

# **THE MANAGEMENT OF INFANT DEVELOPMENTAL NEEDS BY COMMUNITY NURSES**

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## ABSTRACT

The aim of this study was: to describe what the responsibilities of community nurses are, according to the scope of practice of registered nurses, with regard to the management of developmental needs of infants in primary health care clinics in South Africa; and to develop guidelines for the support of community nurses to address the developmental needs of infants 0 - 2 years.

There is an increased awareness that the early years of life are a period of considerable opportunity for growth as well as vulnerability to harm. It is imperative that community nurses take actively part in the promotion of normal development of infants as well as being involved in the early identification of developmental delays and disabilities. While evidence confirms that developmental surveillance should be incorporated into the ongoing health care of the infant, such services are not consistently provided in health care settings and, if provided, the delivery thereof suffers from significant inadequacies.

In the first phase of the study, a case study strategy was used to investigate the phenomenon. People outside the case (the context) were included to elucidate the case, namely health service management concerned with nursing issues; personnel involved in the training of community nurses at the clinic; families with infants 0-2 years who displayed typical development; families with infants 0-2 years with an identified developmental delay or disability; other health care professionals (e.g. speech/language therapists, occupational therapists and physiotherapists).

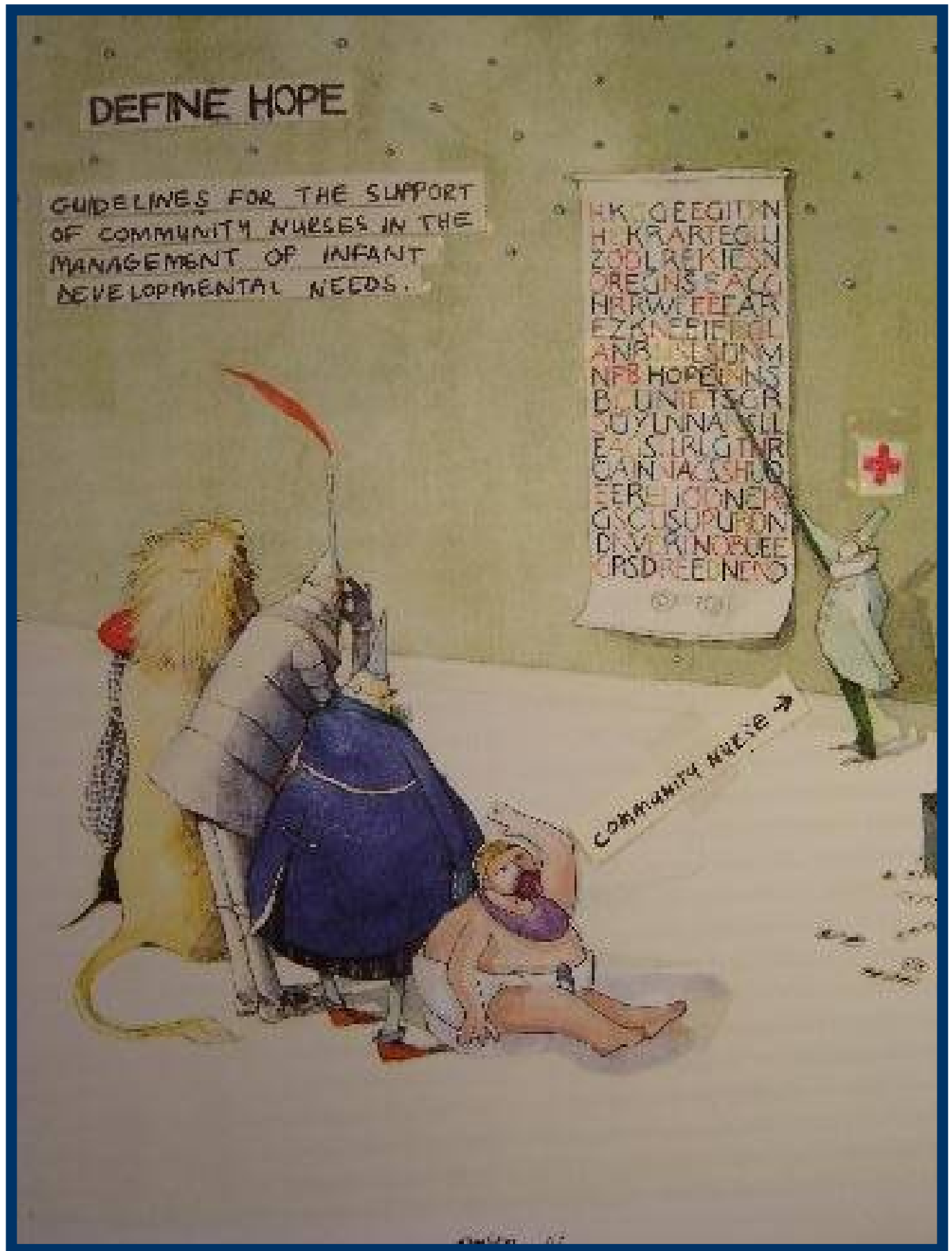
Multiple sources of evidence (interviews, perusal of official documentation and field notes) were used to collect data. Content analysis was used to analyze the data. In the second phase, ten main guidelines aimed at community nurses working in a primary health care clinic in South Africa, were developed. A focus group was utilized to assist with finalizing and validation of the recommended guidelines. All professional groups represented in the case study were included.

The main findings of the research imply that infant developmental care is not included to its fullest potential, in the health care delivered to infants and their families. Community nurses, according to the scope of practice of registered nurses, do not fulfil their responsibilities with regard to the management of developmental needs of infants. They need a greater understanding of what infant developmental care comprises and therefore need additional training to equip them to deliver holistic infant developmental care. Management need to review their commitment and type of support to community nurses if infant developmental care as part of community nurses' responsibilities, is to be effective and of high quality. Community nurses and other health care professionals must recognize the nature and potential of inter-professional collaboration to ensure positive outcomes for infants with developmental delays and disabilities. Furthermore, other health care professionals can be an invaluable source of support and learning for community nurses in the management of infant developmental needs.

The study demonstrated the importance for community nurses, as well as management concerned with nursing issues, personnel concerned with continuous professional development of nurses at the clinic, and other health care professionals, e.g. speech/language therapists, occupational therapists and physiotherapists; of being aware of the importance of addressing developmental needs of infants and their families in a holistic way, and to identify developmental delays and disabilities timely to ensure positive outcomes for infants and their families.

**Key terms** Community nurses, infants 0-2 years of age, infant developmental surveillance, early identification of infant developmental delays and disabilities, management of infant developmental delays and disabilities.





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## **1. INTRODUCTION**

### **1.1 PURPOSE AND OBJECTIVES OF THE GUIDELINE**

This guideline has been developed with the following purpose: to offer information on how to support community nurses in finding “best practice” within their scope of practice, to ensure higher quality of developmental care to families with infants 0-2 years, and to prevent late identification of developmental delays and disabilities.

The objectives are to:

- Create awareness that the early years of life are a period of considerable opportunity for growth as well as vulnerability for harm.
- Create awareness of the distinct benefits of early identification of developmental delays and disabilities for the infant and the family.
- Support community nurses in the management of infant developmental needs.
- Increase awareness about the important role health service management plays in supporting community nurses in the management of infant developmental needs.
- Increase awareness that personal professional development of community nurses is paramount for positive developmental outcomes of infants.
- Promote inter-professional collaboration to support community nurses in the management of infant developmental needs of infants 0-2.

### **1.2 FOR WHOM IS THE GUIDELINE INTENDED?**

This guideline is aimed at those who share in caring for infants to enable them to influence infant health and development positively, to detect developmental delays and disabilities early and to implement appropriate interventions to prevent or diminish loss of developmental potential:

- Community nurses, providing an integrated health care service to infants and their families in primary health care clinics.
- Nursing management concerned with nursing issues in a primary health care clinic.
- People concerned with training of community nurses.
- Other health care professionals e.g. speech/language therapists, physiotherapists and occupational therapists.

### 1.3 WHO HAS DEVELOPED THE GUIDELINE?

The guideline, DEFINE HOPE, was developed by a PhD student in Nursing Science. The developer is a community nurse with 25 years of experience in a primary health care environment and who has a keen interest in infant development.

## 2. DEVELOPMENT OF THE GUIDELINE

Guidelines are recommendations to improve the quality of health care delivery by healthcare professionals. It provides a mechanism by which health care practitioners can be made accountable for health care activities. Furthermore, it helps to translate scientific information into statements that could change practice.<sup>1</sup> Guidelines are intended to be applied by health care providers in real world settings therefore, the recommendations should be practical and feasible to facilitate its translation and implementation.<sup>2</sup>

### 2.1 BACKGROUND

Infants and young children have a human right to develop to their full potential. To allow unmanaged disability and arrested development to occur in these children is a violation of their basic human rights. A greater obligation to protect and help children arises from the fact that children are dependent on others for satisfaction of their rights.<sup>3</sup>

Universally, there is an increased awareness that the early years of life are a period of considerable opportunity for growth as well as vulnerability for harm. The first years lay a crucial foundation for the health and development of children. The support of healthy development of the child is therefore of great importance. Moreover, it is critical not to just maintain, but also to optimize the development and health of infants, as investments in infant development are fundamental for the future of every individual and for the wealth of the society.

<sup>1</sup> Duff, LA, Kitson, AL, Seers, K & Humphris, D 1996, Clinical guidelines: an introduction to their development and implementation, *Journal of Advanced Nursing*, 23(5):888; Scalzitti, DA 2001, Evidence-based guidelines: application to clinical practice, *Physical Therapy*, 81:1622, Available from: [http://web4.infotrac.galegroup.com/itw/infomark/676/430/37775180w4purl=rcl\\_HR](http://web4.infotrac.galegroup.com/itw/infomark/676/430/37775180w4purl=rcl_HR) (Accessed: 19 May 2003).

<sup>2</sup> ACC/AHA n.d., Manual for ACC/AHA Guidelines Writing Committees, Available from: [http://circ.ahajournals.org/manual/manual\\_11step5.shtml](http://circ.ahajournals.org/manual/manual_11step5.shtml) (Accessed 12 November 2005).

<sup>3</sup> Meyers, RG 1993, *Toward a Fair Start for Children*, Paris: UNESCO.

A distinct goal in caring for infants is to identify developmental delays and disabilities, and to provide appropriate services and support as early as possible. The impact of disability is widespread, as it extends beyond the disabled themselves; it touches the lives of family, friends, and fellow community members. Due to this widespread impact, it is imperative to recognise the urgent need to put in place measures to address this growing threat.<sup>4</sup>

There is a concern about the extent to which infants receive basic preventive services beyond immunizations, as many early-emerging developmental delays and disabilities go undetected, and therefore unaddressed by service systems.<sup>5</sup> Community nurses have a vital role in infant development as they have regular access to infants and their families. This provides them with an important window of opportunity to influence infant health and development positively, to detect developmental delays and disabilities early and to implement appropriate interventions to prevent or diminish loss of developmental potential. Therefore, they should accept accountability and responsibility for the delivery of developmental care to infants and their families. The Regulations scope of practice of registered nurses regulates the functioning of community nurses in primary health care clinics in South Africa.<sup>6</sup>

Services during the early years of development, between 0 and 2 years, are more likely to forestall deficits in development than initiation of intervention in the pre-school or school-aged period. With early identification, services and support can be instituted to maximize the child's development and functional abilities within the family and community.<sup>7</sup> While a growing body of evidence confirm that developmental surveillance: reviewing milestones with parents, clinical judgement and the addressing of parental concerns should be incorporated into the ongoing health care of the child. Such routine child development services are not consistently provided in health care settings in South Africa. Furthermore, if these services are provided, the delivery of it suffers from significant inadequacies. Many developmental needs and problems go unrecognised due to missed opportunities for detection thereof.<sup>8</sup> Thus, guidelines are necessary to support community

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<sup>4</sup> Department of Social Development 2002, Transforming the Present – Protecting the Future. Draft Consolidated Report. Report of the Committee of Inquiry into a Comprehensive system of Social Security for South Africa, 101-107, Available from: <http://www.socdev.gov.za/Documents/2002> (Accessed 1 June 2003).

<sup>5</sup> Zuckerman, B, Stevens, GD, Inkelas, M & Halfon, N 2004, Prevalence and Correlates of High-Quality Basic Pediatric Preventive Care, *Pediatrics*, 114(6):1522.

<sup>6</sup> SANC Regulations No. R 2598, 1984

<sup>7</sup> Meisels S J & Atkins-Burnett, S 2000, 2<sup>nd</sup> edition, The Elements of Early Childhood Assessment, in JP Shonkoff, & SJ Meisels, *Handbook of Early Childhood Intervention*, Cambridge: Cambridge University Press.

<sup>8</sup> Baez, C May 2000, News from the districts. Developmental screening in children, *Update*, (52), Available from: <http://www.hst.org.za/update/52/isds.htm> (Accessed 10 November 2002).

nurses in finding “best practice” within their scope of practice to ensure higher quality of developmental care to families with infants 0-2 years.<sup>9</sup>

## 2.2 ASSUMPTIONS UNDERPINNING THE GUIDELINES

Assumptions, underpinning the guidelines ‘**Define Hope – Guidelines for the Support of Community Nurses in the Management of Infant Developmental Needs**’, are embedded in the meta-paradigm of nursing that presents the most global perspective of the nursing discipline. Four concepts: person, health, environment and nursing have been conceptualized and formalized as the meta-paradigm of nursing.<sup>10</sup>

## 2.3 CONCEPTUAL FRAMEWORK FOR THE DEVELOPMENT OF THE GUIDELINES

The Transactional Model of Development,<sup>11</sup> a model from the Disciplines of Child Development and Early Childhood Intervention, has been selected to serve as a framework for the development of guidelines for community nurses to manage the developmental needs of infants. In the Transactional Model of Development, how a child turns out, is not a function of the infant alone or of experience alone. It is rather a product of the combination of the individual and his or her experience. The Transactional Model of Development embeds the infant in an environment of social relationships that will enhance some early characteristics and impede others. The Transactional Model of Development views the development of the infant as a product of the continuous dynamic interactions between the infant and the experience provided by his or her family and the social context. The experiences from the environment are not viewed independent from the infant.

This Transactional Model of Development represents an appropriate conceptual framework to address the management of infant developmental needs by community nurses. This model was borrowed because it indicates the requirements necessary for successful intervention to support infant development (typical and atypical development):

- Child development has multiple contributors (among others, socio-economic disadvantage, parent-child relationship, and parenting skills) at

<sup>9</sup> Cranston, M 2002, Clinical effectiveness and evidence-based practice, *Nursing Standard*, 16:39-43.

<sup>10</sup> McEwen, M 2002, in M McEwen & EM Wills, *Theoretical Basis for Nursing*, Philadelphia: Lippincott Williams & Wilkins.

<sup>11</sup> Sameroff, AJ & Chandler, MJ 1975, Reproductive risk and the continuum of caretaking casualty, in FD Horowitz, M Hetherington, S Scarr-Salapatek & G Siegel (eds.), *Review of child development research*, 4, Chicago: University of Chicago.

multiple levels of the child's ecology (micro-, meso-, exo-, and macrosystem).

- Multiple processes are represented in family thought and cultural symbols at each of these levels and are enacted in family interactions and social services (See Figure 1:9).
- Intervention processes are targeted at a particular problem for a particular infant in a particular family in a particular community.

The Transactional Model of Development relates to the meta-paradigm of nursing<sup>12</sup> as it coincides with all four concepts: person, health, environment and care (nursing). In the Transactional Model of Development, the development of the infant is seen as a product of a continuous dynamic interaction between the infant and the experience provided by his or her family and social context. In comparison in the meta-paradigm of nursing, there is also dynamic interaction between the **person** (recipient of care), the nurse, and the environment. There is an acknowledgement of promotive factors in the Transactional Model of Development, which aid in the general development of infants. In comparison to the meta-paradigm concept of **health** (promotion of optimal development, early identification of developmental delays and disabilities, and appropriate interventions), the Transactional Model of Development also seeks to maintain, promote and restore the development of infants and their families and this is done by focusing on the child-rearing regulatory system. The Transactional Model of Development includes the environment of the infant in such a way that the experiences provided by the environment are not independent of the infant and this correspond with the meta-paradigm concept of **environment** where there is also a focus on the constant interaction between the person (recipient of care) and the environment. The infant, by his or her previous behaviour, may have been a strong determinant of current experiences. Therefore, it helps infants to attain their developmental potential by adjusting him or her to better fit the regulatory system or to adjust the regulatory system to better fit the infant; this coincide with the meta-paradigm concept of **nursing** which has as its objectives the promotion of health, prevention of illness, alleviation of suffering, restoration of health and optimum development of health potential and includes all aspects of the nursing process.

