to respond in the future.

The strategies of open ended questions, affirming, reflective listening and summarizing (discussed in greater depth in the chapter on Motivational Interviewing) are helpful for the coach to use in guiding the reflector through the Reflective Cycle. These strategies ensure that the coach truly understands what the reflector means. They also slow down the dialogue to encourage both the reflector and the coach to process at a deeper level.

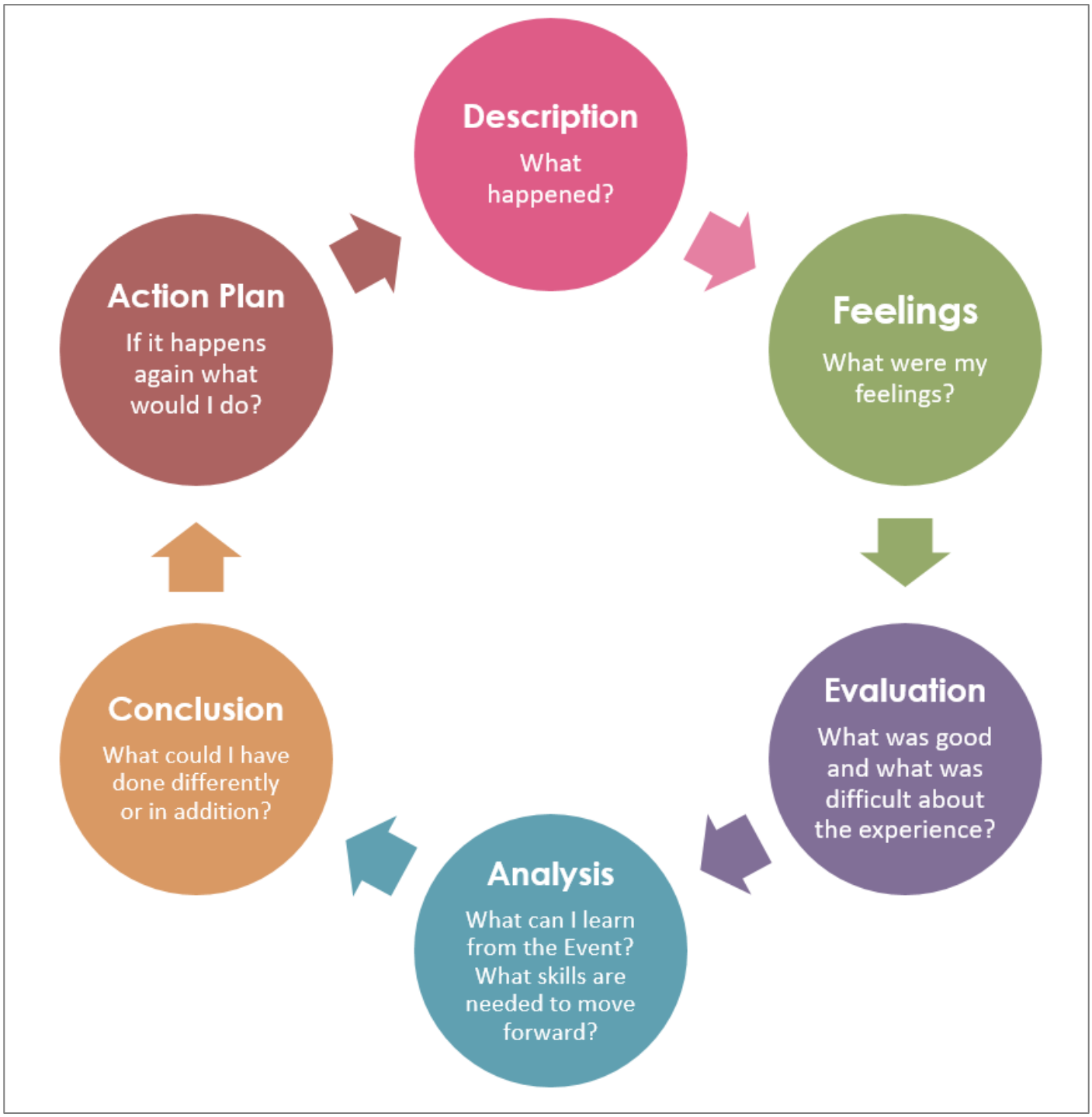
Using the Reflective Cycle to Reflect on Experience

One useful type of reflective practice is reflection on a ***Critical Incident***. A critical incident is a situation or experience that has relevance for improving our practice and furthering our professional development, or in the case of clients, furthering their personal growth. It can be described as an event where:

- Personal action affected the outcome
- Things went unusually well (an exemplar)
- Things didn't go as expected
- The situation was demanding
- It embodies the essence of the work we do

The following diagram is an adaptation of the Gibbs Reflective Cycle:

Using the Reflective Cycle ensures your reflection is comprehensive. At times you and your supervisor may want to try a shorter version of formal reflection which involves three steps. You can also use this method with clients.



From *Learning by Doing: A guide to Teaching and Learning Methods.* Gibbs, G. (1988). Further Education Unit, Oxford Polytechnic.

A Three-Step Method for Formal Reflection

Another form of structured reflection is to ask "what, how, and what now" questions (Rolfe, 2001):

- **What?** This question focuses on what happened and also on what the nurse hopes to learn from reflecting on the event. This is the descriptive phase of the process. It is fact oriented and may begin to surface some values and beliefs the nurse experienced when interacting with the situation.
- **So What?** This question focuses on how the nurse feels about what happened. It requires a safe environment in which to honestly recognize feelings and process them. It is a time to reflect on feelings and on values and beliefs that were challenged by the situation. It also explores the impact the event may have on subsequent actions and leads to the next question.
- **What next?** This question focuses on what the nurse has learned from the situation and how she wants to apply that learning during this event or when a similar situation arises in the future. This is the planning/action phase of the reflective process.

Think About it: Clinical Application…

Read the following mini case study and develop three questions you would use to reflect on this incident.

You are a new nurse home visitor in Nurse-Family Partnership taking over the caseload of a nurse who retired. When you visit Lucy, one of her former clients, she sits on a chair at the other end of the living room, responds to your questions with monosyllable answers and gives you little eye contact. During the visit you notice feelings of discomfort and your speech is becoming faster and louder. Near the end of the visit, an older male stomps through the living room. He glares at Lucy before slamming the door to the bedroom. You ask her if everything is ok, and she responds, "That's my boyfriend. He doesn't like strangers in our place." As you leave, Lucy thanks you for coming.

What?

So What?

What next?

Possible questions you might ask yourself include:

What?	• What happened during this visit? • What was I trying to accomplish? • In what ways did I respond effectively, what ways less effectively in this situation? • What factors contributed to how I felt, thought and responded in the visit? • What unconscious assumptions and beliefs might I have made that I need to surface and address?
So What?	• How were my responses in alignment with my values? How were they not in alignment? • Besides discomfort, what else did I feel and why? • What were my perceptions of Lucy? How did those perceptions contribute to the way I was feeling? • How Lucy's boyfriend feeling appear to feel? What might have made him feel that way? • How is this situation like previous ones I've experienced? Did this trigger anything in me – if so, what? • As I've reflected on this situation, how am I feeling NOW?
What Next?	• What have I learned from this visit with Lucy? • What do I want to learn before I visit Lucy again? • What knowledge and/or skill building resources do I want to access before I visit Lucy again? • How do I want to respond in my next visit with her? • What might be the consequences of the decisions I make for Lucy, her boyfriend and me? • What will I do differently? • What will I do if I encounter a similar situation with another client?

Structured Journaling: Another Way to Reflect on Practice

Although structured journaling is a valuable form of reflection, this is the first time it has been addressed formally in Nurse-Family Partnership education. Keeping a reflective journal can be useful for processing critical incidents (Plack & Greenberg, 2005). You

will keep quite busy with visits, case management, and agency activities. By writing down key events, thoughts and feelings, you can later return and reflect in more depth on what you have experienced (McDonald & Glover, 2000).

A journal offers the opportunity to process an experience over time and on more than one occasion. Through reflecting on multiple occasions, greater depth of learning is possible. Plack and Greenberg (2005) note that journals are only effective tools for reflection if they are used to analyze situations and not just to record facts. Reporting on an event is not the same as reflecting.

One difficulty with journaling is that you do not have the benefit of other nurses and professionals' perspectives as you would have in case conferences, joint visits, and one-to-one supervision. A possible solution is to engage in interactive journaling in which another person reads your journal and asks you questions to encourage reflection and critical thinking (Plack & Greenberg, 2005).

One-to-One Reflective Supervision, Case Conferences, and Joint Visits

There are three specific venues in which Nurse-Family Partnership nurses can reflect, and there are various strategies, which you can use. In the beginning of your work in this program reflection may feel awkward and uncomfortable. You are just beginning the relationship building process and reflection requires trust, safety and a deepening of relationship to seem more natural.

In the following pages you will have the opportunity to review an overview of reflective supervision as well as forms that are used not only in reflection with your supervisor and joint visits but also in case conferences with the team. The forms can be used to guide reflective practice and assessment of your work with clients. Some of the forms are useful for identifying and documenting your plans for future work with clients as well as professional development.

Overview of One-to-One Reflective Supervision Structure and Process

	Nurse Home Visitor	Supervisor
PRIOR	Completes *Getting Ready for Supervision* form	Completes any activities agreed upon at last session
	Has *Reflective Supervision Form* from previous session and charts of clients to be discussed at this session	Has nurse home visitor's supervision file ready, along with a copy of *Reflective Supervision Form* from previous session
DURING	Shares current concerns as outlined on *Getting Ready for Supervision* form and collaborates with supervisor on setting agenda for this session	Asks how nurse is doing and collaborates with nurse on setting agenda for this session
	Reports follow-up on activities agreed upon at previous supervision session	Refers to and makes notes on *Reflective Supervision Form* as nurse shares follow-up
	Discusses current concerns about clients—including facts, feelings, and ideas about how to deal with client issues and challenges—using the *Reflective Cycle*	Listens and asks appropriate questions to elicit details of nurse concerns about clients, feelings about client issues and possible solutions (and makes notes on *Supervision Record Client Notes*)
	Collaborates with supervisor on agreed upon activities for coming week(s) (not all activities will be completed within one week) and plans for next session	Collaborates with nurse on agreed upon activities for coming week(s)/plans for next session and records items on *Reflective Supervision* form
	Receives *Reflective Supervision* form and uses as reminder of activities to be attempted in coming week(s)/plans for next session	Gives nurse *Reflective Supervision* form and keeps a copy to guide *own* activities and as a record in nurse home visitors supervision file
AFTER	Works on completing agreed upon activities	Works on completing own agreed upon activities; reflects on how the session went and makes notes on any items to address at next session

Think about it…

After reviewing the structure and process of one-to-one reflection with your supervisor, what do like about this process? What might be uncomfortable for you? What do you need clarified?

Expectations of Home Visitors for One-to-One Reflective Supervision, Case Conferences, and Joint Visits

The following expectations are based on input from Nurse-Family Partnership nurse supervisors and nurse home visitors who have experienced reflective practice. As you read these expectations, some will seem like common sense. Print these two pages and highlight the expectations you think are more challenging to implement as a new nurse in the Nurse-Family Partnership model and discuss them with your supervisor.

1. Make 1:1 supervision, case conferences, and joint visits a priority equal to client visits.
2. Be prompt for scheduled meetings.
3. Be willing to bring program, client, and therapeutic relationship issues to supervision and case conferences.
4. Actively seek feedback and respond to it productively.
5. Give thoughtful feedback in a professional manner.
6. Bring up-to-date charting of clients you plan to discuss to supervision and case conferences.
7. Prepare for each opportunity to reflect by examining your caseload for specific clients and client issues that challenge you or where you have experienced successes. Consider how you have grown and how you would like to grow professionally.
8. Prepare to discuss your clients' strengths in attitudes, knowledge, skills and support network within the six program domains.
9. Prepare for case conference:
10. If presenting a case, organize your presentation using the "*Case Conference Format*."

11. If case conference is on a theme (e.g., intimate partner violence), reflect on your caseload in order to contribute productively.
12. Prepare clients for joint home visits with your supervisor and peers by requesting permission in advance for him/her to visit. Share that the purpose is to help you develop in your Nurse-Family Partnership nursing practice to be an even more skilled and effective nurse in working with them. You might also share with your client that you want her to meet other members of your team who have expertise and who would be available to support them if you were out on vacation or leave of absence.
13. Maintain confidentiality unless information disclosed is illegal, constitutes gross misconduct, or reveals potential or actual harm to clients or others.

Forms Used in Reflective Practice

The following two-page form is one that you can use to keep track of what you would like to share with your nurse supervisor and what input you would like to request from her/him. One nurse compared it to a 'grocery list.' Another nurse saw a resemblance with the list she makes before an appointment with her physician. This form can help you and your nurse supervisor avoid the 'doorknob phenomenon', which takes place when a nurse remembers a significant challenge right before the session ends. If their supervisor has other meetings or reflective one-to-one sessions scheduled, the last minute issue may have to wait longer than would be ideal. Some nurses carry this list in the vehicle with them so they can jot down notes after visits. Notice that accomplishments since the last meeting is listed second, but you may want to start with that item since it is a reason to celebrate! Even 'small' successes such as finding a client who was missing in action or having a very high-risk client keep her appointment are cause for celebration. Take time to share these moments when it would be easy to focus on challenges and overlook what you are doing well.

Getting Ready for Supervision

Date:_____

1. Significant things that have happened since the last meeting:

2. Accomplishments since the last meeting:

3. Where I need most support from my supervisor::

4. Client collaboration needed:

Client Name	Significant Issues

Think about it…

The following *Reflective Supervision Structure* form provides you with structure for your one-to-one sessions with your nurse supervisor.

1. Where have you seen a similar form?

2. Compare steps 4 through 7 with the steps in the Reflective Cycle. What do you notice?

Answers

1. This form demonstrates a similar structure to that of the Home Visit!
2. Steps 4 through 7 correlate with the six steps of the Reflective Cycle!

Reflective Supervision Structure
A Component of Reflective Practice

1. Greeting and reconnection
2. Review and report (feedback about previous activities)
3. Formulate the agenda
4. Description of cases
   - What happened
   - Thoughts
   - Feelings
5. Evaluation and analysis
   - What is working; what isn't
   - What else could you do if it happens again
   - Make sense and meaning of the situation
6. Explore options
7. Action plan
8. Plans for next meeting

Think about it…

Review the *Reflective Supervision Form* below.

1. What form will you use with clients that is similar to this one?
2. How might this form be useful to you?

Answer

The Home Visit Form! The Reflective Supervision Form can be useful to you in helping you to be organized. Some nurses find the written feedback from their supervisors the encouragement they need when they have lost perspective and can only see their challenges.

Reflective Supervision Form

Home Visitor: _____ Supervisor: _____

Today's Date: _____

FEEDBACK ABOUT PREVIOUS ACTIVITIES

AGREEMENT ABOUT ACTIVITIES

HOME VISITOR AGREES TO	BY WHEN	SUPERVISOR AGREES TO	BY WHEN

NEXT MEETING: _____

Date Time

PLANS FOR NEXT MEETING:

WHITE – Home Visitor YELLOW - Supervisor

The following information is not a form but guidance for preparing to present a client to your team during case conference. Notice that your assessment includes a focus on strengths as well as risk, goals and plans in each of the six domains. Also note that you guide the discussion by determining what input you need from your team.

Case Presentation Format

1. Demographics
   e.g., age, E.D.C., clinical referral source, school/employment, source of income, racial/cultural

2. Family
   e.g., F.O.C., significant others living in household, family history—sociogram, if complicated, history of abuse, parenting role models

3. Assessment of Strengths, Risks, Goals and Plans in 6 Domains

   Personal Health
   Environmental Health
   Life Course Development
   Maternal Role
   Family and Friends
   Health and Human Services

4. Human Services Available and Level of Utilization

5. Client/Home Visitor Relationship

6. Request for Specific Input and Problem Solving

Creating a Therapeutic Environment for Reflection

Now that you have had an opportunity to learn about reflective practice in Nurse-Family Partnership, take a few minutes to consider how you can help your team build a therapeutic environment so that reflection can be helpful to you and your team. One of the ways you can do this is by observing team norms around emotional safety and confidentiality. The Nurse-Family Partnership National Service Office recognizes the level at which you can reflect with team members during the first few months of employment will be quite different from that which can take place after you develop relationships of trust and support with team members.

Print this page and complete the table below with examples of things you can do to promote or detract from a therapeutic environment for your team.

Promotes Therapeutic Environment	Detracts from Therapeutic Environment

Conclusion

Formal reflection occurred in all three trials and is currently practiced in the Nurse-Family Partnership program. The purpose of reflection is to support nurse home visitors in their professional growth and development and in turn develop therapeutic relationships with their clients. Reflection in practice requires commitment, time, and skill building. It requires therapeutic team relationships and trust. Reflection in practice will support you to be successful in your role at Nurse-Family Partnership.

Review what you've learned in this chapter by completing the exercise on the next page.

Review Key Points

For your personal review, write your answers to these questions on a piece of paper.

1. Read over the definitions of Reflective Practice. Write the definition that will best support you in your Nurse-Family Partnership practice.

2. Write down three benefits of reflection for the Nurse-Family Partnership nurse.

3. What are the three ways that formal reflection is practiced in Nurse-Family Partnership?

4. List the expectations for nurse home visitors for 1:1 supervision in Nurse-Family Partnership.

5. List the expectations for nurse supervisors in 1:1 supervision in Nurse-Family Partnership.

6. Of the two examples of a reflective cycle shown, which do you prefer and why?

7. What is one team norm that you hope to establish with your team?

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Chapter 10

Excellence in Nurse-Family Partnership Nursing Practice

Nurse-Family Partnership
Helping First-Time Parents Succeed

Chapter 10: Excellence in Nurse-Family Partnership Nursing Practice

Purpose

The purpose of this chapter is to clarify the nursing role in Nurse-Family Partnership and anticipate areas for professional growth.

Standards Covered in This Chapter

Nurse Home Visitor

Adheres to Standards of Nursing Practice

Nurse Supervisor

Promotes the home visitor's development of competence to deliver the NFP home visiting intervention

Objectives

Part 1 Standards of Nursing Practice

- Define Standards of Nursing Practice
- Discuss why Standards of Nursing Practice are significant in the Nurse-Family Partnership
- Describe how your skills and knowledge relate to the Standards of Nursing Practice

Part 2 Nurse-Family Partnership Path to Nursing Excellence

- Describe the purpose of Nurse-Family Partnership Nurse Home Visitor and Supervisor Standards
- Identify the Proficiencies of each Nurse-Family Partnership Standard
- Identify the difference between job performance evaluations and Nurse-Family Partnership Nursing Standards
- Review the components of the Nurse-Family Partnership Standards and Proficiencies

Introduction

Chapter 10 is organized into two parts.

Part 1 describes the Standards of Nursing Practice and how to use the Standards in Nurse-Family Partnership clinical nursing.
Part 2 introduces the Nurse-Family Partnership Path to Nursing Excellence and the Standards and the Proficiencies that support NFP nurses' professional development.

Part 1 Standards of Nursing Practice and Nurse-Family Partnership

What are Standards of Nursing Practice?

Standards of Nursing Practice are authoritative statements that describe the responsibilities for which nurses are held accountable and describe a competent level of behavior in the professional role. Development of nursing standards began in 1950 when the American Nurses Association (ANA) published the Code of Ethics for Nursing. In 1973 ANA published generic standards for nursing care that could be applied to all health care settings. These standards also provide a framework for the evaluation of nursing practice.

The standards describe performance measures for a competent level of behavior in a professional role. These performance measures are:

Quality of practice
Education
Professional practice evaluation
Collegiality
Collaboration
Ethics
Research
Resource utilization
Leadership

Generally, standards of nursing care include the nursing process, which is a deliberate, problem-solving approach to meet the health care and nursing needs of clients. The nursing process involves:

- Assessment
- Diagnosis/issues
- Outcome identification
- Planning
- Implementation
- Evaluation

.Each state has a Nurse Practice Act that contains statutes that govern nursing. In each Nurse Practice Act, there is a provision for a Board of Nursing that enforce the regulations that govern nursing, licenses qualified nurses, approves nursing education programs, and provides disciplinary actions against nurses who violate the Nurse Practice Act.

A review of the Standards of Nursing Practice and your state's Nurse Practice Act will help you assure that you are familiar with local, state, and national resources that define nursing practice. Nurses are accountable to themselves, their clients, their peers, and society for their professional actions. The regulation of nursing practice is determined by legal requirements to assure the health, safety, and welfare of the general public and to protect the integrity of the nursing profession.

Regardless of clinical setting, nurses are expected to practice to the level of nursing specified in nursing standards. Although standards are not laws, standards of practice are now used to establish and determine quality nursing care by courts, regulatory agencies, and clients. The court's use of a community's 'accepted' common nursing practice is being replaced by national standards to identify acceptable practice and define therapeutic relationships (Helm, 2003). The ANA *Nursing: Scope and Standards of Practice* can be found on the ANA website.

How Do the Standards of Nursing Practice Apply to Nurse-Family Partnership Nurses?

Registered nurses are perceived by the public as holding high standards of ethical practice and honesty, are widely respected as a caring profession, and have strong academic preparation. This gives Nurse-Family Partnership nurses credibility with families and helps make them acceptable as home visitors, welcomed into clients' homes, and respected in the community. Pregnant women have many questions and concerns about their health and the baby's health, and value the expertise registered nurses bring during this critical life transition. The education background and sound judgment of nurses make them ideally prepared to conduct Nurse-Family Partnership strengths-focused assessments and to deliver individualized Nurse-Family Partnership interventions to families. Polls of the American public consistently rank nurses high on a list of professions when it comes to the values of honesty and ethical standards (Gallup, 2017).

The success of the Nurse-Family Partnership program relies heavily on developing a therapeutic relationship with good boundaries. Therefore, nurses are a natural fit because they are a profession that is perceived as trustworthy and knowledgeable. Working with low-income families requires skill, professionalism, and sensitivity that are characteristic to nurses. Nurses must integrate the Nurse-Family Partnership interventions and the Standards of Nursing Practice in order to maintain therapeutic relationships, set appropriate boundaries, and achieve program outcomes. Nurse-

Family Partnership requires that nurses use their nursing clinical knowledge and skills to deliver comprehensive services to clients and families.

As you practice community health nursing, you may feel like a counselor or social worker due to your clients' psychosocial issues. At other times you'll struggle with the boundaries of being a nurse and not the client's mother, sister, or best friend.

If you have previous home visiting experience, you're already well aware of how often your knowledge and skills will be challenged. If you are new to home visiting, you may be surprised at the number of roles you'll play in clients' lives and the extent to which you'll be using all your personal and professional life experiences, skills, and knowledge!

Skills and Knowledge for Your Professional Role

Next let us discuss the clinical skills and knowledge necessary for you to be successful in Nurse-Family Partnership. What is your professional role and responsibility in Nurse-Family Partnership?

You will find that you contribute unique life experiences, professional expertise and skills, knowledge, interest, and talents to your team. What expertise are you proud to contribute?

Each supervisor and nurse is different, and at Nurse-Family Partnership National Service Office we've learned that as a result, every team is unique. Complete the Skills/Experience Assessment Form. This is a tool designed to assist your team in learning what clinical expertise each member holds. Once you have learned the clinical strengths of your team members, you'll know who to rely on for consultation and support. Furthermore, the tool will provide you and your nurse supervisor with information on areas where the team's individual and collective experience is limited in order to address professional development needs.

Sample Skills/Experience Assessment Form

Name:_____ Date: _____

Years of Experience: Public/Community Health ___ Maternal/Child ___ Mental Health ___ Other _____

Experience In This Area Or Working With This Population	Could Mentor Others	Need More Info	Need to Build Skill	Comments
Managing Home Visits				
Safety while Home Visiting				
Normal Pregnancy & Complications				
Assessment of Pregnant Client				
Nutrition & Weight Gain				
Fetal Development				
Developmental/Intellectual Disability				
Substance Use and Abuse				
Depression, Anxiety, Other MH Issues				
Intimate Partner Violence				
Mandatory Reporting				
Preparation for Labor and Delivery				
Post-Partum Care				
Assessment of Post-Partum Client				
Contraceptives				
Discussing Family Planning				
Assessment of Newborn				
Infant Behavior, States & Cues				

Experience In This Area Or Working With This Population	Could Mentor Others	Need More Info	Need to Build Skill	Comments
Infant Nutrition				
Breastfeeding				
Newborn Development				
Infant Development				
Toddler Development				
Well Child Care & Immunizations				
Assessing Home Safety				
Environmental Hazards				
Adapting Care for Teen Moms				
Working with Families				
Working with Poverty				
Homelessness				
Community Resources for Clients				
Life Management Skills (e.g., stress management, time management)				
Supporting Client to Complete School Goals				
Career development/Job Skills				
Other Relevant Experience (not mentioned above)				

Are you fluent in languages other than English? Yes _____No ___ If yes, which ones?_____
What experience do you bring from your own cultural/ethnic background?
What experience do you have working with populations/cultures different from your own?
Is there anything else you would like to add about your background that you bring to the team as an asset or area for growth?

Review Part 1 Key Points

For your personal review, write your answers to these questions on a piece of paper.

Take a few minutes to fill out the Skills/Experience Assessment form. After you've completed it, consider these questions:

5. In what areas can you provide support and mentoring to your team members?
6. In what areas do you need your team members' support and mentoring?
7. In what areas do you need further professional development?
8. Take a few minutes to discuss your professional development needs with your supervisor and create a plan to address them.

   What top three priorities regarding knowledge and skills will you need to enhance?

The Skills/Experience Assessment Form highlights clinical skills and knowledge that you will need to meet the clinical needs of your clients. The education for this content is for the most part addressed by you and your team in the form of review, case conferences, mentoring, classes, and other professional development options. The Nurse-Family Partnership education focuses more on model specific content and is expressed in the NFP Path to Nursing Excellence.

Part 2: Introduction to the Nurse-Family Partnership Path to Nursing Excellence

Nurse-Family Partnership education focuses on aspects unique to the NFP model. The desired knowledge and skill is defined in standards and proficiencies that guide the development of NFP education.

Standards provide a framework for assessing and measuring the extent to which someone performs his or her role within a specified program or organization. The NFP Standards describe what is required for an individual to be successful in delivering the NFP model to clients. The professional growth of a NFP nurse is anticipated to develop

over time, resulting in continuous refinement and improvements of their roles. There are six standards for nurse home visitors which align with the American Nurses' Association Standards. Each standard has a set of proficiencies that further define the standards. There are four standards for supervisors that focus on leadership and management.

Notice that each Chapter in the *Unit 1 Workbook* lists the Standards addressed in that chapter. Every workbook chapter, online module, face-to-face session, and all modules in the Team Meeting Education Handbook (TMEH) begin with the Standards and the outcome expectations associated with the content.

You can track and support your professional development in Nurse-Family Partnership by your understanding and application of materials presented during your education experience. Later in this chapter, you will find the Nurse-Family Partnership Standards and their associated Proficiencies. You will see that the proficiencies are organized starting with more basic knowledge and skill to more complex applications. The purpose is to support ongoing learning, provide a tracking system of professional growth, and identify areas for further education.

The Mastery Assessment and Plan (MAP) forms are used by the nurse home visitor and supervisor to assess and reflect on the nurse home visitor's knowledge and skills in implementing the Nurse-Family Partnership model with a client. The majority of information for MAP assessments is gathered during a joint visit. The supervisor may also include observations and insights from her/his experience of the nurse home visitor during case conferences and other interactions. The supervisor provides feedback and support including affirmation of the nurse home visitor's strengths. In addition, the supervisor and nurse home visitor collaborate to determine levels of skill and knowledge, to identify areas for growth, and to develop a plan for professional growth in the Nurse-Family Partnership model. These are an essential component of a Nurse-Family Partnership career development ladder.

In summary, the Nurse-Family Partnership Nursing Standards are linked with specific proficiencies that assess nurses' progress. This helps home visitors and supervisors identify strengths and support professional growth and development in areas that will benefit from improvement, resulting in the continuous refinement and quality improvement of Nurse-Family Partnership role-related performance.

Frequently Asked Questions about Standards and Proficiencies

Why Use Standards of Professional Development?

The Nurse-Family Partnership model of nursing is comprehensive, complex and requires considerable depth of practice skill. Nurse-Family Partnership Standards identify knowledge and skill needed to be successful in delivering the NFP model. They build on the skills of registered nurses.

What are the Nurse-Family Partnership Standards?

The Nurse-Family Partnership Standards are broad descriptions of the performance expected of home visitors and supervisors in their Nurse-Family Partnership clinical practice. These Standards are an expected outcome of the instruction guided by the Nurse-Family Partnership Nursing Education and Consultation Team.

What are the Proficiency Statements?

The proficiency statements are specific descriptions of knowledge, skills, and attitudes that contribute to each Nurse-Family Partnership Standard. When observed in a nurse's practice they are the evidence that the Standard has been met.

What is the Difference between Nurse-Family Partnership Standards and Job Performance?

Job performance is prescribed in a job description by an agency under the terms of employment and is measured using the agency or employer's criteria with the goal of determining pay raises, etc. Nurse-Family Partnership Standards and Proficiencies are used to assess Nurse-Family Partnership nurses' successes and challenges, document and celebrate successes, and guide plans for professional growth.

What are the Advantages of Using Standards for Professional Development over Traditional Assessment Methods?

Traditional assessment approaches rely heavily on testing recall of information, as an indication that the learner has transferred classroom knowledge into the ability to perform a skill. This passively acquired knowledge is often inert knowledge that does not necessarily translate into role proficiency. Standards-based assessment is a behaviorally based method of assessing role performance.

What Is the Nurse-Family Partnership Nurse Home Visitor's Role in Utilizing Standards for Professional Development?

Nurse home visitors are responsible for their own learning with support from supervisors, peers, and the Nurse-Family Partnership National Service Office Nursing team. They are also responsible for providing evidence of progress toward proficiency in the Nurse-Family Partnership model by collaborating with the supervisor on completion of MAPs (Mastery Assessment and Plans).

What is the Nurse Supervisor's Role?

Integral to the Nurse-Family Partnership Standards of Professional Development is a strong relationship between the nurse home visitor and supervisor. Supervisors provide ongoing assessment of the proficiency for their team of nurse home visitors. This includes utilizing the Mastery Assessment and Plan (MAP) form, largely completed following a joint home visit. The supervisor also has the role of identifying resources and support for his/her own professional development and proficiency as a supervisor.

Nurse-Family Partnership Nurse Home Visitor Standards and Proficiencies

Standard 1: Applies Theories and Principles Integral to Implementation of the Nurse-Family Partnership Model

Theory-based nursing practice guides the consistent clinical application of the Nurse-Family Partnership intervention. Three theories anchor the home visiting intervention. Nurse home visitors foster the development of (a) Albert Bandura's Self-Efficacy Theory, (b) John Bowlby's Attachment Theory; and (c) Uri Bronfenbrenner's Human Ecology Theory. The nurse home visitor's attention is focused on the social, emotional, and economic context of her client's life and her activities are based on a sound understanding of human interactions. The five Client-Centered Principles provide a framework for promoting self-efficacy.

Proficiency 1.1 Applies Self-Efficacy Theory to promote client empowerment and growth.
Proficiency 1.2 Uses client-centered principles to engage, retain, and empower client.
Proficiency 1.3 Applies knowledge of Attachment Theory to establish and maintain relationships with clients.
Proficiency 1.4 Applies Attachment Theory to help client demonstrate consistent, responsive, and nurturing caregiving.
Proficiency 1.5 Applies Human Ecology Theory to strengthen client social network and support systems.

Standard 2: Uses Research, Ongoing Quality Improvement, and Reports from Data Systems to Guide and Improve Practice

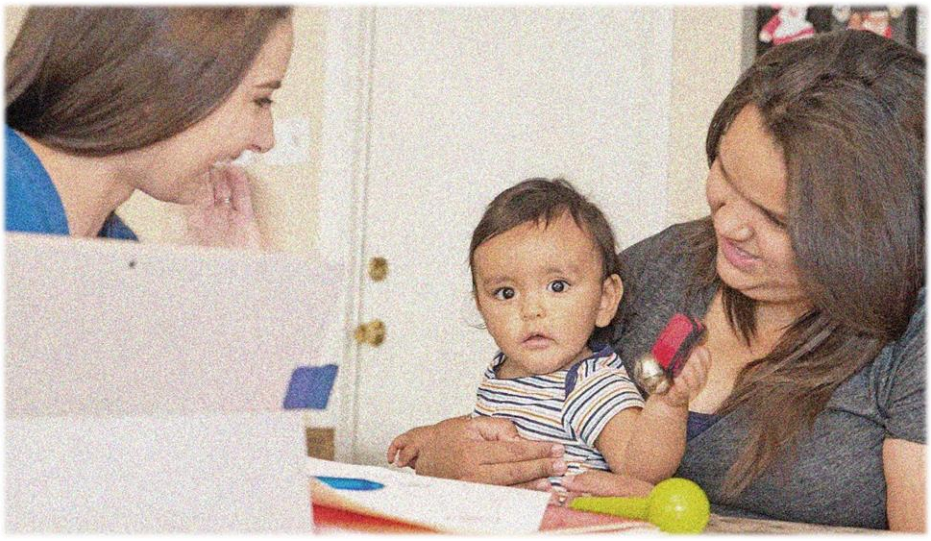
There is a continuous stream of data flowing between the Nurse-Family Partnership National Service Office and Implementing Agencies. Evidence that delivery of the Nurse-Family Partnership model of home visiting has an impact on children, families, and communities is partially determined from this data. Data collected from individual Implementing Agencies are used for program evaluation and quality improvement. The

data collected provides important feedback about achievement of fidelity, gives Implementing Agencies a measure of how they compare with composite (national) Nurse-Family Partnership data, and develops the strength and depth of Nurse-Family Partnership in their community and nationally. When interpreted through Implementing Agency administrators and supervisors, these reports also help home visitors refine their practice.

Proficiency 2.1 Uses appropriate therapeutic communication in gathering information to complete data collection forms.
Proficiency 2.2 Uses clinical judgment and engagement strategies about timing of questions around sensitive issues.
Proficiency 2.3 Uses data to inform nursing assessment and improve client outcomes.
Proficiency 2.4 Uses data to improve individual practice and to set quality improvement goals.
Proficiency 2.5 Practices with fidelity to the Nurse-Family Partnership model elements.

Standard 3: Uses the Nursing Process to Deliver Individualized Client Care and Set Goals Across the Six Domains

Adherence to visit structure, content, and process is crucial to Implementing Agencies achieving fidelity to the model. The Visit-to-Visit eGuidelines describe home visit structure and content which is adjusted to meet individual client needs. Nurse home visitors practice the Nurse-Family Partnership intervention by building on existing nursing skills, particularly psychoeducational approaches to human growth and development.



Supported by the Nurse-Family Partnership Visit Guidance, nurse home visitors conduct comprehensive, strengths-based client assessments and plan interventions with clients across the six domains of the program model: personal health, environmental health, life course development, maternal role, family and friends, and health and human resources. While the guidelines provide ideas for assessment and teaching, nurse home visitors use professional nursing judgment to adapt their approach and materials from the Nurse-Family Partnership Visit-to-Visit eGuidelines for individual client needs and requests.

Proficiency 3.1 Applies critical thinking skills when using the nursing process within the six domains.
Proficiency 3.2 Applies professional clinical nursing judgment and collaborates with the client to individualize the intervention to meet the specific needs of the client and infant.
Proficiency 3.3 Implements the program in a manner that is safe for the client and the child.

Standard 4: Establishes Therapeutic Relationships with Clients

The cornerstone of the nursing process as applied to the Nurse-Family Partnership model is the relationship that develops between the nurse home visitor and the client. Use of the therapeutic relationship as a primary intervention is a distinguishing characteristic of Nurse-Family Partnership. Nurse home visitors build client skills, confidence, and hope through the therapeutic relationship. Nurse home visitors implement the Nurse-Family Partnership home visiting model practice in a paradigm that values their client's ability to determine her own future.

Proficiency 4.1 Demonstrates therapeutic qualities and characteristics. (e.g.: dependability, empathy, trust, respect, professional intimacy, and awareness of power differentials).
Proficiency 4.2 Applies the spirit, principles, and strategies of therapeutic communication to build relationship with client and promote healthy change.
Proficiency 4.3 Identifies challenges to therapeutic nurse-client relationships including boundaries and seeks solutions to resolve them.
Proficiency 4.4 Understands and respects client/family culture, as a foundational element of therapeutic relationship.

Standard 5: Utilizes Reflective Processes to Improve Practice

A reflective nursing practice contributes to sound professional judgments about the client's and child's health, and the home visitor's ability to balance the approach of the Nurse-Family Partnership intervention with the real-world demands of a community

health nursing practice. Together with their supervisors, nurse home visitors determine their own learning needs that contribute to successful outcomes for clients. Clinical supervision using reflection is an important element of the Nurse-Family Partnership program design, providing a critical professional support system for nurse home visitors.

Through reflective supervision and reflective case conferences, individual nurse home visitors are best able to identify gaps in their practice knowledge, ability, and attitudes, particularly as they make a paradigm shift from problem-oriented to client-centered, solution-focused reflective practice. Nurses also partner with their supervisor and colleagues to learn together, gain support, and avoid burnout.

Proficiency 5.1 Understands and applies reflective process to improve practice.
Proficiency 5.2 Recognizes the value of reflective process for personal and professional health to recognize and mitigate the impact of job stress, burnout, and compassion fatigue.
Proficiency 5.3 Uses reflection process to gain insights and to set and accomplish goals to improve practice.

Standard 6: Adheres to Standards of Nursing Practice

Registered nurses are perceived by the public as holding high standards of ethical practice and honesty. In addition, nursing is widely respected as a caring profession with strong academic preparation in the social, life, and caring sciences. This gives Nurse-Family Partnership nurses credibility with families and makes them well-suited as home visitors, welcomed into clients' homes, and in the community.

Proficiency 6.1 Pursues knowledge in maternal-child health and nurse home visitation that reflects most current nursing practice.
Proficiency 6.2 Engages in ethical practice.
Proficiency 6.3 Communicates and collaborates with interdisciplinary healthcare team.
Proficiency 6.4 Demonstrates continuing competency in the nursing role.
Proficiency 6.5 Demonstrates nursing leadership.
Proficiency 6.6 Complies with state and agency nursing legal requirements

Nurse-Family Partnership Supervisor Competencies, Interpretive Statements, and Critical Elements

Standard 1: Provides Administrative Leadership to the Operation and Sustainability of a Nurse-Family Partnership Implementing Agency

Supervisors work within their agencies to assure that the Nurse-Family Partnership intervention is implemented in accordance with the Nurse-Family Partnership Model Elements, the Nurse-Family Partnership Visit-to-Visit eGuidelines, and contract agreements. Nurse supervisors work within their Implementing Agency infrastructure to build Nurse-Family Partnership personnel into a team that successfully delivers the program. Supervisors are liaisons between the Implementing Agency, the community, and the Nurse-Family Partnership National Service Office.

The nurse supervisor facilitates the creation of community interest in Nurse-Family Partnership by establishing partnerships and promoting visibility of the program with the nurse home visitors and others in the agency. The supervisor ensures adequate referrals to help nurse home visitors maintain caseload and fidelity to the Nurse-Family Partnership program. These activities help to assure that the program is appropriately communicated and implemented in the community.

Proficiencies

Builds a Nurse-Family Partnership infrastructure within the supportive structure of the local implementing agency and its service partners.
Collaborates with agency or state administrators to fulfill the terms of the Nurse-Family Partnership contract or agreement.
Builds and sustains public awareness of Nurse-Family Partnership in the community.
Manages the ability of a team of nurse home visitors and non-nursing staff to deliver the Nurse-Family Partnership intervention and collect and submit data.
Assures a physically and emotionally safe work environment for the team.
Ensures that an adequate number of eligible clients are continuously recruited, enrolled, and maintained by home visitors.

Standard 2: Applies Principles of Supervision that Promote the Clinical and Professional Development of All Team Members

A relationship-based approach to supervision is exemplified in the Nurse-Family Partnership model of administrative and clinical supervision. The supervisor is respectful of team members' time, maintains professional boundaries, and utilizes reflection in her/his supervisory practice. The supervisor provides supportive, solution focused, strength based coaching and feedback to nurse home visitors**.**

Proficiencies

Uses a relationship-based approach to supervise a team of nurse home visitors and non-nursing staff.
Uses a reflective practice model to provide clinical supervision to home visitors.

Standard 3: Promotes the home visitors' development of competence to deliver the Nurse-Family Partnership home visiting intervention

While home visitors bring a wide range of clinical expertise to their Nurse-Family Partnership team, they may require assistance assuming the Nurse-Family Partnership community health nursing role. Nurse home visitors may also have learning needs specific to the Nurse-Family Partnership model. These needs are met through instruction and ongoing skill building sessions available from Nurse-Family Partnership National Service Office, peer-to-peer learning, or planned professional development classes both within the Implementing Agency and in the national Nurse-Family Partnership community.

Limitations in the nurse home visitors' clinical experience must be assessed and addressed through educational programs arranged by the supervisor. The supervisor facilitates team activities that catalyze home visitors' practice toward personal and professional expertise and satisfaction.

Proficiencies

Builds home visitors' ability to apply the nursing process, using clinical judgment and standards of nursing practice during delivery of the Nurse-Family Partnership home visiting intervention.
Fosters the integration of theories and principles integral to Nurse-Family Partnership into home visitors' practice.

Coaches home visitors in the application of behavior change strategies that address health promotion and health risks that the client and child may face.
Monitors the use of Nursing Process informing delivery of individualized client care and goal setting across the six domains and supports growth in assessment and interventions in each domain.
Monitors adherence to standards of nursing practice.
Supports the development of home visitors' clinical skill development in the area of maternal and child health, personal health, life course development, following the visit schedule and use of the guidelines.
Guides nurse home visitors' use of data collected via developmental screening tools and observations about mother-child interactions and the child's developmental progress to foster optimum growth and development during the infant and toddler years.
Mentors nurse home visitors' implementation of the PIPE concepts and learning activities.
Mentors nurse home visitors' application of information about maternal and infant regulation.
Develops nurse home visitor expertise in building client self-efficacy in the life course development domain.
Assists nurse home visitors as they develop ability to assess and promote client growth in the maternal role domain.
Supports the nurse home visitor's ability to access community resources for her clients.
Supports the nurse home visitor's ability to identify and develop the client's network of family and friends.
Supports the nurse home visitor as she works with the client to ensure an environment that is safe and conducive to child development.
Promotes the development of therapeutic relationships between nurse home visitors and clients

Standard 4: Implements the Nurse-Family Partnership Program with Fidelity

Fidelity is the extent to which Implementing Agencies deliver the key program components evidenced in the three clinical trials. These components assure that the outcomes achieved by families in the three randomized, clinical trials are also achieved by families who enroll in the program. Supervisors assure that the Implementing Agency demonstrates fidelity to the model guided by the model elements. The model elements provide guidance for quality improvement efforts and long-term targets to achieve over time. Implementing Agency data and reports are provided by the Nurse-Family

Partnership National Service Office. This empowers Implementing Agencies to identify and address local challenges to meeting benchmarks.

Proficiency

Uses evidence, including reports from the Nurse-Family Partnership National Service Office, to guide the continuous quality improvement of nurse home visitors and the agency.
Maintains the integrity of the team's data collection and submission system.
Uses data to monitor agency compliance with Nurse-Family Partnership National Service Office requirements for fidelity.

Review Part 2 Key Points

For your personal review:

1. Re-read the Part 1 Objectives at the beginning of this chapter. Have you accomplished the outcomes? If not, what do you still need?
2. Review all of the Nurse-Family Partnership Standards. In which area you strongest? In what area would you like to improve your skills?

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Chapter 11

Engaging Clients During Enrollment and Visits

Nurse-Family Partnership®
Helping First-Time Parents Succeed

Chapter 11: Engaging Clients During Enrollment and Visits

Purpose

To introduce nurses to Nurse-Family Partnership structure and flexibility that best supports the nurse and client, influences program outcomes, and supports client engagement, enrollment, and retention.

Standards Covered in this Chapter

Nurse Home Visitor

- Applies theories and principles integral to implementation of the NFP Model
- Uses the Nursing Process to deliver individualized client care and set goals across the six domains
- Establishes therapeutic relationships with clients

Nurse Supervisor

- Promotes the home visitor's development of competence to deliver the NFP home visiting intervention
- Implements the NFP program with fidelity to the model

Objectives

- Discover how structure and flexibility are both essential to client recruitment, engagement, and enrollment
- Describe ways to engage a client during the enrollment process
- Describe the value of engaging clients as it relates to client retention

Support Client Engagement, Enrollment, and Retention

High-risk clients may be experiencing unpredictable living situations, have inconsistent parenting figures, physical and mental health challenges, a traumatic childhood, or they may have encountered many other situations that make their lives challenging. These experiences make it difficult to feel safe enough to be fully present, to share their story, to be ready to learn, or be hopeful for the future.

When clients feel **safe and can trust** others, they are more likely to **embrace personal growth and change**. The predictable and respectful structure of NFP helps establish safety and trust between the client and you, the nurse.

Nurse-Family Partnership has built-in features that guide you to support the client in achieving program outcomes:

1. **NFP Visit Schedule**
   The Visit Schedule describes the visit frequency and length depending on the client's phase in the program.
2. **Visit-to-Visit eGuidelines**
   The eGuidelines are designed to support a client's choice and self-efficacy as she sets and achieves goals. The eGuidelines provide useful information and scaffolded learning through handouts and resources the nurse and client can use during facilitated conversations. Individual guidelines documents are often referred to as facilitators.
3. **Home Visit Plan**
   The Home Visit Plan is the high-level outline of how a visit is structured to meet client needs and support her growth.

Together, these elements provide the structure and flexibility you and your client need for your work together in a sometimes-chaotic world.

Each client is unique and has life situations that require flexibility and adaptation. Visits can be adapted to fit the needs of the client. You and the client can agree to:

- The **location of the visit.** This includes the home, client's school, place of work, or a safe or neutral location.
- The **length of the visit**. While we recommend visits be approximately 60 minutes, sometimes clients may prefer shorter visits or, occasionally, need a longer visit.
- The **schedule of visits.** There is a standard schedule during pregnancy and for three months post-partum (also known as the fourth trimester). After this, you will work with your client and use STAR assessment findings to adjust visits as appropriate to meet client needs.
- **Who attends the visits.** Who attends the visit can change frequently depending on how the client wants to involve those closely connected to her and the baby.
- The **content of the visits.** Visit content is adjusted based on nursing assessment and client interest.

Goals are set uniquely to each client's situation, needs, and dreams. One client may have the ability to set many goals and reach them all. Another client may struggle to complete one or two during your entire time together. Goals can be small or large, short or long term.

Program outcomes are the same for each client (self-sufficiency, healthy pregnancy, infant child growth and development) but will look unique to each client. Self-efficacy for a client in a hierarchical system will look very different from a client who is self-determined. Program content can be adapted based on client readiness and interest.

Building the relationship is critical to engaging, enrolling, and retaining clients.

The Prevention Research Center (PRC) at the University of Colorado Denver, conducted a thorough literature review and client discussion groups to discover why clients chose to enter the NFP program, and why clients stay or leave after enrollment. On the next page are some insights discovered from focus groups.

Mahogany & Josiah wi' their NFP nurse Stephanie, NC

Your approach and the client's first impression of you may influence her decision to enroll. Below are engaging approaches that support a client saying **YES!** and less engaging approaches where a client is more likely to say **NO**.

More Engaging	Less Engaging
✓ Meet your client, relax, make eye contact, smile; sit beside or in front of the potential client ✓ **STOP** all the distracting information in your head, **LOOK** at the client, **LISTEN** to what she is saying ✓ Make sure your body language, tone of voice, physical positioning, and personal appearance radiate genuine interest, caring, respect, and unconditional acceptance	× Stand while the client is sitting × Have electronic devices such as tablet, laptop, or phone between you and the client × Focus on devices more than the client × Look busy and preoccupied with the paperwork you need to complete × Appear rushed, distracted, or have time constraints that hinder you from being fully present with the client
✓ Start with a bit of small talk ✓ Develop mutuality by disclosing something minor about yourself that is relevant to the situation and client (this is part of a therapeutic relationship) ✓ Your approach puts the client at ease and shows that you are "genuine" and someone who can be trusted	× Start your conversation by describing the details of the program and how the program or nurse can help the client × Approach this first visit in a businesslike manner
✓ Wear comfortable but professional clothing that fits with the work you are doing and the client's circumstances ✓ Some nurses wear scrubs – this is comfortable and professional attire ✓ Represent to the client that you are approachable, understanding, respectful, and nonjudgmental	× Over dress to the point where the client may feel that you perceive yourself as above her or not comfortable in her environment × Under dress to the point where the client does not feel respected or questions your professionalism
✓ Approach the client with the perspective that you may not know or understand cultural variations, but you are interested in learning and accepting her culture, values, and beliefs ✓ Approach the client from a culturally sensitive perspective knowing that while you may not know or understand cultural variations she employs you are willing to apply the four A's (Acknowledge, Awareness, Ask, Act)	× Explain to the client that you can teach her the right way of doing things × Explain that you and the program can help her learn the right way to do things or how things are done in the US

Think About It…

For your personal review, jot down the answers to the following questions on a piece of paper (you do not need to bring your answers to Unit 2 class).

1. What about the more engaging strategies would you try first and why?

2. What elements of flexibility do you see in this list of the more engaging strategies?

Helpful Things to know about Nurse-Family Partnership

There are two documents that are particularly helpful in engagement. One is a facilitator called “Helpful Things to Know about Nurse-Family Partnership.” The second is the Home Visit Plan, which describes typical elements included in the average 60-minute visit.

First let’s review the “Helpful Things to Know about Nurse-Family Partnership” facilitator (which is included on the next page). This facilitator is used to explain the program to new clients. Some clients will want to see the document and have their own copy, while others will be fine with a conversation about the elements included in the document.

Clients want to know you are interested in them as a person and that you are not just filling out forms, going over procedures, or “teaching” at visits. As you review this facilitator, consider the tips for engaging clients on the previous pages.

To use this facilitator successfully, you will want to:

- ✓ Get to know the information in the facilitator so during your visit you can introduce the information conversationally and elicit client feedback.
- ✓ Understand the schedule during pregnancy and first three postpartum months and why it’s best to maintain this schedule and the flexibility that can be offered in infancy and toddler phases once you know your client and her needs.
- ✓ Use your judgement about how you introduce the duration of the program. You might use a phrase like, “I am available to you until your child is two. You and I can decide what works for you.”
- ✓ Think about the placement of this information in your visit. Remember the tip about having meaningful conversation before introducing too much program information.

If it overwhelms the client, consider not using the facilitator. As you talk together, you or your client can make notes, and she can keep these for future reference or to share with family members who were not able to be present.

> What you have to offer needs to align with the client’s needs first—not the other way around. Clients disengage when they hear, “We can do this for you ...” They engage when they hear, “What are your needs during this stage of your pregnancy...?” People do not feel favorable about being categorized as needing help. Be cautious of the context in which you use the word help.

Helpful things to know about Nurse-Family Partnership

Purpose

- Support you to have a healthy pregnancy
- Support you to have a healthy child
- Support you to find and reach your life's goals

How do Visits Work?

In general, visits take place every other week while you are pregnant. They can be more or less often depending on what you need and want. Once the baby is born and you and the baby are doing well, you may not need visits as often. You and your nurse can work together to come up with a schedule that fits your needs.

Visits usually happen in your home. There may be times you choose to meet at some other location.

Visits usually are about an hour long. Sometimes you may choose more time, sometimes less depending on what you and your nurse want to talk about together.

Responsibilities

Your Nurse Home Visitor will:

- Listen to you and your family, learn about your life and dreams and support you to set goals for your future.
- Provide information and resources to assist you and your baby in areas like your health, baby's growth and development, finding work, going to school and accessing the things you need to have a successful life.

You will:

- Decide who will be present during the visits.
- Set goals for you and your baby.
- Ask for information and resources you are interested in or need for yourself, your family and your baby.
- Celebrate the goals you reach.

Communications

- It's important to have a way for you and your nurse to get touch between visits if you need to change or cancel a visit or when you have questions.
    - Here's how you can reach your nurse: _____
- Visits usually happen in person. However, there may be times when it works better for you to have visits by phone or other technology. You and your nurse can decide together how or when this might work for you.

Additional insights on client engagement:

More Engaging	Less Engaging
✓ Ask the client about her current interests, needs, and what is most important to her during this time in her life ✓ When you fully understand her needs, then share with her what the program can offer that aligns with her specific interests, needs, etc.	× Share with the client everything that NFP can provide to the client and what the program can help her do before learning what she needs and wants × Fail to align the program with her needs and wants
✓ Discuss flexibility in the time visits are offered, location, content—the program is meant to meet the client's needs	× Describe the standard visit schedule as being required with no flexibility
✓ Offer that you (the nurse) are available to the client until the child is two years old ✓ Offer that every few months you will review together what's working and what can improve	× Make it sound like she must make a two-plus year commitment at enrollment
✓ You might need two "enrollment" appointments; a meet and greet where you just spend time getting to know one another and, a second appointment where you can go deeper into how the client's needs and the program align ✓ Offer to contact the client in *X* number of days to see if she is interested in participating in the program and to answer any additional questions she or her family and friends may have	× Push for an immediate enrollment at the first occasion you meet the client × Fail to follow-up as promised
✓ Begin to develop a relationship; obtain only necessary information to reach the client again, such as name and contact information ✓ Use judgement about data to collect; if you collect data, do it in a conversational manner	× Jeopardize the early relationship by filling in too many data collection forms or forms that overwhelm her or are too sensitive this early

More Engaging	Less Engaging
✓ Ask the client what interested her about the program and how she can see its usefulness to her ✓ As part of this conversation, explore what barriers she might have with the program; i.e., schedule, place of visit, who attends, her commitment to the program, others who might need to "approve" for her to be in the program, etc. ✓ Respond to her concerns with thoughtful conversation about how the two of you can address each item	× Explain all the great benefits of the program and that it can help her × Respond to her concerns with descriptions of the benefits of the program instead of listening and finding out what she wants and needs

Think About It …

For your personal review, jot down the answers to the following questions below (you do not need to bring your answers to Unit 2 class).

1. What is the schedule during pregnancy? What type of flexibility can you offer during pregnancy?

2. What do you need to do to make client enrollment conversational, enjoyable, and engaging for both you and the client?

Home Visit Plan

The Home Visit Plan is intended to give guidance to elements typical in every visit. This document is for the nurse to use when planning visits. A copy of the Home Visit Plan is included at the end of this section.

Clients benefit when there is a certain predictability to the visits and yet the visits are still client centered in their content.

This standardization in visits also helps the nurse to set and maintain boundaries that help to focus on goals and program outcomes while still providing a client centric approach.

The Home Visit Plan has six elements, but the order may not always look like this:

1. **G**reeting
2. **I**ssues/Concerns
3. **R**eview and Report
4. **A**ssessment
5. **P**lanned Topics: Program Topics and Client Topics
6. **P**lanning and Goal Setting

We call this **GIRAPP.**

While NFP has provided guidance around visit structure, you have the flexibility of deciding where you will place your emphasis on any visit based on your nursing clinical judgement.

Greeting

Greetings are important. They can set the tone and mood for the rest of the time together. A greeting can help both you and the client feel relaxed, establish who might be involved in the visit, and even set boundaries around distractions.

Consider your client's perspective. We typically only invite family and friends into our homes. Other people who visit our clients may be perceived as judging or prying.

Consider ethnic and religious beliefs, values of the community you serve and how those values and beliefs will impact your relationship with your client. These are keys to client engagement and retention.

Before you go to your client's home, some questions to consider are:

- What is the makeup of this family, what do they value, and how will they know that I respect them?
- Which cues help me know what values are important to this family?
- What strategies help me greet my clients in a way that helps them feel valued, respected, and important?
- How comfortable is this family with people in their home?
- What cultural norms should I be aware of? For instance, does eye contact mean that I care or is it considered disrespectful? Do I take my shoes off? Are there other expectations?

Think About It…

Consider your personal self in this equation. If you are feeling low-energy, distracted, or not comfortable in this home, how might that come across?

How can you show your sincere interest in your client and be emotionally present even when you're experiencing personal distractions?

Issues and Concerns

Identify concerns that are on your client's mind. When your client presents an issue or concern, you will need to decide two things:

1. Does your client need assistance to solve the problem or just a caring listener?
2. Does this concern require immediate attention?

The best way to know this is to ASK. You might say something like, "You've shared a lot with me about what has happened since the last time we met. Let me make sure I got it all." (Summarize what you heard.) "I'm wondering if you would like to talk about one or two of these concerns now, or if you just needed to get it off your mind and want to move on to what we planned to do for this visit? You let me know what you need most right now."

Think About It…

Reflect on your own experience. How well do you focus on learning when you are worried about something? What would happen if you had an upsetting situation, and had no opportunity to discuss it?

Review and Report

You and your client will review progress since the last visit. This could be progress around a specific goal, feedback on a facilitator you had left for her review or follow-up on a PIPE activity.

You might hear this information during the greeting or issues and concerns. These elements aren't sequential or as finite as this list. As the conversation progresses, you'll elicit and discover the elements in a natural conversational flow.

When your client has successfully completed a task or achieved a goal, provide positive feedback of her achievements. Acknowledge your client's small steps. Work with her to evaluate and revise her plan if needed.

Assessment

In the past you may have assessed using a head-to-toe or systems approach. In NFP we assess through the six domains. This ties to the Strengths and Risks Framework (STAR Framework) and is the first step in the nursing process. Chapter 5 talks about the domains in detail.

Within each domain, you'll do a systematic assessment of the status of your client and her infant specific to the developmental stage of pregnancy, infancy, or toddlerhood. You will also want to do a physical assessment at each visit, such as checking the blood pressure and weight of a pregnant client, as well as length, weight, and head circumference of the baby. Many agencies have physical assessment forms to use along with what you document in your chart and in the STAR Framework documents. The STAR Framework will provide guidance and organize your comprehensive assessments. You will learn more about STAR at Unit 2.

Planned Topics

Both the nurse and the client have an opportunity to choose topics. The program, or nurse topic, will be based on your assessment. The client topic will be based on the client's interest and readiness to engage in the topic discussion.

Program Topic

The Visit Guidance posted on the eGuidelines website indicates some important topics to address in each phase. Additional topics will be determined by nurse assessment.

Client Topic

The Client chooses this topic. Often, you'll know what your client is interested in through your conversations as she provides cues about what is important to her. There are also some strategies to elicit client choice in the Visit-to-Visit Guidelines chapter

Whether you're presenting a program or client topic, you have options about how to present or chat about the topic. Options can include:

- Using a facilitator to get the conversation started.
- Showing a video from a recognized professional website.
- Use a PIPE activity or a teaching box.
- Use your imagination and ideas from other nurses on your team. Even knitting or discussing the use of public transportation are great avenues for learning and discussion.

Any combination of the above and anything else your imagination contributes!
You may not have time to do two topics at every visit depending on other elements and the time they take. Use your nursing judgement and assess your client's cues so you don't overload her with information.

Facilitators are designed to facilitate an intentional conversation to meet a client need; they are not handouts that are just given to a client.

Planning and Goal Setting

The purpose of this segment is to bring together all that has been done during the visit and agree on what will be done between visits. On the Home Visit Form (see the visit guidelines chapter later in the workbook), the client records what she will do before the next visit and what topic she has chosen for the next visit. The nurse home visitor also writes down what she will do between visits.

You can summarize the high points of the visit, paying particular attention to what your client has already done to set her own goals or overcome barriers to the realizations of those goals. On this form, include an affirmation of what the client accomplished.

This segment also focuses on setting long- and short-term goals. You will support your client in identifying these goals. One way is to remember to set SMART goals, developed by Paul J. Meyer (as cited by Reed, 2004). Set goals that are **S**pecific, **M**easurable, **A**chievable, **R**ealistic and **T**ime-bound.

Ideally, planning and goal setting happened during the discussion of content, and you are only documenting what you've already agreed on during earlier in your discussion.

To Sum Up…

Client engagement and retention is the key to lasting success as clients strive to succeed in their goals and outcomes.

Clients must be engaged to want to enroll in the program.

Engagement is a continual process that leads to retention.

Home Visit Plan

Visit length: 1 – 1 ½ hours

Greeting

- Hello!
- Where will the visit take place today?
- Who will participate in the visit today?

Issues/Concerns

- Has anything changed since we last saw each other? Do we need to talk about it today?
- Re-establish the agenda for today's visit. Reflect on current concerns, questions, goals and plans from the last visit.

Review and Report

- How did plans from the last visit work out?

Assessment

- How are you and your family and baby doing?
- This includes:
    - Health (physical and mental)
    - Relationships
    - Home, school, work

Planned Topics

- Topic chosen from client menu
- Program topic

Planning and Goal Setting

- Bring together all that we have done during this visit
- Agree on what will be done between visits. Client chooses a topic from the menu for the next visit. On the Home Visit Form, the client records what she will do between visits and what topic she has chosen for the next visit. The Nurse Home Visitor also writes what she will do between visits on the Home Visit Form. The Nurse Home Visitor briefly introduces the program topic for the next visit.

Practice Recalling What You Learned

For your personal review, write the answers to the following questions (you do not need to bring these answers to Unit 2).

1. How can visits be both structured and flexible?

2. How is the “Helpful Things to Know About Nurse-Family Partnership” facilitator used?

3. What are the six elements of the Home Visit Plan?

4. True or false? You must use a facilitator at every visit.

5. What are two ways nurses can express genuine interest in their clients?

(Answers can be found on the next page)

How Did You Do?

Answers to the Review Questions

1. The nurse and the client can agree on almost any factor of the visit (e.g., place, length of visit, content), which allows visits to be both structured and flexible.

2. The Helpful Things to Know About Nurse-Family Partnership facilitator describes for the client what is typical for a visit; i.e., place, time, and length of visit. However, because there is so much flexibility built into the program, it is best to have this discussion in a conversational way and possibly have the nurse or the client write out what they understand about the program rather than just going over the facilitator.

3. The six elements of the home visit plan are GIRAPP: **G**oals/objectives, **I**ssues and concerns, **R**eview and report, **A**ssessment, **P**lanned topics, and **P**lanning and goal setting.

4. False. Facilitators are meant to start a conversation and are not the only strategies for learning.

5. Two ways nurses can express genuine interest in their clients are seeking to understand them and knowing their wants and needs. (See the insights from the literature review and discussion groups for more ideas.)

Chapter 12

Data in a Client-Centered World

Nurse-Family Partnership
Helping First-Time Parents Succeed

Chapter 12: Data in a Client-Centered World

Purpose

The purpose of this chapter is to introduce you to the forms used most frequently in NFP practice. These forms are the basis of data collection in NFP. Data collection has three goals:

1. To increase the probability that both clients and NFP teams will reach program outcomes
2. To assist nurses in client engagement
3. To deepen insight into the client's story—both the history of that story, and the future of that story.

Knowing our client's story allows us to gear the intervention to the specific needs of each client, set goals with the client that are meaningful and timely, and develop client self-efficacy in reaching those goals by utilizing the client's strengths to overcome her challenges. This leads to clients experiencing higher satisfaction with the NFP program and directly impacts higher client retention.

Standards Covered in this Chapter

Nurse Home Visitor

- Uses research, ongoing quality improvement, and reports from data systems to guide and improve practice.

Nurse Supervisor

- Provides administrative leadership for operations and sustainability of the program.
- Implements the NFP program with fidelity.

Objectives

- Identify forms used at every visit, those used at certain time points and those that are part of larger frameworks
- Familiarize yourself with the NFP Data Collection Manual and data collection process to guide completion of the NFP data collection forms
- Describe benefits of data collection in fidelity with the NFP model
- Explore strategies for addressing challenges that may arise in gathering data
- Use a practice scenario to complete some key forms

Become familiar with your forms

Forms Used at Every Visit

Home Visit Form
Encounter Form

Forms Used at Specific Time Points

Maternal Health Assessment: Pregnancy Intake
Demographics – Pregnancy Intake & Update
Health Habits
Clinical IPV Assessment
GAD-7 & PHQ-9
Use of Government & Community Services

Forms That Are Part of Living Documents

STAR Coding Sheet(s) – the documentation component of STAR Framework

Value of NFP Data Collection

As a nurse home visitor, you'll complete many forms during home visits. You'll collect information about the services you are providing and the status of your moms and babies. You'll be able to run reports on the data entered to see improvements in your clients and their babies.

The following document, "Overview of Data Collection Forms used by Nurse Home Visitors," gives you an at-a-glance view of forms that are essential in NFP. These same forms have been used throughout program implementation and provide essential guidance to nurses and teams. These forms are essential elements in building the relationship between you and your client. They provide key insights that give you a fuller picture of

- Your client's strengths
- Her networks of support
- Her knowledge about herself and about her world
- Key areas of risks and insight into her stage of change in relation to her goals

Data allows you to tailor your intervention to each individual client.
Data tells her personal story; past, present and future.

Take a look at the overview of forms used in NFP. Familiarize yourself with this document.