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<sup>12</sup> McEwen, M 2002, in M McEwen & EM Wills, (eds), *Theoretical Basis for Nursing*. Philadelphia: Lippincott Williams & Wilkins.



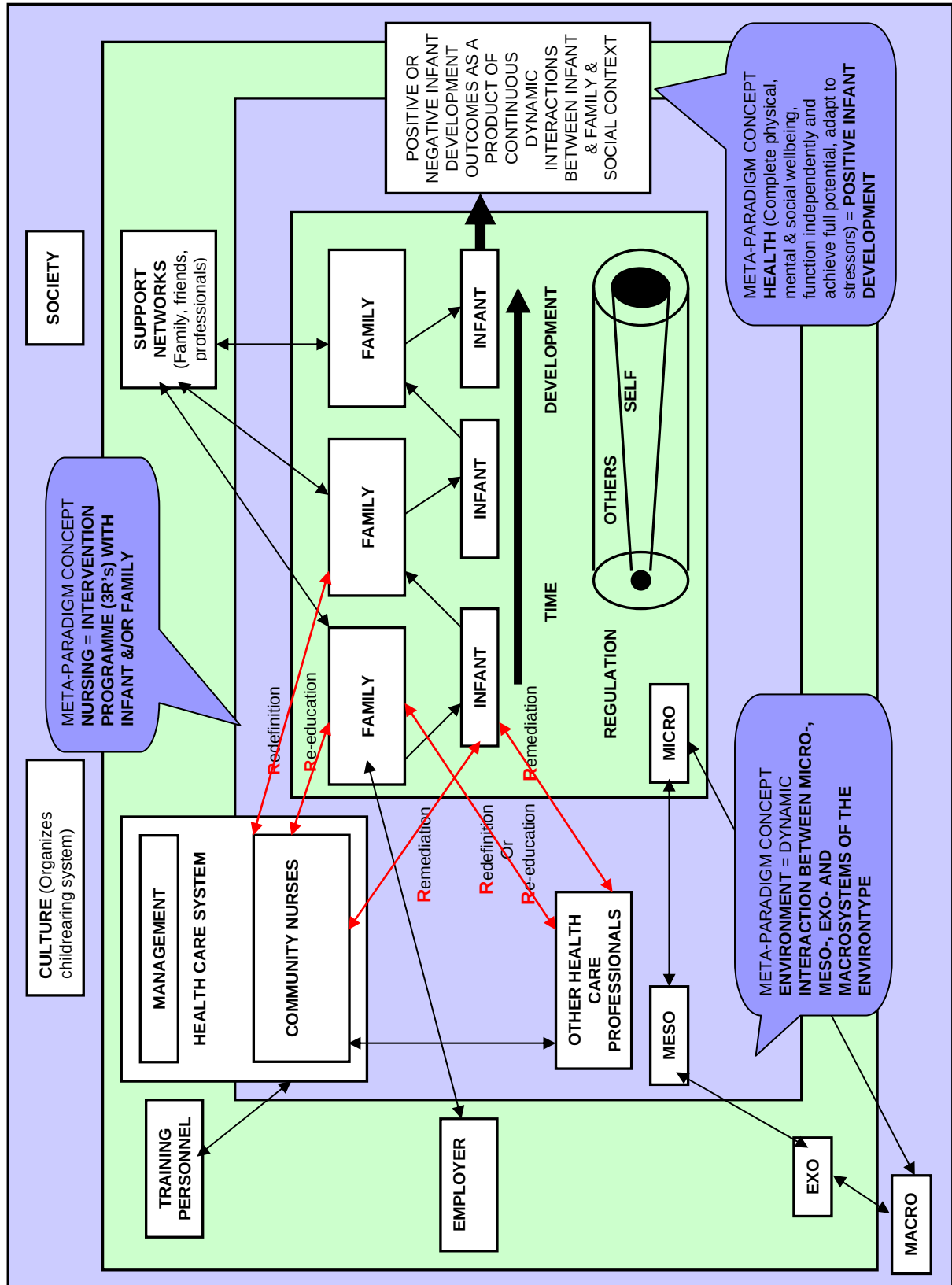


FIGURE 1 Diagram to indicate how the Transactional Model of Development and the meta-paradigm concepts of nursing are intertwined in the management of infant developmental needs by community nurses.

## **2.4 CLARIFICATION OF CONCEPTS**

Certain concepts need to be clarified to enhance comprehension of the guidelines.

### **2.4.1 TYPICAL INFANT DEVELOPMENT**

Typical infant development involves change that is cumulative and systematic. It refers to the refinement, improvement and expansion of existing skills that is orderly. The result is a consistent modification in behaviour that contributes to a higher level of functioning in the infant.<sup>13</sup> Development of infants could be described as a process of mutual interaction between the infant and his/her environment. It takes place within a culturally determined field in which the developing properties of an infant are a response to the physical, cultural and social circumstances, challenges and obstacles that it encounters. The possibilities and limitations that the environment offers infants, channel the developmental process.<sup>14</sup>

### **2.4.2 PROMOTION OF INFANT DEVELOPMENT**

The risks to healthy infant development are multifaceted and dependent on both detrimental and nurturing factors. Due to this multifaceted nature, promotion of infant development should focus on the ecology of human development and community nurses should implement strategies that encompass the four levels of human ecology: microsystem (individual family), mesosystem (infant day care and health care services), exosystem (parent's workplace and government agencies that set policies that affect the infant indirectly), and macrosystem (broad cultural system) (See Figure 1:9).

To promote infant development and enhance emerging competencies, the focus in the delivery of services to infants and their families must be on a multifaceted, transactional model.<sup>15</sup>

### **2.4.3 IDENTIFICATION AND MANAGEMENT OF DEVELOPMENTAL DELAYS AND DISABILITIES**

Infants develop at different rates and this creates variation among individuals. This understanding of individual differences provides the foundation for recognizing normal variations as well as extreme differences among infants and thus for

<sup>13</sup> Hooper, SR & Umansky, W 2004, *Young children with special needs*, 4<sup>th</sup> edition, Upper Saddle River: Pearson Education.

<sup>14</sup> De Winter, M, Baerveldt, C & Kooistra, J 1999, Enabling children: participation as a new perspective on child-health promotion, *Child: Care, Health and Development*, 25(1):16.

<sup>15</sup> Upshur, CC 1990, in JP Shonkoff & SJ Meisels, (eds), *Handbook of Early Childhood Intervention*. Cambridge: Cambridge University Press.

identifying those who may have special needs. The monitoring of infants' development should be one of the most fundamental activities of child primary health care. The reason being is that developmental delays and disabilities should be identified at the earliest possible point of manifestation, as the outcome could be improved by preventing loss of developmental potential. Community nurses are in a crucial position to identify infant developmental delays and disabilities early, because they are in regular contact with them. They can also monitor development over time. Furthermore, they are often aware of underlying social and familial factors at work in the infant's immediate environment.<sup>16</sup>

## 2.5 METHODOLOGY

The strategy used to investigate the phenomena was that of the case study, as it is the preferred strategy when "how", "why" and "what" questions are asked; when the researcher has little control over the event or when the research is being carried out in a real life context.<sup>17</sup>

The case was the management of developmental needs of infants 0-2 years by community nurses. Attention had been given to other people outside of the case, to enhance the insights into the single case e.g. management concerned with nursing issues; personnel concerned with continuous professional development of community nurses; families with infants 0-2 years with typical development; families with infants 0-2 years with an identified developmental delay or disability; and other health care professionals (e.g. speech/language therapists, occupational therapists and physiotherapists). A single local government primary health care clinic had been used, because the functioning of primary health care clinics in South Africa is sanctioned by national/district health policies. Therefore, information obtained from one clinic could be applicable to other clinics.

Participants, from the following groups were interviewed to collect data:

- Community nurses working at the site;
- Managers concerned with management and supervision of community nurses in primary health care clinics;
- Personnel concerned with the continuous professional development of the community nurses;

<sup>16</sup> Dworkin, PH 1989, British and American Recommendations for Developmental Surveillance Monitoring: The Role of Surveillance, *Pediatrics*, 84(6):1007; Magnusson, M, Persson, K & Sundelin, C 2001, The effectiveness of routine health examinations at 2, 6, 9 and 12 months of age: experience based on data from a Swedish county, *Child: Care, Health and Development*, 27(2):118; Rydz, D, Shevell, MI, Majnemer, A & Oskoui, M 2005, Developmental Screening, *Journal of Child Neurology*, 20(1):5.

<sup>17</sup> Yin, RK 2003, *Case study research: design and methods*, 3<sup>rd</sup> edition, Thousand Oaks: Sage Publications.

- Other health care personnel concerned with infant development e.g. physiotherapists, speech-language therapists and occupational therapists.
- Families with infants 0-2 with typical development.
- Families with infants 0-2 with identified developmental delay/disability.

A basic approach, namely content analysis, has been utilized for analysing the data. Content analysis has been defined as "A systematic, replicable technique for compressing many words of text into fewer content categories based on explicit rules of coding."<sup>18</sup> During the data analysis process, data were segmented into relevant units of meaning. Themes, categories and subcategories were identified. These themes, categories and subcategories were used to define the scope of the guidelines. Two independent qualitative researchers analysed all interview transcripts to verify that all relevant themes, categories and subcategories have been identified. The analysis produced by the two independent researchers corroborated the findings of the researcher. Therefore, the recommended guidelines were developed from themes, categories and subcategories that were based on validated research findings.

## **2.6 REVIEW OF THE LITERATURE**

An extensive literature review had been done to specify the scope and the content of the guidelines; to eventually enable community nurses to address the developmental needs of infants. One of the advantages of using a literature review is that it is easier to support the guidelines.<sup>19</sup>

The literature search had been carried out by searching several platforms (Blackwell Synergy, Ovid, Ebsco Host, ScienceDirect and Infotrac) provided for e-journals, by the Academic Information Services of the University of Pretoria to identify existing, published scientific information on the management of infant developmental needs.

## **2.7 DEVELOPMENT OF THE GUIDELINES**

Literature had been analyzed and synthesized to develop a set of recommendations. Scientific information is necessary, but not sufficient when making recommendations. Taking the evidence and turning it into useful

<sup>18</sup> Stemler, S 2001, An overview of content analysis, *Practical Assessment, Research and Evaluation*, 7(17), Available from: <http://pareonline.net/getvn.asp?v=7&n=17> (Accessed: 8 May 2005).

<sup>19</sup> Van Meijel, B, Gamel, C, Van Swieten-Duifjes, B & Grypdonck, MHF 2004, The development of evidence-based nursing interventions: methodological considerations, *Journal of Advanced Nursing*, 48(1):84-92.

recommendations depend on the judgement, experience, and good sense of the researcher.<sup>20</sup>

Following development of the guidelines, a focus group has been utilized to discuss and finalize the recommended guidelines. All professional groups represented in the case study namely community nurses, nursing management, personnel involved in the training of community nurses and other health care professionals were included in this group that consisted of eight members.

A brief, but detailed overview of the research was presented to enable comprehension for each specific guideline and its rationale. Each guideline and sub-guideline was discussed and accepted in principle. However, certain amendments pertaining to the grammatical structure of the guidelines and sub-guidelines were recommended, and where appropriate the changes were implemented.

### **3. VALIDATION OF THE GUIDELINES**

Guidelines should be subject to peer review prior to widespread dissemination and implementation to ensure content validity, reliability, clarity and applicability.<sup>21</sup> A number of desirable attributes for guidelines are indicated in the literature and these attributes were adapted to compile the criteria for evaluation of the guidelines. The criteria and rating scale, according to which the recommended guidelines were evaluated, are indicated in Table 1 below.

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<sup>20</sup> National Health and Medical Research Council, 1998, *A guide to the implementation and evaluation of clinical practice guideline*, Available from: <http://mrc.gov.au/publications/synopses/cp30syn.htm> (Accessed 16 April 2003).

<sup>21</sup> Shekelle, PG, Woolf SM, Eccles, M & Grimshaw, J 1999, Developing guidelines, *British Medical Journal*, 318:596.

Table 1 Criteria and rating scale for evaluation of recommended guidelines<sup>22</sup>

| CRITERIA                                                                                                                                                               | RATING SCALE          |              |                 |                          |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|--------------|-----------------|--------------------------|
|                                                                                                                                                                        | STRONGLY AGREE<br>(1) | AGREE<br>(2) | DISAGREE<br>(3) | STRONGLY DISAGREE<br>(4) |
| <b>Validity:</b><br>Correct interpretation of available evidence so that implementation of the guidelines will lead to improvement in promotion of infant development. |                       |              |                 |                          |
| <b>Cost-effectiveness:</b><br>The guidelines should generate health improvements at an acceptable cost.                                                                |                       |              |                 |                          |
| <b>Reliability:</b><br>Given the same circumstances, another health professional would apply them similarly.                                                           |                       |              |                 |                          |
| <b>Applicability:</b><br>Target population identified in accordance of evidence, as well as a clear description of the target population.                              |                       |              |                 |                          |
| <b>Clarity:</b><br>Guidelines should be precise, unambiguous and user-friendly.                                                                                        |                       |              |                 |                          |

The majority of the group agreed that the guidelines were valid, cost-effective, reliable, applicable and clear.

#### 4. NAMING OF THE GUIDELINES

The researcher decided to make use of the acronym; **DEFINE HOPE**, to name the set of recommended guidelines. This acronym indicates that there is 'hope' for community nurses in South Africa to enhance positive developmental outcomes for infants and their families and to prevent late identification of developmental delays and disabilities:

<sup>22</sup> Carnett, WG 2002, Clinical practice guidelines: a tool to improve care, *Journal of Nursing Care Quality*, 16:60-70; Royal College of Paediatrics and Child Health, 2001, *Standards for Development of Clinical Guidelines in Paediatrics and Child Health*, 2<sup>nd</sup> edition, Available from: [http://www.rcpch.ac.uk/publications/research\\_division\\_workforce\\_docs/StandardsCG.pdf](http://www.rcpch.ac.uk/publications/research_division_workforce_docs/StandardsCG.pdf) (Accessed 16 April 2003); Rycroft-Malone, J 2002, Clinical Guidelines, in C Thompson & D Dowding (eds), *Clinical decision making and judgement in Nursing*, London: Churchill Livingstone.

- |          |                                                                 |
|----------|-----------------------------------------------------------------|
| <b>D</b> | – Developmental care focus                                      |
| <b>E</b> | – Establish infrastructure and resources                        |
| <b>F</b> | – Family-centered care                                          |
| <b>I</b> | – Interdisciplinary collaboration                               |
| <b>N</b> | – Networking with other agencies                                |
| <b>E</b> | – Ethical nursing and professional accountability               |
| <b>H</b> | – Health care governance                                        |
| <b>O</b> | – Organizational culture and climate                            |
| <b>P</b> | – Personal professional development                             |
| <b>E</b> | – Efficient management of developmental delays and disabilities |

## 5. SET OF RECOMMENDED GUIDELINES

Following is a description of the recommended guidelines. Ten main guidelines were identified. Following each guideline a rationale and actions are given. The rationale, if necessary, is elucidated with additional information to ensure full understanding of the guidelines. Where appropriate, sub-guidelines, in addition to the main guideline were developed to ensure a comprehensive set of guidelines.

Guideline 1: Nursing management implements health care governance, as a shared responsibility of management and community nurses, to optimize the management of infant developmental needs and quality of care by community nurses.

### a. Rationale

Health care governance (HCG) is a framework through which health care service organizations are “accountable for continuously improving the quality of their services and safe guarding high standards of care by creating an environment in which excellence in care will flourish.”<sup>23</sup> According to the literature, HCG is a clearly outlined framework that clarifies concepts of accountability, clinical practice improvement, management of risks, monitoring and evaluation of clinical standards and quality improvement.<sup>24</sup>

### b. Actions (Health care governance)

Nursing management:

- Accepts responsibility for the HCG process and shows their commitment to HCG and quality improvement by supporting this initiative as a key strategic and operational priority within the service structure, thereby supporting

<sup>23</sup> Arya, D & Callaly, T 2005, Using continuous quality improvement to implement a clinical governance framework in a mental health service, *Australasian Psychiatry*, 13(3):241.

<sup>24</sup> Ibid:242

community nurses in the quest for improved management of infant developmental needs.

- Acquires the necessary knowledge to effectively implement this process to ensure that there is minimal duplication of effort, and decision making is streamlined, thus allowing community nurses to dedicate themselves more diligent to the delivery of infant developmental care.
- Holds community nurses accountable to deliver a quality infant developmental care service by including this facet of infant health care as a key performance aspect in the personal performance management of community nurses.
- Provides clear leadership and direction at both clinical and organizational levels so that there is no role confusion or role diffusion concerning integration of infant developmental care into the comprehensive health care delivered to infants and their families. To further elucidate role clarity, newly appointed community nurses attend induction to identify and fill gaps in their knowledge, as well as learn about their new working environment before they enter into their practice role.
- Confronts entrenched practices and re-engages staff that have become disenchanted and disillusioned, for whatever reason, in the management of infant developmental needs.
- Establishes a bottom-up approach to lead continuous quality improvement of services to ensure an environment in which excellence of infant developmental care can flourish. They help community nurses to be users of knowledge by developing a training strategy that includes:
  - Commitment to continuous professional development by providing opportunities for community nurses to attend seminars, workshops and conferences that include the management of infant developmental needs in the programme content.
  - A training needs analysis of individual community nurses (not only focused on government priority programmes).
  - Identification of knowledge and skills that is necessary and required of the person working within a specific role.
  - Identification of key people, required to support and enable staff to gain skills to meet the identified needs (with suitable preparation for the role).
- Engages community nurses in service-wide programmes (e.g. clinical documentation audits and induction of staff), and individual-specific programmes (e.g. all staff develops an annual individual plan in which they identify their goals, as well as plans to reach these goals), thereby maximizing efforts to support community nurses in their delivery of infant developmental care.



- Ensures consistent application of policies and procedures pertaining to infant developmental needs by appointing a sub-committee that is responsible for development, up dating, reviewing and dissemination of these policies and procedures.
- Incorporates client feedback in the HCG process to facilitate the holistic management of infant developmental needs by community nurses.

Guideline 2: Nursing management creates a positive organizational culture and climate in which community nurses can reach their full potential to manage infant developmental needs optimally.

#### **a. Rationale**

Organizational culture is defined as “ways of thinking, behaving, and believing that people have in common.”<sup>25</sup> This shared understanding is obtained through group socialization and learning. A culture of excellence positively influences job satisfaction, enhances self-esteem and achievement of organizational goals.<sup>26</sup> The desirable culture is seen as being one which is open and honest and which has a no blame approach.<sup>27</sup>

Organizational climate influences group behaviour and encompasses the value base and expectations of workers. It is the perception of how it ‘feels’ to work in a particular environment. It is directly linked to productivity, job satisfaction, client satisfaction, staff retention and organizational commitment. It is also the most overlooked aspects when determining the performance of a particular work team. Leaders are primarily responsible for creating the climate in their organization or their work units. The following dimensions can be measured: flexibility, responsibility, standards, rewards, clarity and team commitment.<sup>28</sup>

It is evident from the literature that workplace culture and climate are multifaceted and assert a major influence on individual and group behaviour, client care, the change process, job satisfaction and ultimately organizational success.<sup>29</sup>

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<sup>25</sup> Ingersoll, G, Kirsch, JC, Merk, SE & Lightfoot, JBS 2000, Relationship of Organizational Culture and Readiness for Change to Employee Commitment to the Organization, *Journal of Nursing Administration*, 30(1):11.

<sup>26</sup> Wilson, VJ, McCormack, BG & Ives, G 2005, Understanding the workplace culture of a special care nursery, *Journal of Advanced Nursing*, 50(1):28.

<sup>27</sup> Wilkinson, JE, Rushmer, RK & Davies, HTO 2004, Clinical governance and the learning organization, *Journal of Nursing Management*, 12:110.

<sup>28</sup> Snow, JL 2002, Enhancing Work Climate to Improve Performance and Retain Valued Employees, *Journal of Nursing Administration*, 32(7/8):393-394; Wilson, VJ, McCormack, BG & Ives, G 2005, Understanding the workplace culture of a special care nursery, *Journal of Advanced Nursing*, 50(1):28.

<sup>29</sup> Ibid.

## **b. Actions (Organizational culture and climate)**

Nursing management:

- Trains in, and is knowledgeable about, aspects such as organizational culture and climate that could have a negative effect on organizational commitment to manage infant developmental needs;
- Develops a method to measure the dimensions of organizational culture and climate and if warranted, develop strategies to address issues timely, before the context in which infant developmental care is delivered, is affected negatively
- Coaches and mentors staff individually and collectively, to support them in their management of infant developmental needs;
- Focuses explicitly on effective two-way communication and feedback, because if it is not in place, community nurses are at a disadvantage and it is more difficult for them to effectively promote positive infant developmental outcomes;
- Fosters a supportive relationship by focusing on the following qualities that define a supportive manager:
  - respect and trust,
  - praise, recognition and positive reinforcement,
  - role-modelling and helping behaviour,
  - personal caring behaviour,
  - absence of personal defensiveness.

Guideline 3: Nursing management evaluates, prioritizes and addresses existing infrastructure and resource (financial and human) constraints in a timely manner, to enable community nurses to deliver sustainable quality developmental care to infants and their families.

## **a. Rationale**

Infrastructure and resources play a critical role in the improvement of the quality of health care, especially in an era of limited resources. Infrastructure and resource strategies need to be developed or re-examined to ensure more effective and equitable provision of health services. Therefore, plans to strengthen sustain and maintain appropriate health care infrastructure and resources to deliver essential health care need to be a priority.<sup>30</sup>

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<sup>30</sup> O'Brien-Pallas, L, Baumann, A, Donner, G, Tomblin Murphy, G, Lochhaas-Gerlach, J & Luba, M 2001, Forecasting models for human resources in health care, *Journal of Advanced Nursing*, 33(1):121; World Health Organization, 1998, Health Care Infrastructure, Available from: <http://w3.who.org/rdhome/rdspeech/318health.htm> (Accessed 25 September 2005).

## **b. Actions (Infrastructure and resources)**

Nursing management:

- Utilizes a bottom-up approach, so that all staff are involved in the identification of resource and infrastructure constraints that negatively affect the delivery of quality infant developmental care;
- Develops innovative plans to prioritize and address constraints, which if left unattended, affect the sustainability of effective infant developmental care by community nurses.

Guideline 4: Nursing management pursues interagency collaboration to obtain the necessary intellectual and institutional resources to enable community nurses to provide sustainable quality infant developmental care.

## **a. Rationale**

The need for partnerships between health care professionals within geographical communities is becoming increasingly important as new health care needs and issues are identified. Collaboration is perceived as working together towards a common goal. The elements of networking, leadership and vision are all important as relationships between stakeholders are developed. A lack of collaboration between agencies could be the reason that infants fall through the gaps and do not receive the necessary health care services that they need. Infants have complex issues relating to health, development and behaviour and they do not fall neatly into one of the service categories into which services are divided. No one professional discipline can be expected to have the knowledge and skills required to deal with them.<sup>31</sup>

Working together is a continuum that includes unidisciplinary, multidisciplinary, interdisciplinary and transdisciplinary working. At each point along the continuum, there are opportunities for services and professionals to work together to improve the quality of services delivered to infants and their families. Research indicated that transdisciplinary working offers the most benefits to infants and families.<sup>32</sup>

Collaboration have a number of positive outcomes for health care: enabling the provision of the best quality and most effective care for infants who require multiple services; saving money by reducing overlap and duplication between services;

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<sup>31</sup> Boswell, C & Cannon, S 2005, New horizons for collaborative partnerships, *Online Journal of Issues in Nursing*, January 2005, 10(1) manuscript 2. Available from: [www.nursingworld.org/ojin/topic26/tpc26\\_2.htm](http://www.nursingworld.org/ojin/topic26/tpc26_2.htm) (Accessed 16 February 2005).

<sup>32</sup> Watson, D, Townsley, R & Abbott, D 2002, Exploring multi-agency working in services to disabled children with complex healthcare needs and their families, *Journal of Clinical Nursing*, 11:374.

providing a means for managers to share their responsibility for community care and reduce organizational stress.<sup>33</sup>

However, these benefits of collaboration come with many operational and philosophical challenges. Among others, developing a unified mission with mutually recognized goals understanding and integrating professional perspectives and capitalizing on the individual strengths of multiple stakeholders.<sup>34</sup>

#### **b. Actions (Interagency collaboration)**

Nursing management:

- Recognizes the necessity to work collaboratively with other agencies in the community, to ensure the delivery of holistic infant developmental care by community nurses;
- Understands the process and the necessity of collaboration with the various agencies and if not, actively obtains the necessary information to enable this process;
- Fosters strong relationships with other agencies by focusing on personal contact and networking, mutual respect and credibility, and accessibility and sharing of information, to ensure that community nurses are in a position to deliver and sustain developmental care to infants and their families;
- Decides together with prospective partners what form the collaboration will take on and devise protocols accordingly to reduce overlap and duplication between services focused on developmental care for infants and their families;
- Identifies and addresses the barriers to collaboration to ensure the continuity of developmental care to infants and their families.

Guideline 5: Community nurses engage in infant developmental care in such a way that it is a central focus of each contact that the community nurse has with the infant.

#### **a. Rationale**

Developmental disability is an important health problem as it carries an appreciable burden to the individual, family and society. The importance of promoting the development of infants and children is increasingly apparent in literature. The monitoring of infants' development should be one of the most fundamental activities of infant primary health care. The reasons being: delays in development

<sup>33</sup> Salmon, G 2004, Multi-agency collaboration: the challenges for CAMFS, *Child and Adolescent Mental Health*, 9(4):157; Van Eyk, H & Baum, F 2002, Learning about interagency collaboration: trialling collaborative projects between hospitals and community health services, *Health and Social Care in the Community*, 10(4):262.

<sup>34</sup> Alkema, GE, Shannon, GR & Wilber, K H 2003, Using Interagency Collaboration to Serve Older Adults with Chronic Care Needs, *Family & Community Health*, 26(3):223.

are common; early intervention is effective for infants with developmental delays; infants at risk of poor developmental outcomes also benefit from early intervention and community nurses are uniquely positioned to identify and refer infants with developmental delays in a timely manner to other health care professionals.<sup>35</sup>

Developmental care will result in infants being identified at a younger age, when intervention has its maximum benefit to alter their developmental trajectories favourable.<sup>36</sup>

#### **b. Actions (Infant developmental care)**

- Infant development and developmental surveillance are included in the content of all training programmes (pre-service and in-service) to ensure community nurses have the necessary knowledge and skills to identify developmental delays and disabilities timely, when intervention has its maximum benefit to alter the developmental trajectory of infants favourably.
- Community nurses, by becoming more evidence-based orientated in their daily practice will recognize the importance of developmental care as a priority in the daily care of infants.
- Community nurses identify strategies to incorporate a more comprehensive developmental service in their daily care of infants.
- Community nurses include the Transactional Model of Development in the theoretical framework that underpins the delivery of developmental care to infants to ensure that they have the necessary knowledge to deliver a quality infant developmental care service.
- Community nurses focus on relationships between parent and infant, and family and service providers, to ensure sustainability and acceptance of infant developmental services.

Sub-guideline 5.1: Community nurses acknowledge and incorporate the right of infants to develop to their full potential in their health care delivery to infants and families.

#### **a. Rationale**

There is global consensus that children's rights need special attention and the importance of good care and protection of children is embedded in the culture of all

<sup>35</sup> King, TM & Glascoe, FP 2003, Developmental surveillance of infants and young children in pediatric primary care, *Current Opinion in Pediatrics*, 15:624-625; Rydz, D, Shevell, MI, Majnemer, A & Oskoui, M 2005, Developmental Screening, *Journal of Child Neurology*, 20(1):17.

<sup>36</sup> Pinto-Martin, JA, Souders, MC, Giarelli, E & Levy, SE 2005, The Role of Nurses in Screening for Autistic Spectrum Disorder in Pediatric Primary Care, *Journal of Pediatric Nursing*, 20(3):163,167.

societies.<sup>37</sup> The Constitution of South Africa (1996) devotes a special section to children and a range of children's rights is specified, including the right of every child to basic nutrition, shelter, basic health care services and social services.

## **b. Actions (Rights of infants)**

Community nurses:

- Have the best interests of the infant at heart and guarantee the rights of infants according to the three P's: protection (from maltreatment, neglect, and all forms of exploitation), provision (of food, health care, education and social security) and participation (in all matters concerning them) in their daily developmental care to infants;
- Acknowledge and incorporate the right to life, survival and development of the infant in their daily developmental care to infants and families to ensure that the infant is well developed physically, mentally, socially and emotionally, thereby placing them in a better position to eventually contribute to family, community and country;
- Have a responsibility to see that parents have the necessary knowledge to provide an environment conducive to the healthy development of their infant.

Sub-guideline 5.2: Government priority programmes address the scope of infant development comprehensively.

## **a. Rationale**

The World Health Organisation recognizes the importance of infant development and acknowledges that supporting the development of infants should become a greater priority in health programmes.<sup>38</sup> However, many early-emerging developmental delays and disabilities go undetected, and therefore unaddressed by service systems.<sup>39</sup>

Timely assessment of infant development makes it possible to identify and manage developmental delays and disabilities at the earliest possible point of manifestation and to prevent or diminishes loss of developmental potential. It can furthermore,

<sup>37</sup> Meyers, RG 1993, *Toward a Fair Start for Children*, Paris:UNESCO, p.37.

<sup>38</sup> World Health Organization 1999, IMCI Care for Development. Available from: [www.who.int/child-adolescent-health/New\\_Publications/IMCI/IMCI\\_Care.pdf](http://www.who.int/child-adolescent-health/New_Publications/IMCI/IMCI_Care.pdf) (Accessed: 21 May 2003).

<sup>39</sup> Carter, AS, Briggs-Gowan, M & Ornstein Davis, N 2004, Assessment of young children's social-emotional development and psychopathology: recent advances and recommendations for practice, *Journal for Child Psychology and Psychiatry*, 45(1):118; Magnusson, M, Persson, K & Sundelin, C 2000, The effectiveness of routine health examinations at 2, 6, 9 and 12 months of age: experience based on data from a Swedish county, *Child: Care, Health and Development*, 27(2):118; Zuckerman, B, Stevens, GD, Inkelas, M & Halfon, N 2004, Prevalence and Correlates of High-Quality Basic Pediatric Preventive Care, *Pediatrics*, 114(6):1522.

help to identify developmental risk factors and target effective anticipatory guidance to assist parents in promoting optimal developmental outcomes.<sup>40</sup>

#### **b. Actions (Government programmes address infant development comprehensively)**

Community nurses:

- Use every contact with the infant and family to assess and positively influence infant health and development;
- Have the necessary understanding of human development to identify biological risk factors and to reduce its deleterious effects on infant development;
- Have the necessary knowledge about assessment, specifically the principles and elements of assessment, at their disposal to identify infant developmental delays and disabilities;
- Establish a good working relationship with families to amplify insight in how familial and cultural contexts influence the infant's repertoire of skills;
- Employ home visiting, as means to provide early intervention services to improve infant and parent outcomes;
- Identify and address barriers to developmental care in a timely manner to ensure sustainability of infant developmental care.

Guideline 6: Community nurses ensure that their professional practice, regarding developmental care to infants and their families, meets the standards of the profession.

#### **a. Rationale**

Community nurses are responsible, both legally and ethically for the care that they provide. Nurses in South Africa must practice in accordance with the Nursing Act, 1978, as amended and its regulations. The Draft Charter of Nursing Practice, 2004 stipulates the code of conduct and ethics of nursing; standards for nursing practice; competencies for nursing practice; scope of the professions of nursing and midwifery; conditions for practice and education and training for nursing practice. Although the final responsibility for the quality of care rests with the chief executive of the work place, it is the responsibility of the individual registered nurse to act competently and ethically and be accountable for his or her nursing practice. By virtue of their professional accountability and contracts of employment, community

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<sup>40</sup> Carter et al., 2004, Assessment of young children's social-emotional development and psychopathology: recent advances and recommendations for practice, *Journal for Child Psychology and Psychiatry*, 45(1):118; Halfon N, Regalado, M, Sareen, H, Inkelas, M, Peck-Reuland, CH, Glascoe, FP & Olson, LM 2004, Assessing Development in the Pediatric Office, *Pediatrics*, 113(6):1926; Magnusson et al., 2001, The effectiveness of routine health examinations at 2, 6, 9 and 12 months of age: experience based on data from a Swedish county, *Child: Care, Health and Development*, 27(2):118.

nurses have a responsibility to enhance the provision of their service to the public.<sup>41</sup>

#### **b. Actions (Professional Accountability)**

- Community nurses deliver infant developmental care in accordance with their scope of nursing practice, specifically clinical practice and quality of practice, as stipulated in the Draft Charter of Nursing Practice (2004).
- Community nurses uphold the mandate given by the people of South Africa, by accepting and demonstrating accountability and responsibility for own professional judgment and actions in the daily delivery of developmental care to infants and their families, as stipulated in the Draft Charter of Nursing Practice (2004).
- Ethical infant nursing practice of community nurses is based on the ethical principles and standards, code of conduct, and values fundamental to nursing, as stipulated in the Draft Charter of Nursing Practice (2004).
- The assumptions that underpin the practice of health care have changed from a framework where practice was based on experience to one where practice is based on evidence and community nurses need to take a personal responsibility for this change to evidence-based practice.
- Community nurses consult with more experienced nurse practitioners when infant developmental care requires expertise beyond their current competence.
- Community nurses consult with other health care professionals when the developmental needs of infants and their families fall outside the scope of nursing practice.