Overview of Data Collection Forms Used by Nurse Home Visitors

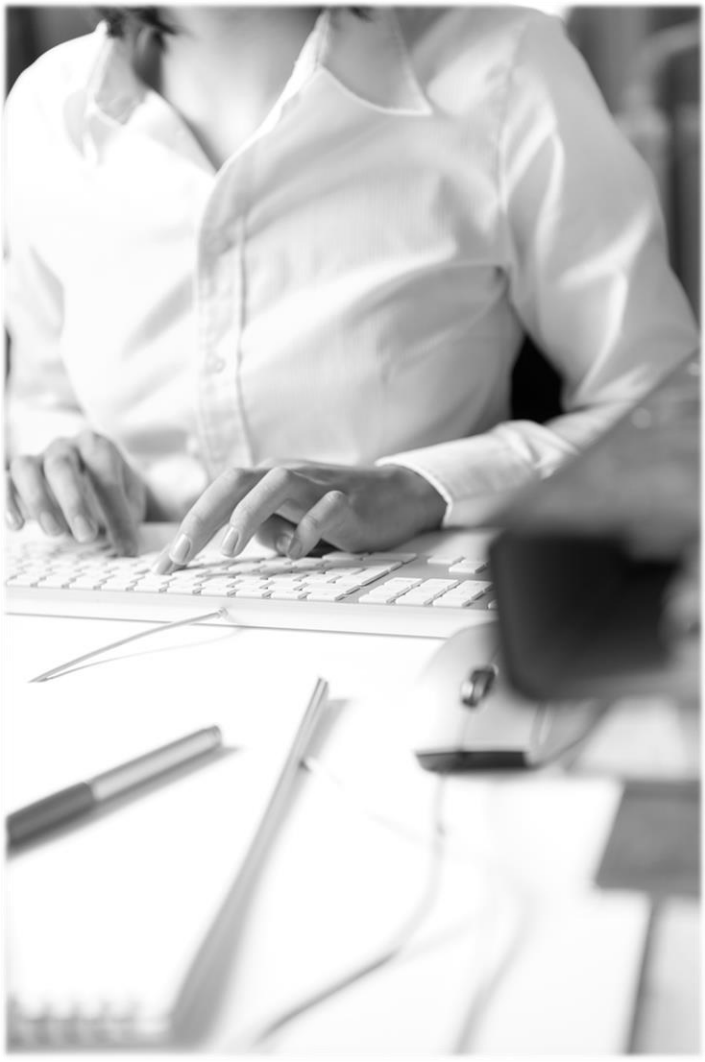
(Effective July 1, 2012)

Phase	Form	Data Entry
All Phases		
	Encounter	Every encounter
	Referral to Services	Every encounter when indicated
	Health Care Services	Every encounter when indicated AND at child's age 6,12,18, and 24 months
	STAR Framework: - STAR guides nursing assessment and planning each visit. The summation for data entry occurs as noted below	See Summary data entry time points below
Referral and Enrollment		
The forms below are completed before and shortly after enrolling in NFP		
Pre-Enrollment	Referral to NFP Program	Pre-enrollment
Enrollment	Client Funding Source	On date of enrollment, following agency protocol
Pregnancy		
The forms below should be completed during the first five visits. The goal over the first few visits is to gain an understanding of her needs and to begin to build a connected, trusted relationship. Nurses are expected to apply nursing judgment regarding sensitive questions.		
Initial Visits		
	Demographics: Pregnancy — Intake	1st — 5th visit, as early as possible
	Maternal Health Assessment	1st — 5th visit
	Use of Government & Community Services	1st — 5th visit
	STAR Framework - STAR guides nursing assessment and planning each visit, summation for data entry occurs within the first 5 visits.	1st — 5th visit
	Health Habits	1st — 5th visit
	Generalized Anxiety Disorder — 7 (GAD — 7)	1st — 5th visit*

	Edinburgh Postnatal Depression Scale (EPDS) OR Patient Health Questionnaire-9 (PHQ-9). PHQ-9 is encouraged.	1st — 5th visit*
	Clinical IPV Assessment- Should not be completed prior to 5th visit	5th — 7th visit* *Should NOT be completed prior to 5th visit.*
End of Pregnancy		
	Health Habits	36 weeks pregnancy
	Edinburgh Postnatal Depression Scale (EPDS) OR Patient Health Questionnaire-9 (PHQ-9)	36 weeks pregnancy*
	STAR Framework- STAR guides nursing assessment and planning each visit, summation for data entry occurs at end of pregnancy.	36 weeks pregnancy
	Generalized Anxiety Disorder — 7 (GAD — 7)	36 weeks pregnancy*
Infancy		
	Infant Birth	1st postpartum visit
	Use of Government & Community Services	1st postpartum visit
	Edinburgh Postnatal Depression Scale (EPDS) OR Patient Health Questionnaire-9 (PHQ-9)	1 — 8 weeks postpartum*
	Generalized Anxiety Disorder — 7 (GAD — 7)	1 — 8 weeks postpartum*
	STAR Framework: STAR guides nursing assessment and planning each visit, the summation for data entry occurs in the around 8 weeks postpartum.	8 weeks
	DANCE	1 — 3 months
	Clinical IPV Assessment	3 months*
	ASQ-3	4 months*
	Edinburgh Postnatal Depression Scale OR Patient Health Questionnaire-9	4 — 6 months*
	Generalized Anxiety Disorder — 7 (GAD — 7)	4 — 6 months*
	Infant Health Care (ASQ-SE2)	6 months
	Health Care Services	6 months
	Demographics Update	6 months
	Use of Government & Community Services	6 months
	DANCE	8 — 10 months
	ASQ -3	10 months*

	Infant Health Care (ASQ-SE2)	12 months
	Health Care Services	12 months
	Demographics Update	12 months
	Use of Government & Community Services	12 months
	Health Habits	12 months
	Edinburgh Postnatal Depression Scale OR Patient Health Questionnaire-9	12 months*
	STAR Framework: STAR guides nursing assessment and planning each visit, summation for data entry occurs near the child's 1st birthday.	12 months
	Generalized Anxiety Disorder — 7 (GAD — 7)	12 months*
Toddler		
	DANCE	15 — 17 months
	Clinical IPV Assessment	16 months*
	Infant Health Care (ASQ-SE2)	18 months
	Health Care Services	18 months
	Demographics Update	18 months
	Use of Government & Community Services	18 months
	STAR Framework: STAR guides nursing assessment and planning each visit, summation for data entry occurs around the time the child is 18 months old.	18 months
	DANCE	21 — 23 months
	ASQ (ASQ-3) - optional	24 months*
	Infant Health Care Form ASQ-SE2	24 months
	Health Care Services	24 months
	Demographics Update	24 months
	Use of Government & Community Services	24 months
	H.O.M.E. Inventory —**Only** if required by funder: not required by NFP-NSO	Child aged 6 and 18 months
	*In addition to the required collection time points, the EDPS, PHQ-9, GAD-7, Clinical IPV, ASQ-3, and ASQ-SE2 may be repeated as indicated by nursing judgment	

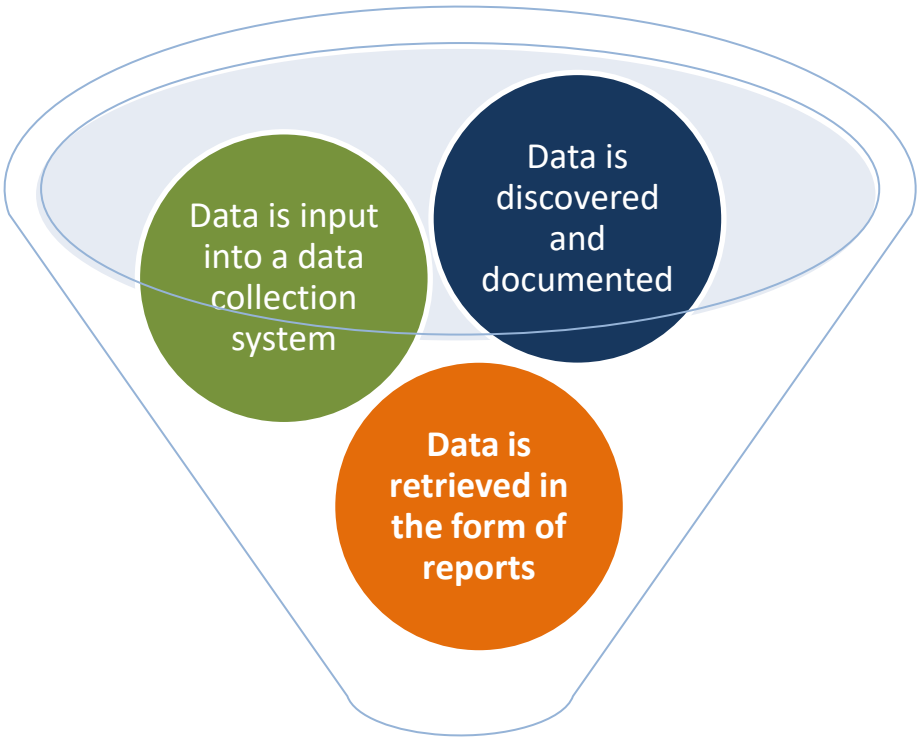
Discharge		
	Client Dismissal	On completion of NFP or date of discharge or transfer.
Supervisor Responsibility Data		
	1:1 clinical supervision: at every reflective supervision	Weekly
	Team Meeting and Case Conference	Weekly
	MAPS: 4 months after 1st client enrollment and every 4 months thereafter	Every 4 months following the first home visit
	Community Advisory Board (CAB) Meeting	4 times per year



Process of Data Collection

NFP nurse home visitors conduct comprehensive assessments, collect information about the services you provide, and note what is happening with their clients and their babies—both progress and challenges.

The NFP National Service Office (NFP NSO) refers to the many pieces of information you collect as data. After you collect data, a designated person at your Implementing Agency enters the data into a web-based database. From this input, nurses and supervisors are able to extract reports that show a variety of progress points against program outcomes.



All data is information that is used to guide practice and create or update your plan of care.

Data collection is integral to your everyday practice. We've already shared how data informs the picture you have of your client and provides you with key information to tailor your delivery of the intervention to a client's specific needs. Data can also:

- Monitor program performance and effectiveness
- Improve overall service delivery
- Help nurse home visitors bring up sensitive issues with a client
- Supplement clinical assessment
- Provide documentation of services received by clients enrolled in the program
- Assist administrators and program staff in tracking families' progress in attaining program goals
- Help supervisors and nurse home visitors identify caseload issues
- Help supervisors and nurse home visitors identify and address professional development needs
- Enhance funding opportunities for your program

The NFP data collection forms cannot substitute for certain requirements your state or local agency or funders may have. Check with your agency to determine what other assessments you may need to do along with the NFP forms.

Using the NFP Data Collection Manual

The NFP Data Collection Manual contains all the NFP forms you will need to gather information as you work with clients. Detailed guidance for completing each form can be found in this manual.

> Go to the NFP Community and download the Guidance for all Forms as of June 2018 Manual. You will be using it for the rest of this chapter: http://community.nursefamilypartnership.org/Tech-Updates/New-Data-Collection-System

In the NFP Data Collection Manual, use the Table of Contents to find the following items. Read each one before going to the next form. Note that detailed instructions are included for each form.

- The Demographics: Pregnancy Intake & Update
- Clinical IPV Assessment
- Health Habits
- Encounter
- Maternal Health Assessment
- STAR Coding Sheet

In addition to the forms in this manual there is one other form you'll need to complete this chapter. Ask one of your teammates or your supervisor for the *Home Visit Form*. Take a look at it. Is it in duplicate or triplicate? Ask your team member why it's created

this way and how this form is used to help set goals for each visit, provide accountability for the nurse and client, and set some useful reminders for you and your client.

Think About It…

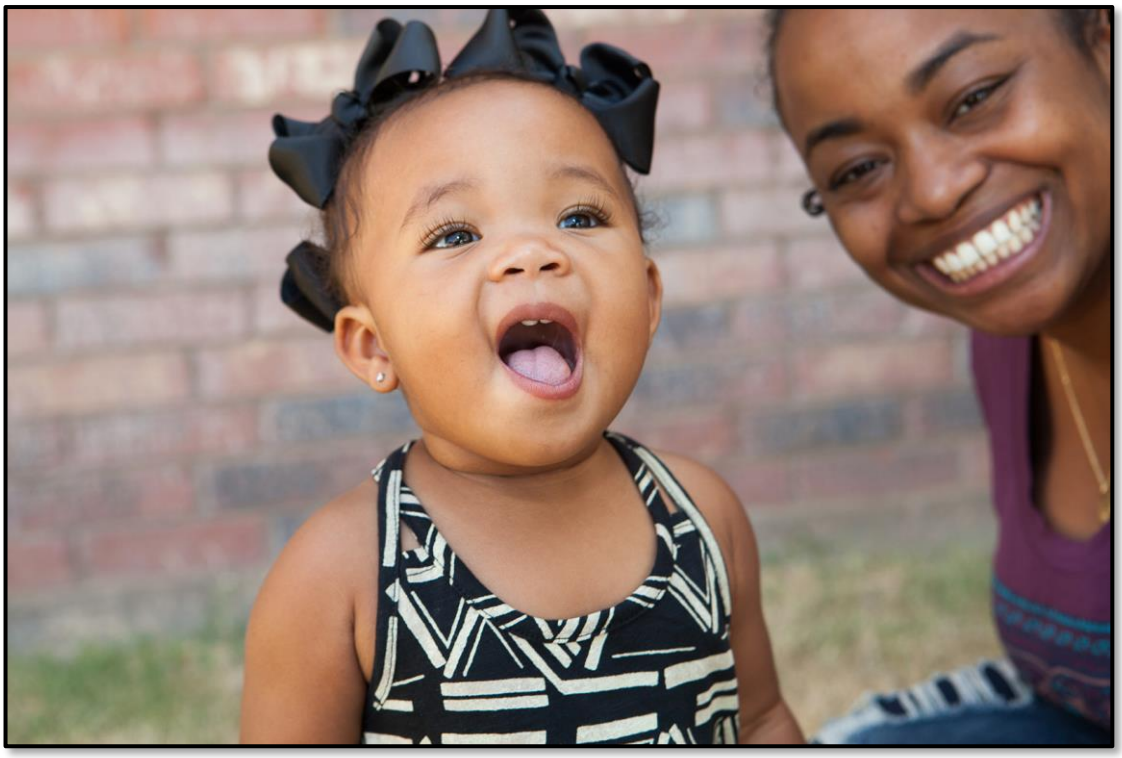
Agencies that provide this form in triplicate give one copy to the client (usually the first copy), place one copy in the travel chart, and one copy in the office chart.

Find out the process your team uses with the Home Visit Form.

Fun Facts Hunt

Following is a Fun Facts Hunt that will help you build familiarity with the forms.

Let's have some fun!



Essential Forms Used in visits

★Activity: Fun Hunt for Forms

Write down the answers to these questions on a piece of paper. Your answers are for your review and do not need to be brought to Unit 2 or submitted to NFP NSO. After you answer the questions, click here to check your answers at the end of this chapter.

1. Find the **Encounter Form** in Guidance for All Forms and compare it to a **Home Visit Form.** Although these forms have similar names, they are not the same and are used for different purposes.

   A. Which form is the NFP data collection form?
   B. On which form do you record the amount of time spent in each program area (domain)?
   C. Which form is used to set goals, provide feedback, and make plans for the next visit?
   D. Which of these forms should be completed for every visit?

2. There are three forms used to collect clinical data: **Maternal Health Assessment** , **Demographics: Intake**, and **Health Habits**.

   What is the time frame for doing these forms with your client?

3. **The Demographics: Intake Form** asks questions around race, ethnicity, and ancestry.

   In your own words, how would you explain to your client the need to ask these questions? How would you ask them in a way that minimizes any offense the client might feel when being asked these questions?

4. Review the **Health Habits** and **Clinical IPV Assessment** form.

   A. These forms deal with sensitive subjects. What are some ways you can address these difficult topics without creating distress for your client?
   B. What does the guidance recommend about when to complete the Health Habits and the Clinical IPV Assessment?

5. Suzie just completed the 12-month **Health Habits** form with Bianca, a 17-year-old client who lives with her boyfriend and his parents. Suzie asked question number 5: "Over the past 14 days, on how many different days did you use alcohol?" Bianca stated that she drinks beer with her boyfriend and his parents every weekend.

A. What domain(s) does this assessment form relate to?
B. What are two things you learned about Bianca reading this short paragraph?
C. What do you want to know more about?

Benefits of Data Collection

Think about it…

From what you've read so far, jot down four benefits you've discovered about data and how it's used to benefit the nurse and/or the client.

Click here to see a few examples of data benefits

In reaching program outcomes we provide the possibility of our clients changing their lives for good – and their babies' lives for good – and their babies' lives for good . . .

Take a few minutes to read the **Maternal Health Assessment** form and instructions in the NFP Data Collection Manual.

Think about it…

What information is missing that you would need to assess in your clients during pregnancy?

Nursing Assessment Forms and NFP Data Collection Forms

The **Maternal Health Assessment** is not comprehensive and is an example of where your agency may require more detailed information. The primary difference between a nursing assessment form and an NFP data collection form is the purpose and focus of each.

A nursing assessment form may focus on the physical, cognitive, or psychosocial health and status of a client with the purpose of intervening through education and referrals. It may also focus on issues such as the environmental health or social support network of a client for the same purpose of providing appropriate interventions.

The purpose of NFP data collection form is to support your professional practice and acquire quality improvement information about progress toward the client and agency goals.

Information from both types of forms provides insight that informs your overall client assessment and plan of care, and is noted on the Strengths and Risks Assessment (STAR) Coding sheet you create for each client.

Confidentiality: When talking with your clients, you will need to let them know that you are collecting information about the services you are providing and how the client is doing over time. This data is not used in research and is held in confidence in the data system. The data system uses anonymous client ID numbers in place of names as part of maintaining confidentiality. Just like we would protect her information at a clinic or doctor's office, in NFP the client's information is private.

Addressing Sensitive Issues with Clients

As health care providers we've all had to address sensitive issues. Home visiting can make this a different experience, particularly as nurses begin delivering this intervention with varying backgrounds and clinical experiences.

Depending on your professional background, you may feel quite comfortable with the assessments and interventions you'll be conducting. However, the frequency of visits, the intensity of the relationship, and the fact that you are entering a client's home rather than working in a clinical setting can sometimes cause a sense of discomfort about addressing issues.

Let's consider some data collection items that provide opportunities to discuss sensitive topics. One example is the Demographics form where we discuss finances.

Look at the Demographics form excerpt provided in this workbook. This portion lists questions around work, school and income. The questions do not have to be read out loud or in order, asked in the same way as they are worded on the form or asked in the same order they are on the form.

You can personalize your delivery of this form in any way that works best for you and your client.

Think about it…

Jot down your thoughts and responses to these questions on a piece of paper. This is for your personal review and does not need to be brought to Unit 2.

Why might it be essential to know education, work, and financial information about your client?

How might you explain the need to ask these questions?

How would you introduce these questions to your client?

Click here to see some ideas on answers to these questions

Excerpt from Demographics Form – Finances

1. ♦Have you completed high school, GED, vocational/certification, and/or higher educational programs (check all that apply)?
   - ☐ Yes
     - ☐ High school
     - ☐ GED
     - ☐ Vocational/certification/technical training program
     - ☐ Some college (no degree)
     - ☐ Associate's degree
     - ☐ Bachelor's degree
     - ☐ Master's degree
     - ☐ Professional degree (for example: LLB, LD, MD, DDS)
     - ☐ Doctorate degree (for example: PhD, EdD)
     - ☐ Non-US based post primary education
   - ☐ No. What is the last grade you have completed? ☐ grade

2. ♦Do you **have a** plan to enroll in any ***additional*** kind of school, vocational, certification or educational program?
   - ☐ Yes
   - ☐ No

3. ♦Are you currently working?
   - ☐ Yes
     - ☐ Full-time: 37+ hours per week
     - ☐ Part-time
       - ☐ 20 – 36 hours per week
       - ☐ 10 – 19 hours per week
       - ☐ less than 10 hours per week
   - ☐ No
     - ☐ Unemployed and seeking employment
     - ☐ Not employed (student, homemaker, other)

4. ♦Which of the following categories best describes your total yearly household income and types of benefits you receive? Include your income and any other income you may have received. For the purpose of this question, the household should include only you and your child. Remember that this information will be kept private and will not affect your access to services (Use public assistance programs that are for low-income families as a marker if the client does not know and she qualifies or receives a public assistance program).

   - ☐ Less than or equal to $6,000
   - ☐ $6,001 - $9,000
   - ☐ $9,001 - $12,000
   - ☐ $12,001 - $16,000
   - ☐ $16,001 - $20,000
   - ☐ $20,001 - $30,000
   - ☐ Over $30,000

Another potentially sensitive topic is the birth control method your client uses or plans to use in family planning. The **Demographics: Update** form is completed every six months after delivery. While you may discuss family planning during pregnancy, data on family planning is first collected when you complete the **Demographics: Update** form with a client whose infant is six months old.

We know that our high-risk clients can change their minds or experience life circumstances that change their thoughts on family planning. Sometimes clients might answer questions in a way that will please you but not necessarily in a way she intends to proceed. Following is an excerpt from the **Demographics: Update** form.

Excerpt from Demographics Update Form – Birth Control

Birth Control and Additional Pregnancies

13. ♦In the last 6 months, have you been using any form of birth control?
- ☐ Yes. If yes, please indicate the reason.
  - ☐ To prevent another pregnancy
  - ☐ Other reasons
- ☐ No. If no, do any of the following apply? (Check all that apply and skip to 16)
  - ☐ Female partner
  - ☐ Plan to become pregnant
  - ☐ Currently pregnant
  - ☐ Not sexually active

14. Please tell me all the different types of birth control you have used in the last six months. Mark all that apply.
- ☐ Male condom (rubbers)
- ☐ Natural family planning (rhythm method)
- ☐ Spermicides/jelly/foam/cream/suppositories/vcf
- ☐ Diaphragm/Cervical cap/Sponge
- ☐ Withdrawing (pulling out before coming)
- ☐ Birth control pills
- ☐ Patch
- ☐ Cervical ring
- ☐ Quarterly birth control shot (Depo-Provera)
- ☐ Monthly birth control shot (Lunelle)
- ☐ IUD
- ☐ Emergency contraception
- ☐ Female Condom
- ☐ Birth Control Implant
- ☐ Tubal ligation or hysterectomy
- ☐ Partner has a vasectomy
- ☐ Practicing abstinence
- ☐ Other (please specify) _____

15. Thinking about all the times you've had sexual intercourse in the last six months, about how often did you use birth control?
- ☐ Some of the time
- ☐ About half the time
- ☐ Most of the time
- ☐ Every time

16. Do you plan to use birth control in the next six months?

- ☐ Yes. If yes, please indicate the reason.
  - ☐ To prevent another pregnancy
  - ☐ Other reasons

Please indicate the different types you plan to use (Please check all that apply).

- ☐ Male condom (rubbers)
- ☐ Natural family planning (rhythm method)
- ☐ Spermicides/jelly/foam/cream/suppositories/vcf
- ☐ Diaphragm/Cervical cap/Sponge
- ☐ Withdrawing (pulling out before coming)
- ☐ Birth control pills
- ☐ Patch
- ☐ Cervical ring
- ☐ Quarterly birth control shot (Depo-Provera)
- ☐ Monthly birth control shot (Lunelle)
- ☐ IUD
- ☐ Emergency contraception
- ☐ Female Condom
- ☐ Birth Control Implant
- ☐ Tubal ligation or hysterectomy
- ☐ Partner has a vasectomy
- ☐ Practicing abstinence
- ☐ Other (please specify) _____
- ☐ None

☐ No. If no, do any of the following apply? (Check all that apply)

- ☐ Female partner
- ☐ Plan to become pregnant
- ☐ Currently pregnant
- ☐ Not sexually active

Below are some challenges nurses often face when talking about family planning. Think about how you could address these challenges with a client.

Challenges to Collecting Data on *Demographics Update* Form	Ideas for Addressing the Challenges
A client has a partner or family member who is opposed to family planning because this baby needs a sibling close in age.	
A client is a first-generation immigrant. The nurse learns that the client is using an herbal remedy from her native country as her means of family planning.	
When asked by her nurse, a client states that her partner uses a condom "once in a while." Besides she is breast feeding and cannot get pregnant.	
A 15-year-old client is sexually active and is not using birth control. Her mother is present for all of the home visits but isn't aware her daughter is still sexually active. The client shared this information during a visit that took place at the client's school.	
A client has a baby that is about 8 months old and shares that she thinks she is pregnant again.	

Print out this page, and write down your ideas. Then talk with a team member or your nurse supervisor about the ideas you have. See what ideas they have and compare your insights. (*Note: this does not need to be brought to Unit 2 or submitted to NFP NSO.)*

As you become more familiar with forms you will find these conversations can occur quite naturally, and the form may not ever appear at the visit! Here is an example of how a conversation can occur around family planning. The form isn't visible or around, but the nurse can make a note of the client's answers and fill out the form after the visit.

Nurse: While you were pregnant with Jason and after he was born, we talked about different forms of birth control you could use and how you felt about each. The last time we talked about it, you were using the pill. Now Jason is six months old. I'm wondering if the pill still seems like the right method for you.

Client: I'm using the pill but it's not working for me. I didn't want Depo because of getting fat but I'm getting fat on these stupid pills. And sometimes I forget to take them with me when I stay with John at his apartment. I guess I use them most of the time.

Think about it…

Knowing the questions on the form is useful in starting the conversation. With this one reflection, you know that your client is inconsistently using the pill, has considered other options, is worried about weight gain, and is sexually active. You also know she probably does not want to be pregnant again, or she wouldn't have started using the pill. However, it is not working as well for her as she hoped.

Remember that the form is not just to collect data – but to learn your client's story and decide how you want to tailor the intervention for your particular client.

How might you continue this conversation? Write down some ideas and chat with your supervisor as follow up on this activity.

Another sensitive issue you will face with your clients is intimate partner violence (IPV). The Clinical **IPV Assessment** will help open the discussion on this topic. But it might need some client-centered conversation before the form is introduced. Read the form and instructions and then answer the question in the "think about it" section.

Go to the Guidance for All Forms and review the **IPV Assessment** and instructions.

Think about it…

Each client is unique. It is suggested that this form be done in a conversational style. After reading the instructions consider how you will approach gathering information about intimate partner violence with your client.

How might the tone of your voice or your body language alter the client responses when you are conversing?

How will you know whether to score the form and provide feedback then and there or wait to score it later and save feedback for another visit?

What items would you want to address during the visit even if you didn't score the form?

What other items do you want to consider as you learn more about how this form is introduced and used in NFP?

Following is an example that shows one way this conversation might go.

Emily, an NFP nurse home visitor, is planning on making her seventh visit to Angela, a client with whom she has established a good relationship. To prepare for completing the Clinical **IPV Assessment**, Emily read the instructions in the Guidance for All Forms and made a mental note to discuss this form with her client in private. At an earlier visit, Emily addressed briefly what confidentiality means and knows her state laws regarding mandated reporting. She does not have to report IPV in her state, so she does not plan to bring up anything else about mandated reporting at this time. Emily plans to do the

IPV form as her program topic after she and Angela talk about the client topic chosen by Angela last week, “Baby Needs Checklist.”

Nurse Emily: Angela, it sounds like you have already thought about some of the things you need for the baby. I’m going to leave this handout with you, and you can use it as you keep gathering items you want for the baby. Check off items as you get them and let me know if you need help with any resources for items you can’t find. I’m excited to see what you’ve gathered at our next visit.

Client Angela: This is kind of fun, and I’ll show you what I find. I think I want to talk about my body changes next time, too. I don’t feel bad but I’m not sure what to expect next in this pregnancy.

Nurse Emily: Good to know. It’s really exciting to start to plan for the baby, and it would be good to know what to expect next in this process. I have one other item I wanted to chat about today. Remember I talked about some forms and questions we’d talk about together, and this is one of those forms I was referring too. It talks about the relationship between you and your partner or ex-partner. This will probably take about 15 minutes, so I wanted to make sure we’re OK on time.

Client Angela: No, I’m good. Let’s finish up.

Nurse Emily: Most of the time we can just chat about the forms, and sometimes I don’t even bring the form out at our visit. For the one we’re going to do today, it’s really helpful to have the form out and look at it together. Whenever we do these forms remember the goal is to support you and your baby and to make sure you’re getting what you need to reach your goals. There are only eight questions, so it’s nice and short.

The specific purpose of this form to make sure you feel safe and you have a safe environment for your baby when he comes. You’ve mentioned how important it is for you to be a great Mom, and safety is one of the ways you are a great Mom. Earlier we talked about a safe crib and car seat, so I know you’re already thinking about safety. Another way to make sure you and baby are safe is to talk through relationships you have with others and decide if you feel they are safe for you and your baby. Sometimes relationships are amazing. Sometimes they aren’t so good, so we want to identify what isn’t great and change what we can. Let’s take a look at the form, and then you can ask me any questions you have before we start.

(Emily sits side by side with Angela and shows her the form. She points out a few items to her as follows.)

Nurse Emily: For the first four questions—this column on the left is the question—you can see that all you have to do is circle the answer that seems most accurate to you. This column on the right gives some examples. So, when question number one says, “has your partner or ex-partner physically hurt you?” the column on the right gives some examples of what that means.

Before we get started, what questions do you have?

Client Angela: Wow—it's kind of personal. I mean, I don't think I've ever been hurt, but why do you have to ask these questions?

Nurse Emily: I'm really glad that you know you haven't been hurt by a partner. That tells me you have tried to choose partners who treat you well and help you feel safe. So, when we fill this out, you can let me know what choices you've made in your life to be safe. That is what this conversation is all about—making sure you are safe, you know how to stay safe, and keep baby safe, too. How about we do a few questions, and you can see how it works.

If you decide you don't want to finish or would rather do this at another visit, you let me know that. I will do whatever works best for you, so you tell me if you'd rather do this at a different time or if you need to stop; because feeling safe applies to you and me too, and it's most important that we feel safe with each other. Would you rather read this silently and mark it? Or we could read it together out loud, we could talk about the examples…what works best for you?

Client Angela: Well, let's do it together and see how it goes. Let me read it and tell you the answer as I mark it.

Nurse Emily: OK. I know you're not really with Royal right now, and you shared you didn't have anyone special in your life, so think about relationships you've had in the last 12 months only. You don't have to go back in time—just the last 12 months.

(Angela reads silently to herself, "Has your partner or ex-partner ever physically hurt you in the past 12 months? Never, rarely, sometimes, often, frequently." She circles "never" and moves to question 2.)

Client Angela: Insulted? I'm not sure what that means. I mean we used to "dis" one another a lot, but that's just the way we talk, right?

Nurse Emily: That's really an important distinction and it's why they put these examples over on the right; so, let's take a look and see if this is helpful. Tell me if any of them occurred in your relationship with Royal.

Angela reads through the list silently. She points to "called names."

Client Angela: Ok – he called me names a lot; He was pretty rude to me when he was with his boys. He never broke or hurt any of my stuff. So, I guess I'd say "sometimes".

Nurse Emily: Yeah, so sometimes he was rude to you, called you names, and was critical of you in front of others. It sounds like sometimes you didn't like the way he spoke to you.

Client Angela: Yup—and you don't see that bottom feeder around here anymore, do you?

(Something to make note of that doesn't go on the form: Angela has indicated that the insults went both ways and her sharing, "we used to dis one another," and use of the term "bottom feeder" underscores this. This doesn't need to be noted on the

form but it might be a good note to make on her STAR as this could be a basis for situational couple violence if this pattern of communication is common to her relationships. It is also great insight into supporting her in her communication skills and might lead to some ideas for future conversations.)

Nurse Emily: Nope—he's not around! So, it sounds like that wasn't behavior you wanted to put up with, and you didn't want it around the baby. You made a choice between him and feeling good about yourself and being safe. How about this next one, "Has your partner ever threatened to harm you?" Look at the examples. . .

Once you complete the questions, scoring can be done in the moment or you can do it later and follow up on another visit. Again, assess your client's comfort level with the topic as well as the form itself. Adjust as needed. If the form creates problems there are other ways to collect this data, and you can still use STAR to make notes and create a plan of care.

Safety is primary. This topic should only be discussed when others are not present at visits.

IPV is not isolated to one socio-economic group and members of our team, as well as our clients, may have experienced trauma related to IPV. The NFP NSO strongly recommends that every nurse home visitor and nurse supervisor obtains training or assistance, if needed, on intimate partner violence. Even if you have experience in this area, you may want to make certain that you are up-to-date with the most current research, recommended interventions, and local laws.

You have now reviewed **Demographics: Intake and Update**, **Maternal Health** , **Health Habits**, and **Clinical IPV**. These are forms that are used at specific time points with clients. To know these forms in detail, take time to review the forms and instructions in the Guidance for All Forms. Consider doing this early and often so forms become familiar to you and can become more conversational in delivery.

Key Forms Used at Every Visit

So far, you've looked at forms used in early visits and at specific time points during the two-and-a-half year relationships with your clients. You also explored some challenges around filling out these forms—especially when your relationship with your client is new. There are three other key forms to explore in this section that will prepare you for Unit 2 education: the **Home Visit Form**, the **Encounter Form**, and **STAR Framework Coding Sheet**.

The Home Visit Form and the **Encounter Form** are used at every visit. **STAR Framework** is not completed at every visit, but is a living document that can be updated at any visit. It is filled out gradually over time, and added to and updated as you learn more about your client. STAR coding is reviewed at specific time points, so you can evaluate progress in each of the key risk categories. Remember that STAR is a framework and the first step of the Nursing Process. The coding sheet is how STAR observations are documented.