Guideline 7: Community nurses accept responsibility and accountability for their own continuous professional development pertaining to the developmental needs of infants and their families.

#### **a. Rationale**

Community nurses serve best public interest and specifically that of the infant when they constantly improve their application of competence and thereby increasing their focus on infant development. Community nurses need to be able to recognize their own limitations and training needs; they need to look at their practice with fresh eyes to be able to plan on how to meet such needs best.<sup>42</sup>

<sup>41</sup> McSherry, R 2004, Practice development and health care governance: a recipe for modernization, *Journal of Nursing Management*, 12:145; Tait, AR 2004, Clinical governance in primary care: a literature review, *Journal of Clinical Nursing*, 13:723.

<sup>42</sup> Spouse, J 2001, Work-based learning in health care environments *Nurse Education in Practice*, 1:15, 17; Tennant, S & Field, R 2004, Continuing professional development: does it make a difference? *Nursing in Critical Care*, 9(4):168.



#### **b. Actions (Continuous professional development)**

- Community nurses assume responsibility for lifelong learning and maintenance of competence concerning infant development.
- Community nurses identify own individual limitations and learning needs to enhance professional knowledge to improve developmental care delivered to infants and their families. Formulate, implement and evaluate individual learning plans to address the identified needs.
- Organizations support lifelong learning by ensuring that time and necessary resources are available for staff development.
- Organizations encourage community nurses to participate in evidence-based learning by subscribing to scientific journals that contain evidence on how to improve infant developmental care.
- To enhance delivery of developmental care to infants and their families, specific content can be included in all education programmes (pre-service, in-service and CPD). This includes: infant development; developmental vulnerability; adaptive and maladaptive parenting; protective factors and individual resilience; theoretical frameworks for intervention and specifically the Transactional Model of Development; elements of assessment and intervention (infant, family and community); human ecology of early risk; cultural differences as sources of developmental vulnerabilities; family-centered care; service delivery models for developmental care of infants, specifically infants with developmental disabilities and family-professional partnerships (collective empowerment model).

Sub-guideline 7.1: The providers of continuous professional development (CPD) programmes for community nurses have the necessary expertise and competence to present courses in infant developmental care.

#### **a. Rationale**

The nurse educator role requires specialized preparation and every individual engaged in the academic enterprise must be prepared to implement that role successfully. A core of knowledge and skills is essential if one is to be effective and achieve excellence in the role. It is critical that all nurse educators know about teaching, learning, and evaluation. The nurse educator's role is essential to the ongoing professional development of the community nurse.<sup>43</sup>

<sup>43</sup> Zungolo, E 2002, The preparation of nurse educators: developing the knowledge base to transmit the discipline of nursing, *Nursing Education Perspective*, 23(5):267.

**b. Actions (Expertise and competence of educators)**

- Appoint educators with the necessary competence in infant developmental care to implement this role successfully.
- Educators engage in lifelong learning activities to maintain and expand expertise, to ensure that community nurses increase their competence in infant developmental care.
- Educators focus on evidence-based learning by including scientific journals that contain articles on infant developmental care in the programme content.
- Educators support and employ inter-professional education to prepare community nurses to have a more holistic approach to their infant developmental care.

Sub-guideline 7.2: Community nurses are proactive and involved in their own continuous professional development regarding infant developmental care.

**a. Rationale**

CPD is defined as “an individual who takes responsibility for the development of his/her own career by systematically analysing development needs, identifying and using appropriate methods to meet these needs and regularly reviewing achievement compared against personal and career objectives.”<sup>44</sup> Although continuous professional development is not yet a requirement for annual registration for nurses in South Africa, CPD provides a learning framework for community nurses to adapt to the changing paradigm of evidence-based health care.

**b. Actions (CPD regarding infant developmental care)**

- Each community nurse identifies individual learning needs pertaining to infant developmental care.
- Community nurses develop a specific professional development plan, which includes the specific strategies and time limit to meet learning needs.
- Community nurses review achievements against personal and organizational objectives concerning management of infant developmental needs.

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<sup>44</sup> Cusick, A & McCluskey, A 2000, Becoming an evidence-based practitioner through professional development, *Australian Occupational Therapy Journal*, 47:163.

Guideline 8: Community nurses embrace family-centered care as their philosophy of care to infants and families.

**a. Rationale**

A family-centered care approach in service delivery is considered best practice. In family-centered care, nurses respond to family priorities, empower family members, employ a holistic (ecological) approach to the family and demonstrate insight and sensitivity to families.<sup>45</sup> In this approach the strengths, vulnerabilities and patterns of family functioning are considered in order to support child-rearing families and to encourage healthy coping strategies for families facing a crisis. This means that health assessment should include consideration of social, emotional and financial resources as well as the physical environment of the home and community.<sup>46</sup>

**b. Actions (Family-centered care)**

Community nurses:

- Become well-grounded about the dimensions of family-centered care to increase the possibility of a more holistic approach in the delivery of infant developmental care;
- Become more active in cultivating a working relationship with parents to enhance positive developmental outcomes for their infants. Eliciting parents' view and expectations of the community nurse will assist in this process and promote excellence in service delivery to infants and their families;
- Employ the Collective Empowerment Model as means to empower family members to activate the intrinsic competencies in all families and to utilize the natural and formal resources in the environment of the family, to support and sustain their identified goals for positive infant developmental outcomes;
- Become familiar with the available resources in the community to assist families in addressing the developmental needs of their infants, in the context of available and accessible community resources;
- Respect and support family decision making in the management of infant developmental needs;
- Are cultural competent in the provision of infant developmental services, and are aligned to meet the needs of the infant in a manner that is culturally acceptable to the family;
- Include reflective practice intervention in the delivery of infant developmental care to enhance the quality of family-centered care.

<sup>45</sup> Harbin, GL, McWilliam, RA & Gallagher, JJ 2000, 2<sup>nd</sup> edition, Services for Young Children with Disabilities and their Families in JP Shonkoff & SJ Meisels (eds), *Handbook of Early Childhood Intervention*, Cambridge: Cambridge University Press.

<sup>46</sup> Glascoe, FP, Altemeier, WA & MacLean, WE 1989, The Importance of Parents' Concerns About Their Child's Development, *American Journal of Developmental Care*, 143:958.

Guideline 9: Community nurses ensure efficient management of infant developmental delays and disabilities.

**a. Rationale**

The long-term problems of infants at risk for developmental delay have been well established. A growing body of literature has supported the benefits of early identification and intervention. Community nurses can play a vital role in the management of such developmental delays and disabilities.<sup>47</sup>

Sub-guideline 9.1: Community nurses focus on early identification of developmental delays and disabilities.

**a. Rationale**

The monitoring of infants' development should be one of the most fundamental activities of child primary health care. The reason is that developmental delays should be identified at the earliest possible point of manifestation, as the outcome could be improved by preventing loss of developmental potential. Community health care providers are in a crucial position to identify infant developmental delays early because they are in regular contact with them. They can also monitor development over time. Furthermore, they are often aware of underlying social and familial factors at work in the infant's immediate environment.<sup>48</sup>

**b. Actions (Early identification of developmental delays and disabilities)**

Community nurses:

- Incorporate developmental surveillance into comprehensive health care to infants and view all encounters as an opportunity for developmental surveillance to ensure early identification of developmental delays and disabilities thereby, increasing the possibility of intervention to have a positive effect on infant and family outcomes;
- Become knowledgeable about aspects of developmental surveillance, elements and principles of assessment and utilize the Transactional Model of Development as theoretical framework to conceptualize the factors that determine high-risk infant developmental outcome, thereby optimizing early identification of infant developmental delays and disabilities by community nurses.

<sup>47</sup> Miles Curry, D & Duby, JC 994, Developmental Surveillance by Pediatric Nurses, *Pediatric Nursing*, 20(1):42.

<sup>48</sup> Dworkin, PH 1989, British and American Recommendations for Developmental Surveillance Monitoring: The Role of Surveillance, *Pediatrics*, 84(6):1007; Rydz et al., 2005, Developmental Screening, *Journal of Child Neurology*, 20(1): 5.

Sub-guideline 9.2: Community nurses are knowledgeable about formal and informal support resources in the community to facilitate access for families.

#### **a. Rationale**

According to Dunst and Trivette<sup>49</sup> informal supports, and by extension resources, positively influence infant and family outcomes. Support, according to Finfgeld-Connett<sup>50</sup> is “an interpersonal process that is context specific and involves the exchange of information.” It consists of facts, advice, words of reassurance, positive affirmation and empathy. Support can be formal (professionals) or informal (family, friends and the like).<sup>51</sup>

#### **b. Actions (Support resources in community)**

Community nurses:

- Become knowledgeable about the resources available in the community for infants and their families to be able to assist families in the identification of the necessary resources to meet their needs;
- Become knowledgeable in the functional elements of support to institute the correct type of support for the family in need;
- Develop an eco-map for each family to identify available and accessible resources and sources of support.
- Build community capacity by recognizing the strengths and assets of a community by demonstrating how these strengths address infant and family desires and by eliminating barriers through the use of other resources.

Sub-guideline 9.3: Community nurses act as advocates for infants and their families.

#### **a. Rationale**

Advocacy is defined as “pleading the cause of another.”<sup>52</sup> Nursing has as its end purpose the welfare of other human beings. Nurses act as advocates when they act in the best interest of the client. The nurse is seen as a resource person who gathers information to assist clients and families in their efforts to become informed about their rights. The nurse, as advocate, supports the client’s right to fully participate in the decision making process and act as a buffer to prevent others from undermining the process.

<sup>49</sup> Wolery, M 2000, 2<sup>nd</sup> edition, Behavioral and Educational Approaches to Early Intervention, in JP Shonkoff & SJ Meisels (eds), *Handbook of Early Childhood Intervention*, Cambridge: Cambridge University Press.

<sup>50</sup> Finfgeld-Connett, D 2005, Clarification of Social Support. *Journal of Nursing Scholarship*, 37(1):6.

<sup>51</sup> McWilliam, RA & Scott, S 2001, A Support Approach to Early Intervention: A Three-Part Framework, *Infants and Young Children*, 13(4):57-59.

<sup>52</sup> Stanhope, M & Lancaster, J 1984, *Community Health Nursing*, St Louis: The C.V. Mosby Company.

## **b. Actions (Advocates for infants and their families)**

Community nurses:

- Share information on developmental delays and disabilities with local organizations to increase their awareness of the needs of members in their community;
- Present the client's concerns about his or her infant's developmental delay or disability when necessary in a succinct and convincing manner;
- Identify resources to be utilized for the client's benefit leading to positive outcomes for both the infant and the family;
- Identify sources of information on specific developmental delays and disabilities so that family members can be better informed about the infant with a developmental delay or disability;
- Link families with family organizations who will help them advocate for their infant with a developmental delay or disability;
- Assist clients toward assertive behaviour in personal health practices to improve developmental outcomes for their infants;
- Motivate and empower families in the delivery of infant developmental care to act on their own behalf to gain and maintain control over their own well being.

Sub-guideline 9.4: Community nurses acknowledge the effect of developmental delays and disabilities on the family and determine the most beneficial strategy to facilitate the process of adaptation.

## **a. Rationale**

Parental reactions after receiving the diagnosis of impairment in a child can range from fear, denial, anger, frustrations, guilt, grief and mourning. These are just the beginning of chronic stress, sadness and consequently ongoing distress and dysfunction in the family.<sup>53</sup> After receiving the diagnosis, the parents progress through a predictive sequence of stages before they are able adapt to the situation.<sup>54</sup> These stages have been compared to that proposed by among others, Elizabeth Kubler-Ross in her theory of grief, ranging from initial shock to eventual acceptance.<sup>55</sup> Community nurses therefore need to be aware of the enormous effect that the disability may have on each member of the family. They have a

<sup>53</sup> Kearney, PM & Griffin, T 2001, Between joy and sorrow: being a parent of a child with developmental disability, *Journal of Advanced Nursing*, 34(5):582-583.

<sup>54</sup> Pelchat, D & Lefebvre, H 2004, A holistic intervention programme for families with a child with a disability, *Journal of Advanced Nursing*, 48(2):124

<sup>55</sup> Wittert, DD 2004, Parental Reactions to Having a Child with Disabilities, *Nursing Spectrum*, Available from: [www.nsweb.nursingspectrum.com/ce/ce181.htm](http://www.nsweb.nursingspectrum.com/ce/ce181.htm) (Accessed 15 February 2004).

significant role to play in facilitating the process of adaptation, providing family support, facilitating access to local services, and co-ordinating services.<sup>56</sup>

#### **b. Actions (Effect of developmental delays and disabilities on the family)**

Community nurses:

- Are aware and sensitive to stages of grief and adjustment of a family with an infant who has been diagnosed with a developmental disability;
- Become well-grounded in counseling and communication skills to ensure the necessary and ongoing support for families with a developmental delayed/disabled infant;
- Bolster parental perceptions of control, support and coping to improve parental emotional well being and behaviour, thereby promoting positive developmental outcomes for both parents and the infant;
- Provide information on the diagnosis, prognosis and daily care of the infant, with a developmental delay or disability in the family environment to facilitate the family's adaptation;
- Boost parental self-esteem and confidence by acknowledging and respecting the expertise of the family in caring for the child and promote family interaction by including siblings and extended family in the daily care-giving of the developmental disabled infant;
- Facilitate access to parent support groups to ensure the family receives the necessary support, thus, enhancing the family's well being and increasing the likelihood of positive developmental outcomes for the infant;
- Mediate between families and the various health care professionals to promote continuity of care and support.

Sub-guideline 9.5: Community nurses focus on anticipatory guidance in the management of infant developmental delays and disabilities.

#### **a. Rationale**

Anticipatory guidance is seen as the cornerstone of child health services. It is the information health care professionals give to families about what they should expect in their child's development, what they should do to promote this development, and the benefits of these healthy lifestyles and practices. Research indicates that anticipatory guidance improves infant and family functioning.<sup>57</sup>

<sup>56</sup> Kirk, S 1999, Caring for children with specialized health care needs in the community: the challenges for primary care, *Health and Social Care in the Community*, 7(5):351; Pelchat, D & Lefebvre, H 2004, A holistic intervention programme for families with a child with a disability, *Journal of Advanced Nursing*, 48(2):125; Sloper, P 1999, Facilitators and barriers for co-ordinated multi-agency services *Child: Care, Health & Development*, 30(6): 91.

<sup>57</sup> Nelson, CS, Wissow, LS & Cheng, TL 2003, Effectiveness of anticipatory guidance: recent developments, *Current Opinions in Pediatrics*, 15:630, 634.

Dines<sup>58</sup> and Cantrell<sup>59</sup> suggest that community nurses are well placed to undertake anticipatory guidance due to their closeness to their clients and their families.

#### **b. Actions (Anticipatory guidance)**

Community nurses:

- Include individualized anticipatory guidance in every contact session with infants and families to promote infant development;
- Assess client's health literacy to increase the likelihood of comprehension of anticipatory guidance and they use plain lay language and avoid medical jargon, speak slowly, use pictures and visual images, limit the amount of information communicated in one encounter, ask clients to recall essential information, and create a trusting and shame-free therapeutic environment;
- Utilize the Transactional Model of Development to focus on the regulatory processes to identify parental lack of knowledge about child rearing or misinterpretation of infant behaviour to provide the necessary anticipatory guidance to rectify the identified shortcoming, thereby improving infant developmental outcomes;
- Elicit family concerns and base anticipatory guidance topics on these concerns or ask open-ended questions to prompt parents to raise issues on which they wish to receive guidance;
- Utilize pre-visit questionnaires and checklists to help identify specific developmental concerns and risks to ease the workload;
- Are guided by developmental needs of the family and community, population risks and morbidity, and the scientific evidence previously summarized to choose topics for discussion.

Sub-guideline 9.6: Community nurses apply best-practice principles in early intervention efforts, to promote positive outcomes for the infant and the family.

#### **a. Rationale**

According to Blann,<sup>60</sup> nurses have a long history in participating in early intervention programmes and community nurses can play a vital role in the provision of early intervention services to infants and families with special needs. However, for intervention to be successful it must adhere to certain design and helping principles.

<sup>58</sup> Dines, A 1994, What changes in health behaviour might nurses logically expect from their health education work? *Journal of Advanced Nursing*, 20:219.

<sup>59</sup> Cantrell, J 1998, District nurses' perceptions of health education, *Journal of Clinical Nursing*, 7:90.

<sup>60</sup> Blann, L 2005, Early Intervention for Children and Families: With Special Needs, *The American Journal of Maternal/Child Nursing*, 30(4):265.



## **b. Actions (Best practice principles in early intervention)**

Community nurses:

- Create a family-centered therapeutic process by encouraging family members to participate in the intervention process;
- Apply the transactional diagnosis decision flowchart for choosing the appropriate form of intervention. Family decision making is respected and supported by community nurses in early intervention efforts;
- Support care-givers/parents of a developmentally delayed or disabled infant by showing understanding for their concerns and frustrations, and discuss and explain procedures with family;
- Adhere to the following principles for effective and sustainable intervention efforts to enhance positive infant developmental outcomes:
  - utilize a theoretical underpinning to make sense of what are being observed and learned about families and to decide how and where to intervene.
  - decide on a clear mission and boundaries for intervention efforts.
  - start where the family is developmentally.
  - build a good relationship with the family.
  - work from a strengths-based perspective.
  - view the infant in the family-context, but do not lose the infant when using a family-centered lens.
  - do not promise more than what can be delivered.
  - convey to parents that change is gradual, fragile and reversible and it should be measured in small units;
- View assessment and intervention in the management of infant developmental delays and disabilities as interactive processes in which each informs the other.

Guideline 10: Community nurses implement and promote interdisciplinary collaboration in the delivery of infant developmental care.

## **a. Rationale**

Infants with developmental delays and disabilities often require the expertise of numerous professions; without collaboration there would be no continuity of care.<sup>61</sup> Collaboration with other health care professionals is an important strategy to ensure that clients have access to holistic and comprehensive health care services. Collaboration of this nature can enhance intellectual resources and allow individual

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<sup>61</sup> Stayton, V. & Bruder, MB 1999, Early Intervention Personnel Preparation for the New Millennium: Early Childhood Special Education, *Infants and Young Children*, 12(1):61.

health care providers to fulfil their optimal potential within their respective professions.<sup>62</sup>

#### **b. Actions (Interdisciplinary collaboration)**

Community nurses:

- Acquire knowledge about the roles and functions of other health care professionals to facilitate the referral process of infants with developmental delays and disabilities, thereby ensuring timely intervention;
- Institute a referral process that initiates feedback and communication between health care professionals to assist the community nurse in the management of infant developmental needs;
- Follow up on referrals to ensure the continuity of care and thereby positive developmental outcomes for both parents and infants.

Sub-guideline 10.1: Community nurses establish and sustain, interdisciplinary/transdisciplinary working teams to address infant developmental delays and disabilities.

#### **a. Rationale**

Infants with complex problems, such as developmental delays and disabilities, do not fall neatly into the service categories into which e.g. health, social and services are divided. No one professional discipline can be expected to have the knowledge and skills required to deal with these infants. Thus, the need for interdisciplinary collaboration has been clearly recognised to address the needs of these infants in a holistic manner.<sup>63</sup>

Transdisciplinary working allows for flexible definitions of role and responsibility, and thereby enriches the team and the family while simultaneously empowering individual members. Team members must first improve their own knowledge base and clinical skills to enhance their self-confidence in order to become fully active members of the team. Role release involves the infusion of information unique to the specific profession into the collective knowledge base of the team.<sup>64</sup>

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<sup>62</sup> Pringle, D, Levitt, C, Horsburgh, ME, Wilson, R & Whittaker, M 2000, Interdisciplinary collaboration and primary health care reform, *Canadian Family Physician*, 46:764.

<sup>63</sup> Salmon, G 2004, Multi-agency collaboration: the challenges for CAMFS, *Child and Adolescent Mental Health*, 9(4):157.

<sup>64</sup> Watson, D, Townsley, R & Abbott, D 2002, Exploring multi-agency working in services to disabled children with complex health needs and their families, *Journal of Clinical Nursing*, 11:372.

## **b. Actions (Interdisciplinary/transdisciplinary teams)**

Community nurses:

- Include parents in the interdisciplinary/transdisciplinary teams to ensure that interventions start where families are developmentally and that it begins with parents' own experience of their situation;
- Are confident in their own role to deliver infant developmental care and respect the expertise and roles of other health care professionals;
- Acquire the necessary knowledge to perform as a member of an interdisciplinary/ transdisciplinary team;
- And other health care professionals develop a unified mission with mutually recognized goals for the team, and find common ground among team members to determine what contribution each of the members can provide in infant developmental care;
- Establish effective communication and a common language for use among team members to ensure an effective service to infants and their families;
- Identify barriers to collaboration and address it timely to ensure sustainability of the management of infant developmental needs.

Sub-guideline 10.2: Community nurses engage in interdisciplinary education to enhance their knowledge and skills to facilitate a more holistic approach to infant developmental care.

## **a. Rationale**

The impetus for interprofessional education initiatives originated in the World Health organization Alma Ata in 1978, which stated the need for a more holistic approach to health care.<sup>65</sup> Inter-professional training has been defined as “learning together to promote collaborative practice.”<sup>66</sup> Different professional groups learn with and from each other to increase collaborative practice and to improve the effectiveness of care delivery.<sup>67</sup> However, it would be naïve to assume that learning together is without its difficulties. It is therefore necessary to carefully consider how such learning opportunities are planned and structured.<sup>68</sup>

<sup>65</sup> Mandy, A, Milton, C & Mandy, P 2004, Professional stereotyping and interprofessional education *Learning in Health and Social Care*, 3(3):154.

<sup>66</sup> Cooper, H, Carlisle, C, Gibbs, T & Watkins, C 2001, Developing an evidence base for interdisciplinary learning: a systematic review, *Journal of Advance Nursing*, 35(2):229.

<sup>67</sup> Cooper, H, Braye, S & Geyer, R 2004, Complexity and interprofessional education, *Learning in Health and Social Care*, 3(4):180.

<sup>68</sup> Fowler, P, Hannigan, B & Northway, R 2000, Community nurses and social workers learning together: a report of an interprofessional education initiative in South Wales, *Health and Social Care in the Community*, 8(3):187.

## **b. Actions (Interdisciplinary education)**

Community nurses:

- Improve communication and working practices across professional and organizational boundaries to initiate interdisciplinary education to enhance their competence to ensure a more holistic approach to infant developmental needs;
- Obtain support from management to ensure sustainability of interdisciplinary education;
- Join other health care professionals with a view to assign the initial planning process to a designated planning team and acquire the necessary infrastructure support, such as space for group meetings and teaching equipment;
- Join other health care professionals to form small (no more than eight), but diverse (no fewer than four) groups to enhance interaction to allow members to learn from one another and develop a common conceptual understanding;
- Recognize the effect of cognitive factors such as attitudes toward each other, to help understand the complexity of interdisciplinary relations in delivery of infant developmental care;
- Recognize the effect of emotional factors such as perceptions of interdisciplinary education and its effects, to help understand the facilitation processes involved in developing this type of intervention;
- Recognize social-environmental variables, such as social norms and influences of peers and gatekeepers, to help understand the development of stereotypes;
- Identify and address barriers to collaboration and shared learning to ensure that community nurses reap the benefits of other health care professionals' expertise and competence and thereby, increasing the effectiveness of infant developmental care.

## **6. SCHEDULE FOR REVIEW**

After 1 year of implementation, a panel of professionals should review the guideline. These professionals should be experts in the fields of infant developmental care and early childhood intervention. It should be a multiprofessional group, including community nurses, nursing management on various hierarchical levels, personnel concerned with CPD of community nurses, speech/language therapists, physiotherapists and occupational therapists.

## CHAPTER 1

### ORIENTATION TO THE STUDY

#### 1.1 INTRODUCTION

The purpose of this study is: to describe the responsibilities of community nurses according to the legal scope of practice of registered nurses, with regard to the management of developmental needs of infants in primary health care clinics in South Africa: to develop guidelines for the support of community nurses to address the developmental needs of infants 0 - 2 years.

#### 1.2 BACKGROUND AND RATIONALE

Infants and young children have a human right to develop to their full potential. To allow unmanaged disability and arrested development to occur in these children is a violation of their basic human rights. A greater obligation to protect and help children arises from the fact that children are dependent on others for satisfaction of their rights (Meyers, 1993:37). According to Blackwell (In Creswell, 2004:618) "We are not tinkers who merely patch and mend what is broken ... we must be watchmen, guardians of the life and the health of our generation, so that stronger and more able generations may come after".

Universally, there is an increased awareness that the early years of life are a period of considerable opportunity for growth as well as vulnerability for harm. The first years lay a crucial foundation for the health and development of children. The support of the healthy development of the child is thus of great importance. Moreover, it is critical not to just maintain, but also optimize the development and health of infants, as investments in infant development are fundamental for the future of every individual and for the wealth of the society. Furthermore, a distinct goal in caring for infants is to identify, as early as possible, developmental delays and disabilities and to provide appropriate services and support (Anderson, Shinn, Fullilove, Scrimshaw, Fielding, Normand & Carande-Kulis, 2003:32; Blann, 2005:263; Coghlan, King & Wake,

2003:49; Halfon & Inkelas, 2003:3136; Köhler & Rigby, 2003:553; Magnusson, Persson & Sundelin, 2001:118; Meisels & Shonkoff, 2000:3).

It is, however, experienced by other health care professionals involved in early childhood care in South Africa, that the “diagnosis” of developmental disability is done much too late for effective intervention. Mothers and caregivers bring infants too late for evaluation of their development “due to a lack of knowledge about child development and the functional skills (milestones) children should reach at certain stages” (Eksteen, 2000:25).

It is not in South Africa only that problems are experienced with delayed identification of disability and developmental needs. The results of a study by O’Nualláin & Flanagan (2001:n.p.), looking at the effectiveness of developmental screening in Ireland, also indicate that many children were referred late for remedial services due to late identification. These findings are supported by Barker Dunbar and Niman Reed (1999:196) from the United States of America, who also expressed their concerns, related to a lack of timely identification and no referral to early intervention services.

This indicates that the delivery of a comprehensive child health care service should extend beyond the scope of services currently provided by community nurses in primary health care clinics in South Africa. Community nurses should accept accountability and responsibility for timely identification of developmental delays and disabilities as part of their daily health care services to infants and young children.

### **1.2.1 PREVALENCE OF DISABILITY IN SOUTH AFRICA**

According to the White Paper on an Integrated Disability Strategy (South African Government, 1997), there is a lack of reliable information on disability in South Africa. However, the available information provides a rough sense of the scope of disability. According to the 2001 census (Statistics South Africa, 2003) the prevalence of disability in South Africa is 5.0%, as compared to the 10-12% of any population that has been estimated by the World Health

Organisation (The Child Health Policy Institute, 2001:6). Several other surveys between 1996 and 1999 put the prevalence of disability between 5.9 and 12.8%. The disparity between these results could be due to different methodologies used or the lack of clear uniform definitions of disability (Ibid:4).

The extent of childhood developmental disability is undetermined in South Africa and available prevalence rates for childhood disability, as indicated by three small rural disability surveys, vary between 3.3 and 6.4%. These results are comparable with other developing countries' prevalence rates (McLaren, Solarsh & Saloojee, 2003/2004:170; The Child Health Policy Institute, 2001:6). The Community Agency for Social Enquiry (CASE) puts the prevalence in South Africa at 1.6% for the age category 1-5 years (The Child Health Policy Institute, 2001:6). The Child Health Policy Institute (2001:9) suggests that an overall rate of 3-4% for childhood disability be utilised for planning and budgeting purposes in the South African context.

The fact that children only account for a small portion of national disabilities in South Africa, might be due to late identification, restricted access to services or a lack of hard evidence describing the epidemiology of disability (McLaren et al., 2003/2004:164; Viljoen, Craig & Hymbaugh, 2003:662). However, the number of disabled children in South Africa could rise in line with international trends if the latter could be addressed. Disability among children is a major concern because of the long-term impact on their quality of life. The health burden of children with disabilities could be greatly reduced by either prevention or early detection and effective intervention by community nurses in primary health care clinics.

### **1.2.2 HEALTH SERVICES IN SOUTH AFRICA**

Before election of the ANC (African National Congress) Government, health care in South Africa was fragmented, inefficient and inequitable. However, since the election in 1994 a major transformation of the health care delivery system took place (Forman, Pillay & Sait, 2003/2004:14).

A unified National Health System (NHS), based on the District Health System (DHS) model, was developed. It comprises of the Department of Health, provinces and districts, with the districts as the major locus of implementation of health care (National Department of Health, 1997). Each of these structures has its own distinct role and functions, with among others, formulation of health policy and legislation, quality assurance, capacity building, allocation of resources, liaison with other agencies and rendering of services. The DHS policy was implemented throughout the country from 1995 onwards and eventually the entire country was divided into 53 health districts in December 2000 (Barron & Asia, 2001:21-27). Structured co-operation and collaboration exist between provincial and local government departments of health, to render health care services in these health districts (National Department of Health, 2003).

The Primary Health Care system (PHC) was adopted as the vehicle for delivery of health care because it is the most effective and cost-effective means of improving the population's health (National Department of Health, 2001). PHC as defined in the Alma-Ata declaration includes promotive, preventive, curative and rehabilitative care with preventive and promotive services, rather than curative services as the main focus of health care (Gilbert, Selikow & Walker, 2002:105). Each health district is to develop a service delivery plan according to the PHC package and the aim is to provide the full PHC package as listed in the PHC Norms and Standards publication produced by the National Department of Health (National Department of Health, 2003).

Health services for children are therefore part of the comprehensive, integrated primary health care services and the pursuit of optimum health for children is one of the principal goals of the Reconstruction and Development Programme (RDP). The RDP is a framework developed by the Government to address various problems facing the majority of the people of South Africa, e.g. the health of the population, effectively (National Department of Health, 1997).



Various divisions within the Department of Health such as Child and Youth Health, Nutrition, Women's Health and Genetics, HIV/AIDS and STI's, Chronic Diseases and Disabilities, Oral Health, Mental Health and Substance Abuse are responsible for programmes that impact directly or indirectly on the health of children. Each has specific programme-related goals and objectives (Solarsh & Goga, 2003/2004:104). Various national strategies and programmes stem from these goals and objectives and the following are the core strategies for child health:

- Integrated Management of Childhood Illness (IMCI). This is the key national strategy to reduce morbidity and mortality from common childhood illnesses that affect children under the age of 5 years.
- Prevention of Mother-to-Child Transmission of HIV (PMTCT). This is a package of proven and cost-effective interventions (counselling, HIV testing, modified obstetric practices, a short course of Nevirapine and support for infant feeding options), which was integrated into existing mother and child health services.
- Perinatal Problem Identification Programme (PPIP). This is a computer-based audit system based at 27 sentinel health facilities throughout South Africa and it aims to estimate a national perinatal mortality rate and to identify the causes of perinatal mortality.
- Kangaroo Mother Care. The focus is on the care of the low birth weight infant to improve perinatal and neonatal survival and wellbeing.
- Expanded Programme on Immunisation, South Africa (EPISA). This programme aims to decrease childhood morbidity and mortality from vaccine-preventable diseases.
- Integrated Nutrition Programme (INP). The focus is on children under 2 years, pregnant and breastfeeding women as well as improvement of the nutritional status of all South Africans

(Solarsh & Goga, 2003/2004:109-110).

The commitment to children in South Africa is evidenced by the numerous initiatives that aim to improve the health and wellbeing of children. This attainment of wellbeing requires a focus on urgent child health priorities. As to

date there is, however, no specific policy that addresses the management of infant developmental needs by community nurses.

### **1.2.3 ADDRESSING INFANT DEVELOPMENTAL NEEDS BY COMMUNITY NURSES**

Nurses in South Africa play a vital role in the delivery of primary health care. It can be expected from them, as supporters of health promotion, to devote a significant amount of their time to the promotion of optimal development, early identification of delays and impairments and the implementation of appropriate interventions.

The scope of practice of registered nurses (South African Nursing Council, 1984) regulates the functioning of community nurses in primary health care clinics. Applicable functions have been described as:

- The diagnosing of health needs and the development and execution of a nursing regimen to meet these needs
- The prevention of disease and the promotion of health
- The facilitation of the attainment of optimum health for all
- The promotion of physical and mental health
- The referral of patients to other registered professionals where necessary
- The provision of effective patient advocacy to enable patients to obtain the necessary health care

While a growing body of evidence confirm that developmental surveillance i.e. reviewing milestones with parents, clinical judgement and addressing parental concerns should be incorporated into the ongoing health care of the child, such routine child development services are not consistently provided for in health care settings. Furthermore, if these services are provided, the delivery of it suffers from significant inadequacies (American Academy of Pediatrics, 2001:n.p; Dworkin, 1989:1006; VanLandeghem, Curtis & Abrams, 2002:2; Wright, Kuo, Halfon & Regalado, 2001:8).

In December 1999, the Developmental Screening Programme was adopted as formal policy within the Western Cape Province of South Africa. The Children's Institute of the University of Cape Town (2003:65-68) evaluated the implementation of the programme and according to their findings, it was hampered by multiple challenges and barriers within the broader health care system. Systemic factors including the transformation/restructuring of health services, staff and capacity issues, training, and referral systems have been cited as constraints in the delivery of these types of programmes (The Children's Institute, 2003:65-68).