Each of these forms has a specific purpose:

Home Visit Form (HVF)

The Home Visit Form is usually in triplicate: a copy to the client, copy to the travel chart, and a copy to the office chart (this may vary from agency to agency and can also be dependent on EMR (electronic medical records) systems).

1. Client name or ID #, DOB, and date of the visit are filled in
2. Feedback section: This is where the nurse fills out an affirmation to the client based on interactions during the current visit. It can be related to progress the client is making on goals.
3. The client fills out any goals or commitments she is working on for the next visit
4. The nurse reminds herself of items she needs to prepare for or bring to the next visit
5. When client and nurse agree on the next visit, the day, date, and time are filled in.
6. Any general plans can be documented separately from the client and nurse agreements.
7. The nurse fills in her contact information, so the client is reminded of how to get in touch. The client can fill in her phone number, too, so the nurse always has the most recent number for the client.
8. The nurse and client sign the agreement.

Check out the following example and see how this form might look after the visit between Emily and Angela where the nurse filled out the **IPV Assessment**.

Nurse-Family Partnership Home Visit Form

NAME: Angela 1 DATE OF BIRTH: 1/1/2001

DATE OF TODAY'S VISIT: 2/22/2017

2

FEEDBACK ABOUT PREVIOUS ACTIVITIES: Angela – you've started to prepare for the baby and are already gathering some items you'll need. You are really excited for this baby to come and it shows how much you're already thinking like a Mom!

AGREEMENT ABOUT ACTIVITIES BETWEEN VISITS:

3 4

Family Agrees To	Nurse Home Visitor Agrees To
Going to show Emily what else she's found for the baby.	Prepare some resource options in case Angela expresses a need to access these for items she couldn't find yet or can't afford.
Wants to talk about changes that are occurring during the pregnancy – especially what comes next	Be prepared to talk about changes during this next phase of pregnancy – physical, mental and emotional preparation that will be helpful for Angela. Consider facilitator "What's New and What's Next" or "As Baby Grows"
	Follow-up about relationships – what Angela would like to see in future relationships she chooses.

5

NEXT VISIT:

DAY Wednesday DATE 3/8/2017 TIME 3:00 p.m.

6

PLANS FOR NEXT VISIT: Preparing for what's to come in pregnancy – we'll meet at Angela's work next visit as her schedule is changing.

NURSE HOME VISITOR: Emily Margentis SIGNATURE Emily Margentis

7&8

PHONE NUMBER: Emily 727-883-9945 Angela 727-793-2287

CLIENT NAME: Angela Harper SIGNATURE: Angela Harper

Encounter Form (EF)

The Encounter Form is for the nurse home visitor and is entered into the NFP NSO data system. From this form, you and your nurse supervisor will get reports related to how much time is being spent in domains, on planned content, and on who was present and engaged in the visit. Each of these items has specific value to you as a NHV.

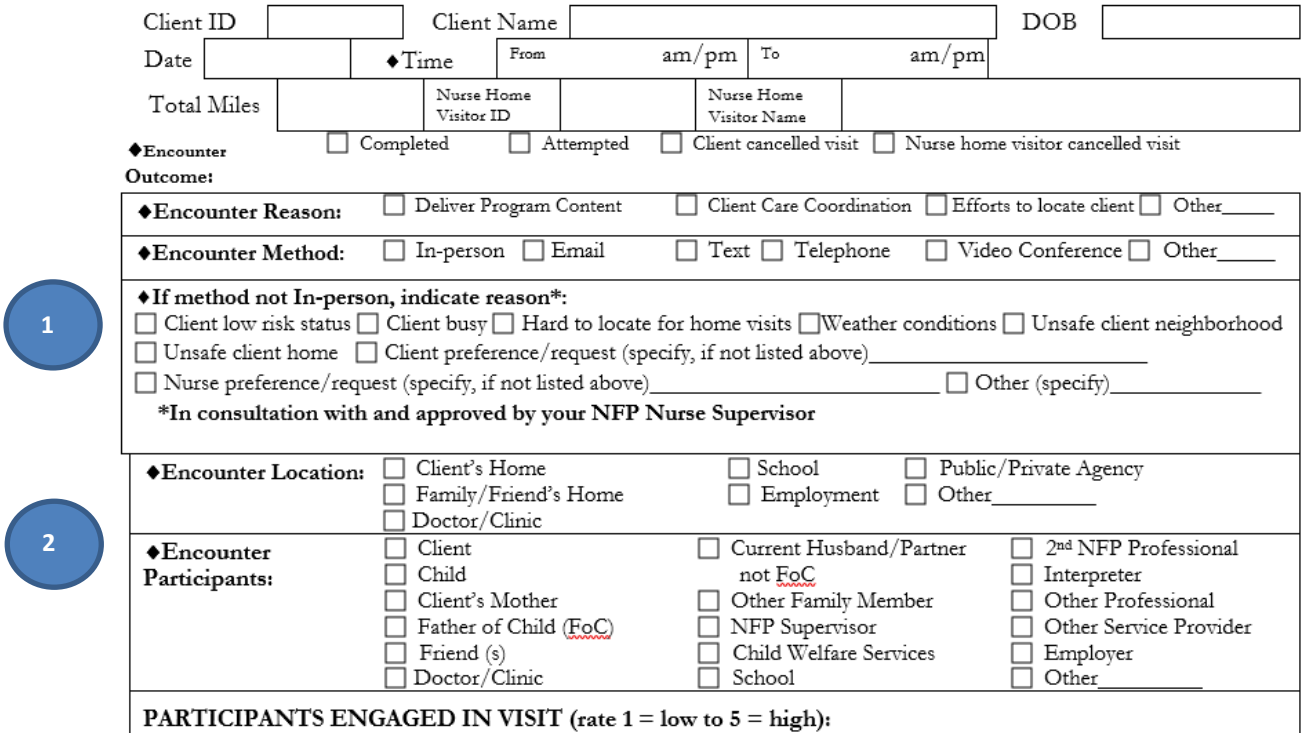
There are detailed instructions for this form in Guidance for All Forms. You'll also receive guidance from your team on filling out this form. During this section, we'll address some highlights of the form.

1. **Where the visit took place**: Sometimes agencies need to know this for billing purposes. Keeping track of this information can also show trends in client requirements. For instance, it may show a trend that more clients need to meet at work or school in order to continue visits. That's great news in terms of client engagement—meeting the client where it works best for her. It's also great news in terms of client self-sufficiency, as it may point out the client is reaching goals for education and jobs. This also tracks when you meet clients to support her in clinic or PCP visits.

   Documenting these trends helps NFP stay connected to what is really working for clients.

2. **Who was present**: Often family and significant others are present at visits and are invited by the client to attend. Sometimes family members are present even though not invited by the client. Living conditions aren't always conducive to privacy in visits. Who is present can impact the content shared at a visit and the need for the nurse and client to be creative in their place of visits when privacy is required – for instance when IPV is discussed.

   Again, the EF describes "Who". STAR can be used to explain "Why" (i.e., if there is a risk involved). If there is a risk, an example of a note that might be made in the IPV section of STAR is, "Boyfriend wants to be present at all visits and appears to be very controlling of client; did not discuss IPV."



Client ID | Client Name | DOB
Date | ♦Time From am/pm To am/pm
Total Miles | Nurse Home Visitor ID | Nurse Home Visitor Name
♦Encounter Outcome: ☐ Completed ☐ Attempted ☐ Client cancelled visit ☐ Nurse home visitor cancelled visit

♦Encounter Reason: ☐ Deliver Program Content ☐ Client Care Coordination ☐ Efforts to locate client ☐ Other_____

♦Encounter Method: ☐ In-person ☐ Email ☐ Text ☐ Telephone ☐ Video Conference ☐ Other_____

1

♦If method not In-person, indicate reason*:
☐ Client low risk status ☐ Client busy ☐ Hard to locate for home visits ☐ Weather conditions ☐ Unsafe client neighborhood
☐ Unsafe client home ☐ Client preference/request (specify, if not listed above)_____
☐ Nurse preference/request (specify, if not listed above)_____ ☐ Other (specify)_____
*In consultation with and approved by your NFP Nurse Supervisor

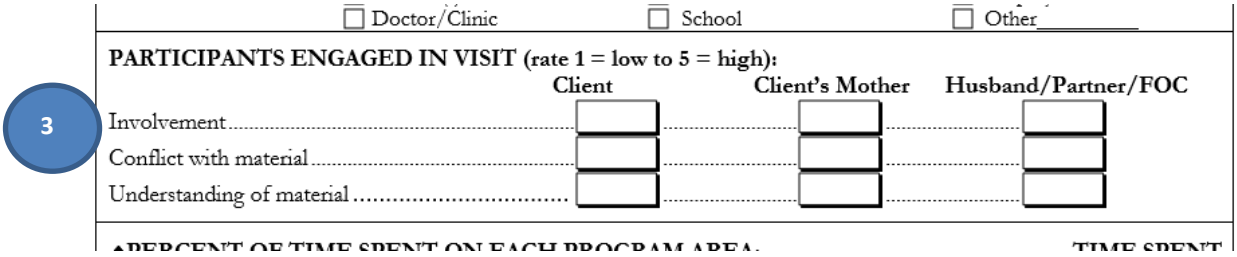
2

♦Encounter Location: ☐ Client's Home ☐ School ☐ Public/Private Agency ☐ Family/Friend's Home ☐ Employment ☐ Other_____ ☐ Doctor/Clinic

♦Encounter Participants:
☐ Client ☐ Current Husband/Partner not FoC ☐ 2nd NFP Professional
☐ Child ☐ Interpreter
☐ Client's Mother ☐ Other Family Member ☐ Other Professional
☐ Father of Child (FoC) ☐ NFP Supervisor ☐ Other Service Provider
☐ Friend (s) ☐ Child Welfare Services ☐ Employer
☐ Doctor/Clinic ☐ School ☐ Other_____

PARTICIPANTS ENGAGED IN VISIT (rate 1 = low to 5 = high):

3. **Participants engaged in the visit**: Engagement may be the single biggest predictor of whether a client stays in the program through graduation.



☐ Doctor/Clinic ☐ School ☐ Other_____

PARTICIPANTS ENGAGED IN VISIT (rate 1 = low to 5 = high):

	Client	Client's Mother	Husband/Partner/FOC
Involvement			
Conflict with material			
Understanding of material			

♦PERCENT OF TIME SPENT ON EACH PROGRAM AREA: TIME SPENT

3

Being "present" doesn't mean the person participated in the visit or interacted in any significant way with the content. If your client and/or others are interacting with the content – we classify this as "engagement". Engagement has 3 different categories: involvement, conflict with material, and understanding of material. Let's look at each one:

Involvement: How is the client interacting with you as you talk about the content? Involvement can be shown in non-verbal cues. What cues is she giving you? Is she making eye contact, does she nod her head in understanding? Does she lean toward you or take the handout and look at it for herself? In the example with

Angela, what rating would you write in the above box for her involvement in the visit? Mark between 5, for high involvement, and 1 for low involvement.

At this visit, no one else was present, but if her mom or her partner was present you would rate their involvement in the same way.

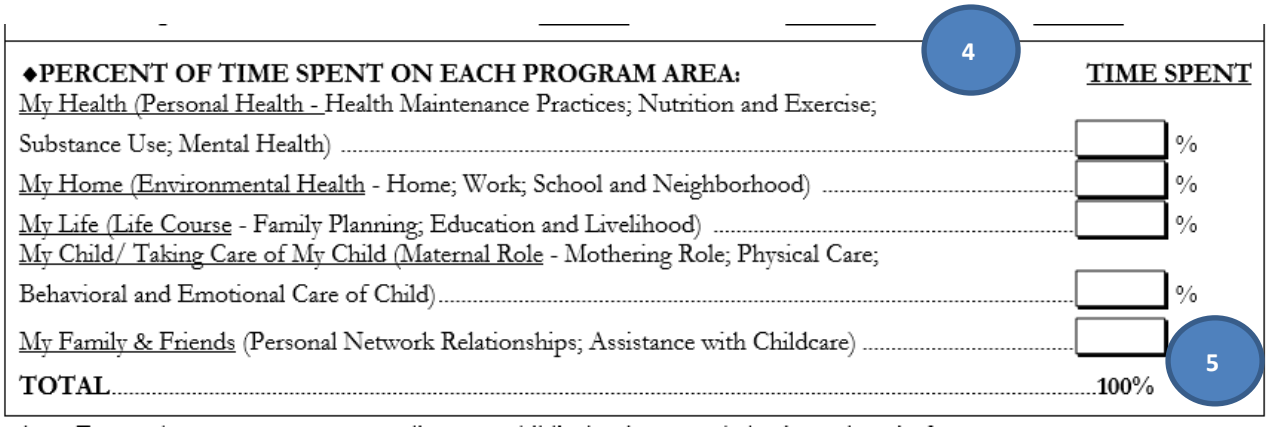
Conflict with material: There is a difference between not understanding the material and disagreeing with the material. In the case of Angela – do you think she agreed or disagreed with the material? Or did she try to clarify what you were saying so she could answer accurately? Based on what you think – write in 1 for "no conflict" up to 5 for "high conflict".

Understanding of material: In the beginning the client may not understand everything and may need additional guidance. That is different from not understanding material by the end of your conversation. As Emily gave Angela the guidance she needed around the IPV Assessment, did Angela seek to understand the overall purpose of the assessment?

Keep in mind that the assessment wasn't all of the material presented at this visit. As you evaluate the whole conversation, baby preparation as well as the IPV work, where would you place Angela on understanding of material? Use a scale of 1 to 5: 1 for no understanding to 5 high understanding. Again, if another family was participating you would include a rating for them as well.

4. **Percent of time spent on each program area (domains)**: During different phases you may spend more time in one domain than another. For instance, you may spend lots of time during pregnancy on Personal Health, but begin to transition more time toward Maternal Role as the pregnancy progresses.

   The goal is to reach balance in domains depending on your assessment of the client's individual needs. Even though Personal Health is important during pregnancy, if the client is homeless you may have to shift focus to Environmental Health. The **Encounter** form documents how much time you're spending in a domain. STAR provides insight into why you're spending time in a domain. The two forms go hand in hand.



The intention is not that nurse home visitors reach 100% of plan all the time. Life happens and you may often change planned content to respond to new circumstances that crop up between visits.

How Did You Do on Calculating Percent of Time from Emily's Visit with Angela?

♦PERCENT OF TIME SPENT ON EACH PROGRAM AREA:	TIME SPENT
My Health (Personal Health - Health Maintenance Practices; Nutrition and Exercise; Substance Use; Mental Health)	0 %
My Home (Environmental Health - Home; Work; School and Neighborhood)	25 %
My Life (Life Course - Family Planning; Education and Livelihood)	0 %
My Child/ Taking Care of My Child (Maternal Role - Mothering Role; Physical Care; Behavioral and Emotional Care of Child)	25 %
My Family & Friends (Personal Network Relationships; Assistance with Childcare)	50 %
TOTAL	100 %

Go to the Guidance for All Forms and review the STAR Framework form and instructions.

Strengths and Risks Assessment (STAR) Coding Sheet

In Unit 2 we'll take a deep dive into how we utilize the STAR Framework to get a clear view of the client's story by assessing her strengths and risks. STAR is the first step of the nursing process.

The STAR Assessment Coding Sheets are used to document the assessment we continue to make of the client over time. There are three separate coding sheets developed for how individual nurses prefer to document.

1. The STAR Coding Form for Data Collection System (DCS) is used to enter STAR coding into the NFP NSO data system. This is required by the NFP NSO. Entering this data into the NFP NSO data system is Data Collection System (DCS) allows us to capture the strengths and risks of our moms. .
2. The six-page coding sheet has three lines for each risk category. This provides an in-depth view of the client that can encompass multiple assessments on each risk into one document.
3. The two-page coding sheet is an at-a-glance option that some nurses prefer so they can see every category at once.

There is also a continuation page, which is a blank sheet that can be used with either the six-page or the two-page form as "extra" notes on a risk. Sometimes the client may

only have one or two risk categories, but there is a lot of change you want to document. The blank continuation page can be used when you run out of room on one of the other two forms.

Carefully review each of the forms and instructions in the manual. After reading the instructions, ask your supervisor what a STAR Coding Sheet looks like when it's in the process of being filled out.

Data Wrap-Up

You have now completed the chapter on data and the most frequently used forms. There is much more to learn, but this chapter provides a foundation on the essential forms used in visits and how to have client-centered conversations—even when you're filling out forms.

Challenge: What are two questions you still have? Find a team member or your nurse supervisor and discuss your questions.

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Examples of the Benefits of Data

- Insights from data directly correspond to reaching program outcomes.
- Data collected at key points allows us to assess client progress and make course corrections in our plan of care
- All the data informs our plan of care over 2 ½ years so the client receives individualized input from the nurse related to what she needs at the right time so she can more readily reach her goals.

Why the Demographics Form?

- Does she qualify for the NFP program?
- What resources does she have access to?
- What other programs and government assistance might she qualify for?

Fun Facts Hunt Answers

Question 1

A. Encounter Form (EF)
B. EF
C. Home Visit Form
D. Both

Question 2

A. Visits 1- 5
B. Be flexible and can extend out to visit 7 or 8 if needed

Question 3

We want to know what populations we're working with. Asking these questions helps us know if we need to do anything differently as we work with different groups of people. It can sometimes help us to receive funding so that we can continue to offer this program at no cost to people who really want it.

Question 4

A. Example, "I know you have goals and dreams. Sometimes our friends and family help us reach out goals. Sometimes these relationships don't help us reach our goals. From time to time we'll talk about the important relationships and some specific things in those relationships that might help or hinder you from getting what you want in your life."
B. At about 7-8 weeks but be flexible and safe.
C. The relationship might need more time to develop trust, it's not safe, there's no privacy. Nurse home visitors may have to be creative about finding a private time or place to meet.

Question 5

A. Maternal Role and/or Personal Health
B. Lives with boyfriend's family, underage to drink, trusts nurse because she discloses drinking
C. Is she still breastfeeding, what are a "few" beers, where is baby while all adults are drinking, are they over legal limit for driving and if so, what is the plan for an emergency with a baby?

Chapter 13

Maternal Role

Nurse-Family Partnership

Helping First-Time Parents Succeed

Chapter 13: Maternal Role

Purpose

The purpose of this chapter is to describe how a client evolves in her new role as a mother and to provide ideas and strategies that support healthy maternal role development.

Standards Covered in this Chapter

Nurse Home Visitor

- Applies theories and principles integral to implementation of the Nurse-Family Partnership model
- Uses the Nursing Process to deliver individualized client care and set goals across the six domains

Nurse Supervisor

Promotes the home visitor's development of competence to deliver the Nurse-Family Partnership home visiting intervention

Objectives

- Recognize stages of typical role development.
- Discuss theories of maternal role attainment.
- Identify tools to use with clients to support healthy maternal role identity and attachment.

Note: there are several "Think about It…" exercises in this chapter. Be sure to take the time to write down the answers when indicated, but your answers do not need to be submitted to Nurse-Family Partnership National Service Office or brought to Unit 2 education. They are to expand your understanding of a complicated topic.

Why Do We Work with First-time Mothers in Nurse-Family Partnership?

First-time mothers are open to discovery about who they are as a mother. They have not yet decided completely what a good mother looks like, how it feels to be a mom, what they expect of themselves as a mother. As a woman moves through pregnancy and begins caring for her new baby, she develops a new role identity as a "mother."

You will be working with low income first-time mothers. These are few of the questions we hear Nurse-Family Partnership nurses ask:

- Will she become a nurturing and responsive mother?
- Will she want to avoid spoiling so much that she is distant and too strict?
- Will she be so wrapped up in survival needs that she ignores the relational needs of her baby and perhaps of herself?

In Nurse-Family Partnership we can have an effect on mothers, their babies, and the generations that follow by guiding clients toward healthy, nurturing, and responsive mothering.

Stages of Role Development

Typically, individuals move through stages when developing a new role identity. In her article *Becoming a Mother Versus Maternal Role Attainment*, Ramona Mercer (2004) used Thornton and Nardi's Four Stages to describe this development.

Stage	Activities
Anticipatory	Thinking about, imagining, planning
Formal	Following the advice of 'experts' and copying others
Informal	Using own judgment based on experience and adapting others' advice
Personal Identity	Confident and satisfied with new role identity

Four Stages of Role Acquisition (Thornton and Nardi as cited by Mercer, 2004)

Think about it…

For your personal review, jot down your answers to these questions on a piece of paper.

All of us go through stages when acquiring a new role. Think for a minute about how you became a nurse.

1. **Anticipatory stage**: How did you anticipate becoming a nurse? When did you start thinking about it? What did you imagine? How did you plan?
2. **Formal stage**: When you first graduated how did you follow the experts or copy others?
3. **Informal stage**: How long was it before you used more of your own judgment?
4. **Personal Identity stage**: What did you do differently when you were confident as a nurse?

Stages of Maternal Role Development

The stages of role development are the same for a young low-income, first-time mother acquiring her maternal role identity. Using this four-stage model of role acquisition, pregnancy is when our clients are in the first stage, the Anticipatory Stage, of developing their maternal role identity. Because your first encounter with all clients is when they are pregnant and in the Anticipatory Stage, it will help to have some examples in mind in case your client hasn't started thinking about it yet.

Think about it…

Jot down some ways you or someone you know thought about, imagined, or planned for becoming a mother. Here are some examples:

I think my baby is going grow up to be handsome, just like his daddy.

I took care of all my brothers and sisters, and I always knew I'd become a mother someday.

Mercer (2004) also reviewed theories that explained the importance of maternal role attainment. Her review found the following predictors:

- Positive maternal attention on the baby during pregnancy predicted more feelings of self-efficacy after birth
- A more positive maternal perception of the infant predicted an earlier establishment of a healthy maternal identity
- Self-confidence and mastery predicted competence in the maternal role

In *Promoting Maternal Mental Health* (2001), JoAnne Solchany noted that a woman's concept of her 'dream' baby remains stable until the child is about one year old. Solchany warned that a mother who holds negative concepts of her fetus has a high probability of retaining that negative view of her infant. Relationships can repair in time. However, early shifting to a more positive model can prevent a lot of problems and heartache.

Why Learn about Attachment and Bonding Before Babies Are in Your Client Caseload?

The work of Solchany (2001) and Mercer (2004) provides good evidence that healthy bonding **during** pregnancy predicts good long-term attachment. In their book *Bonding*, Klaus, Kennel, and Klaus (1997) cite studies corroborating this. Among their examples is a British study. When asked when they first felt love for their baby,

- ♥ 41% of mothers stated they first felt love for their babies during pregnancy.

Klaus, Kennel and Klaus (1997) also cited an Australian study. When asked about their feelings regarding their 8-12 week old fetus,

- ♥ 30% of pregnant women could picture the fetus and felt it was real.

Nurse-Family Partnership nurse home visitors have an important responsibility supporting healthy adaptations to the maternal role and promoting secure attachment as women develop their new identity as a mother. Having a framework to guide your efforts will help.

Rubin's Four Tasks of Pregnancy

Reva Rubin (1967) published her work on "Maternal Role Attainment" in *Nursing Research* and it has stood the test of time. Her four tasks of pregnancy remain a useful framework.

- Ensuring safe passage for self and baby
- Ensuring acceptance of self and baby
- Bonding
- Giving of self

Let's look at how the four tasks of pregnancy help a woman evolve in her confidence as well as her beliefs and values as a mother. We'll also look at how you can support your client's development of secure attachment through each task.

Rubin's First Task: Ensuring Safe Passage for Self and Baby

A pregnant woman who is committed to herself and her baby becomes protective of herself and her baby. She attends to her own comfort and safety in the first trimester. As ambivalence about pregnancy subsides, the baby becomes more real. This is when she can begin extending her efforts for comfort and safety to her baby. During pregnancy, she may be especially protective, anticipating and fearing the outcome of labor and delivery for both herself and her baby. She may also become quite concerned about the "dangers" of riding in a car, walking in the neighborhood, etc.

Your clients will benefit from gathering useful information that allay their fears and help them gain a sense of control. They need a network of supportive relationships that allows them to examine their feelings and reflect on how to manage their concerns.

Think about it…

Babies attach to caregivers differently, depending on their interactions with the baby. What are behaviors that might indicate the caregiver is ensuring safe passage for self and baby?

Print out the following table or make your own on a piece of paper. Use the left column to list behaviors indicating that a pregnant client is managing this task in a healthy way. In the right column, list a few behaviors that might indicate the need for deeper assessment or reflection.

BEHAVIORS	
Could Indicate Positive Attachment or Bonding & Development of a Positive Maternal Role Identity	**Could Indicate a Need for Further Assessment, Specific Interventions, or Possibly Referral**
• *Example: More cautious for self and baby, protects from bumps and falls.* •	• *Example: Refuses to give up illegal drugs, "This is my body, I do what I want!"* •
•	•
•	•
•	•

In their book *Bonding*, Klaus, Kennell, and Klaus (1997) point out that fathers must reevaluate their roles as well. New fathers look for role models in their fathers and others. They evaluate what it means to be a provider and they think about and decide what physical and emotional support they will provide for their partner and their baby. Sometimes they are the only support for their little family because of our mobile society. The relationship with their partner will inevitably change with the birth of the baby. Choices and freedoms will change; activities, friends and allocation of money all change.

Think about it…

As you learn about bonding and attachment, the stages of role acquisition, and the maternal tasks of pregnancy, ask yourself, "What might a man do towards defining himself as Dad?"

Complete the table below, thinking specifically of the father's role. While many of the same behaviors you listed for mothers will apply, list a few that you feel apply specifically to fathers or other primary caregivers.

BEHAVIORS	
Could Indicate Positive Attachment or Bonding	**Could Indicate a Need for Further Assessment, Specific Interventions, or Possibly Referral**
• *Example: More cautious driving the car, reminds the client to wear a seat belt.* •	• *Example: Gets drunk and fights with others when client is present.* •
•	•
•	•

Rubin's Second Task: Ensuring Acceptance of Self and Baby

Ambivalent Feelings

Acceptance of pregnancy and the baby is a challenge for pregnant women. Most women experience some ambivalence when they discover they are pregnant. They may be happy to be pregnant, just "not now." Even women who have planned their pregnancy may experience some ambivalence.

Any woman can feel guilty at some point for having been ambivalent, for having considered abortion, for having wished for relief from their confusion by having a spontaneous loss, or for feelings related to previous pregnancy losses. These feelings frequently fly under the radar. They can remain unresolved secrets that interfere with bonding.

Relationships

Changing relationships challenge the pregnant woman. She will want to rework her relationships and surround herself with people who are supportive of both herself and her baby. It is useful to examine feelings about what happened when the woman disclosed her pregnancy to others. Find out how she perceives her relationships in terms of current and future support needs. She may need help changing and redefining relationships. Your client may need to deal with perceptions of rejection in her personal network at school, work, or in the medical community. Your client will need to appreciate and negotiate differing values among family members regarding such things as child rearing, family rituals and religion.

Body image

A pregnant woman will need to adjust to her changing body, the discomforts of pregnancy, and loss of control of her body. A changing body image is particularly challenging for teenagers.

Think about it…

It is useful to view these challenges as part of a developmental stage in adulthood. If the mother is adapting well, she learns to project her pregnancy and baby in a positive way so that the important people in her life feel positive about the baby and her changing role. How can you help your clients manage these challenges and achieve a good, healthy attachment without consciously or unconsciously blaming the baby?

Complete the following table, using the left column to list things a client might say that could indicate positive progress toward Acceptance of Self and Baby. In the right column, list things clients might say indicating a need for further assessment, specific interventions, or possibly even referral. Put a star (★) beside behaviors that you believe may also apply to father or other caregivers.

Ambivalent Feelings

- *Example: Your client shared that she miscarried in her first pregnancy. She looked embarrassed and sad when she said it.*
-

Positive Indicators	Behaviors that could indicate a need for further assessment
• *Example: Although she feels sad, she is planning for this baby.* • •	• *Example: She feels like she did something that caused the loss and is sure she'll do it again.* • •

Relationships

- *Example: Your pregnant client cannot continue to attend her regular school and be with her friends.*
-

Positive indicators:	Behaviors that could indicate a need for further assessment:
• *Example: She chooses to attend an alternative school and see friends on weekends.* • •	• *Example: It's this baby's fault that I (you) can't party anymore – plus I'm (you're) sick all the time. ** • •

Body Image	
• *Example: Your client realizes that she can't wear her jeans because of her baby bump.* • •	
Positive indicators:	**Behaviors that could indicate a need for further assessment:**
• *Example: Those jeans will be out of style after the baby is born anyway. I'll get some new ones then.* • •	• *Example: This baby made me fat; I can't stand it!* • •

Rubin's Third Task: Bonding

An essential part of achieving a positive identity as 'mother' is bonding with the baby. There are several behaviors indicating your client is beginning to bond with her baby.

Interacting with Her baby

The woman shifts to thinking more about the baby and begins to interact with the baby. She will engage in numerous bonding behaviors, such as touching her tummy to gently contact her baby, talking to her baby, reading to her baby, singing to her baby, telling her baby what's going on, and asking her baby how it feels about things. ("You didn't like that big noise, did you?") The woman who is bonding well may also invite others into her world of relating to baby by doing such things as asking others to feel the kicks, talk and sing to baby, and plan for baby.

Imagining and planning for her baby's future

The woman will also bond with the baby by imagining the baby's positive traits and appearance, dreaming and day dreaming about the baby and her role as a mother, imagining caring for the baby, naming the baby (in most cultures), and giving the baby nicknames. Another way a woman bonds during pregnancy is by making plans for the baby and establishing the physical space for the baby; this may include finding room in the home, getting a baby supplies, planning a baby shower, and so forth.

Think about it…

Your client Hailie is 34 weeks pregnant. She never touches her tummy in response to baby movement. She talks about the difficult pregnancy but never mentions the baby. She has no name picked out for the baby, no space for the baby in the home, no baby clothes or toys. Think about assessing this client in relationship to her socio-cultural context.

In the left column below, list actions that indicate positive progress toward bonding. In the right column, list responses indicating a need for further assessment, specific interventions, or possibly even referral. Put a star beside behaviors that you believe may also apply to father or other caregivers.

INTERACTING WITH HER BABY	
Positive Indicators	**Behaviors That Could Indicate a Need for Further Assessment**
• *Example: Responds with a smile and caress when she feels baby kick.* • •	• *Example: Says, "I don't like it when he kicks; he's trying to bug me."* • •

IMAGINING AND PLANNING FOR HER BABY'S FUTURE	
Positive Indicators	**Behaviors That Could Indicate a Need for Further Assessment**
• *Example: Is beginning to plan the nursery.* • •	• *Example: No name is picked out. (Assessment may indicate that it is culturally appropriate to wait.)* • •

Rubin's Fourth Task: Giving of Self

Pregnant women must make changes in their health habits and activities of daily living to facilitate a healthy pregnancy. The pregnant woman may need to change activities that could endanger her pregnancy or would be inconsistent with her beliefs (or the beliefs of her significant others) about what a good mother does.

They may need to shift priorities regarding school or career goals. Dreams may be "put on the backburner" or relinquished. She will also alter her spending habits, adjusting her budget to accommodate her baby.

During the first pregnancy women alter friendships. There is a great need to talk to other women. Women want to reflect on their experiences and values regarding pregnancy and mothering with other women and discuss their changed status. Relationships with the pregnant woman's mother and her partner will be reevaluated. In the process of becoming "mother," your client may become aware consciously or unconsciously of ways her needs for nurturing are either not currently met, or were not met in the past. Klaus, Kennel and Klaus (1997) give an example of a woman whose mother had postpartum depression when she was an infant. The woman did not understand her sad feelings when she looked at her baby.

Think about it…

To become an effective nurturing mother, she may need to give what she did not get when she was little. What is the first thing you would do with this depressed mother? How will you help her begin giving to the baby during this pregnancy?

Think about it…

Your client Nakia likes to party. Even though she has been told about the effects of smoking and alcohol on a fetus, she continues. How can you invite her to consider how her choices affect her baby? What can you do to help her move toward greater commitment to her baby's needs?

In the left column of the following table, list behaviors that might demonstrate Giving of Self. On the right, list behaviors that might concern you. Put a star (★) beside behaviors that you believe may also apply to fathers or other caregivers.

GIVING OF SELF	
Positive Indicators	**Behaviors That Could Indicate a Need for Further Assessment**
• *Example: Cuts back on smoking, even though it isn't easy.* • •	• *•Example: Skips meals regularly, even though she knows it is not good for baby.* • •

What Helps Women Achieve These Tasks and Establish Their Identity as a Mother?

According to Rubin (1967), women copy the way other mothers dress, their gestures, eating habits, good luck practices, folk remedies, and rituals. Sometimes women try on the role of mothering by baby-sitting, bathing a doll, or learning to install a car seat. Your client may also fantasize a great deal regarding the baby, the ideal mother, and how she will care for their baby.

They sort through their concepts of the 'idealized' mom versus the 'real' mom by considering and discussing topics with other women such as breastfeeding, managing labor, and buying cribs. Women invariably use their own mothers as models and resources in this process. If their mother has died or is emotionally unavailable, they may grieve and look for a mother surrogate.

Think about it…

Raine's mother is not around much and even when she is, she is invariably drunk or emotionally challenging. Raine has no mother to model or confide in. What can you do?

In the process of identifying more and more with, "I am a mother," a woman grieves consciously or unconsciously the losses of her former self, such as her career, education goals, spontaneity, and freedom from responsibilities. Sometimes this creates ambivalence or guilt. If you can normalize these feelings it helps the client.

Note: If you are struggling with answers to any of these exercises, this important topic will be covered again during the Maternal Role session of your face-to-face education.

Lederman's Adaptations in Pregnancy

In her work *Psychosocial Adaptation in Pregnancy: Assessment of Seven Dimensions of Maternal Development* (1996), Regina Lederman described maternal role. Some of Lederman's dimensions overlap with Rubin's tasks of pregnancy. They also expand on Rubin's work. The seven dimensions are:

1. Acceptance of Pregnancy
2. Identification with a Motherhood Role
3. Relationship to the Mother
4. Relationship to the Husband or Partner
5. Preparation for Labor
6. Prenatal Fear and Loss of Control in Labor
7. Prenatal Fear and Loss of Self-Esteem in Labor

Lederman initially studied 32 married, primigravidas ages 20 to 32 in a four-year project to understand the developmental conflicts in pregnancy, the variables related to prolonged labor, fetal-newborn health, and maternal prenatal adaptation. She subsequently followed 689 low-income pregnant women (52% white, 29% African American, and 17% Hispanic) to validate the findings. The study showed reliability of all seven dimensions across each trimester and across each ethnic group.

Identifying with Mothering Role

One of the seven dimensions is Identifying with the Mothering Role. As Rubin (1967) noted, women have beliefs and develop a philosophy about motherhood that may begin in pregnancy. Examples are 'Mother knows best' or 'The best mothers use more discipline.' Pregnancy itself has meaning to people. To some people it means a woman is now a real woman, who is somehow more lovable. To others it means a long-awaited dream to parent and be a family has come true.

Lederman (1996) noted that within the dimension of Identifying with the Mothering Role, we must consider one's motivation to have a child. The motivation may be conscious or unconscious. In addition to what are commonly viewed as positive motivations for pregnancy could be such things as getting pregnant to ensure a relationship, to achieve adult status, to escape home, to be more like mother/sisters/aunts/friends, and so forth.

Finally, within this dimension Lederman (1996), like Rubin (1967), addresses the image of self as mother. Perhaps the client wonders, "How can I be a mother, I'm just a kid!" or "Mothers are so wise, but I'm not." The following story illustrates the importance of the pregnant woman's image of self as mother:

Dana was referred to the high-risk clinic after losing three pregnancies. The clinic found no physical causes either in the chart review or physical exam. They followed her closely, but the only difference in her care was intense support and encouragement to reflect about the pregnancy and becoming a mother. After several visits of building a trusting relationship, she finally told her nurse that she had married into a wonderful family. The only concern was that they were very committed to her having babies right away. She did not want to disappoint her mother-in-law and sisters-in-law who in every other way supported, loved, and encouraged her. She said, "I just don't think I could do a good enough job; they are such good mothers!" Over time, Dana and her nurse discussed how her in-laws learned about parenting (she found out when she asked them that sometimes they had learned the 'hard way') and found out that they didn't think they had been perfect moms. Dana started being more confident, and had a healthy baby. Two years later, her nurse saw her again in the OB clinic. She bragged, "I don't need a high-risk clinic this time; I've got this down!" She was in full bloom—her face and her belly.

Relationship with the Client's Mother

This refers to the availability of the client's mother—is her mother physically and emotionally present?

Like Rubin, Lederman noted that women connect with their mothers during their first pregnancy and reflect on their mothers' pregnancy and birth experiences. If the client's mother is not present, the pregnant woman may need to use relatives to help fill in the blanks. She may choose other women as mother surrogates. She may experience grief and loss in a new way as she emotionally processes what she did not get as a child.

In the article "Towards a Definition of Infant Mental Health" researchers Zeanah and Zeanah (2001) noted generational attachment patterns. Mothers tend to have attachment patterns with their babies that match the attachment patterns they have with *their* mothers. They note that grandmothers tend to have an attachment pattern with their grandchildren that match the pattern they have with their daughter. This adds another dimension to the importance of the client's insight into her relationship with her mother and the people she might choose as a surrogate mother or role model.

This dimension also refers to the client's mother's adaptation to being a grandmother. Does the new grandmother welcome the pregnancy and the baby, or reject it?

Lederman (1996) expands on this concept. Sometimes the new grandmother sees the pregnancy as representing a failure and a loss of dreams for the daughter. It may result in a financial impact for the new grandmother, more responsibility, and lost freedom. Sometimes the grandmother rejects her teenage daughter when she announces her pregnancy. Conversely, sometimes her daughter's pregnancy might mean the answer to a dream, an occasion to celebrate.

Think about it…

Imagine for a minute that you are the mother of a 14-year-old who has just told you she is pregnant. List some of your concerns for yourself, your daughter, and the baby.

Does the grandmother have respect for the client's autonomy? Lederman notes that helping the client and new grandmother gain insight into past relationship patterns and issues of control and dependency is useful. Negotiating expanding roles, especially between teen moms and their mothers can be challenging to the new mother's role identity as well as her ability to develop a positive attachment. This is a frequent challenge in managing Nurse-Family Partnership caseloads.

Think about it…

Take a minute to think through some of the issues and anticipate some of the ways you might handle them.

How much parenting might an emotionally young 14-year-old manage? How much (or what part) might be best to defer to her mother?

How would your expectations be different with an emotionally appropriate 18-year-old?

What can you do/say to help the teen and the parent have developmentally appropriate expectations regarding their parenting skills?

Relationship to the Husband or Partner

Do the client and the partner have concern for each others' needs? Lederman also expanded on the client's relationship with her partner. The client and the partner may reflect on the impact the pregnancy will have on their changing roles, acceptance by the partner's family, identification with the parenting role, and managing conflict. Does the father have anyone to share with, to sort things out? Does the partner listen and understand?

Preparation for Labor

Lederman concludes in her studies that knowledge and preparation for labor may significantly influence birth outcomes, including anxiety during labor and duration of active labor. It is important for the nurse home visitor to assess the pregnant client's level of understanding about the process of labor in order to effectively assist her in preparation for birth. How does she perceive and deal with pain? Does she have plans for how to manage labor and delivery? Does she have a birth plan and how flexible is she about necessary changes?

Prenatal Fear and Loss of Control in Labor

Lederman notes that prenatal fear and loss of control in labor contributes to anxiety during labor and may contribute to poor outcomes. Nurse home visitors have an opportunity to explore and address fears the client may have about labor. What stories has she heard? Do they cause concern? Is she worrying about the loss of control? Does she have strategies for feeling in control? Is she at risk for feeling vulnerable to being controlled? Can she advocate for herself?

Prenatal Fear and Loss of Self-Esteem in Labor

Worries, beliefs, and concerns about loss of self-esteem in labor can have a significant impact on maternal role and bonding. The client may reflect during pregnancy on her individual fear of loss of self-esteem in labor. Is she worried about how she will behave? Are there people who would make her feel "on guard" if they were present during labor and delivery? Does she have unrealistic expectations of herself or the baby?

Tools for Supporting Maternal Role Development

The Nurse-Family Partnership Visit-to-Visit eGuidelines provide you with regular ideas, assessments, and handouts to support the Maternal Role. You will find handouts in your Visit-to-Visit eGuidelines to help with initial role development.

Approximately one year after attending Unit 2, you will learn DANCE. The Dyadic Assessment of Naturalistic Caregiver-child Experiences (DANCE) was developed for Nurse Family Partnership to better help nurses support clients in the care they provide to their children. The DANCE gives nurses a strengths-based tool to objectively assess the interaction between a caregiver and child during a home visit. Nurses use information from the DANCE to have conversations with caregivers, reflecting on

current parenting behaviors, and guiding caregivers by selecting targeted activities that address the unique strengths and opportunities for growth of each client.

The DANCE, developed by Dr. Nancy Donelan-McCall at The Prevention Research Center for Family and Child Health at the University of Colorado, is a valid, reliable, and clinically useful tool. This work was championed by Dr. David Olds in his commitment to continually improve the Nurse-Family Partnership program in community-based practice.

Partners in Parenting Education (PIPE) (Dolezol & Butterfield, 1994) is an interactive parent-child curriculum. While many parenting curricula focus on growth and development, this curriculum focuses on building emotional connectedness between parents and babies. PIPE addresses growth and development, although the central focus of this curriculum is to assist the new parent with building parenting skill and confidence and improving the probability of secure attachments characterized by nurturing, responsive caregiving. The Nurse-Family Partnership Visit-to-Visit Guidelines will prompt you to use lessons from PIPE regularly. The PIPE curriculum was designed originally for teen mothers in a school system and has been adapted for home visits. In 2005, we developed “PIPE to Go” lessons that are simplified versions. The “PIPE to Go” lessons that were developed were those chosen as the Nurse-Family Partnership nurse home visitors’ favorites.

You will learn more about the many tools in planning care and developing strategies for promoting healthy maternal role development when you attend Unit 2.

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Chapter 14

PIPE

Nurse-Family Partnership
Helping First-Time Parents Succeed

Chapter 14: PIPE

Purpose

This self-study is designed to provide you with a foundation for understanding and using the *Partners in Parenting Education* (PIPE) instructional model and curriculum with clients.

Standards Covered in this Chapter

Nurse Home Visitor

- Establishes therapeutic relationships with client.
- Uses the Nursing Process to deliver individualized client care and set goals in the maternal role domain

Nurse Supervisor

- Application of principles of supervision that promote the clinical and professional development of all team members
- Promotes the home visitor's development of competence to deliver the Nurse-Family Partnership home visiting intervention

Objectives

- Identify the primary focus of PIPE
- List reasons why PIPE is used in the Nurse-Family Partnership
- Describe how PIPE can help parents and children develop and emotional connection
- Describe the eight core emotional concepts or "threads" that are woven throughout the PIPE curriculum
- Introduce the ASKS Model and describe its use in developing a PIPE lesson
- Identify the components of the PIPE Instructional Model
- Describe the purpose of each step of the Instructional Model
- Describe the focus of the Listen, Love and Play Units
- Locate the list of topics for each unit
- Identify the format used in every topic
- Describe the components of the curriculum and how to use them to develop a lesson plan (Educator's Guide, Parent Handouts Notebook and Activity Cards)

Introduction

In this chapter you will acquire a foundation for understanding and using the instructional model and curriculum of *Partners in Parenting Education* (PIPE).

In addition to this workbook, you will need the materials listed below (your supervisor is responsible for ordering these materials from How to Read Your Baby at http://www.howtoreadyourbaby.org/):

- *Partners In Parenting Education Educator's Guide*
- *Partners In Parenting Education Parent Handouts*
- *Partners in Parenting Education Activity Cards*

Think about it…

If you were creating a parenting curriculum for high-risk parents, what would you want to make sure was included? Write down your thoughts on a piece of paper read the next section on PIPE. Compare your ideas with what PIPE offers.

What is PIPE?

Partners in Parenting Education (PIPE) is an interactive parent-child education model and curriculum used during the Denver trial and in replication of the Nurse-Family Partnership model. The nonprofit organization How to Read Your Baby originally created this research-based curriculum in the early 1990's to address the needs of teen parents with infants in the Colorado public school system. You can find more information on How to Read Your Baby at www.howtoreadyourbaby.org and on page 1 of the *Partners In Parenting Educator's Guide.*

Over the years How to Read Your Baby has revised and enhanced the curriculum, and PIPE is now used with a broader audience. Many parenting curricula are focused on growth and development. In Nurse-Family Partnership, you have the tool *Ages and Stages Questionnaires* to support you in screening and teaching about child development. While growth and development are addressed in PIPE, the primary focus is to support parents in grasping concepts of emotional connectedness and to develop skills in emotionally connecting with their children. This curriculum is beneficial to Nurse-Family Partnership clients and is supported by the Attachment Theory, a foundation of the Nurse-Family Partnership model.

"PIPE recognizes that a new baby is often a motivator for change and that parenting education has the most impact when it starts early… A parenting education partnership approach was devised to help the parent educator involve the child as the teacher by

focusing the parent on the child's needs and on emotional communication." (*Partner's In Parenting Education Educator's Guide*, p.1). PIPE promotes positive relationships and interactions between parents and children. As the parent-child relationship develops, a child will experience enhanced social and emotional competence in every relationship.

What is How to Read Your Baby's Philosophy of PIPE?

"The PIPE model and curriculum are designed to draw on the strengths of each parent to help the parent become more emotionally available. Our belief is that the skills of emotional availability can be learned and will become internalized if parents have the right information and have the opportunity to practice with the support of a knowledgeable and caring educator or home visitor. This sharing and caring can lead to a new and enduring internalized model of behavior" (*Partner's In Parenting Education Educator's Guide*, p.1).

Why Use PIPE in Nurse-Family Partnership?

Nurse-Family Partnership clients are first-time, high-risk parents who can benefit from the conceptual teaching with concrete application, role modeling, and interactive skill building, which you provide through PIPE. A number of factors make PIPE the curriculum of choice:

PIPE Is Based on Sound Educational and Psychological Research.

The theoretical framework is derived from the models of Liz Bates, T. Berry Brazelton, Robert Emde, Stanley Greenspan, Louis Sanders, Allan Stroufe, Edward Tronic, and Lev Vygotsky.

PIPE is Child-Focused.

Parents learn skills in observing and responding appropriately to their children. They learn that their baby can teach them. The baby is their parenting training manual!

PIPE is Inclusive in its Approach.

The curriculum acknowledges more than just the parent and child. The following individuals are recognized as having expertise. Their expertise and involvement play a role in the development of the parent and child's relationship:

- Parent
- Baby
- You, the nurse home visitor!
- Family members
- Childcare providers/child development specialists
- Program supervisor/administrator

PIPE is Experiential.

The curriculum is experiential because it allows you to use the parent's experiences to teach the parenting concepts in each topic. Those experiences might be from the parent's past or the experience will arise because of an activity that you and the parent do together. It is also experiential because you demonstrate activities they can do with their children while you quietly support them.

PIPE Addresses the Emotional Relationship between a Parent and Child.

PIPE is Fun!

It's easier for parents to connect with their children (and with you) when they are having fun. One nurse home visitor who has used PIPE consistently in her visits with clients shared that the laughter and fun moments that she and her client, Anna, experienced during the PIPE lessons with her son, Johnny, were the 'glue' to their relationship. PIPE promoted a positive relationship, not only between Anna and Johnny, but between Anna and this nurse!

Think about it…

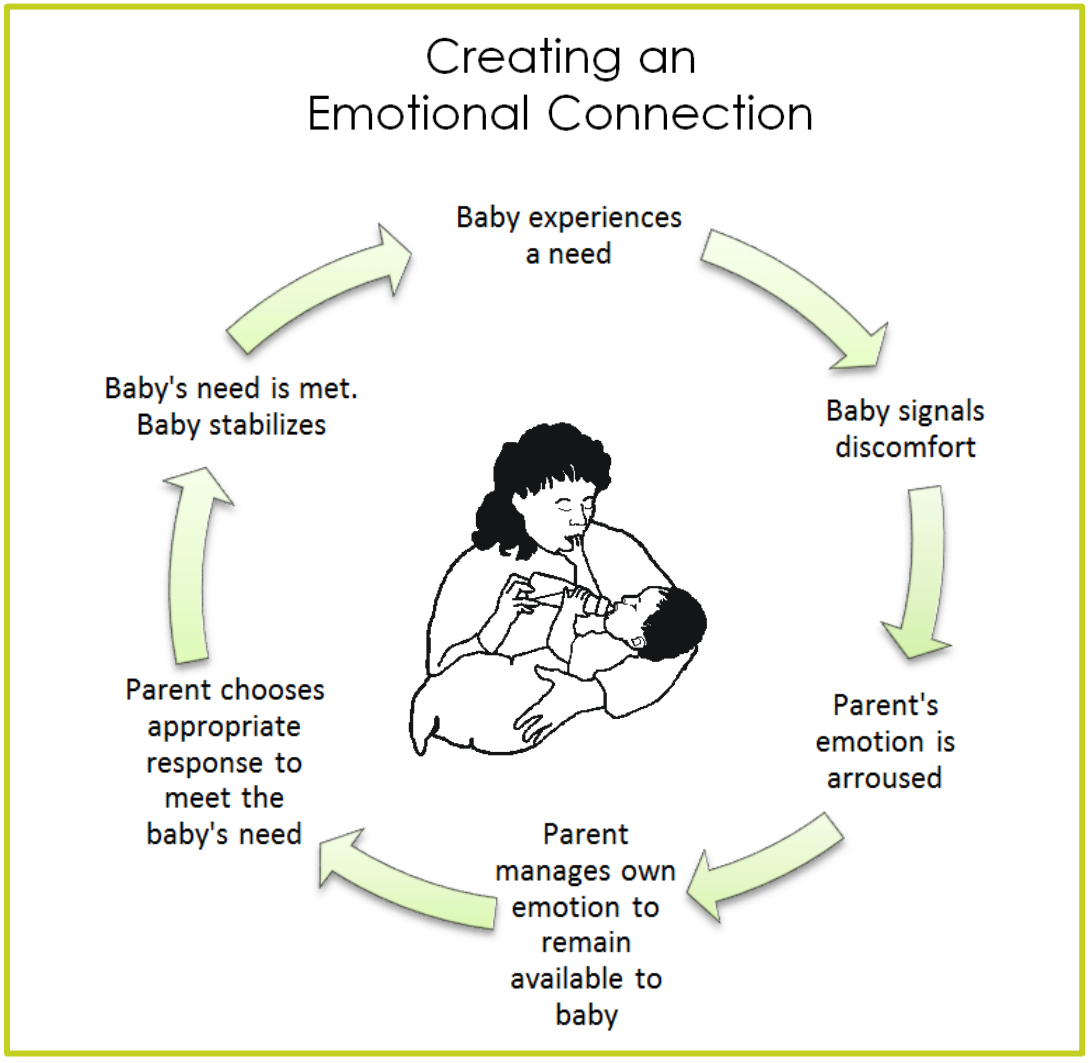
Think about the characteristics and life situations of Nurse-Family Partnership clients. Take a moment to reflect on the following questions.

- What are the strengths?
- What are the challenges they are facing or will face as new mothers?
- What kind of parent does each client want to be and what does she hope to achieve with her child?
- How might the PIPE curriculum be useful in your visits with Nurse-Family Partnership clients?

PIPE and Emotional Connectedness

Parents and children need to develop an emotional connection. Learning to emotionally connect can be a complex and challenging process. It is vital to the child's development. Likewise, supporting a parent and child to develop an emotional connection can be a challenge while also very rewarding. Since the goal of PIPE is to promote emotional

connectedness of parents and children, and this is one of your goals as a nurse home visitor, let's consider what this connection will look like. An emotionally responsive parent is "able to read, listen to, and respond appropriately to a baby's emotional signals" (Dolezal, S.F., Knox, R.M., Meyer, J. & Perkins, J., *PIPE Training and Implementation Manual* 2002, p.11). When on a repeated basis, a baby signals a need and the parent responds appropriately, an emotional connection develops and secure attachment is more likely to occur. The infant also learns how to self-regulate through the positive mutual regulation in the relationship.



Take a few minutes to review the 28 PIPE topics on the next page that you will have the opportunity to use with clients. As you read the brief descriptions, try to match some of the topics with different areas of the cycle in "Creating an Emotional Connection" above. Which topic(s) would support a client to recognize her baby's signals of discomfort?

Instructional Topics of the Three PIPE Units

'Listen, Listen, Listen' focuses on emotional communication, regulation skills, and respecting baby as an individual.
'Love is Layers of Sharing' focuses on attachment and relationship building.
'Playing is Learning' focuses on play as a way children learn and the importance of emotional stability for learning

PIPE Unit Topics

Listen, Listen, Listen

Listen

Cribside Commmunication
Reading a baby's state of awareness

Patterns and Expectations
Biorhythms and establishing a daily routine

Baby Cues
How a baby uses body and voice to communicate

Tune In/Tune Out
Engagement and disangagement cues

Floor Time
Guidelines for playing

Learning Language
Developmental stages of language: the parent's role in expanding language

Music and Rhythm
Use of music and rhythm for regulation

Reading to Baby
Reading is a fun shared activity that helps a baby learn

Love is Layers of Sharing

Love

Love Is in the Palm of Your Hand
A baby's first relationship is with parents

Each Child is Different
Temperament concepts; sensitivity to another's uniqueness

Love Needs a Safe Base
How a baby learns trust

Joy and Laughter
Sharing positive emotions builds relationships; negative emotions caution and alert

Touch Tones
Touching communicates love

Attachment
Feelings of belonging and commitment

Love Is Letting Go
Allowing and respecting separation and autonomy

Love and Limits
Quiet discipline; regulation of emotional extremes

Love Is Sometimes a Rocky Road
Ambivalent feelings are normal; problem-solving techniques

Emotional Refueling
Need for personal identity, space and support systems

Playing is Learning

Play

Playing Is Learning
Playing is a good way to learn and master skills

Playing Is Learning About Diferences
Developmental stages; appropiate expectations; differences in temperament

Baby's First Teacher
Modeling; routines; teachable moments

What are Children Really Learning
Teaching styles; stabilization; socialization

Learning the "Do's"
The "do's" of behavior; sharing fun can regulate and communicate

Roadblocks to Learning
Negative emotions can sidetrack learning; limit setting

Playing Stimulates the Senses
Children learn through their senses

Playing Is Imitation and Turn Taking
Guidance; modeling; the give and take of interaction

Playing Is Communicating
Play sets communication patterns; finger playes can teach

Playing Is Problem Solving
Experimentation; autonomy

Each of the 28 PIPE lessons you just reviewed teaches parents how to connect with their children. Through relationships with their parents, children are learning vital lessons.

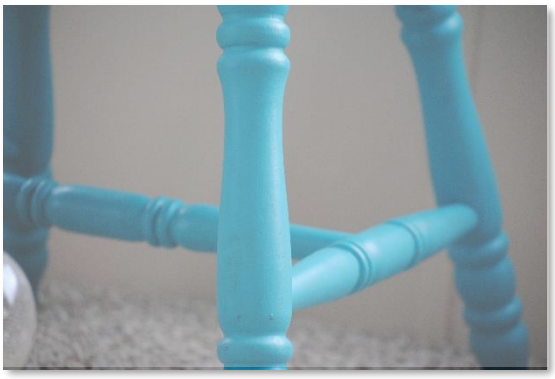
> What is learned at the beginning of life establishes a set of capabilities, orientations to the world, and expectations about how things and people will behave that affect how new experiences are selected and processed. The infant who has learned that he can engage his parents in play and makes objects do what he wants them to do acquires a fundamental belief in his ability to affect the world around him.
>
> *Shonkoff & Phillips, Eds. (2000) From Neurons to Neighborhoods, National Academy of Sciences, USA*

For these reasons, PIPE focuses on supporting parents in building strong positive relationships with their babies. Babies learn the following from their first relationships:

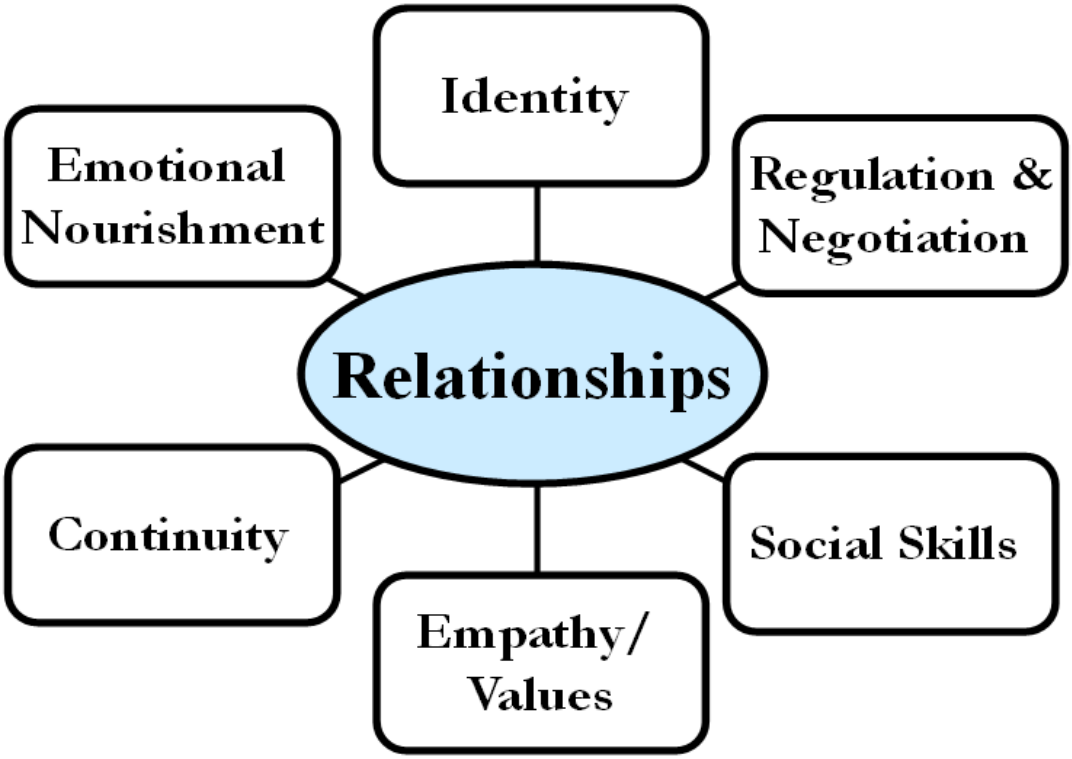
Identity	*Empathy/values*
Continuity	*Regulation/negotiation*
Social skills	*Emotional nourishment*

During a home visit, Johnny, an eighteen-month old in the Nurse-Family Partnership Program, demonstrated in a humorous way to his parents and their nurse what he was learning about relationships. After Susan and her nurse discussed the hazards of choking when a toddler is mobile with food in his mouth, Susan purchased a small plastic chair at a flea market that was just Johnny's size, as well as a wooden chair for herself. She would sit beside Johnny as he ate so that he would remain seated in his chair.

On this visit Johnny's mother went to the kitchen to prepare his lunch. Dad, who had a rare day off from work, sat down in the wooden chair. Johnny threw a fit. That was Mom's chair! He was not satisfied until his father moved to a different chair. Johnny's parents and his nurse enjoyed how Johnny had learned a 'rule' without their awareness of what they had been teaching him. Children learn social skills in their first relationships! As you review the relationship wheel, identify an example of what a child might learn in each area.



Major Areas Affected by the First Relationship



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Think about it…

Jot down the answers to the following question on a piece of paper

In the following table, match the descriptions of what babies learn (column A) with the characteristics (column B).

COLUMN A	COLUMN B
1. Learn if it is safe to have my feelings, if it is safe to express them and be genuine; I learn to relate to other's feelings through how my family relates to my feelings. 2. My family manages their feelings in a certain way and I learn how to manage my feelings from them; I learn to negotiate to get my needs met; when I can regulate my behavior I can sustain my relationships. 3. Who am I? I am loved; I have self-worth. 4. These are the rules in our home and our relationships; this is how I have learned to behave; this is what I expect to do and to experience in society. 5. When I feel loved, I can reach out; I can become interdependent. 6. My caregivers are here for me – over and over; I learn trust and I become resilient.	A. IDENTITY B. CONTINUITY C. SOCIAL SKILLS MODEL D. EMPATHY/VALUES E. REGULATION/NEGOTIATION F. EMOTIONAL NOURISHMENT 

Click here to check your answers

Core Emotional Development Concepts

The following eight core concepts of emotional development foster healthy parent child relationships. These concepts are like colorful threads woven throughout the PIPE curriculum. They are based on research and good practice. You can find the concepts on page 4 of the *Partners In Parenting Education Educator's Guide*:

When your clients are able to internalize these concepts and apply them by appropriately reading and responding to their babies' emotional signaling, their family relationships will be strengthened and as a result their children will be likely to demonstrate more confidence and resilience. Furthermore, when you are able to

demonstrate understanding of these emotional development concepts and apply them to your interactions with your clients, you will strengthen the emotional connection with your clients which in turn will influence the opportunities you have to support them in connecting with their children.

Think about it…

For each concept, reflect on the questions and jot down your answers and thoughts on a piece of paper.

Shared Positive Emotions: Building an emotional connectedness by sharing positive emotions

How will you and your clients share positive emotions together on visits? What might you do to increase the shared positive emotions?

Regulation: Behavior management through anticipatory response and quiet discipline

How will you observe ways y our clients self-regulate? How do you self-regulate? How will your clients' skills or vulnerabilities in this area affect how she will interact with her infant and support the baby's development of self-regulation?

Temperament; Individual differences and individualizing caregiving

How might you grow to appreciate your clients' temperaments? Which kinds of temperament do you find easier to interact with because of your temperament? Which temperamental traits present challenges for you?

Autonomy: Respecting the child's view, developing mastery skills, and using scaffolding techniques

How can you demonstrate respect for a client's need for autonomy? How can you support a client to further develop their autonomy? What challenges do you suspect you will encounter in teaching clients how to support their infants' development of autonomy?

Communication Skills: Listening, relationship building, language, and problem solving

How will you and your clients communicate? What strengths do you have in this area? What challenges might your clients experience in communicating with others?

Emotional Refueling: Time when the caregiver can refresh and renew

Emotional refueling is essential for coping with the stressors of life. Nurse home visiting can drain you of your energy. How can you emotionally refuel? What are ways that your clients might manage their stress? How might learning about emotional refueling support them to be more effective, nurturing and emotionally responsive parents?

Trust: Being constant, reliable, and supportive; feeling safe

How can you demonstrate to your client that you are trustworthy? What are challenges you might experience with clients in gaining their trust? How will their past history affect their ability to trust? Who in your personal life is consistently there for you and makes you feel safe?

Interdependence: Sharing commitment to another; feeling a unique connection or sense of belonging; attachment

With whom do you feel unique connections and a sense of belonging? How can you support a client to develop a commitment to her infant, and promote connections between your client and her infant? What do you see as challenges with clients in this area?

The PIPE Model: Assessing Your Clients

As you prepare to teach PIPE and support clients in setting goals, as well as provide them with the information or skill building opportunities they lack as new parents, you will need to first assess their strengths and vulnerabilities in a given area. Nurse-Family Partnership Nurse Home Visitors use the acronym 'ASKS' as a reminder to assess a client's *attitude* regarding a certain topic for learning and potential behavior change, her *knowledge*, *skills* and the quality and quantity of *support* she has from family, friends and other professionals. Once you have assessed the client (and her partner if he is present) in all four areas, then you can affirm strengths while addressing areas of vulnerability. Here is the ASKS acronym with brief definitions:

- **A**ttitude**:** Client's values and beliefs, which may surface during the PIPE lesson
- **S**kills**:** Client's abilities to perform
- **K**nowledge: Client's understanding of the concepts, ideas, and facts
- **S**ituational Supports: Family, friends, professionals, and community support for the client in developing new behaviors

With each client you will want to assess all four areas and note where her strengths are and where she will need more support.

Case Studies

Below you will are two case studies for clients Adriana and Lucy.

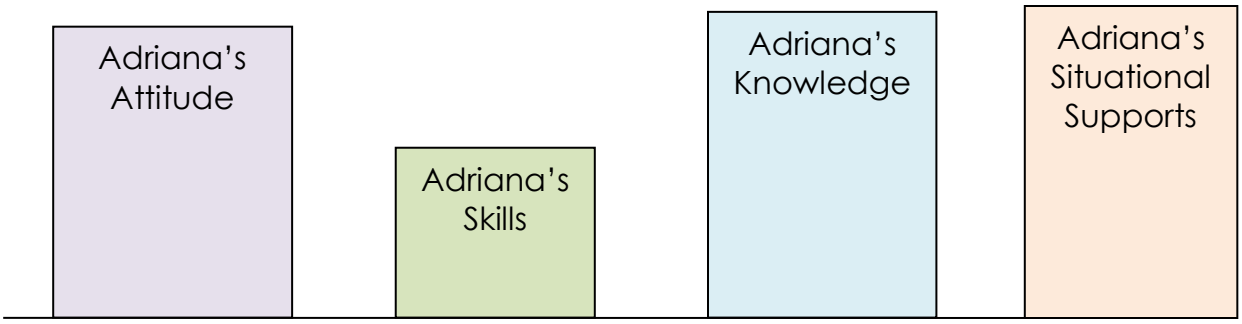
Adriana

On a home visit, Adriana shares with you, "I know it's very important for me to understand what Josh is trying to tell me. I really want to be there to meet his needs just like my mom was there for me. She told me that I can't spoil Josh by being there for him when he needs me. I get really upset when he cries, and I can't figure out what he is trying to tell me. How can I be a good mom when I'm not sure what Josh is saying when he cries?!" Because Adriana is a teenager, you know that the prefrontal cortex of her brain is still developing, and it is normal for her to have more difficulty reading Josh's cues.