The introduction of free health services for children under six and pregnant women by the South African government in 1994 increased the caseload that nurses have to handle at PHC clinics, as patients flock to clinics to receive free medication for minor ailments (Baez, 2000:n.p.; Geyer, 1999:n.p.; National Department of Health, 2001). Due to the latter, the workload of nurses in PHC clinics increased with the result that they are too overloaded to devote time to developmental surveillance. This essential aspect of the wellbeing of children is therefore overlooked. Many developmental needs and problems go unrecognised due to missed opportunities for detection thereof (Baez, 2000:n.p.; Haber, 1991:1; Wright et al., 2001:18). According to a report on Developmental Paediatrics (2002:n.p.) the latter should be considered as being an important component of childcare at primary health care level. Large numbers of children with developmental disabilities remain undetected or lack access to services. Any improvement in basic developmental surveillance will serve to increase the number of children warranting developmental services (Developmental Paediatrics, 2002:n.p.). Deviations will be detected earlier and interventions can be implemented sooner (Köhler & Rigby, 2003:552).

By virtue of their access to young children and families and their scope of practice, community nurses are well positioned to participate in the promotion of the normal development of infants as well as the early detection of developmental delays and disabilities. According to Chandler (2001:39), nurses are ideal candidates to screen for motor delays because of their training in observation skills. The counselling of families on how to support the

normal development of infants as well as the implementation of appropriate interventions in cases of delayed development and disabilities are applicable. With early identification, services and support can be instituted to maximize the child's development and functional abilities within the family and community (Miles Curry & Duby, 1994:40; Dworkin, 2000:328; Glascoe, 2000: 251; King, 1996:504; Magnusson et al., 2001:118; Meisels & Atkins-Burnett, 2000:232; Van Landeghem et al., 2002:5).

#### **1.2.4 SUPPORT FOR PARENTS/FAMILIES WITH INFANTS WITH SPECIAL DEVELOPMENTAL NEEDS**

When a child is diagnosed with a developmental delay or disability, the impact on the parents and the family as a unit is profound. The stages of their adjustment are similar to those proposed by Elizabeth Kubler-Ross in her theory of grief, ranging from initial shock to eventual acceptance (Pillitteri, 1999:1084; Wittert, 2004:n.p.; Ziolk, 1991:31).

The support that nurses render during the initial crisis, as well as through the different stages of grief and adjustment, can facilitate the acceptance of the parents and help to enhance the adaptation of the family in order to accept the infant and his/her special needs. Community nurses, as part of the support network of the families, make an invaluable contribution to enable the families to take care of the developmental needs of their infants.

#### **1.2.5 TRAINING OF COMMUNITY NURSES TO ADDRESS THE DEVELOPMENTAL NEEDS OF INFANTS**

To be able to guide parents in the promotion of the normal development of infants, as well as the early identification of developmental delays and applicable referral for further evaluation, community nurses will need a strong foundation of knowledge and skills regarding normal growth and development (Miles Curry & Duby, 1994:41). The nurses' basic training should equip them to recognize typical or delayed growth and development in infants in order to

make the necessary referrals and to be able to support infants and their parents during intervention (Stepans, Thompson & Buchanan, 2002:240).

Different aspects of the training of nurses concerning the promotion of normal growth and development of infants, the early identification of delays, the referral of infants for intensive evaluation and the ongoing support of parents and infants with identified disabilities have been the focus of several researchers and authors of textbooks:

- Pillitteri, A: Child developmental theories (1999:185-193). Factors that influence infant growth and development (1999:175-180).
- Garbarino, J & Ganzel, B: Ecological perspective on developmental risk (2000:76-91).
- Halpern, R: Family dynamics and the systems theory (2000:368-369). Best practice principles of assessment and intervention (2000:377-379).
- Garcia Coll, C & Magnuson K: Cultural differences (2000:94-111).
- Bornman, J: Zoom lens approach to assessment (2000:6).
- Meisels, SJ & Atkins-Burnett S: Social utility approach to assessment (2000:252-253).
- Wolery, M: Resource-based approach (2000:194-196).
- Turnbull AP, Turbiville V & Turnbull HR: Service delivery models (2000:638-646).

The responsibility of community nurses in the South African context, within the scope of practice of registered nurses, in addressing the developmental needs of infants have, however, not been researched. Such findings will determine the support that community nurses need in training and continuous professional development in order to attend effectively to the promotion of infant development, timely identification and addressing of developmental delays and disabilities, as well as appropriate referral of these infants and their families to other health care professionals, if the management of the developmental delay or disability falls outside the scope of practice of the community nurse.

### 1.3 PROBLEM STATEMENT

Although children only account for a small portion of the diagnosed and reported disabilities in South Africa, the incidence of disability is likely to increase in line with the international trends as soon as the care rendered to these infants is improved to enhance the early identification of such delays and disabilities. The impact of disability is widespread as it extends beyond the disabled themselves – it touches the lives of family, friends and fellow community members. Due to this widespread impact, it is imperative to recognise the urgent need to put in place measures to address this growing threat (Department of Social Development, 2002:n.p.).

Growth and development in the earliest years of life are fundamental for the future of every individual. Supporting the growth and development of infants add to their quality of life. Every step necessary should be taken to ensure that infants grow up in environments where their developmental needs are met. Failure to invest time and resources in these crucial early years may have long term effects – not just on the individual, but on society at large (Centres for Disease Control and Prevention, n.d.:n.p.). The societal costs of less than optimal development are enormous and far-reaching.

It is therefore imperative that community nurses actively take part in the promotion of normal development of infants as well as being involved in the early identification of delays and disabilities. Services during the early years of development (between 0 and 2 years) are more likely to forestall deficits in development than initiation of intervention in the pre-school or school-aged period. In improving the infants' developmental care, services should focus on infants who are most at risk.

Community nurses, due to their access to infants and families, should play a significant role in the development and implementation of measures to address this growing threat. However, the following questions need to be answered before community nurses can embark on this daunting task:

- **What are the responsibilities of community nurses in South Africa, according to their scope of practice, with regard to the management of developmental needs of infants in primary health care clinics in South Africa?**
- **What support do they need in either training, continuing professional development or co-operation with other health care professionals and managers in order to attend to the developmental needs of infants and their families?**

### **1.3.1 AIMS AND OBJECTIVES**

The aims of the study are:

- To describe what the responsibilities of community nurses are, within their scope of practice, with regard to the management of developmental needs of infants at a primary health care level; and
- To develop guidelines for the support of community nurses in either training, continuing professional development or co-operation with other health care professionals and managers, in order to attend to the developmental needs of infants.

In the description of the responsibilities of community nurses with regard to the management of developmental needs of infants in primary health care clinics in South Africa and the support they need to fulfil the role, specific objectives are addressed.

The objectives of the study are to:

- Determine the developmental needs of infants and their families;
- Describe the developmental care that community nurses can address within their legal scope of practice;
- Determine the training needs of community nurses in the management of developmental needs; and to
- Describe the support that is needed to enable community nurses to fulfil their responsibilities towards these infants.

## **1.4 ASSUMPTIONS OF THE RESEARCHER**

Assumptions underlying this research are embedded in the meta-paradigm of nursing which presents the most global perspective of the nursing discipline. The four main concepts of the meta-paradigm include person, health, environment and nursing (Kozier, Erb & Olivieri, 1991:58). Definitions for each concept are presented.

### **1.4.1 PERSON**

In nursing, person refers to the recipient of care that includes physical, spiritual, psychological and socio-cultural aspects of care. Reference to person as recipient of such care does not exclude the family or even the community. The person is envisaged as an open, holistic and adaptive system that is in constant interaction with the environment during the phases of the life span. Experiences to grow occur through the adaptation to changes. The person is an active participant in learning and development. He/she is capable of determining when and how to seek health care (Grant MacEwan College, 2001:17; McEwen, 2002:41; Salve Regina University, 2002:7).

The person in this research is the infant in his/her family, within the community. The researcher will focus on the responsibilities of community nurses with regard to the management of developmental needs of infants in primary health care clinics.

### **1.4.2 HEALTH**

“Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity” (Kozier et al., 1991:83).

Health can be seen as the intrinsic right of the person and it is a dynamic, interactive process that can be presented as a continuum with death/disease/disability at the one end and a high level of wellness at the other



end. Health is a goal of nursing and the emphasis is on health promotion and disability prevention rather than on disability and treatment. Health means that a person can function independently and achieve his/her full life potential. It also indicates successful adaptation to life's stressors and is a reflection of the whole person – mind, body and soul (Gilbert et al., 2002:4; McEwen, 2002:41; Thorne, Canam, Dahinten, Hall, Henderson & Reimer Kirkham, 1998:1261). In this research, the researcher will focus on the responsibilities of community nurses with regard to the promotion of health. The management of the developmental needs of infants (promotion of optimal development, early identification of developmental delays and disabilities, and appropriate interventions) is the focus of the research. Guidelines to support community nurses to fulfil their responsibilities to promote optimum health and thus the development of infants are the envisaged result of the research.

#### **1.4.3 ENVIRONMENT**

In nursing, the environment refers to both the internal and external conditions, circumstances and influences that affect the person. Internal conditions, circumstances and influences could be genetic, intellectual, spiritual or the disease process. External conditions constitute the physical, social and economic relationships of a person. The environment includes the immediate as well as the larger environmental contexts and there is a constant interaction between a person and this environment (Thorne et al., 1998:1262).

In this research, the focus will be on both the internal and the external environment of 1) the infant in his/her family within the community, and 2) the community nurse in the primary care clinic. In the external environment the researcher will focus specifically on the micro- (the immediate settings in which individuals develop), meso- (relationships between micro-systems in which the individual experiences reality) and exo-systems (settings that have bearing on the development of children) (Garbarino & Ganzel, 2000:78-79).

#### 1.4.4 NURSING

According to Koziar et al., (1991:3) nursing means "... the identification and treatment of human responses to actual or potential health problems and includes the practice and supervision of functions and services that, directly or indirectly, in collaboration with a client or providers of health care other than nurses, have as their objectives the promotion of health, prevention of illness, alleviation of suffering, restoration of health and optimum development of health potential and includes all aspects of the nursing process".

Nursing is a dynamic process based on arts, sciences, humanities and a growing evidence-based body of nursing knowledge. In South Africa, nursing is regulated by the South African Nursing Council and specifically by the regulation on the scope of practice (Regulation 2598, 1984, as amended), which includes the acts and procedures applicable to health care that may be performed by a person who is registered as a nurse or midwife in terms of the Nursing Act, 1978, no. 50, 1978, as amended. It includes the care of both the well and the sick, and seeks to assist with self-care activities. Furthermore, it seeks to maintain, promote and restore the health of individuals, families and communities and therefore helps individuals to attain their human potential by reducing and ameliorating the effects of disability and disease. The focus is thus on strengths and potentials and on promotion of harmony between the individual and the environment. Nursing has as its object, caring that encompasses all of the professional values, roles, core competencies and knowledge that the cultural congruent professional nurse employs to facilitate optimal health. To assist with this facilitation of optimal health, nursing also employs effective communication and collaboration with other health care providers (Feeley & Gerez-Lirette, 1992:802; McEwen, 2002:42; Salve Regina University, 2002:6; Thorne et al., 1998:1265).

In this research, the researcher will focus on the nursing therapeutics of community nurses with regard to the management of developmental needs of infants.

## **1.5 CHAPTER OUTLINES**

The research will be presented in six chapters. Chapter 1 provides a basic orientation and motivation for the study, formulation of the problem statement and research questions and assumptions of the researcher that underlies the study as well as an outline of the chapters.

The research design and methodology is set out in chapter 2. Firstly, the design of the study is described in general. It is followed by a description of phase one which includes the rationale for a case study strategy, theory and logic of the case study design in research, sampling and data collection methods, measures to ensure rigour, and lastly the process that had been followed to analyse the data. In the second half of the chapter, a description of phase two, the formulation and validation of the guidelines is presented as well as the ethical considerations and summary of the chapter.

In chapter 3, the data analysis is discussed and in chapter 4, the theoretical framework is presented. This is followed by a description of the development of the guidelines in chapter 5. In chapter 6 the conclusions and implications of the study are presented, together with a critical evaluation of the study, the validation process and recommendations for future research. The final version of the developed guidelines is presented in a booklet format.

## **1.6 SUMMARY**

This chapter provided the motivation for the study by describing the background information and rationale that led to its development. This was followed by formulation of the problem statement and research questions. Thereafter a discussion followed of the researcher's assumptions that underlie the study and in conclusion, an outline for the different chapters has been presented.

## CHAPTER 2

### RESEARCH METHODOLOGY

#### 2.1 INTRODUCTION

In this chapter, the researcher describes the research methodology used to address the aims of the study that are:

- To describe the responsibilities of community nurses within their scope of practice, with regard to the management of developmental needs of infants at primary health care level; and
- To develop guidelines for the support of community nurses in training, continuing professional development, co-operation with other health care professionals and managers in order to attend to the developmental needs of infants.

To assist with the description of the responsibilities of community nurses with regard to the management of developmental needs of infants in primary health care clinics in South Africa the following objectives were addressed:

- To describe the developmental care that community nurses can address within their scope of practice;
- To determine the developmental needs of infants and their families;
- To determine the training needs of community nurses in the management of developmental needs of infants; and
- To describe the support that is needed to enable community nurses to fulfil their responsibilities towards these infants.

Firstly, the design of the study is described in general. It is followed by a description of phase one, which includes the rationale for a case study strategy, theory and logic of the case study design in research, sampling and data collection methods, measures to ensure rigour, and lastly the process followed to analyse the data. In the second half of the chapter a description of phase two, the formulation and validation of the guidelines, is presented as well as the ethical considerations and summary of the chapter.

## **2.2 RESEARCH METHODOLOGY**

According to Yin (2003:19-20) the research design of a given study provides the logic, thus the “blueprint” that links the data to be collected to the initial questions. The research design therefore, assists the researcher to execute the study in such a way that the validity of the findings is maximized.

The research design includes two phases. The focus in the first phase is on the approach used to explore the responsibilities of community nurses with regard to the management of the developmental needs of infants in primary health care clinics. In phase two the development of guidelines to support these nurses are addressed.

### **2.2.1 PHASE 1: DESCRIPTION OF THE RESPONSIBILITIES OF COMMUNITY NURSES ACCORDING TO THEIR LEGAL SCOPE OF PRACTICE, WITH REGARD TO THE MANAGEMENT OF DEVELOPMENTAL NEEDS OF INFANTS IN PRIMARY HEALTH CARE CLINICS IN SOUTH AFRICA.**

#### **2.2.1.1 RESEARCH DESIGN OF PHASE ONE**

A qualitative approach, with the objective of exploring and describing, had been adopted in this study because it can be used to better understand any phenomenon about which little is yet known (Hoepfl, 1997:48). Qualitative research broadly defined by Strauss & Corbin (In Hoepfl, 1997:48) means “any kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification.” In other words, it is research, which presents facts in words - a complex, holistic picture with detailed descriptions of informants’ perspectives. This is directly applicable to this study as holism is essential to understand the person as a complex entity interacting with the environment. The underlying assumptions of the researcher, as stated in 1.4:12, refer to the person as an open, holistic and adaptive system that is in constant interaction with the environment. Inductive reasoning, followed in this

study, allows the qualitative researcher to explore and discover with an emerging research design. A naturalistic approach is followed as data are collected from people in their natural settings (McMillan & Schumacher, 2001:35,598).

The strategy used to investigate the phenomena was that of the case study. A case study strategy had been chosen because it is the preferred strategy when the questions “how”, “why” and “what” are asked (the exploratory nature of the study); when the researcher has little control over the event or when the research is being carried out in a real life context (Yin, 2003:5-9). In this study the researcher attempted to answer the “what” and “why” questions (What are the responsibilities of community nurses? What support do they need? Why is the management of developmental needs of infants important?). The researcher did not need to have control over the situation as it had been the views of nurses, management, other health care personnel and parents that were being explored and these views were obtained in their natural setting. This study met all of the aforementioned criteria. Therefore, the decision to use the case study strategy was vindicated.

The case study approach has been sanctioned as an acceptable research method due to the increased acceptance of qualitative research (Haigh, n.d.:1). Case studies can be a valuable way of investigating issues in nursing practice, as a “multiplicity of factors impinge on care delivery, including the social context and organisational culture in which care is delivered” (Hewitt-Taylor, 2002:33). The goal of this case study was to describe as accurately as possible the most complete description of the case, namely the management of developmental needs of infants 0-2 years by community nurses (Zucker, 2001:2). The case study is an ideal methodology for an in-depth investigation as it brings out the details from the viewpoints of the participants. In this study, it enabled the researcher to gain in-depth insight into personal experiences of the participants (Tellis, 1997:n.p.). Several authors explain the process of case study methodology and offer valuable insights into case study research (Aita & McIlvain, 1999: 255; Soy, 1997:n.p.). The researcher adopted Yin's (2003) approach to the conducting of case studies for this study.