What are Adriana's strengths?

Where does she need support?

A bar graph depicting an ASKS assessment of Adriana's strengths and vulnerabilities might look like this:

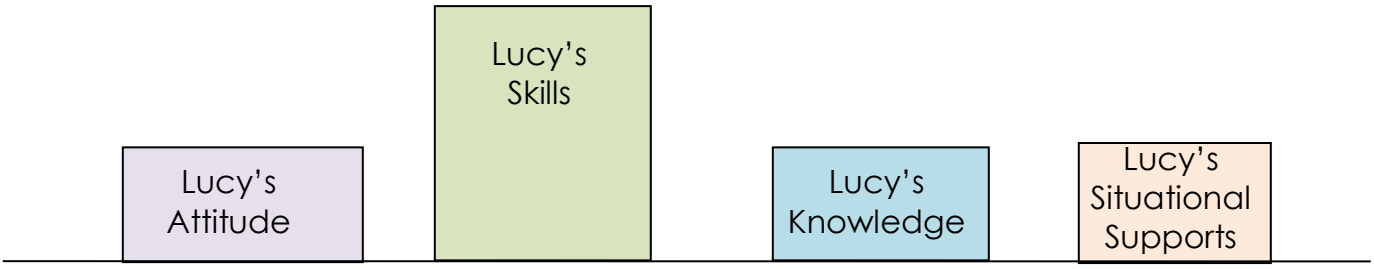


You respond to Adriana, "It can be hard at first to read a baby's cues. Thank you for sharing with me how frustrated you feel. I have a handout that many clients tell me is really helpful for them to understand what their babies are saying. It's called "Infant Cues." I carry extra copies with me for situations like this. Would it be helpful to you for us to discuss this now? (Your agency should have copies of the NCAST Infant Cues booklet; use a copy when reviewing this section.) After completing this self-study and attending Unit 2 you will also have topics from the PIPE curriculum, which will enhance your clients' knowledge and skills in reading their infants' cues.

Lucy

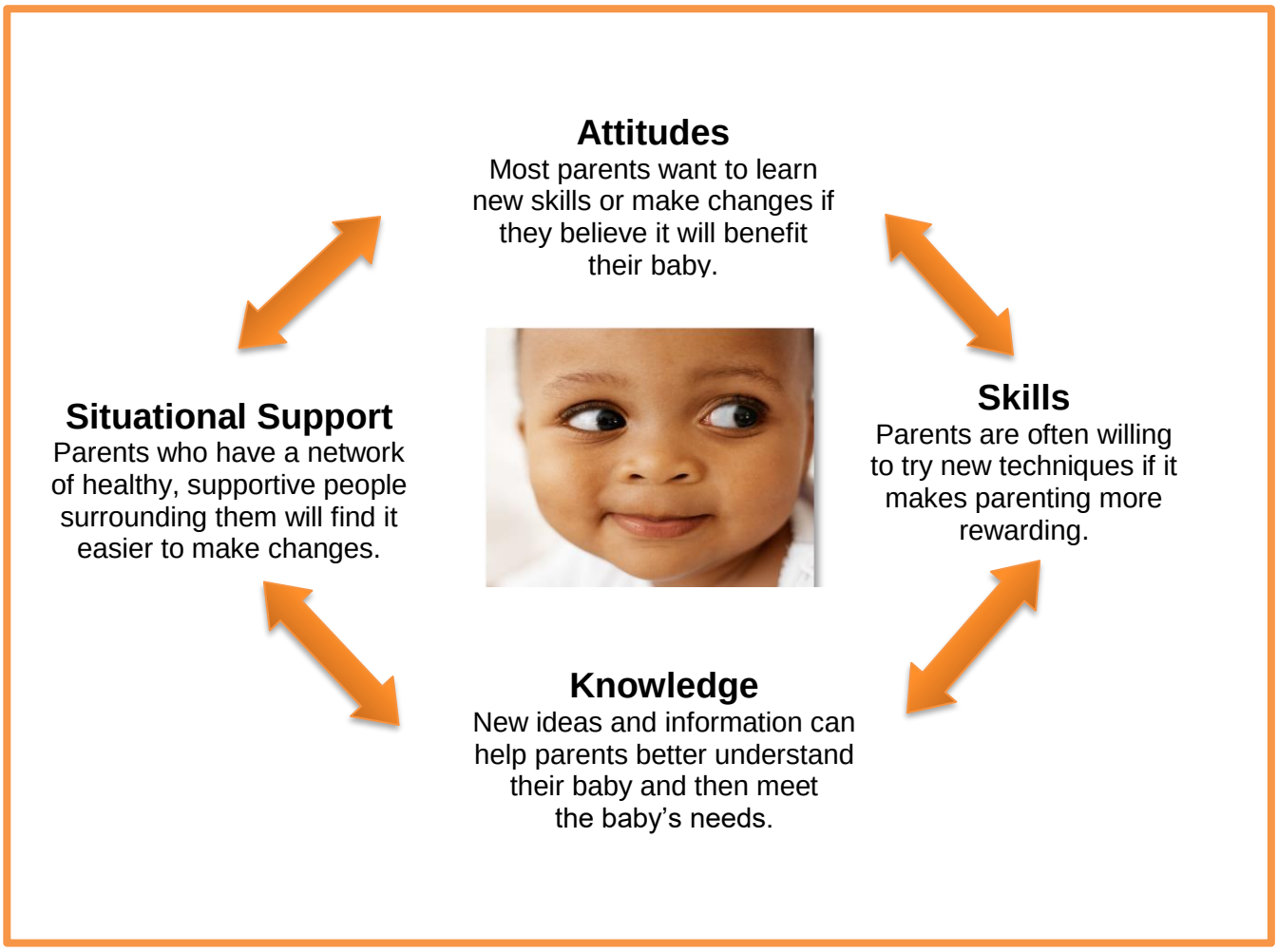
Lucy is a client in a different situation as she seems quite competent in her skills of reading her baby's cues. However, Lucy believes she will 'spoil' her baby if she responds to his cries too soon.

She knows when he is hungry, wet, or sleepy but delays responding to help him, "be tough." Her grandmother is supportive of Lucy and encourages her to respond to her baby. However, Lucy's boyfriend, John, has told her he doesn't want a 'sissy' for a son. He tells her to let the baby cry, and Lucy seems eager to please him. In this case, you have a lot more work to do with Lucy in the areas of her attitude and knowledge. You also have work to do with John. You read about Motivational Interviewing this workbook and will learn more about it in Unit 2 education. You will want to use MI strategies to seek to understand Lucy and John, as well as to support them in considering their options. A bar graph depicting an ASKS assessment might look something like this:



A New Baby Becomes a Motivator for Change

In the PIPE Model, the baby is the teacher. When parents become skilled at reading their babies' cues, their job as parents is easier and may be more satisfying.



Handout adapted from "P.I.P.E Training/Implementation Manual," 2002, p. 14.

The PIPE Instructional Model

You are likely to be more effective as an educator if you have a curriculum which structures parent learning according to researched learning strategies. The good news is that the PIPE curriculum gives you an instructional model based on sound educational research. The goal of this model is to, "provide a framework for parents to become aware of the concepts of emotional development and attachment and integrate them into their parenting philosophy and practice" (Dolezal, S.F., Knox, R.M., Meyer, J. & Perkins, J., 2002, p.19). Every parent can benefit from seeing a demonstration of theoretical concepts actualized concretely in doable parenting skills. Every parent can

also benefit from having the opportunity to practice with a coach. High-risk clients need to observe role modeling; practice hands-on learning activities receive feedback and have someone facilitate reflection. Their sense of self-efficacy may be low. From the research behind Motivational Interviewing and Self-Efficacy Theory we know that no one makes a change until they are ready, willing, and able. Clients who are only provided with theoretical concepts are not likely to develop the confidence and skills they need to follow through when you are not around.

There are four steps to the PIPE Instructional Model. Take a moment to look at the steps, and then in the space provided compare the PIPE step to what each nursing step would be if you were teaching a newly diagnosed diabetic how to give herself an insulin injection rather than teaching her a parenting concept and skill.

PIPE Instructional Model Steps

1. **Presentation of Concepts**
2. **Demonstration**
3. **Supervised Parent-Child Interaction (In the Nurse-Family Partnership we choose to call this step the Return Demonstration)**
4. **Evaluation**

Now take a few minutes to read descriptions of each of the steps. How will teaching a parent PIPE using the four steps be *different* from your experience as a nurse teaching a diabetic?

PIPE Instructional Model Steps

1

Presentation of Concepts:

The concepts provide a client with a knowledge base and understanding which can last a lifetime. When you teach the concepts, you will want to support the client to consider how the concepts apply in her life as a parent with an infant or toddler. Frequently these concepts apply in other relationships. Additionally, many of the concepts can be helpful for the parent to remember and use when their child is older. Here is what you will want to do:

- Introduce the topic so your client sees the value (what's in it for me, also known as the 'hook') and can relate to it.
- Introduce the topic in a fun, fast, and focused manner. Sometimes using animal artwork is faster than the suggested activity.
- Explore with the client how these concepts are applicable not just for the current stage of the infant or toddler's life but also in other relationships and in the future when her child is older.

2

Demonstration:

You will want to give your client a choice of two or three activities from which she can choose. You will demonstrate the activity your client indicates is interesting with a doll or stuffed animal, which represents your "infant" or "toddler". You might also consider asking your client to play the role of their child and demonstrate with them. You will not want to use the client's child for demonstration. Can you think of reasons why not? This is what you will want to demonstrate:

- What a positive interaction between a parent and child might look like.
- How a parent can have fun and enjoy their child.
- How to use simple games, songs, and caretaking routines to create opportunities for parents and children to interact positively.
- What a parenting skill looks like so that the client can see that it is doable.
- How to have fun while bridging the gap between a theoretical concept and how it looks in real life.

TIP: When you are preparing to demonstrate an activity and need to understand the purpose, look at "Why" under Step 3: Supervised Parent-Child Interaction.

3 **Supervised Parent-Child Interaction (In the Nurse-Family Partnership we choose to call this step the Return Demonstration)**

You will want to position yourself out of the line of vision of the child but where you can observe the interaction. Share with the client that you enjoy watching them interact with their child. You are available if they need support but you don't want to be a distraction. You will want to:

- Provide an opportunity for your client to practice.
- Provide an opportunity for your client and the child to enjoy each other.
- Ensure your client can successfully apply the concept.
- Ensure your client doesn't just know what works, but they can do it.
- You will only interrupt the interaction if your client and/or the child become frustrated, tired, or upset and your client is unable to resolve the problem. The goal is to ensure that both parent and child are enjoying the interaction and staying connected.

4 **Evaluation:**

This step actually needs to occur throughout every step. Observe for your client's understanding and how each member of the dyad is enjoying the experience. After you have presented the concept(s), demonstrated and observed the return demonstration, you will want to explore with your client what worked and did not work and how they might interact even more effectively in the future. You will want to:

- Ask your client open-ended questions to help her "wait, wonder and respond". This skill will be addressed in the Maternal Role face-to-face session.
- Reflect on the parent-child interaction by asking your client if she or he liked it and what they thought of it. You don't have to ask a question if it was obvious that enjoyment was occurring.
- Ask the parent how they felt their child responded to the activity.
- Each topic has questions you can ask or you can use the "Face Check" parent handout.
- Check for integration of the topic by exploring your client's understanding of the concept.

An example of a question you might ask is: "If you were telling _____ (someone important to the client) why _____(whatever the topic is) is important for babies and parents, what would you share?

Important Point: Even though the PIPE curriculum labels the four steps in sequence and you will need to be familiar with each of the steps, there are times when you might present a good lesson in a different order. For example, you might demonstrate an activity and then give the client the knowledge base. However, you will **ALWAYS** want to demonstrate before you ask your client to interact with her baby. Why do you think demonstration first is so important for high-risk clients who may not have had healthy role models?

The following table provides you with an overview of the research of Joyce and Showers (2002). When you read the table, please pay special attention to the influence of coaching on a learner's ability to transfer skills to the work setting. If the home is the client's 'work setting' for parenting, what would happen if you only present concepts, demonstrate, and provide a little feedback? Coaching in the home setting is an *essential* educational strategy to support client's in developing knowledge, being able to demonstrate the behavior and, most importantly, transferring the knowledge and skills to their parenting when you are not there. What can you do to become more comfortable and confident with providing feedback to clients after the PIPE lesson?

	OUTCOMES		
Components	**Knowledge**	**Skills**	**Transfer**
Study of Theory	10%	5%	0%
Demonstrations	30%	20%	0%
Practice	60%	60%	5%
Coaching Supervised Practice	**95**%	**95**%	**95**%

From Bruce Joyce and Beverly Showers' book Student Achievement Through Staff Development printed in 2002

% = Number of trainees who reach level of competence

Summary of the PIPE Model

Think about it…

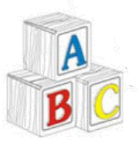
We've explored the PIPE Model's focus on emotional connectedness, the eight core concepts, assessment through use of the ASKS Model, and, lastly, the four-step PIPE Instructional Model. On a piece of paper, write down any questions you have at this point and plan to ask them when you attend Unit 2.

The PIPE Curriculum

The *Partners In Parenting Education Educator's Guide* (2002) is composed of three units. The following icons are used to differentiate each unit:

Puzzle pieces represent the *Listen Unit*. Sometimes parents can be quite puzzled by infant and toddler communication! The "Listen" Unit is very useful during the first year of a child's life. This unit supports parents to learn skills in emotional connection, regulation and demonstrating respect for their children as unique individuals.

A teddy bear represents the *Love Unit*. This unit focuses on attachment and relationship building. Any of the topics in this unit may be used through age three. Relationships experienced in early childhood can have a long-term effect on the mental health and social well-being of children.



Building blocks represent the *Play Unit*. This unit supports parents to understand how children learn through play. Parents also will begin to understand the importance of emotional stability for human learning.

The three units in the *Partners In Parenting Education Educator's Guide* are separated by a purple page divider with a different photo of an infant highlighted for each unit and the title of that unit in bolded white text. Take a few minutes to find each divider in one of your team's copy of the educator's guide.

Think about it…

At the beginning of each unit, you will find a page listing the topics with a brief description of each. Turn to page 21 in the *Partners In Parenting Education Educator's Guide* and find out how many topics are in the Listen Unit.

If you were working with a client whose life is very chaotic and routines appear to be lacking, which topic(s) might you want to present as soon as possible?

Now turn to pages 22 to 23 in the *Partners In Parenting Education Educator's Guide*. Notice that these pages provide you with a conceptual plan with more details. If you were uncertain which topic you wanted to use, this plan might support you to figure out quickly what the key concepts are. Each unit has the eight concepts of emotional connectedness woven in them but each topic highlights certain concepts to a greater degree. While you can't go wrong in what you choose, if you need to emphasize one concept, you may want to look at the conceptual plan to identify the topic best suited to the need.

See how quickly you can find the topic, which contains the key concept "Children will engage in play for a longer time when parents teach by scaffolding rather than trying to direct their child's play": What is the topic's title?

Next you'll want to find the ten topics and the conceptual plan for the *Love Unit*. Which layers of love might you want to begin teaching while a client is pregnant?

How to Read Your Baby recommends you use a doll to demonstrate and that the client then interacts with her child after you demonstrate. During a client's pregnancy, you can always use a doll and then have the client use it. Nurse-Family Partnership nurses have found this works well if they feel comfortable with the doll and have practiced how to make it 'come to life' through their tone of voice and interactions. Finding a doll that you can bond with is important! Naming it may also be helpful. One Nurse-Family Partnership nurse home visitor described how she chose the name of a favorite nephew because she could envision her interactions with him and transfer those skills to the demonstration with the doll. Please keep in mind that if you don't feel comfortable demonstrating with the doll, your client won't feel comfortable either. Another strategy might be to ask the client to pretend to be her child. Then you demonstrate an activity with her so that she sees the interaction modeled. Some nurses find they are more comfortable with this teaching strategy, and that clients enjoy the role play.

Think about it…

Why do you think How to Read Your Baby recommends you NOT demonstrate using the client's child?

What name might you choose for a male doll baby? A female?

How will you make the experience of demonstrating with a doll or with the client fun?

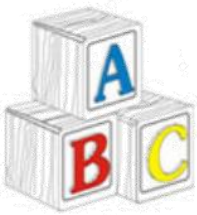
How will you develop your confidence in demonstrating a parent-child activity so that the client can envision from your role modeling how she will interact with her baby?

There is one unit left to explore. See if you can find the ten topics and conceptual plan for the *Play Unit.*

- If one of your clients is struggling with anger management, which *Play* topic might you want to use?
- What is the total number of topics in the PIPE curriculum?

How many Listen topics?

How many Love topics?



How many Play topics?

Now we're ready to look at the format for each PIPE Topic. Please keep in mind that the icons will change depending on which unit you are looking at; however, the format of each topic will always be the same. Turn to the *Listen Unit*, Topic 1, Cribside Communication and see if you can find the following sections. For each section, take a few minutes to answer two questions.

 **LISTEN UNIT:** **PIPE Topic** Cribside Communication	**Where is this section in this topic?**	**How will I use it?**
Topic Title Page  **Inquiry Questions**		
Conceptual Overview		
Tools for Presentation • Suggested Activities • Other Materials and Supplies • Master Pages in Parent Handouts Notebook	Notice that the Master Pages without page numbers in parenthesis are found only in the Parent Handouts Notebook while a page number in parenthesis means it is also in the Educator's Guide.	

Instructional Plan
• Presentation of Concepts
• Demonstration
• Supervised Parent-Child Interaction
• Evaluation
  ○ Evaluating the Parent-Child Interaction
  ○ Topic Evaluation and Closure		

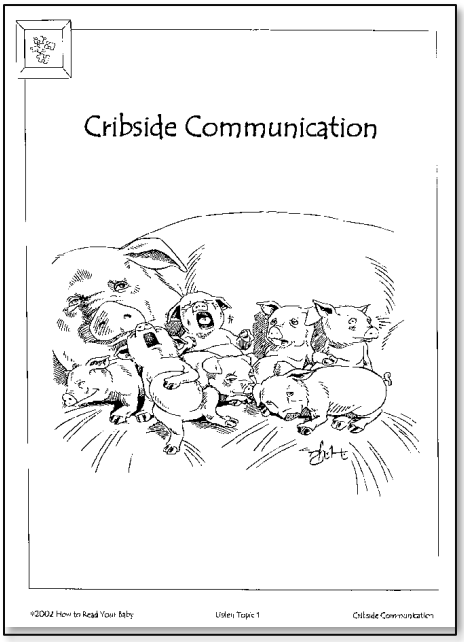
Topic Enhancers & Instructional Aids		

Turn to page 25 of the *Partners In Parenting Education Educator's Guide* and read the five inquiry questions.

How comfortable are you in answering these questions? How confident are you that you can *teach* a parent the concepts and skills associated with these questions?

If you don't know the answers to these questions, what section of the *Listen Unit*, Topic 1, "Cribside Communication" would you want to read carefully?

Now turn to pages. 30 to 31 and count the large shaded squares (■). How many are there? Whenever you see a large shaded square in the Instructional Plan, it alerts you to a key concept. The smaller shaded squares are sub-concepts. The empty squares (☐) indicate teaching strategies. In a home visit you will not have time to teach all of the concepts. You will want to choose one or two key concepts to teach.



To complete a PIPE Topic you are likely to need one or two parent handouts. Turn in your *Partners In Parenting Education Parent Handouts* binder to "Cribside Communication," which is behind a purple divider in the *Listen* section. Look for the animal artwork you see to the left.

Every topic has animal artwork. Many parents enjoy the animal artwork and they can be very effective with low literacy clients or teenagers. An advantage of the Animal Artwork is that it is ethnically neutral. This is a mother pig with piglets in the various states of awareness. Some nurses find it easy and fun to use the artwork to introduce a topic quickly to a client.

What open-ended questions might you ask a client when using the Animal Artwork to help her think about the various states of these piglets and what the mother pig might be feeling? Here are some examples of questions that could lead to good discussion:

- This pig has seven little piglets and each one is communicating a different state. If this parent knows how to read the states of her piglets and respond to them, parenting will be so much easier and the piglets and parent will be happier!!! What do you think this pig is feeling right now?
- When you look at each of these piglets, what do you think they are communicating?

- Which of your baby's states is easiest for you to understand and respond to?
- What do you find most difficult with your baby's states?

In addition to the *Partners In Parenting Education Educator's Guide* and the *Partners In Parenting Education Parent Handouts*, you will need a set of *PIPE Activity Cards*. Turn to page 28 in the *Partners In Parenting Education Educator's Guide* and note the seven activity cards suggested in the silhouette of a file card.

Each topic includes suggestions for Activity Cards, which you can use in the Demonstration, and then let your client practice with her baby. When you leaf through the entire set of Activity Cards, you will notice that there are other activities which you might use that are not listed in that specific topic. It is fine for you to use different activities as long as they provide an opportunity for the client to practice the parenting skills discussed in the topic while she is interacting with her child, so that emotional connectedness and understanding occur. You need to be clear on why a parent is doing an activity. The reason why a parent is doing an activity is always addressed in Step 3, Supervised Parent/Child Interaction (Return Demonstration).

Activity Cards with Numbers:

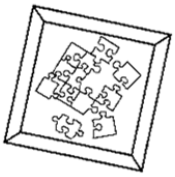
- 1 to 54 are games in English. If you have the most current cards, a Spanish translation is on the reverse side of the card.
- 55 to 106 are rhymes and songs in English. In the most current version (2008), 55 to 133 are rhymes and songs with English on one side and Spanish on the other.
- 107 to 133 are rhymes and songs from the Latino culture in Spanish on one side and English on the other.

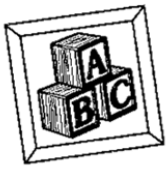
If you see the letter 'I' after the number, this means that the activity is most appropriate for infants. If you there is a letter 'T', you can use the activity with a toddler. If there is only a number, then this tells you the activity will work with both age groups.

On the next two pages, are four examples of suggested activities from the topic "Cribside Communication." Take a few minutes to examine your own set of Activity Cards and find other ones you might use with this topic.

#14

DANCE, BABY DANCE



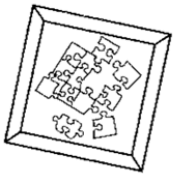


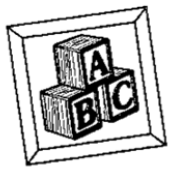
Materials: Children's fun music

Directions: Hold baby/toddler in your arms as you dance with the music or let baby stand on your lap as you sway to the music. Toddlers may want to stand on the floor to dance. Kneel in front of older baby. Hold onto baby's hands or just let baby stand. Turn on music and move with the beat. Show your baby how to enjoy the music. Clap your hands. Swing your arms. Sway and snap your fingers. Laugh and have fun.

#43-I

SECRETS

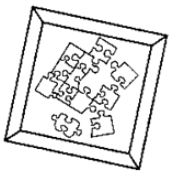


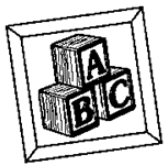


Materials: Rocking chair or quiet corner

Directions: Cuddle baby close to you and tell baby how special he/she is to you. Try whispering or using a squeaky voice; keep changing voice tones and see which voices baby likes. Make sure your baby can see your eyes.

#89





ROCK-A-BYE BABY

Materials: Rocking chair and a quiet corner

Directions: Cuddle baby/toddler up close and softly sing a lullaby. Here is a famous old one most everyone knows.

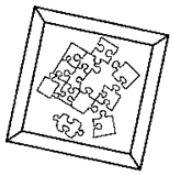
Rock-a-Bye Baby…In the tree top.

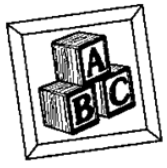
When the wind blows…Your cradle will rock.

If the bough breaks…Your cradle will fall.

And I will catch Baby…Cradle and all.

#109





ARROZ CON LECHE

Instrucciones: Síentese con su Bebé/Nino mirandola a usted. Crea sus propios movimientos para esta rima.

Arroz con leche,
Me quiero casar
Con un mexicano
Que sepa cantar.

El hijo del rey
me manda un papel,
me manda decir
que me case con él.

Con este si,
con este no,
con este mero me caso yo.

RICE PUDDING WITH MILK

Directions: Sit with baby/toddler facing you. Make up your own motions to go with this rhyme.

Rice pudding with milk,
I'd like a gold ring
From a Mexican boy
Who knows how to sing.

The son of the king
Has sent me a letter
To say, as my husband,
That he would be better.

With this one yes,
With this one no,
Eeney, meeney, miney, mo!

On the following pages is a sample teaching guide, or lesson plan called a "PIPE Planning Sheet," for the *Listen* topic "Cribside Communication." Take time to read the teaching guide and then carefully read the Instructional Plan on pages 30 to 33 of the *Partners In Parenting Education Educator's Guide*. As you read the Instructional Plan, refer back to the "PIPE Planning Sheets" and answer the following questions (it might help to write them down on a piece of paper):

1. Which key concepts (■) did the educator choose to use for the PIPE Planning Sheet?

2. If the baby is in the right state of interaction, why did the educator who created the PIPE Planning Sheet decide that Step 2 should demonstrate one of the activity cards before having the parent do so?

   Hint: While the PIPE curriculum emphasizes demonstration before the client performs a return demonstration, in this particular lesson the focus is on states. Although demonstrating a specific activity is not mentioned for this topic always remember to demonstrate an activity first. The activities for each topic are found in Tools for Preparation under Suggested Activities.

3. Which questions in Step 4 of the *Partners In Parenting Education Educator's Guide* do you like the best?

   Why?

Sample PIPE Planning Sheet/Teaching Guide: Cribside Communication (Listen, Topic 1)

Step 1 – Presentation of Concepts

- Help your client understand that communication between parent and baby begins at birth and babies help direct their care through their states of awareness.
  - ☐ Discuss the states of awareness that your client has noticed in her baby. You may want to play the suggested game of "Communication Charades" with a young client.
  - ☐ If she cannot identify states use the animal artwork found in the *Partners in Parenting Education Parent Handouts* (for low literacy clients), the handout "States of Awareness Chart" (higher literacy), or NCAST Keys to Caregiving Booklet #1.

Step 2 – Demonstration of Concepts

Help your client recognize her baby's different states and demonstrate the appropriate action to take for each state.

- If the client's baby is in a quiet alert state and ready for interaction, use one of the suggested activities to **demonstrate** with the doll what you would like the client to do with her baby. You might bring two or three photocopies of different Activity Cards and let the client choose which one she wants to learn. (The Activity Cards are listed on p. 28 of the *Partners in Parenting Education Educator's Guide*: #14, 43, 55, 57, 89,. 109, 114)
- If the client needs to build skills in calming and stimulating her baby, use your doll to demonstrate using repetitious activity to calm, and variety or novel activity to stimulate.

Step 3 – Return Demonstration (Supervised Parent-Child Interaction)

If the baby is in a quiet alert state, the parent interacts with her baby using the activity you demonstrated or she can use repetitious activity to calm her baby or variety and novel activity to stimulate. Observe for examples of how she is demonstrating appropriate actions to change her baby's state.

Step 4 – Evaluation – concept & interaction

- Ask the client how understanding and responding to her baby's states might promote enjoyable connections. How did the client and baby enjoy the activity? Affirm her strengths.
- Assess client's understanding of different states and ways to regulate states.
- Ask the client how understanding and responding to her baby's states might promote enjoyable connections. How did the client and baby enjoy the activity?
- If the client needs reinforcement, ask her to watch other people this week who are having success or difficulty regulating baby's states; then follow up at the next visit. What worked? What didn't? What could they have done differently?

Think about it…

For your own review, take some time to think about these questions and jot down your answers on a piece of paper. You don't need to bring this to Unit 2, but we will spend significant time reviewing and practicing PIPE.

Three things I like about PIPE:

1.
2.
3.

Three things I will find challenging about PIPE:

1.
2.
3.

Answers to Emotional Connectedness Matching Activity

1. **Matches → D**
2. **Matches → E**
3. **Matches → A**
4. **Matches → C**
5. **Matches → F**
6. **Matches → B**

Chapter 15

Introduction to Using the eGuidelines

Nurse-Family Partnership
Helping First-Time Parents Succeed

Introduction to Using the eGuidelines

Purpose

The purpose of this chapter is to give NFP nurses an introduction to using the eGuidelines, the online Visit-to-Visit Guidelines and Facilitators.

Objectives

- Access and navigate the Visit-to-Visit Guidelines website, the eGuidelines
- Search for facilitators to address client needs using keywords and filters andplace facilitators in the cart
- Create planners for new clients and identify the functions of planners in organizing client information
- Identify the difference in specific and general nurse instructions, and how they support the nurse in using facilitators to discuss key topics with clients
- Explore Visit Guidance and how it supports planning for visits

Before You Proceed

This chapter requires you to be online in the eGuidelines website. To make it easier to navigate this chapter, we recommend you print it so you can follow the directions in the chapter while being in the website at the same time. Another option is to use two monitors and have this chapter opened in one monitor, and the eGuidelines open in another monitor.

The Visit-to-Visit eGuidelines Website

The Visit-to-Visit Guidelines, also known as facilitators, are housed in the eGuidelines website at https://vtov.nursefamilypartnership.org/Login. Throughout this chapter you will be asked to go to the website and practice using the guidelines.

As you prepare for Unit 2, use this time to learn how the eGuidelines work and become familiar with the site. At Unit 2, you will use technology to further access the eGuidelines and plan client visits.

The Visit-to-Visit Guidelines were developed to support nurses in addressing key areas within each domain.

- Each facilitator topic within the guidelines flows from one of the six domains and directly leads to one of the three key program outcomes.
- Facilitators are intended to open the door to key conversations with clients.
- They are a client centered means to assist clients toward significant behavior change and goal setting.

Facilitators and the eGuidelines:

1. Assist clients achieve program outcomes
2. Provide client choice
3. Offer guidance for discussions about topics of interest and importance to clients
4. Facilitate nursing assessment
5. Help nurses plan for future visits

Introduction to Using the eGuidelines

Open the eGuidelines; we recommend using either Google Chrome or Safari. If you can avoid it, do not use Internet Explorer, as this browser is no longer supported by Microsoft and may have performance issues.

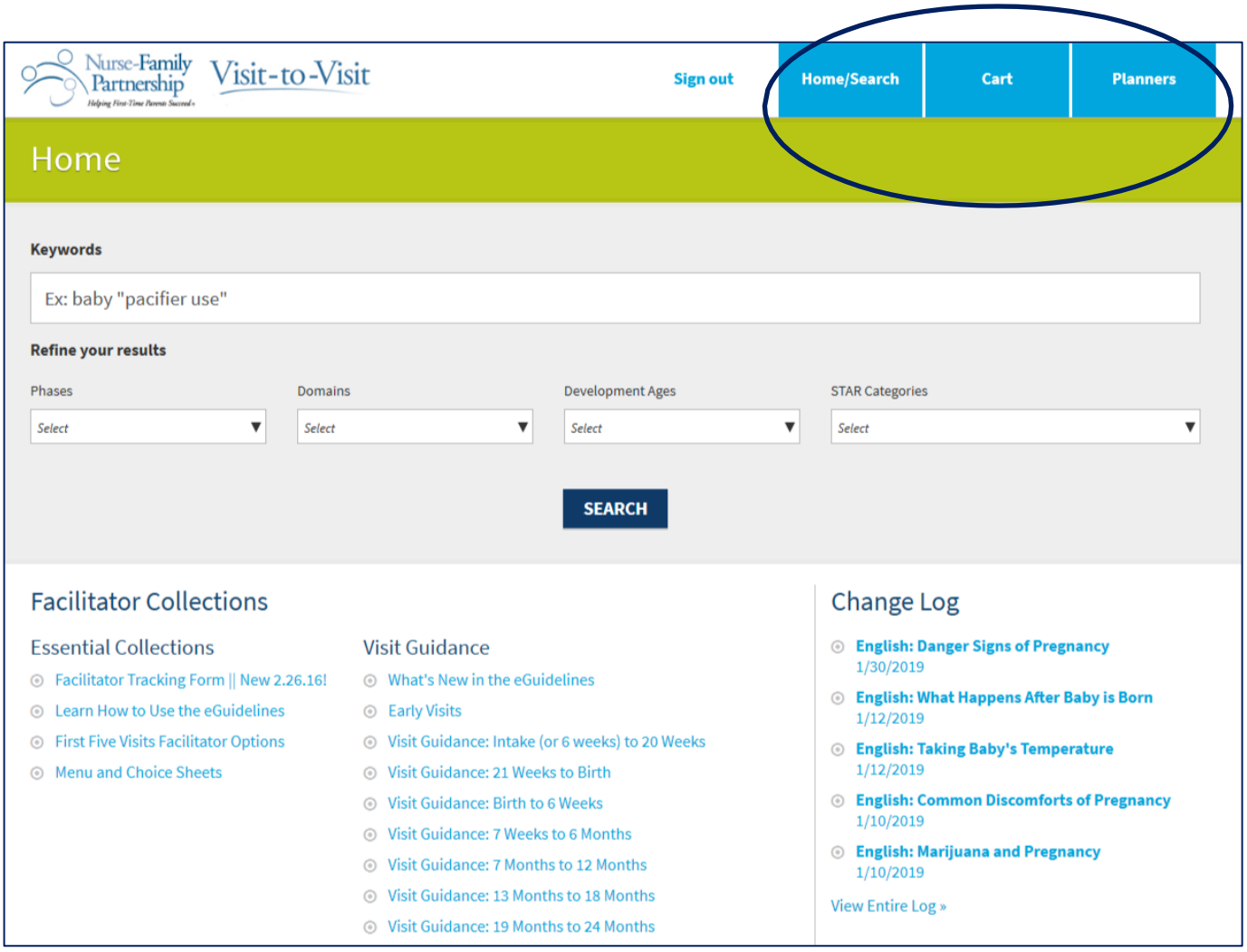
The eGuidelines uses the same username and password you use for the NFP Community. If you have not received your NFP Community logon credentials, contact NFP Technical Support for assistance at support@nursefamilypartnership.org.

The eGuidelines home page is divided into two key areas:

1. The large grey area near the top of the page is the search mechanism for the site. This includes a keyword search box and filters to refine your search.

2. The white area at the bottom half of the home page window is nursing information. Note that the Visit Guidance found in this section is critical nursing practice information—especially for new NFP nurses as they learn how to implement the Nurse-Family Partnership model.

At the top of the home page are three tabs, one each for the three key sections of the site. The tabs indicate the flow of how the site works: the **Home and Search** tab; **Cart** (a holding place); and **Planners** (electronic client folders).



First, we'll explore best practices for searching for topics and facilitators. Then, we'll look at the flow of the site as we practice how to move facilitators from the search results to the cart to planners. Finally, we'll discuss the nursing Visit Guidance.

Searches, Keywords, and Filters

Let's explore the **SEARCH** function first. There are two ways to start: either by using a keyword, like "breastfeeding," or using a specific facilitator name, like "Cradle Cap." Most of the time the specific facilitator name may not be known, and a topical search is made instead. The search function works best when the search word or term is enclosed in quotation marks (" ").

Activity

1. Start a broad topic search by using the keyword **"breastfeeding"**
    - Put the search term in **quotes** (" ") to make sure your search is specific.
    - This should produce over 50 results.

2. Next, narrow the results with the use of filters
    - There are four filters that can be used in any combination: phases, domains, developmental age, and STAR.
    - For this activity, choose **STAR/Substance Use and Abuse** filter.
    - This narrows down the results to approximately seven facilitators.

3. Clear these results by clicking on the **Home/Search** tab, which returns you to the Home/Search page.

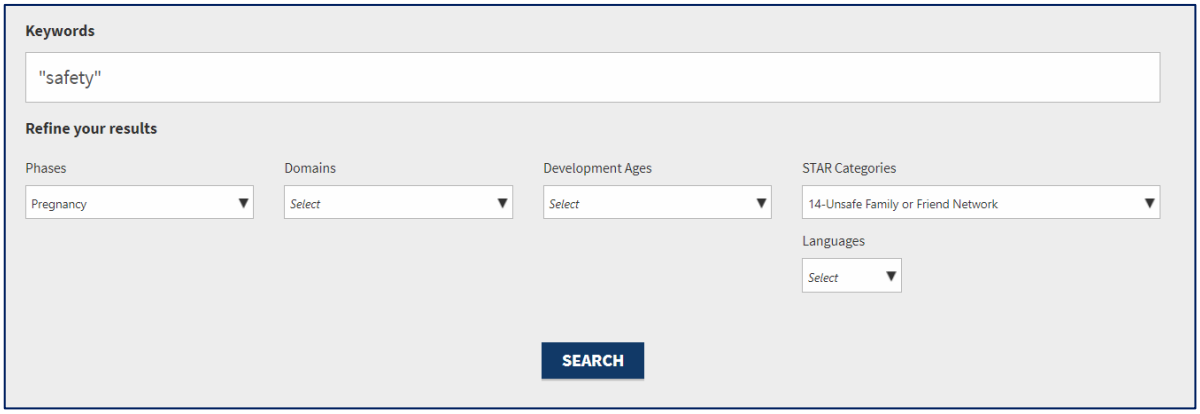
4. Try a search for a specific facilitator by using the search term **"As Baby Grows"** (note: case doesn't matter; you could also type "as baby grows").
    - The result will still be a list of facilitators dealing with baby's growth, but the first one on the list will be the one named in the search.

Activity: Try it #1

1. Log on to the Visit-to-Visit eGuidelines

2. Type **"safety"** into the keyword box and click on search (remember the quotation marks). Remember to use quotes around the search word. This produces approximately 136 results. Way too many to read!

3. Your client is still pregnant, so use the Phases filter; choose the **pregnancy** filter and click search. The results are narrowed by half—but still too many to read.



4. Your client is experiencing Intimate Partner Violence and wants to know about safety in her relationship; although, she's not ready to leave her partner. Use the **STAR** filter and select **Unsafe Family and Friend Network**. The results are now narrowed down to 11 facilitators. A much more manageable amount to review and to determine which might be best for your client.

You have successfully used the first tab, Home/Search, and searched using keywords and filters! Keep these results as we'll use them to learn about the cart and planner functions.

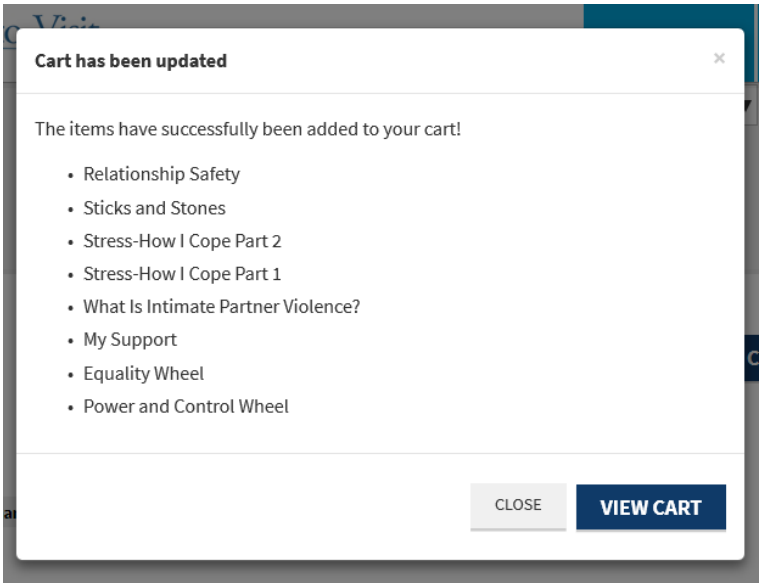
The eGuidelines Cart

The next tab is the **Cart**. The Cart functions just like on any e-commerce site. You put things in your cart until you decide what you want to keep or remove. The cart is a holding place. You can search for many clients at one time and move all your results to the cart and then move items from the cart to separate planners.

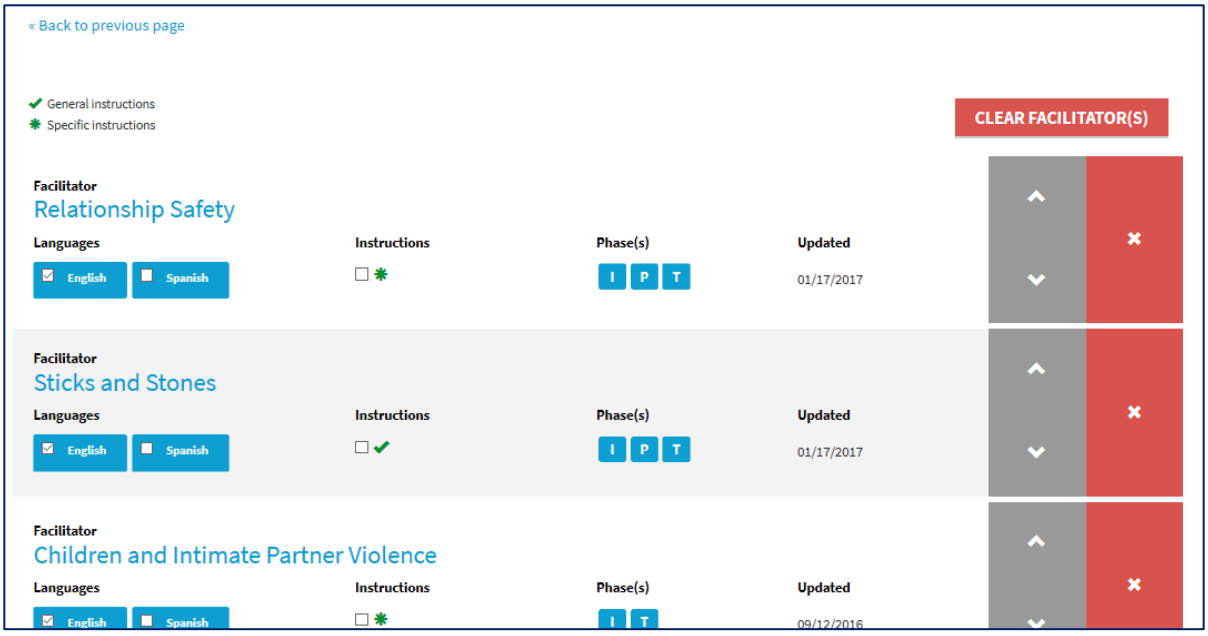
Activity: Try it #2

Using the search results from the Try it #1 activity, your next task is to move these facilitators to your Cart.

1. First, check the **Select All items on page** box. A check mark will appear to the left of each of the facilitators in the search results.
2. Next, click the blue box **ADD SELECTED ITEMS ON PAGE TO CART**. A pop-up confirmation window like the one below will appear.



3. Click the **CLOSE** button. Your search results are still there.
4. Click the blue **VIEW CART** button. Your search results are also in your cart.



You have successfully searched for and added items to your cart. If you want to return to your search, click on the blue **< Back to previous page** link at the top of the cart. To clear the search and go to a clean home page, click on the **Home/Search** tab at the top of the window.

Activity: Try it #3

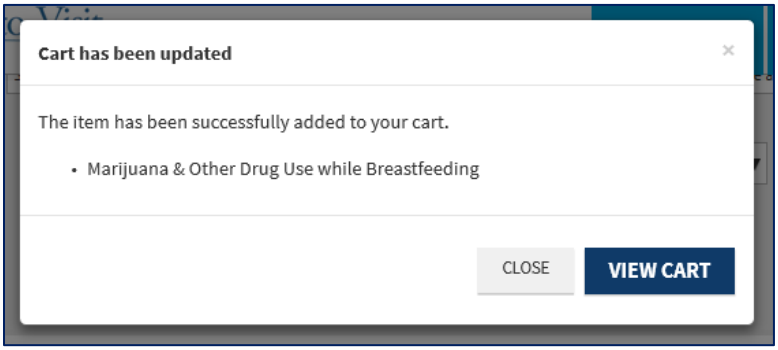
Let's try another search for a different client.

Since you're searching for material for a different client, start by clicking on the blue **Home/Search** tab at the top right of the window. This will clear the previous search, and the window will look like it did when you first logged in.

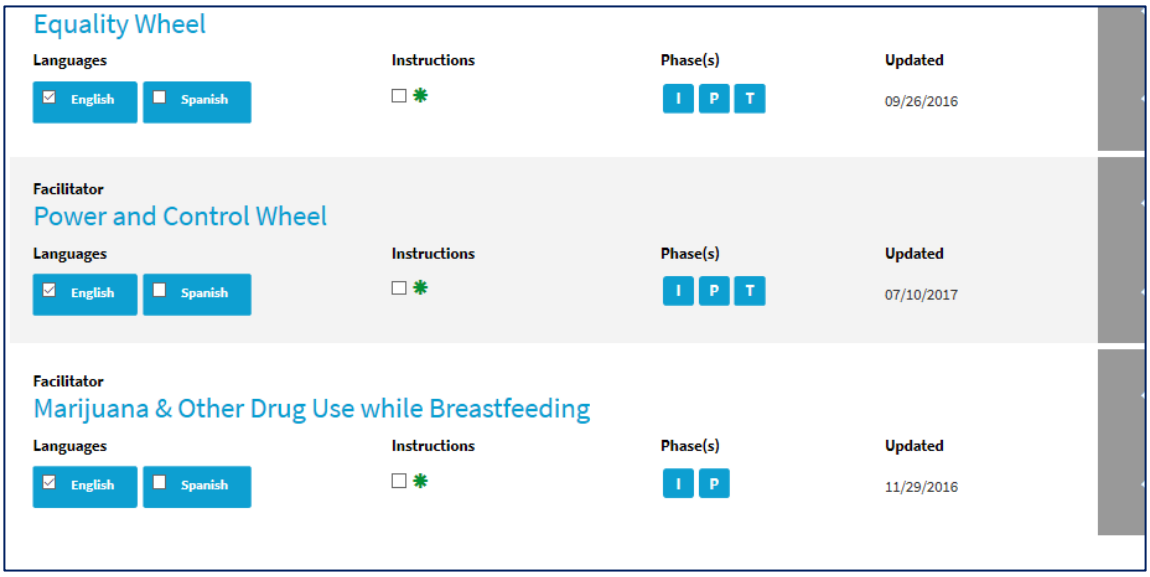
This client wants to know about breastfeeding. She is seven months pregnant and using substances. She wants to know how substances might factor into her choice to breastfeed.

1. The broad topic is **"breastfeeding"**. Type this into the keyword search field—be sure to use the quotation marks. When you click on search, this produces over 50 results.
2. Since your client is pregnant, select **pregnancy** in the phase filter. Click on search. This narrows the results to around 40 facilitators.

3. Because your client is using substances, use the **STAR** filter **Substance Use and Abuse**. This time when you click on search your results are narrowed to exactly what your client needs as she considers breastfeeding and her substance abuse.
4. Your client is using marijuana, so only click the selection box next to **Marijuana and Other Drug Use while Breastfeeding**.
5. Add the selected item to your cart. A pop-up box will confirm that your cart has been updated with the chosen facilitator.



6. This time, click on the **VIEW CART** button. Your cart now includes the facilitators from your first search and the facilitator you just added from this search.



Congratulations! You have now successfully searched for facilitators for two different clients and added facilitators to your cart. Now it's time to decide which facilitators to keep for each client and to add them to a planner. Stay on this page, your cart, for the next steps.

Using the eGuidelines Planner: Creating and Adding Facilitators

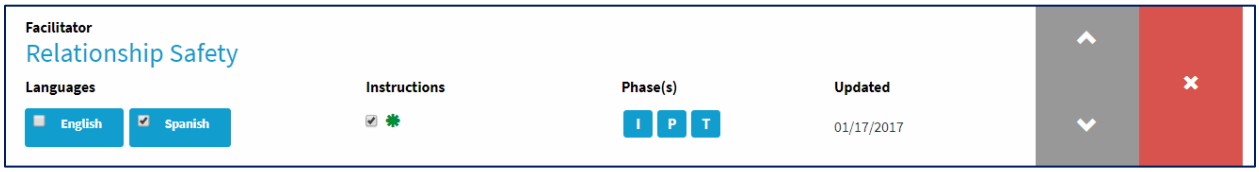
The cart page allows you to specifically pick and choose facilitators you selected based on your client's needs and save them to a planner. Additionally, if your client who wants to know about relationship safety is a Spanish-speaking client, you can select the Spanish version of the facilitator instead of the English one. You can also decide if all of the searched for and selected facilitators are appropriate for what a particular client needs, or if you only want a few of them for now.

Activity: Try it #4

This activity builds on your results from the last three activities.

Scenario: your client is Spanish-speaking and wants to know about relationship safety. There are several facilitators from the search that can be selected, but you probably don't want to cover all of them—particularly not at first.

1. Look at the 10 or so facilitators you have in your cart for this client.
2. Select **Relationship Safety**, Spanish. Make sure the English version is not checked (English is selected by default and needs to be unchecked).

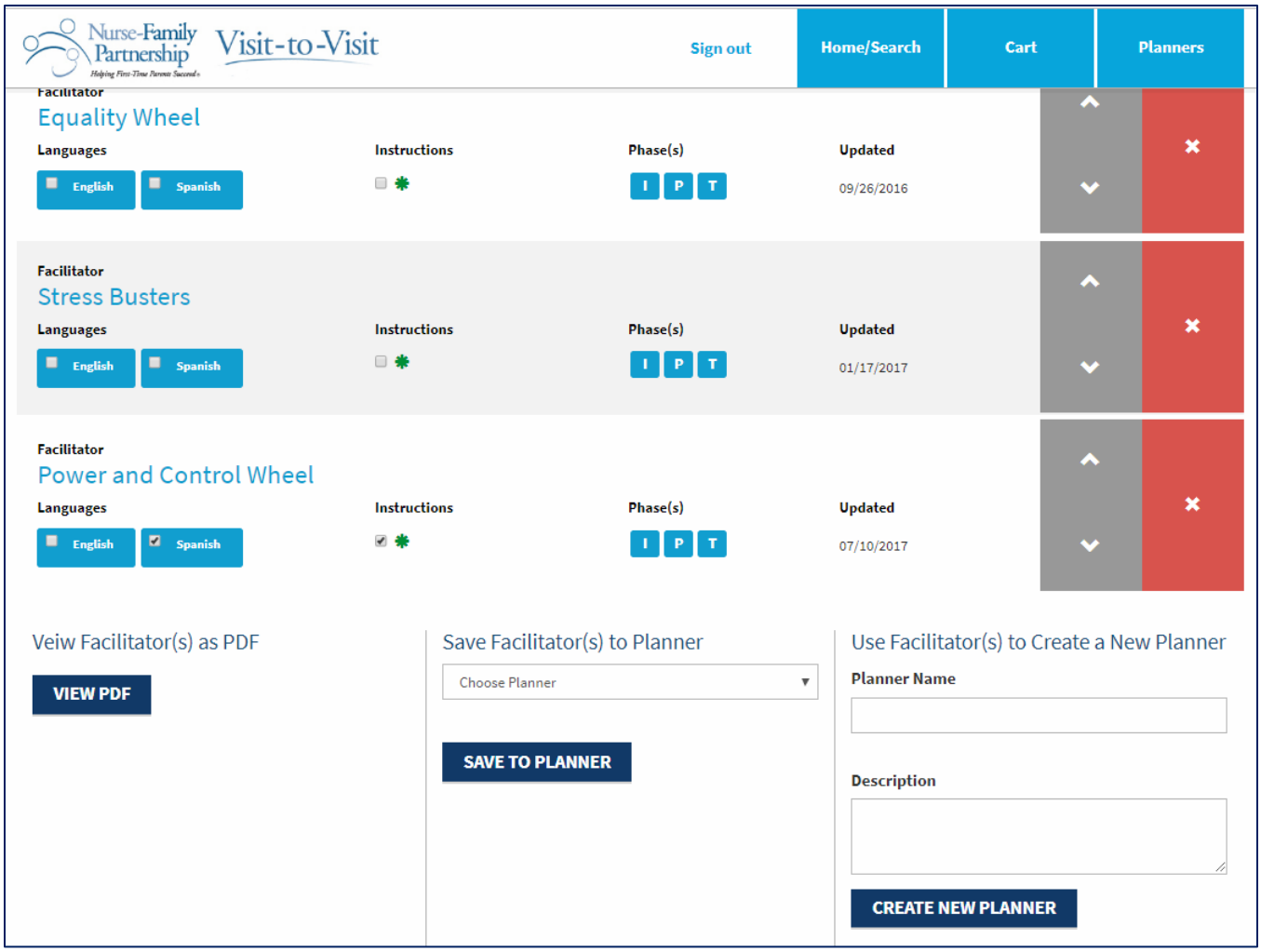


3. You'll notice that this facilitator has specific instructions, as indicated by the asterisk (*****) in the Instructions column. Many facilitators share the same general instructions, as indicated by a checkmark (✓) in this column. Some facilitators, though, have very specific instructions for how to use it; this is one of them. Check the box under Instructions next to the asterisk *****.
4. Next, locate the facilitators **What is Intimate Partner Violence** and **Power and Control Wheel** in the list of facilitators in your cart. Check Spanish and Instructions for both of these facilitators, too. Be sure to uncheck English.
5. There are now three facilitators in Spanish with nurse instructions selected for this client.
6. Make sure nothing else on the page is checked or selected.

The facilitators and instructions that will be most helpful to your client have now been selected. It's time to create the planner for this new client and move these facilitators into her planner. A planner is just an electronic client folder. It's the place to store

facilitators for this client, and it allows you to plan for future visits and store specific facilitators for your client until you need them.

Scroll to the bottom of your cart page. You'll see a section that looks like this.



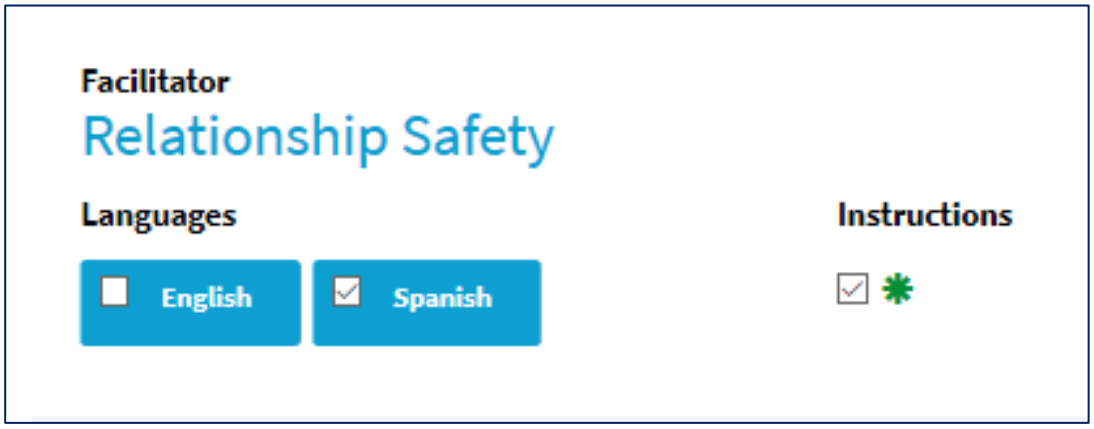
In the Cart page there are several options:

- View the facilitator or instructions you've checked (helpful if you're not sure of the information in the facilitator)
- Safe the checked facilitator and instructions to an existing planner (for clients you're already set up)
- Create a new planner

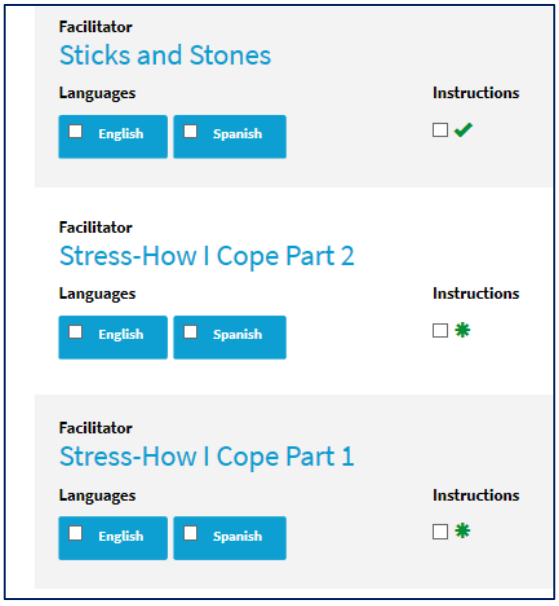
Since this is a new client, let's create a new planner.

Activity: Try it #5

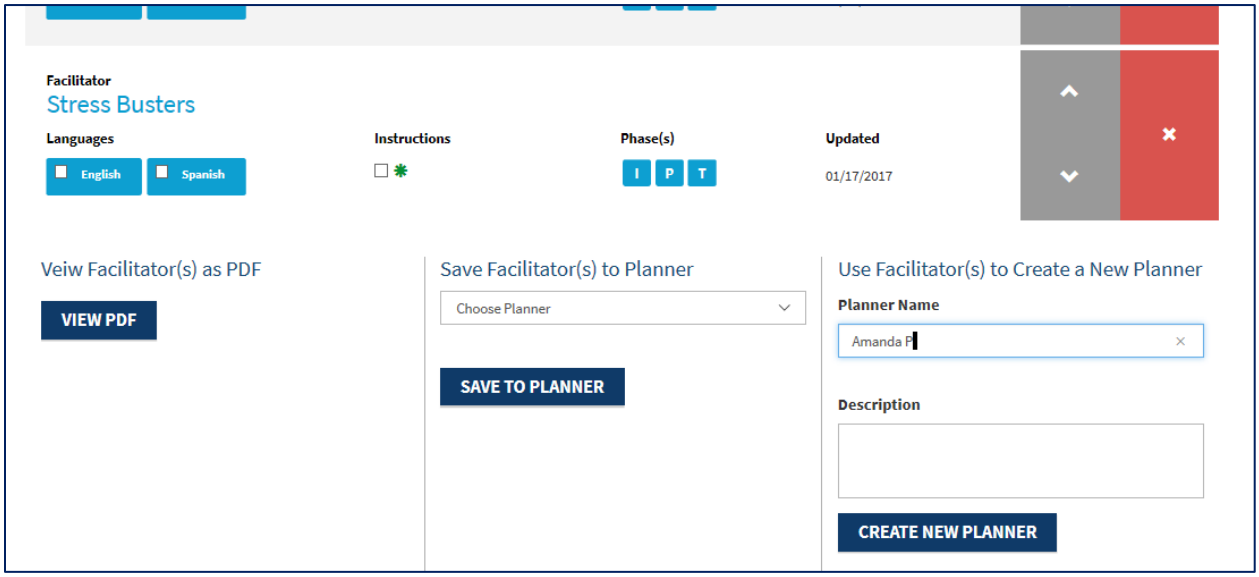
1. For this activity, using the cart above, we'll be selecting three facilitators for your new client, Amanda. The facilitators being used are: **Relationship Safety**, **My Support**, and **Who to Call**. Note that all three of these facilitators have specialized nurse instructions.
2. Amanda is Spanish-speaking. By default, the English version of each facilitator is selected. For each of these three facilitators, uncheck English, check Spanish, and also check the Instructions box for each.



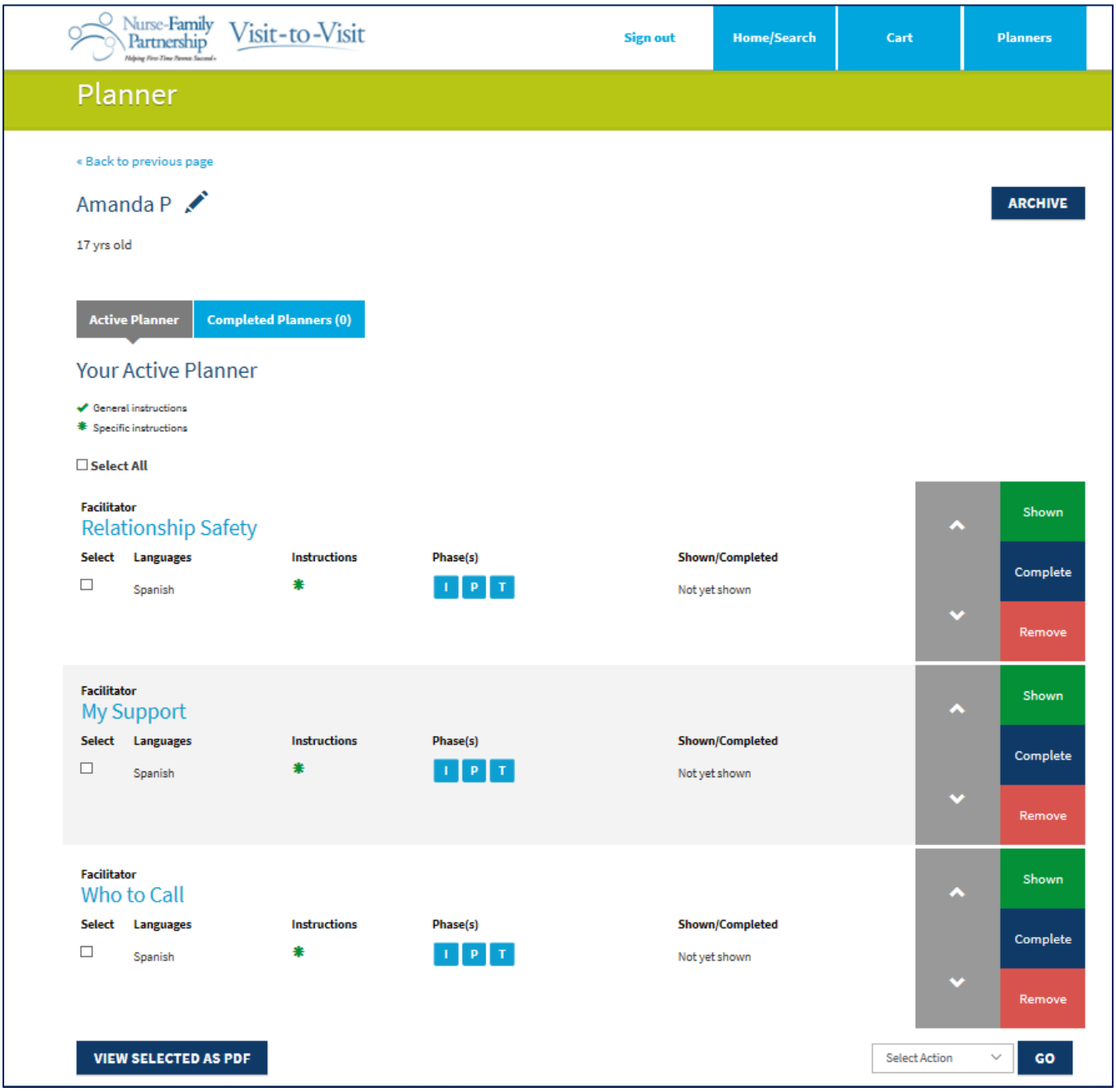
3. Since we're going to add only these three facilitators to our planner, uncheck the other facilitators in the cart by clicking on any check marks in the English, Spanish or Instructions boxes (remember to uncheck the two facilitators from Try It #4, step 4 we opted not to use).



4. In the **Use Facilitator(s) to Create New Planner** section, type **Amanda** in the Planner Name field. However, in this scenario you have two clients named Amanda, so add her last name initial, and type **Amanda P** in the Planner Name field. You can use the description box to add additional information; e.g., 16 weeks pregnant or 17 years old.



5. Click on the **CREATE NEW PLANNER** button. The new planner will open (a graphic of with an example the new planner is on the next page).



You successfully created a new planner with three facilitators and their instructions in it!

Tip: If you left any facilitators in the cart checked when you created the planner but decide you don't want them in the planner, click on the red **Remove** button to the right of the facilitator name.

Activity: Try it #6

Click on the **Cart** tab to return to the cart you created in the last activity.

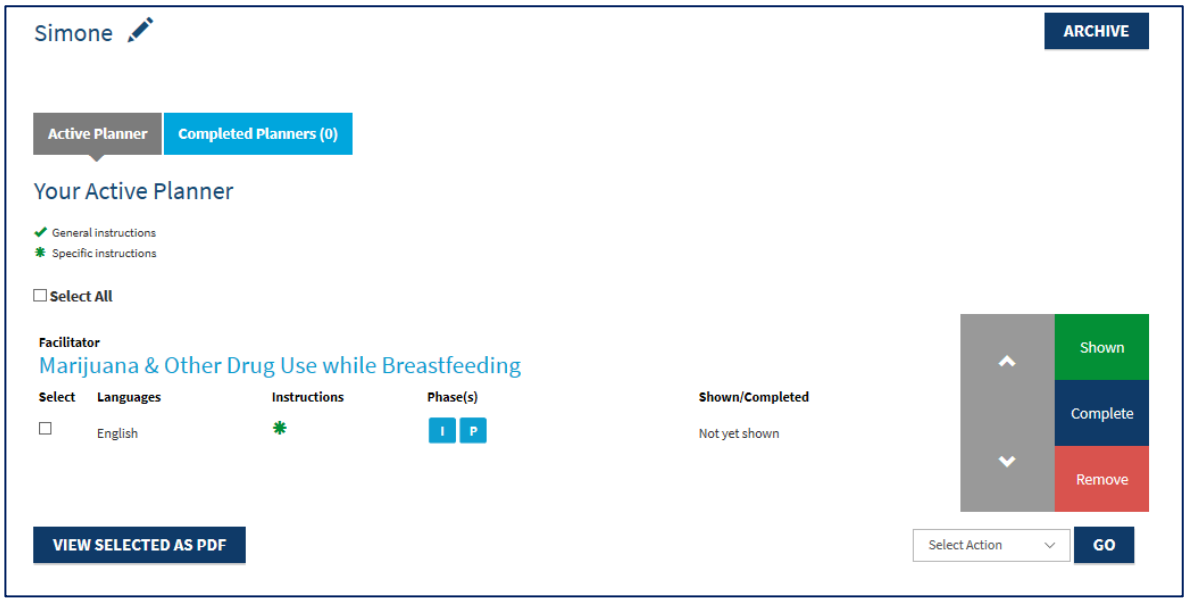
1. You have another new client, Simone, who is pregnant and is interested in

breastfeeding—see Activity: Try it #3 and repeat the facilitator search, including adding them to the cart. The client uses marijuana wants to know how marijuana will affect breastfeeding. Make sure no facilitators or instructions are selected in the cart.