Yin (2003:21) indicates that five components of a case study research design are especially important:

- **A study's questions:** The questions applicable to the study are stated in 1.3:10;
- **Its propositions:** Due to its exploratory nature, there are no propositions in this study. The researcher stated assumptions that are embedded in the meta-paradigm of nursing which is a global perspective, therefore the assumptions are comprehensive and not specific and the exploratory nature of the study is not restricted;
- **Its unit(s) of analysis:** The unit of analysis applicable to the study is stated in 2.2.1.1.2:21;
- **The logic of linking the data to the propositions:** In this study the data is linked to the purpose and aims of the study as stated in 2.1:16;
- **The criteria for interpreting the findings:** This is discussed in chapter 5.

To address the research questions a single-case (holistic) study design has been used to explore and describe the phenomena under investigation. According to Yin (2003:41-43) a single-case study is an appropriate design especially when it is a representative or typical case. The objective is to learn from the circumstances and conditions of an everyday situation in an institution and the lessons learned are assumed informative regarding the experiences at the average institution. Even though the case study was about the management of developmental needs of infants 0-2 years by community nurses (the immediate topic of the case study), attention had been given to other people outside of the case (the context for the case study) i.e. management concerned with nursing issues; personnel concerned with continuous professional development and training of nurses at the clinic; families with infants 0-2 years with typical development; families with infants 0-2 years with an identified developmental delay or disability; and other health care professionals (e.g. speech/language therapists, occupational therapists, and physiotherapists). The purpose of the inclusion of other people was to enhance the insights into the single case (Yin, 2003:24, 45-46). To elucidate the case and the context, appropriate documents were used e.g. patient clinic

records, policy documents and training programmes. (See Figure 2.1, Participants of the case and the context).

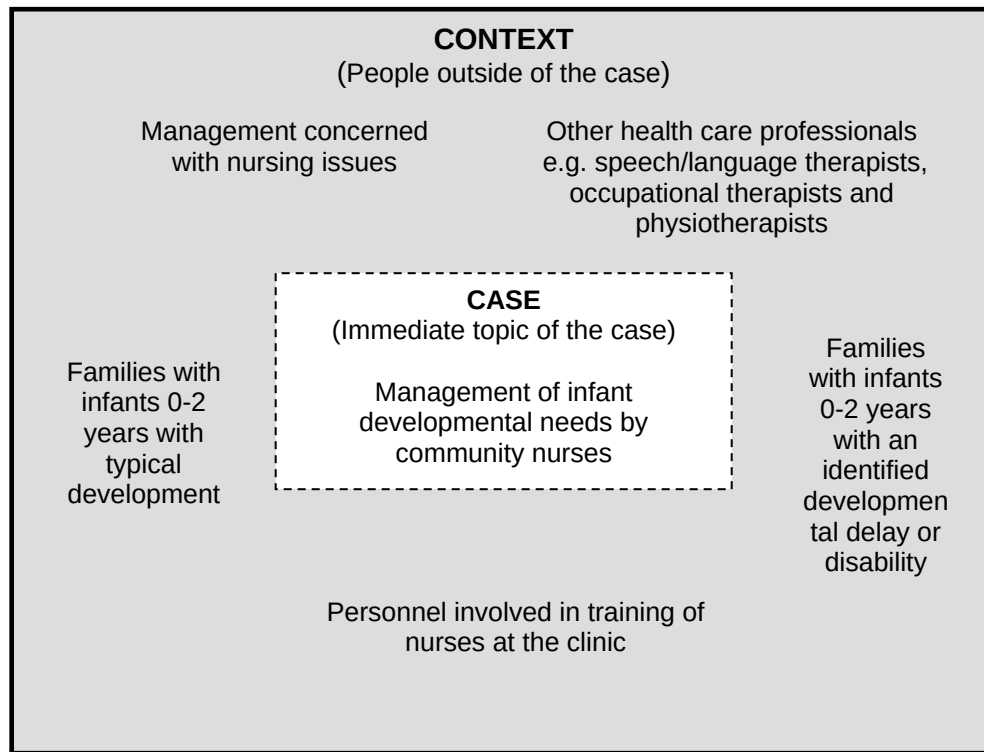


Figure 2.1 Participants of the case and the context

#### 2.2.1.1.1 LITERATURE REVIEW TO SUBSTANTIATE THE PROBLEM STATEMENT

A selective review of the literature, aimed at contributing to the understanding of the nature of the problem, is described in chapter 1 of the study. A brief discussion of related literature demonstrated the underlying assumptions behind the general research questions. It identified the area of knowledge that the study intended to expand (Fouché & Delport, 2002:127, 266; Yin, 2003:26). The specific value of the literature review is that it is a means to an end and not an end in itself as it provided a frame of reference from which data were collected (Yin, 2003:9).



### 2.2.1.1.2 UNIT OF ANALYSIS: CASE DEFINITION AND SELECTION OF THE SITE

The unit of analysis is a critical factor in case study research, as it defines what the case is. Furthermore, the elements that comprise the unit are related to the way the initial research questions have been defined (Aita & McIlvain, 1998:258; Tellis, 1997:n.p.; Yin, 2003:22). In this research, the case was the management of developmental needs of infants 0-2 years by community nurses and the site the local government primary health care clinic in Klerksdorp, North West (See Figure 2.2, below, for the geographical location of North West province and Klerksdorp). Therefore, the community nurses working in this clinic were seen as the ideal participants to:

- Describe the responsibilities of community nurses, within their scope of practice, with regard to the management of developmental needs of infants.
- Determine the training needs of community nurses are in the management of developmental needs of infants.
- Describe the support that is needed to enable community nurses to fulfil these responsibilities.



Figure 2.2 Map of North West Province

([http://www.commonwealth-towns.net/members/south\\_africa/north\\_west.htm](http://www.commonwealth-towns.net/members/south_africa/north_west.htm))

The context of the case study, however, included other people who elucidated the case:

- Management concerned with nursing issues.
- Personnel involved with the training of nurses at the clinic.
- Families with infants 0-2 years who display typical development.
- Families with infants 0-2 years with an identified developmental delay or disability.
- Other health care professionals (e.g. speech/language therapists, occupational therapists and physiotherapists).

The inclusion of these people provided an important opportunity to explore:

- The overall perception of the responsibilities of community nurses in South Africa, according to their scope of practice, with regard to the management of developmental needs of infants in the primary health care clinic.
- The extent of the support management provided to assist community nurses in their day-to-day management of infant developmental needs.
- The interaction between community nurses and families with infants 0-2 years of age, to determine the developmental needs of infants and their families.
- The co-operation between community nurses and other health care professionals to see what level and type of support are needed to enable community nurses to fulfil their responsibilities towards infants.

The rationale for using a single site in this study is that in South Africa health care is rendered according to the principles of the primary health care (PHC) approach. As indicated in the previous chapter, the implementation of the PHC strategy requires a decentralised management and the major locus of implementation is the district. “A District Health System based on PHC is a more or less self-contained segment of the national health system ...” (National Department of Health, 2001). Functioning of primary health care clinics is sanctioned by national/district health policies. Therefore, information obtained from one clinic should be applicable to other clinics functioning within the district health system.

The site, the local government primary care clinic in Park Street, Klerksdorp, was chosen by means of purposeful sampling as it had the likelihood that all the viewpoints or actions, as related to the research problem and purpose, were present and could be studied (McMillan & Schumacher, 2001:401). Both local and provincial health authorities manage the clinic. The clinic used to be staffed by local government personnel, but since the release of the White Paper for the Transformation of the Health System in South Africa (National Department of Health, 1995) a moratorium has been established on the appointment of new personnel. At present, personnel from the provincial health authority are seconded to the local government primary care clinic as needed. As indicated in the White Paper (National Department of Health, 1995), the country is divided into geographically functional health districts, these health districts are consistent with political and administrative boundaries, and it has been decided that the term health district will refer to a Municipality. Municipalities are divided into different categories and certain category municipalities may be sub-divided into smaller geographical administrative units, which would then form "health sub-districts" (Barron & Asia, 2001:21-22). Klerksdorp is situated in one of the four health sub-districts of the Southern District of the North West Province in South Africa.

The KOSH sub-district (an acronym for the four towns in the sub-district: Klerksorp, Orkney, Stilfontein and Hartbeesfontein) in the Klerksdorp Municipality (See Figure 2.2:21), appointed a team to be responsible for the planning and management of all local health services. Together with the local government, they render primary health care services at the clinic. In Table 2.1:24, a summary of the type and number of personnel at Park Street Clinic, for both local and provincial authority, is given.

Table 2.1 Personnel working at the Park Street Primary Health Care Clinic

| Category                                                                      | Provincial Health<br>Department Personnel | Local Health<br>Department Personnel |
|-------------------------------------------------------------------------------|-------------------------------------------|--------------------------------------|
| Assistant director                                                            | 1                                         | 0                                    |
| Registered nurses                                                             | 6                                         | 2                                    |
| Nursing auxiliaries                                                           | 3                                         | 0                                    |
| Medical officer of health                                                     | 0                                         | 1                                    |
| Hospital doctor                                                               | 1                                         | 0                                    |
| Health workers                                                                | 1                                         | 2                                    |
| HIV counsellors<br>(Service provided by<br>Non-Governmental<br>Organisations) | 0                                         | 0                                    |
| Clerks                                                                        | 1                                         | 1                                    |
| Cleaners                                                                      | 1                                         | 1                                    |

#### 2.2.1.1.3 SELECTION OF PARTICIPANTS

Sampling, where a selection is made out of a population (a priori parameters of populations) is improper in a case study (McMillan & Schumacher, 2001:404; Tellis, 1997:n.p.). As a single case study is concerned with a particular case, focusing on a specific phenomenon in a given context, sampling was done on two levels, that is one for the case itself (See 2.2.1.1.2:21) and the other for the study sample within the case (Winegardner, n.d.:n.p.). People from outside the case (See 2.2.1.1.2:21; Figure 2.1:24) from the context, were included to enhance insights into the case. Therefore, the study had to include participants from all of these groups. Sample sizes were guided by the question “*Would adding more information yield any new insights?*”

A sample frame was developed for this study and comprised of the following participants:

- Community nurses working at the site (Park Street Clinic);

- Managers concerned with management and supervision of community nurses in primary health care clinics in the KOSH area;
- Personnel concerned with the continuous professional development of the community nurses at Park Street Clinic;
- Other health care personnel concerned with infant development e.g. physiotherapists, speech-language therapists and occupational therapists working in the KOSH area;
- Families with infants 0-2 years of age, with typical development, residing in the KOSH area;
- Families with infants 0-2 years of age, with identified developmental delay/disability, residing in the KOSH area
- The participants either had to be Afrikaans- or English-speaking, or had a very good comprehension of one of the two languages. This was decided to ensure that language problems did not influence the effectiveness of the interviews.

Due to the qualitative nature of the research, non-probability samples were used in this study to identify information-rich participants who could be studied in depth (Hoepfl, 1997:51). The samples were based on the judgement of the researcher on the basis of the existing knowledge of the participants (McMillan & Schumacher, 2001:175; Strydom & Venter, 2002:207; Uys & Puttergill, 2003:113). This sampling process was dynamic and was conducted at the same time that the researcher collected data (Aita & McIlvain, 1999:258; McMillan & Schumacher, 2001:403, 433).

#### **a. Community nurses**

By means of the site selection, the community nurses were selected. The Head: Department of Health arranged for a meeting with the nurse in charge at the clinic. At this meeting, the researcher informed the nurse in charge about the study: the purpose of the study, the possible benefits of the study, how information would be gathered (tape-recorded interviews and perusal of official documentation e.g. client records, policies, training programmes), that it was voluntary participation, and that the confidentiality of the participants would be

respected. The researcher then obtained permission to approach the nurses working in the clinic. The nurses were approached individually and the researcher informed them about the study. They also received a written document (informed consent form) that contained all the detail about the study. They were given time to ask questions before they agreed to participate. The researcher, the participant as well as a witness then signed the consent form (See Annexure C:399).

Altogether eight community nurses work at the clinic. However, two were not included in this category as they were allocated to other categories i.e. management and personnel involved in training of community nurses. Five out of the remaining six community nurses participated in the study. One of them was not present during the time of the interviewing (See Table 2.2:31, Descriptive information of community nurses).

#### **b. Management**

Purposeful sampling and specifically, maximum variation sampling was used to select four participants. The researcher wanted to obtain maximum differences of perceptions about the topic. Therefore, information-rich participants, who included managers representing the local health department and the provincial health department, as well as from different hierarchical levels, were selected (McMillan & Schumacher, 2001:402) In Figure 2.3, below, the hierarchical levels of management are indicated.

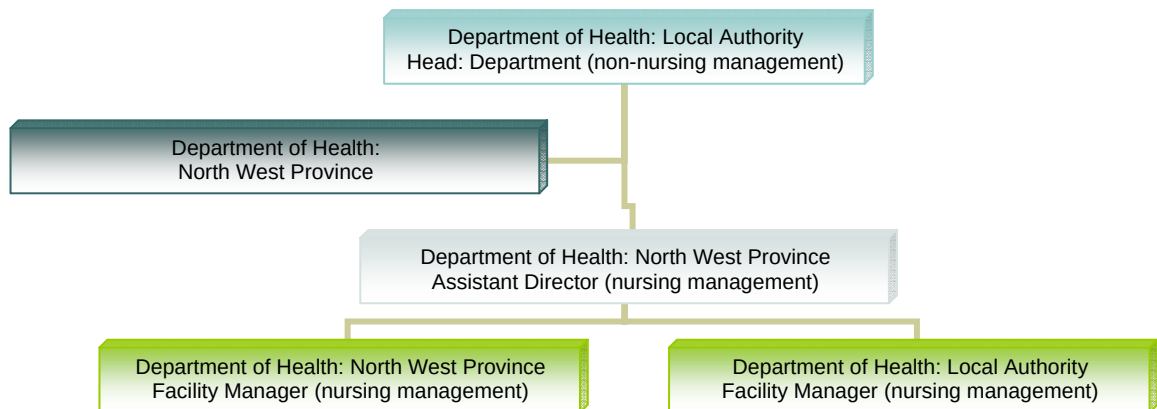


Figure 2.3 Hierarchical levels of management

These managers had to be concerned with management and supervision of community nurses in their daily functioning at primary health care clinics in the KOSH area, to qualify for inclusion. The managers were informed about the study by the head of the department. The researcher approached them individually to discuss the study with them: the purpose of the study, the possible benefits of the study, how information would be gathered (tape-recorded interviews and perusal of official documentation e.g. client records, policies, training programmes), that it was voluntary participation, and that the confidentiality of the participants would be respected. The researcher then arranged a specific date and time for an interview with the managers who were willing to participate (the head of the department, one assistant director, one facility manager from the local authority and the facility manager of Park Street Clinic). However, the assistant director at Park Street Clinic, who initially agreed to be interviewed, withdrew from the study on the day of her interview, without any explanation. The researcher then approached another assistant director, the supervisor of the second facility manager included in the study, to enable her to obtain perceptions from all hierarchical levels of management. She was willing to participate. On the day of the interview a written document (informed consent form) that contained all the details about the study was given to them and they were given time to ask questions before they agreed to participate. The researcher, the participant as well as a witness then signed

the consent form (See Annexure C:399). The logic of purposeful sampling is that a few cases studied in depth may yield many insights about the topic (McMillan & Schumacher, 2001:402; Table 2.3:32, Descriptive information of the management).

#### **c. Personnel involved in the training of nurses**

At the time of the study, only two people were involved in the training of community nurses, one from the local government health department and one from the provincial health department. Therefore, the researcher included both of them in the study. The researcher approached them individually via telephone and informed them about the study: the purpose, the possible benefits of the study, how information would be gathered (tape-recorded interviews and perusal of official documentation e.g. client records, policies, training programmes), that it was voluntary participation, and that their confidentiality would be respected. After the participants indicated that they would participate, the researcher arranged a date, time and venue that would be convenient to them. On the day of the interview a written document (informed consent form) that contained all the detail about the study was given to them and they were given time to ask questions before they agreed to participate. The researcher, the participant as well as a witness then signed the consent form (See Annexure C:399; Table 2.4:33, Descriptive information of personnel involved in the training of community nurses).