Tip: the **Select all items on page** tool acts as a toggle. Click on it once, so that a checkmark appears in the box, and it will select all facilitators; clicking on it again so the checkmark is gone, will unselect all facilitators.

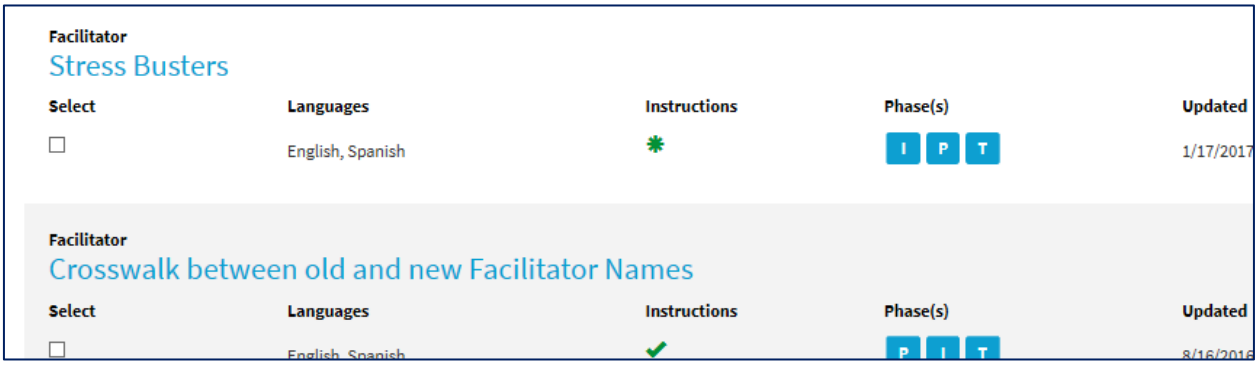
2. You are selecting only one facilitator for this client, **Marijuana & Other Drug use While Breastfeedin**g. Simone is English-speaking, so click the English box.

3. Simone is a new client and doesn't have a planner yet, so follow the steps in Try it #5 to create a planner for Simone. Since this facilitator has specific instructions, select the instructions, too. You are now in Simone's planner with the one facilitator.

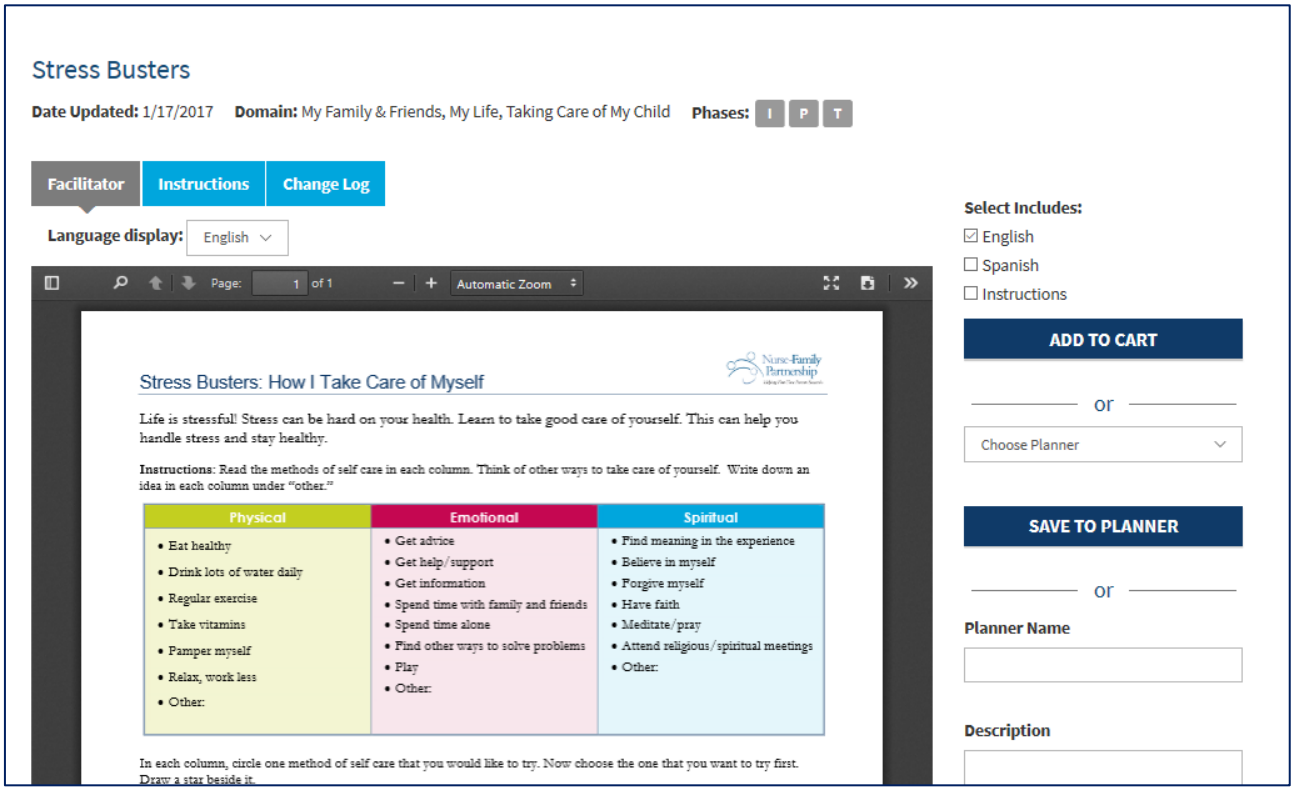


4. You know Simone smokes marijuana because she's anxious. You remember a facilitator called **Stress Busters** and decide to add this to Simone's planner. Click on the **Home/Search** tab at the top of the page and type "stress busters" into the keyword search field. Since this is the name of the facilitator, you don't need to use any filters. Click on **Search**.

5. **Stress Busters** is the first facilitator in the list of search results. Click on the facilitator title.

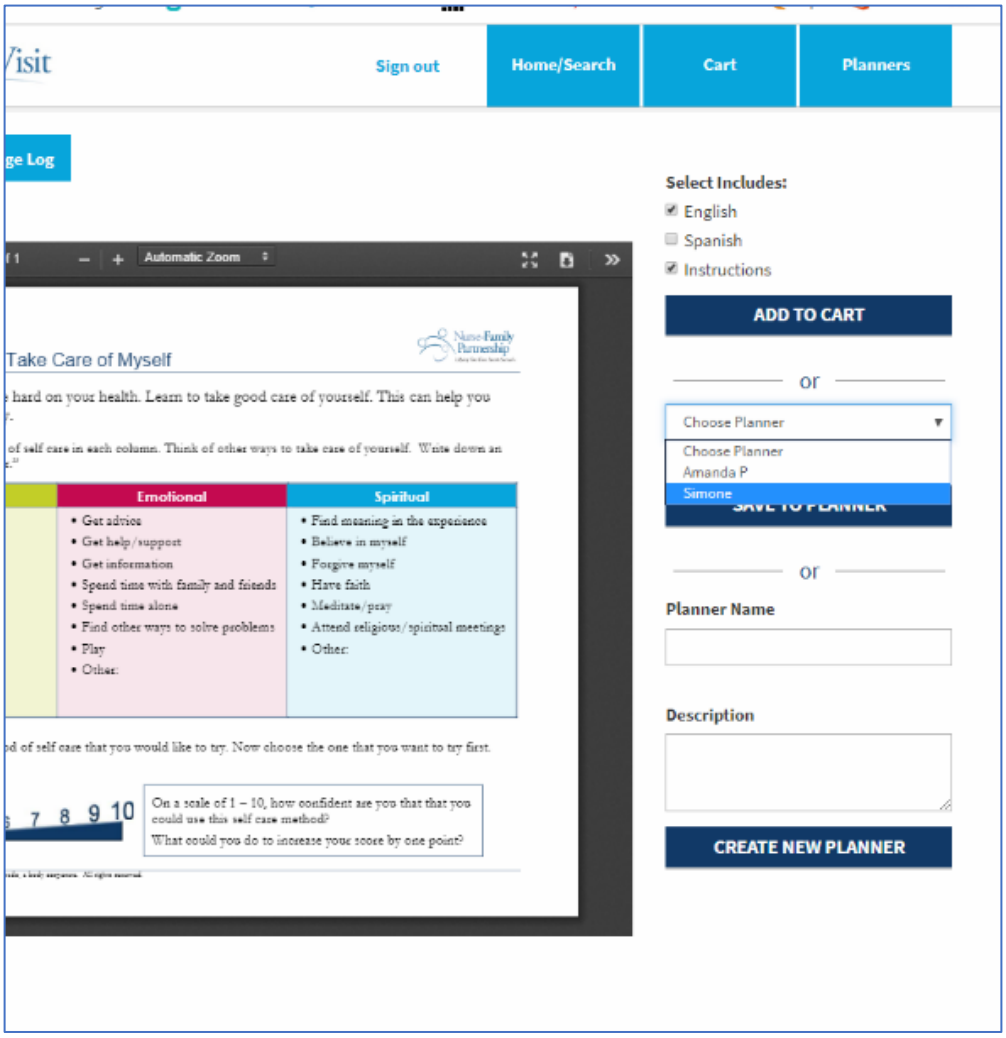


6. When you click on a hyperlink like a facilitator title (all facilitator titles are links), a viewing window will open. In the viewing window, you can review the facilitator to decide if it might be good for Simone.

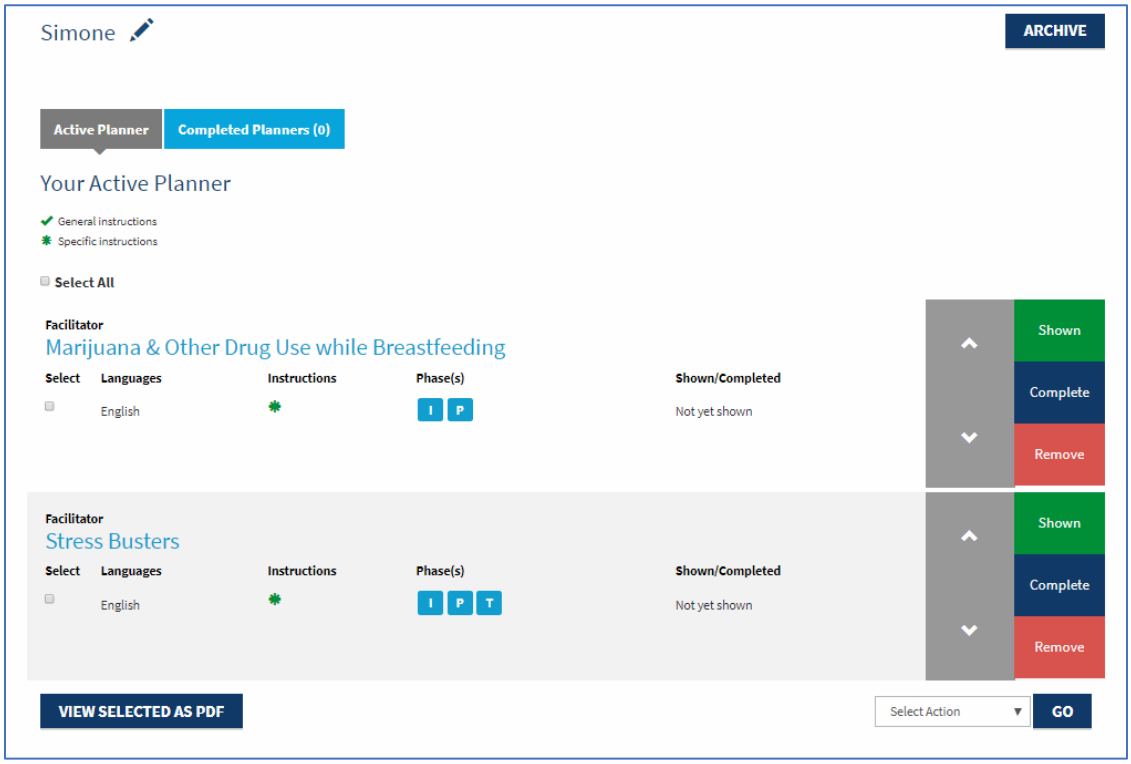


7. After reviewing the facilitator, you decide this might be good for Simone, too. The facilitator viewing page has the same two options as the cart page. You can create a new planner or add the facilitator to an existing planner. You can also add this facilitator to your cart and keep searching for other needs.

8. You have already created a planner for Simone. Make sure that under the **Select Includes** section, both English and Instructions are checked, then click on the down arrow in the **Choose Planner** field. Select the planner you named Simone and click on the **Save to Planner** button.



When you click Save to Planner, Simone's planner will open and now includes both facilitators, **Stress Busters** and **Marijuana & Other Drug Use while Breastfeeding**.

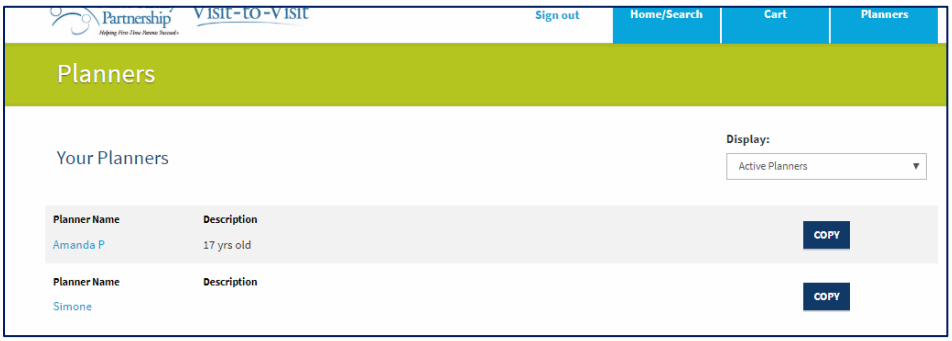


Using the eGuidelines Planner: Features

Recap—What You've Done So Far

- ✓ You searched for facilitators, using filters, for two different clients to meet their individual needs
- ✓ You moved selected facilitators to your cart
- ✓ You reviewed facilitators in the cart and decided what you want to keep or discard
- ✓ You created two planners, one for each client, and moved selected facilitators and nurse's instructions into them
- ✓ You searched for a specific facilitator, viewed it, and added it to an existing planner

Next, we'll look at the features of the Planner page. Click on the **Planners** tab, and you'll see a list of the planners you created. Click on a client name to go to their personal planner.



The Planner has many useful features. It's like a folder you keep for each of your clients. You can plan topics several visits ahead depending on what program topics you want to cover and based on the client topics they've expressed an interest in exploring.

Within the planner, you can:

- Hold as many facilitators as you'd like to store.
- Copy the planner.
- Change the order of your facilitators depending on their priority.
- Mark facilitators as shown to the client. You can show a facilitator more than once and make it shown each time you show it.
- Mark facilitators as completed. Mark it as completed after you've shown it and know you won't need to show it again.
- Click on the Completed tab to view a list of all completed facilitators for the client. This is a helpful tracking form that provides an electronic record of what you have done.
- Remove facilitators if you find you don't need them any longer; for instance, you might have a conversation with a client and decide to watch a video on the facilitator topic on YouTube. The facilitator may not be needed any longer and you can remove it from the planner.
- Select all or any combination of facilitators and print them (click on the facilitator title or click on the View Selected as PDF button, then select print from the onscreen toolbar).
- Save facilitators on an electronic device to show facilitators to your client using a tablet or laptop click on the facilitator title or click on the View Selected as PDF button, then select Save or Download from the onscreen toolbar).
- Archive a planner when a client leaves the program or moves out of your service area. Sometimes a client returns, but you can go to your archive folder and reactivate the planner for a returning client, and you still have a record of what you've reviewed with the client.

Take time to play around with the two planners you created. When you're done, archive both planners. If you already have some clients you'll start seeing after Unit 2, take time now to create their planners.

Tip: many facilitators are interactive, and clients might be encouraged to write-in their thoughts, complete a crossword puzzle, or choose a true/false statement. Even if you can display facilitators electronically, you may decide to bring a copy of these facilitators, so the client can complete the activity. Also, some clients like to keep hard copies of facilitators to show friends or family. It's really up to the client and her preference.

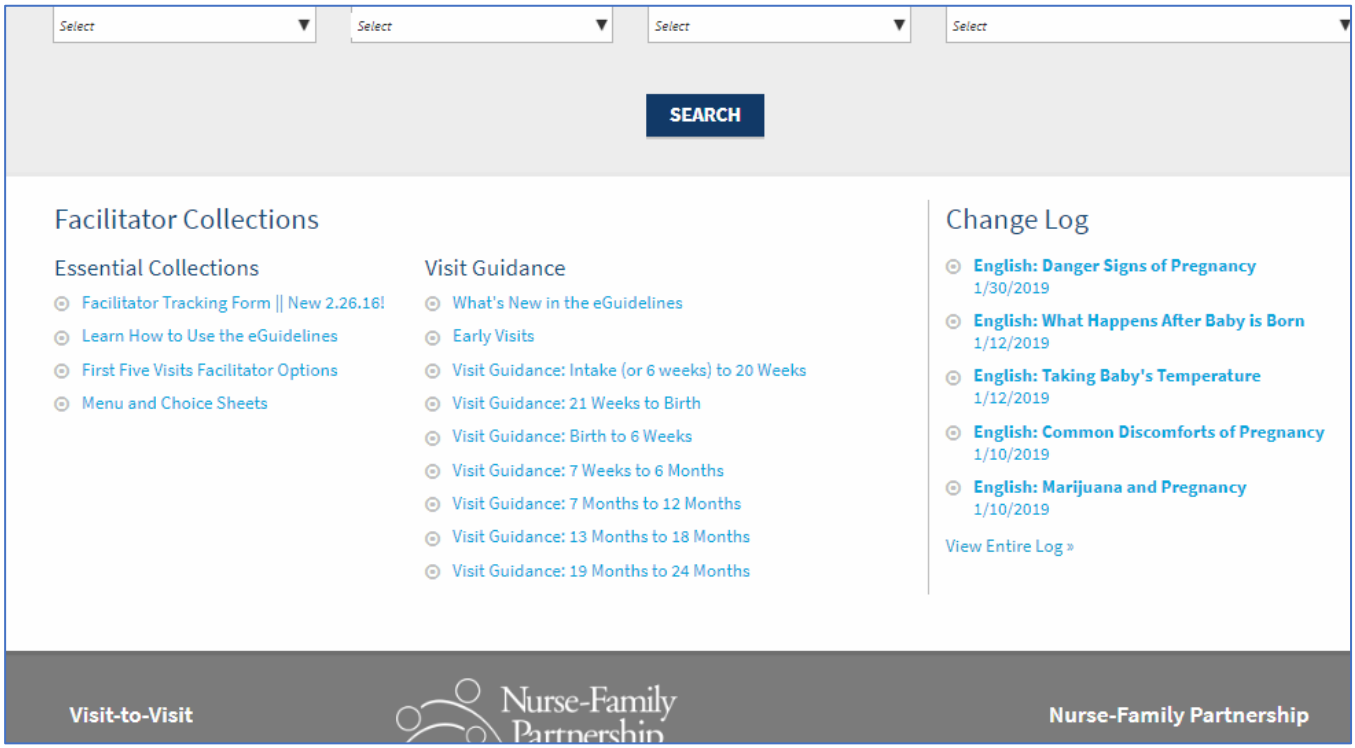
If you found these activities challenging, you can revisit this chapter as many times as you like to get a good feel for the eGuidelines.

The eGuidelines Nursing Section

Nursing Information Section

The nursing information section of the eGuidelines is found in the white section in the bottom half of the home page (Facilitator Collections). This section has key information on how to incorporate all NFP program elements into your visits and it provides guidance around information that is essential during key phases of your client's life. Additionally, you will find information on assessments to complete during key phases, as well as areas to focus on and be aware of as part of your nursing assessment.

There are three key sections in the Nursing Information portion of the home page:**Essential Collections**, **Visit Guidance**, and the **Change Log**.



Visit Guidance

Visit Guidance is essential information for nurses and matches the eight key time periods in the developmental stages filter. Similar to a head-to-toe assessment, the Visit Guidance ensures that you are complete and systematic in your approach to visits. The guidance also reminds you of content that is essential to cover during these key time periods.

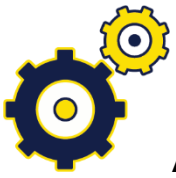
Pregnancy	Visits 1 to 5
	Intake to 20 weeks (may be different than visits 1 to 5 depending on how early or late a client is signed- up for NFP)
	21 weeks to birth (may be different than visits 1 to 5 depending on when a client is enrolled in NFP)
Early and Late Infancy	Birth to 6 weeks (postpartum periods when you might be visiting every week)
	6 weeks to 6 months
	7 months to 12 months
Early and Late Toddlerhood	13 months to 18 months
	19 months to 24 months

Essential Collections

Essential Collections is updated frequently as innovations are introduced to nursing. This is a section you'll want to check out periodically to see what has been added or updated.

Change Log

Change Log is an area you should mark your calendar to check weekly. Any time a new facilitator is developed or an existing facilitator or its instructions have significant updates, it is documented in the Change Log, including a link to the facilitator. This is especially important if you have printed copies of facilitators or have saved a PDF on an electronic device. When a facilitator is updated, remove all older versions so you are only showing clients the most current medical and safety information.



Activity for Unit 2

Search for the following documents and facilitators. Read and become familiar with them as you'll use them in Unit 2 during practice visits. You don't need to print any of the documents or bring them to Unit 2, as you'll use classroom laptops during Unit 2 to find the documents again when they're needed.

Visit Guidance for Visits 1 to 5 (three separate documents	"Helpful Things to Know about Nurse-Family Partnership" facilitator
"Home Visit Plan" document	"Body Image During Pregnancy" facilitator
"Life History Calendar" facilitator and instructions	"Danger Signs of Pregnancy" facilitator and instructions
"Babies and Pets" facilitator and instructions	Read the general facilitator instructions

References

Payne, R. (1996). A framework for understanding poverty. (3rd Rev. Ed.). Aha! Process, Inc., Highlands, TX.

Reed, W. (2004). Use mind mapping with templates to develop SMART goals. Retrieved on February 19, 2019 at http://www.innovationmanagement.se/imtool-articles/use-mind-mapping-with-templates-to-develop-smart-goals/

Glossary and Appendix

Additional Information to Support Your Practice

Nurse-Family Partnership®
Helping First-Time Parents Succeed

Glossary and Appendix

Nurse-Family Partnership List of Common Terms

Term	Nurse-Family Partnership Definition
Attachment Theory	Historically, Nurse-Family Partnership owes much to John Bowlby's theory of Attachment. This theory holds that human beings have evolved a repertoire of behaviors that promote interaction between caregivers and their infants, and that these behaviors tend to keep specific caregivers in proximity to defenseless youngsters, thus promoting their survival, especially in emergencies. (Olds, D., Hill, P., Mihalic, S., & O'Brien, R.1998). Blueprints for Violence Prevention, Book Seven: Prenatal and Infancy Home Visitation by Nurses. Boulder, CO: Center for the Study and Prevention of Violence.)
Client	Nurse-Family Partnership clients are low-income, first-time mothers who have had no previous live births. Enrollment and participation is voluntary. Criteria qualifying clients as low-income is established by local Nurse-Family Partnership Implementing Agencies. In unusual cases clients may lose custody of their children. When the legal caregiver (e.g. the biological father) requests support from the Nurse-Family Partnership, Nurse Home Visitors continue to make visits, and this becomes the client.
Client-Centered Approach	An approach to working with clients that develops solutions based on information provided by the client and presumes that the client is the expert on her own life. The Nurse-Family Partnership model embraces five client-centered principles. • The client is the expert on her own life • Follow the client's heart's desire • Focus on strengths • Focus on solutions • Only a small change is necessary
Community	When developing the Nurse-Family Partnership in an area, and prior to the identification of an implementing agency, we work with the community (stakeholders, advocates, champions, health and human service providers) to vet the Nurse-Family Partnership as a programmatic option.

Term	Nurse-Family Partnership Definition
DANCE	Dyadic Assessment of Naturalistic Caregiver-Child Experiences (DANCE). A strengths-based tool to objectively assess the interaction between a caregiver and child during a home visit.
Denver Trial	The third replication of the research study that forms the foundation of NFP (performed in Denver, Colorado, beginning in 1994). It found that using paraprofessionals instead of RNs produced no clinically significant benefits. The Prevention Research Center (PRC) still tracks participant and control families today, gathering data and analyzing results.
Domains	Subject areas covered with mothers by Nurse-Family Partnership Nurse Home Visitors. Time allocation among the domains varies over the program's cycle of visits. • My Health (Personal Health) • My Home (Environmental Health) • My Life (Life Course Development and Health & Human Services • My Family & Friends (Family & Friends) • My Child (Maternal Role) • Taking Care of My Child (Maternal Role)
EDC	Estimated date of confinement – a traditional term for a baby's due date.
EDD	Estimated date of delivery – a contemporary term for a baby's due date.
Elmira Trial	The original research study that forms the foundation of Nurse-Family Partnership (performed in Elmira, New York, beginning in 1977). The Prevention Research Center (PRC) still tracks participant and control families today, gathering data and analyzing results.
Environmental Health Domain (My Home)	The Nurse-Family Partnership domain which addresses factors within the home, school, neighborhood or community having the potential to adversely impact a client or child's health and safety.
DCS (Data Collection System)	The system used to enter NFP data and generate reports.
Evaluation Report/Annual Report	Report provided to agencies implementing Nurse-Family Partnership including program implementation and outcome measures. Reports are provided annually as contracted.
Evidence-Based	Interventions that involve standardized treatments and that have shown through controlled research to improve outcomes across multiple research groups.

Term	Nurse-Family Partnership Definition
Family And Friends Domain (My Family and Friends)	The Nurse-Family Partnership domain which addresses a client's development of social networks and other support systems, changes in relationships with spouse/boyfriend or significant other.
Fidelity	A term that describes replication of a research-based program in a manner consistent with the original research and hence likely to produce results consistent with the results measured in the research.
Nurse-Family Partnership Visit-to-Visit eGuidelines	The Nurse-Family Partnership Visit-to-Visit Guidelines serve multiple purposes. The guidelines help maintain consistency in implementing the Nurse-Family Partnership model across the country, ensure comprehensive and essential information is introduced to clients, provide the flexibility needed to meet clients' needs and desires, as well as program goals, offer a framework that helps nurses and clients avoid focusing solely on the day-to-day challenges clients are facing, and introduce content that supports clients in developing the knowledge, skills, and self-efficacy to obtain the three Nurse-Family Partnership outcome goals.
Health and Human Services Domain (My Life)	The Nurse-Family Partnership domain which addresses the potential community resources available to a client. Not to be confused with the Department of Health and Human Services.
HIPAA	Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) requires the US Department of Health and Human Services (HHS) to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addresses the security and privacy of health data.
Human Ecology Theory	Urie Bronfenbrener's theory holds that the individual grows and adapts through interchanges with its immediate ecosystem and more distant environments. It explain how individual and family systems are influenced in their development by different environments.
Implementation	A specified set of activities designed to put into practice Nurse-Family Partnership with fidelity to the model.

Term	Nurse-Family Partnership Definition
Implementing Agency	A public or private, state or local organization responsible for delivering the Nurse-Family Partnership in a particular area.
IPV	Intimate Partner Violence, also called domestic violence and abuse, occurs when one person purposely causes either physical or mental harm to another, including: physical abuse, psychological or emotional abuse, sexual assault, isolation or control of all the victim's money, shelter, time, food, etc.
LBW	Low birth weight. A first weight of a newborn obtained immediately after birth that is less than 2,500 grams (about 5 pounds 8 ounces).
LCD	See Life Course Development.
Life Course Development Domain (My Life)	The Nurse-Family Partnership domain which addresses a client's plans for the future related to education, job training, employment, and decisions about planning further children.
Maternal Role Domain (My Child and Taking Care of My Child)	The Nurse-Family Partnership domain which addresses a client's adjustments to the responsibilities of the maternal role, competent caregiving, facilitation of child growth and development, child care, immunizations and well-child care, discipline, , etc.
Model	In the Nurse-Family Partnership, "the model" refers to the unique combination of preventive intervention elements that, when properly implemented in community settings, will theoretically result in effects comparable to those achieved in the three randomized trials.
Multip(s)	Multiparous -relating to a woman who has had more than one child.
Nurse Home Visit	A visit to a client's place of residence or other mutually agreeable location by a Nurse-Family Partnership Nurse Home Visitor.

Term	Nurse-Family Partnership Definition
Nurse Home Visitor	An Nurse-Family Partnership nurse home visitor is a licensed Registered Nurse (RN) who is employed by an agency engaged in implementing the Nurse-Family Partnership program, is engaged on a continuing basis in the Nurse-Family Partnership educational program, visits clients in their homes or other mutually agreed locations, uses *NFP Visit Guidelines* to guide client visits, and implements the program with fidelity to the model.
Paraprofessional	In the Denver RCT, paraprofessionals were visitors who shared many of the social characteristics of the families they served, under the belief of many, that shared social characteristics increase visitors' ability to empathize with their clients who, in turn, are more likely to trust those who are similar to them. This segment of the paraprofessional populations was important to test as the use of community health workers with limited educational backgrounds is a common service delivery strategy in many home visiting programs, and it is estimated that 60% of home visiting programs for children do not require visitors to have bachelors' degrees.
Personal Health Domain (My Health)	The Nurse-Family Partnership domain which addresses a client's pre- and postnatal health.
PIPE	Partners in Parenting Education (PIPE) is a parenting education model and curriculum that teaches the concepts and skills of emotional connectedness to high-risk parents. This curriculum was used during the Denver trial. How to Read Your Baby, a nonprofit organization in Colorado, provides the curriculum. The Nursing Practice Dept. educates supervisors and nurse home visitors in its use. See www.howtoreadyourbaby.com
Portfolio	An accumulation of examples of competency assembled for review. This compilation of evidence is a way to identify professional practice and development issues. A portfolio is only one method of collecting and storing the evidence of NFP home visitor and supervisor competency. Portfolios,when they are used,and the products within them are not measured or evaluated by the NFP.

Term	Nurse-Family Partnership Definition
PRC	Prevention Research Center for Family and Child Health (PRC).Located within the University of Colorado Denver, School of Medicine, Department of Pediatrics. The PRC promotes research testing the efficacy and effectiveness of health, social and educational interventions aimed at preventing a variety of adverse child and family health outcomes. Dr. David Olds is the PRC's Director, and it is the entity that holds ultimate authority over the nature of the Nurse-Family Partnership as a preventive intervention. The Nurse-Family Partnership National Service Office and the PRC operate collaboratively through a carefully-developed Memorandum of Understanding that outlines the roles and duties of each entity.
Quarterly Summary Tables	Program implementation and outcome information produced quarterly and arranged by state. These tables are provided to agencies implementing the Nurse-Family Partnership program within the first month following the end of a quarter. Data for all programs in a given state are included in the tables, with summary data for the state at the end of each table.
Randomized Controlled Trial (RCT)	The most rigorous research method for measuring the effectiveness of an intervention. This is the type of study that the FDA requires of new drugs or medical devices to determine their effectiveness and safety before they are made available to the public. Because of their cost and complexity, these kinds of trials are not often used to evaluate complex health and human services.
Self-Efficacy Theory	Provides a useful framework for promoting women's health-related behavior during pregnancy, care of their children, and personal development. According to Bandura, differences in motivation, behavior, and persistence in efforts to change a wide range of social behaviors are a function of individuals' beliefs about the connection between their efforts and their desired results. According to this view, cognitive processes play a central role in the acquisition and retention of new behavior patterns.
Standards	Standards are broad descriptions of the performance expected of home visitors and supervisors to gain proficiency in their NFP clinical practice.

Term	Nurse-Family Partnership Definition
Supervisor	The Nurse-Family Partnership supervisor is a nurse whose role is to work within the local community and her agency structure to assure that the program is implemented with fidelity to the Nurse-Family Partnership model in accordance with established guidelines and contract requirements. The supervisor, using principles of clinical supervision using reflective practice, provides primary support and oversight to the nurse home visitors. A full-time supervisor is responsible for a maximum of eight nurses.
WIC	Special Supplemental Nutrition Program for Women, Infants and Children