#### **d. Other health care professionals**

Convenience sampling was used to identify other health care professionals concerned with developmental care of infants 0-2 years. Although convenience sampling has limitations with regard to transferring (generalizing) from the sample to any type of population, the primary purpose was not to transfer (generalize), but to better understand the interaction that existed between community nurses and other health care professionals (McMillan & Schumacher, 2001:175). Other health care professionals known to the researcher were approached via telephone or e-mail. During this contact, they



were informed about the study: the purpose, the possible benefits of the study, how information would be gathered (tape-recorded interviews and perusal of official documentation e.g. client records, policies, training programmes), that it was voluntary participation, and that their confidentiality would be respected. After the participants indicated that they would participate, the researcher arranged with each of them individually, a date, time and venue that would be convenient to them. On the day of the interview a written document (informed consent form) that contained all the details about the study was given to them and they were given time to ask questions before they agreed to participate. The researcher, the participant as well as a witness then signed the consent form (See Annexure C:399). One speech-language therapist, one occupational therapist and one physiotherapist consented to participate in the study (See Table 2.5:34, Descriptive information of other health care professionals).

#### **e. Families with infants 0-2 years with typical development**

Five participants were selected by case type and specifically reputational-case, meaning the researcher obtained recommendations of knowledgeable experts for the best examples because the study required an examination of a particular type of case: families with infants 0-2 years with typical development (McMillan & Schumacher, 2001:402). Community nurses working in clinics in the KOSH area were asked whether they could assist with the identification of families. The community nurses contacted the identified families in person to inform them about the study and to ask whether they would be willing to participate in the study. The researcher then made contact, either in person or by telephone, and a date and time was arranged for an interview. During this contact, they were informed about the study: the purpose, the possible benefits of the study, how information would be gathered (tape-recorded interviews and perusal of official documentation e.g. client records, policies, training programmes), that it was voluntary participation, and that their confidentiality would be respected. On the day of the interview a written document (informed consent form) that contained all the details about the study was given to them and they were given time to ask questions before they agreed to participate. The researcher, the participant as well as a witness then signed a consent

form (See Annexure C:399; Table 2.6:35, Descriptive information on families with infants 0-2 years of age with typical development).

**f. Families with infants 0-2 years with developmental delay/disability**

Six participants were selected by case type and specifically reputational-case, meaning the researcher obtained recommendations of knowledgeable experts for the best examples because the study required an examination of a particular type of case: families with infants 0-2 years with developmental delay/disability (McMillan & Schumacher, 2001:402). The researcher asked the other health care professionals that participated in the study, whether they could assist with the identification of families that comply with the sample framework – they had to be in the specific age group and reside in the KOSH area. The other health care professionals contacted the identified families via telephone or letter to inform them about the study and to ask whether they would be willing to participate in the study. The researcher then made contact with three of the families via telephone and a date and time for an interview was arranged individually with each family. The researcher met with the other three families at the occupational therapy department of the local community hospital, when they brought the infants for rehabilitation sessions. During this contact, they were informed individually about the study: the purpose, the possible benefits of the study, how information would be gathered (tape-recorded interviews and perusal of official documentation e.g. client records, policies, training programmes), that it was voluntary participation, and that their confidentiality would be respected. On the day of the interview a written document (informed consent form) that contained all the details about the study was given to them and they were given time to ask questions before they agreed to participate. One of the participants could not read and therefore the researcher had to read the document to her. The researcher, the participant as well as a witness then signed the consent form (See Annexure C:399; Table 2.7:35, Descriptive information on families.)

Table 2.2 Descriptive information of community nurses (Information obtained during interviews)

| Participants    | Age | Sex | Qualifications                                                                                                                                                                        | Years of nursing experience/Years of experience in a PHC clinic | Day-to-day tasks of community nurses in the clinic                                                                                                                                                                                                                   |
|-----------------|-----|-----|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| • Participant 1 | 59  | F   | • 3 year diploma in nursing (general nursing)<br>Post-basic training: Midwifery, community nursing, primary health care and diagnosis and treatment.                                  | • 18 years/<br>10 years                                         | • Clinical care <ul style="list-style-type: none"> <li>▪ Family planning</li> <li>▪ Antenatal</li> <li>▪ Trauma</li> <li>▪ Immunisations</li> <li>▪ Management of minor ailments</li> <li>▪ Management of communicable diseases and some chronic diseases</li> </ul> |
| • Participant 2 | 28  | F   | • 4 year diploma in nursing (general nursing, midwifery, community nursing and psychiatric nursing)<br>Post-basic training: none                                                      | • 5 years/<br>4 months                                          | • Administrative work <ul style="list-style-type: none"> <li>▪ Record keeping</li> <li>▪ Daily &amp; monthly statistics</li> <li>▪ Ordering of drugs/supplies</li> </ul>                                                                                             |
| • Participant 3 | 47  | F   | • 4 year diploma in nursing (general nursing, midwifery)<br>Post-basic training: Community nursing and several short courses. Currently busy with a course in diagnosis and treatment | • 20 years/<br>19 years                                         | • Attending meetings                                                                                                                                                                                                                                                 |
| • Participant 4 | 46  | F   | • 3 year diploma in nursing (general nursing)<br>Post-basic training: Midwifery                                                                                                       | • 11 years/<br>5 months                                         | • Attending in-service training                                                                                                                                                                                                                                      |
| • Participant 5 | 33  | M   | • 4 year diploma in nursing (general nursing, midwifery, community nursing and psychiatric nursing)<br>Post-basic training: none                                                      | • 8 years/<br>1 year                                            | • Ensure clean and safe environment<br>• Supervision of resources & equipment                                                                                                                                                                                        |

Table 2.3 Descriptive information of management (Information obtained during in interviews)

|                                                                                                                                                                           | Age | Sex | Day-to-day tasks/functioning                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Personal information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|-----|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Participant 1<br/>Facility manager –<br/>Local Government<br/>Clinic, Park Street,<br/>Klerksdorp.<br/>Registered nurse</li> </ul> | 45  | F   | <ul style="list-style-type: none"> <li>Clinical care (see community nurses)</li> <li>Personnel management <ul style="list-style-type: none"> <li>Assessment)</li> <li>Resolving conflicts</li> </ul> </li> <li>Quality improvement</li> <li>System co-ordination <ul style="list-style-type: none"> <li>Meetings with management</li> </ul> </li> <li>Leadership <ul style="list-style-type: none"> <li>Support via informal personnel meetings</li> <li>Staff meetings &amp; feedback</li> <li>Mentoring</li> </ul> </li> <li>Operations <ul style="list-style-type: none"> <li>Staffing</li> <li>Scheduling nursing assignments</li> <li>Administrative work: budgeting, supplies, statistics</li> </ul> </li> </ul> | <p>She obtained a diploma in nursing - general and midwifery. Post basic training included community health- and primary health care nursing. She has also done a certificate in diagnosis and treatment. She is an employee of the provincial health department. She has been in charge of the Park Street clinic since August 2004. She worked in the clinic for the past 8 years, but as a primary care nurse. She was transferred from the hospital to the clinic after she completed the course in diagnosis and treatment.</p> |
| <ul style="list-style-type: none"> <li>Participant 2<br/>Departmental Head<br/>Environmental health officer</li> </ul>                                                    | 57  | M   | <p>With regard to the clinic:</p> <ul style="list-style-type: none"> <li>Leadership</li> <li>Finance/budget</li> <li>Personnel management</li> <li>System co-ordination</li> <li>Quality improvement</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <p>He has been the head of the Department of Health at the Klerksdorp City Council for the past 11 years.</p>                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <ul style="list-style-type: none"> <li>Participant 3<br/>Facility manager –<br/>Tsholofelo Clinic,<br/>Jouberton,<br/>Klerksdorp<br/>Registered nurse</li> </ul>          | 55  | F   | <ul style="list-style-type: none"> <li>See participant 1</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <p>She obtained a diploma in nursing (general and midwifery) at the University of Potchefstroom in 1969. She has been with the Klerksdorp City Council since 1986 and she became a facility manager in 1998. Since her basic training, she obtained a certificate in community health nursing.</p>                                                                                                                                                                                                                                   |

|                                                                                                                                                      |    |   |                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                       |
|------------------------------------------------------------------------------------------------------------------------------------------------------|----|---|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Participant 4<br/>Assistant Director,<br/>Provincial<br/>department of Health<br/>Registered nurse</li> </ul> | 48 | F | <ul style="list-style-type: none"> <li>See participant 2</li> </ul> | <p>She obtained a diploma in nursing (general and midwifery). Post-basic training included community health, diagnosis and treatment, and nursing administration and education. She is an employee of the provincial health department sub-district KOSH. She was appointed as an Assistant Director in August 2004. She supervises four of the primary health care clinics in the KOSH district.</p> |
|------------------------------------------------------------------------------------------------------------------------------------------------------|----|---|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Table 2.4 Descriptive information of personnel involved in the training of community nurses (Information obtained during interviews)

| Participants                                                                                             | Age | Sex | Personal information                                                                                                                                                                                                                                                                                                                                                                            | Day-to-day tasks/functioning                                                                                                                                                                                                                                                                                                                                                                                                                      |
|----------------------------------------------------------------------------------------------------------|-----|-----|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Participant 1<br/>Programme<br/>manager: training</li> </ul>      | 39  | F   | <p>She completed a 4-year diploma in nursing in 1990. She also obtained diplomas in public management and perinatal nursing. She was appointed as training officer at the sub-district's provincial department of health in June 2004. Before that, she used to work for a Non-Governmental organization, Love Life. She also worked in a primary health care clinic for a couple of years.</p> | <ul style="list-style-type: none"> <li>Training programmes <ul style="list-style-type: none"> <li>Training-needs analysis</li> <li>Planning of programme</li> <li>Preparations for courses</li> <li>Presenting courses</li> </ul> </li> <li>Quality control</li> <li>System co-ordination</li> <li>Administrative work: budgeting, reports, certificates</li> <li>Information management</li> <li>Clinical care (See community nurses)</li> </ul> |
| <ul style="list-style-type: none"> <li>Participant 2<br/>In-service training<br/>co-ordinator</li> </ul> | 45  | F   | <p>She completed a diploma in nursing and a degree in nursing administration and education. She has been the co-ordinator for in-service training for the past year.</p>                                                                                                                                                                                                                        | <ul style="list-style-type: none"> <li>Training-needs analysis</li> <li>Co-ordination of training programme</li> <li>Administrative work: in-service training reports &amp; statistics</li> <li>Feedback to management</li> </ul>                                                                                                                                                                                                                 |

Table 2.5 Descriptive information of other health care professionals (Information obtained during interviews)

| Participants    | Age | Sex | Day-to-day tasks/functioning                                                                                                                                                                                                    | Personal information                                                                                                                                                                                                                                                                                                                                                                                |
|-----------------|-----|-----|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| • Participant 1 | 37  | F   | <ul style="list-style-type: none"> <li>• Speech/language therapist <ul style="list-style-type: none"> <li>▪ Assessment of infants to identify problem areas</li> <li>▪ Treatment of developmental delays</li> </ul> </li> </ul> | She completed her studies at the University of Pretoria in 1989. She is very interested in early childhood intervention and is currently busy with a Masters degree with a focus on early identification and intervention in feeding problems of infants and children. She also completed courses in developmental care and neuro-developmental therapy.                                            |
| • Participant 2 | 30  | F   | <ul style="list-style-type: none"> <li>• Occupational therapist <ul style="list-style-type: none"> <li>▪ Assessment of infants to identify problem areas</li> <li>▪ Treatment of developmental delays</li> </ul> </li> </ul>    | She completed her studies at the University of Pretoria in 1998. She initially worked with adults, but for the past 5 years, her focus was more on children. She worked in a rehabilitation hospital where a team approach was followed. Currently she is in private practice where she mainly works with infants and children.                                                                     |
| • Participant 3 | 42  | F   | <ul style="list-style-type: none"> <li>• Physiotherapist <ul style="list-style-type: none"> <li>▪ Assessment of infants to identify problem areas</li> <li>▪ Treatment of developmental delays</li> </ul> </li> </ul>           | She completed her studies at the University of the Free State in 1984. She started a private practice and works with people of all ages. She has experience with infants and small children and feels very passionate about early identification and rehabilitation of developmental delays and disabilities. She completed a Master's degree in Education at the University of North West in 2004. |

Table 2.6 Descriptive information on families with infants 0-2 years of age with typical development (Information obtained during interviews)

| Participants    | Age | Relationship         | Personal information                                                                                                                                                                                                                 |
|-----------------|-----|----------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| • Participant 1 | 26  | Mother of the infant | Married. Infant (girl) 3 months old. Currently unemployed, but has training in computers and has applied for several jobs. No other children. Visits clinic regularly                                                                |
| • Participant 2 | 38  | Mother of the infant | Married. Unemployed, but not interested in working currently. Children: infant (boy) 3 months old and a 4-year-old boy. Visits clinic regularly to keep immunisation up to date.                                                     |
| • Participant 3 | 34  | Mother of the infant | Unmarried, but lives with father of children. Children: infant (girl) 18 months old and a 14-year-old boy. Visits clinic regularly to keep immunisation up to date.                                                                  |
| • Participant 4 | 20  | Mother of the infant | Unmarried, stay with parents. Unemployed and no other children. Infant (girl) 3 months old. Visits clinic regularly to keep immunisation up to date.                                                                                 |
| • Participant 5 | 28  | Mother of the infant | Unmarried. Teacher. Works in another town, but comes home over weekends to be with children and father of baby. Children: infant (boy) 11 months old and an 8-year-old boy. Visits clinic regularly to keep immunisation up to date. |

Table 2.7 Descriptive information on families with infants 0-2 years with developmental delays or disabilities (Information obtained during interviews)

| Participants    | Age | Relationship                                           | Personal information                                                                                                                                                                                                                                                                                                                                                                                                               |
|-----------------|-----|--------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| • Participant 1 | 35  | Mother of the developmentally delayed/ disabled infant | Married. Social worker who has a private practice at home for children with emotional problems. Children: infant (girl) 10 months, 2 year old boy. Infant diagnosed at age 8 months, very passive in general movements, did not roll over. Received all her immunisations, but nurses did not identify any problem. Mother was concerned about lack of general movements and took her to an occupational therapist for assessment. |
| • Participant 2 | 52  | Grandmother of the                                     | Mother of infant, 26 years old, unmarried and not working. Father of child                                                                                                                                                                                                                                                                                                                                                         |

|                 |    |                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|-----------------|----|-------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                 |    | developmentally delayed/ disabled infant                    | not involved. Both grandmother and mother get disability grants. Mother HIV+ and stays with her mother, very ill and receives her treatment at home. Baby born prematurely, received immunisation at clinic, but no one noticed any problem. Grandmother realised something was wrong, head lagged excessively and infant very passive. At age 3 months, she asked a nurse at the local hospital for advice. Hospital nurse referred her to physiotherapy department. From there she was referred for occupational therapy.                                                                                                                       |
| • Participant 3 | 30 | Mother of the developmentally delayed/ disabled infant      | Unmarried and not working. Only income is disability grant for child. Stays on her own in a shack. Father of child involved, but he is not employed full time, therefore no financial contribution from him. Infant 15 months old. Problem was identified by nurse in clinic, but only at age of 10 months; hypo tonic, did not roll over, did not crawl, did not reach for objects. Possible brain injury during extended birth time.                                                                                                                                                                                                            |
| • Participant 4 | 57 | Grandmother of the developmentally delayed/ disabled infant | Mother 26 years old, unmarried and not working. She stays with her mother and their only income is a disability grant. Infant 18 months old. Father of child not involved. At age of 1 month very ill, had an operation. Doctor noted that infant was stable and in a good condition, but according to the grandmother since then the child was not well, lacked general movement, head lagged. Nurses at clinic did not identify problem nor referred child for intervention. Eventually grandmother took baby back to hospital and the infant was referred to the CP group at the age of 7 months and since then received occupational therapy. |
| • Participant 5 | 36 | Mother of the developmentally delayed/ disabled infant      | Married to an attorney. Teacher, but not working currently. Children: 4 boys aged 12, 11, 7 years & 18 months. Infant identified at age 11 months with brain atrophy. Received all his immunisations, but clinic nurses did not identify any problem. Mother concerned because he could not sit and took him to an occupational therapist for an evaluation at age 8 months.                                                                                                                                                                                                                                                                      |
| • Participant 6 | 31 | Mother of the infant                                        | She is married and teaches at one of the local pre-primary schools. Children: 2 boys aged 2 years and 10 months. The oldest boy was identified with a growth hormone problem at age 6 months. Currently getting speech and occupational therapy for delayed development. Received all his immunisations. Clinic nurse aware of growth problem, but did not identify speech related problems. Mother was concerned and took him to speech therapist for an evaluation.                                                                                                                                                                             |



#### **2.2.1.1.4 MATERIAL FOR DATA COLLECTION**

##### **a. Interview guide**

A customized interview guide was devised for each of the following categories:

- Community nurses
- Management
- Personnel concerned with CPD
- Other health care personnel
- Families (infant with typical development)
- Families (infant with developmental delay/disability)

Topics were selected in advance and were guided by the objectives of the study (developmental needs of infants and their families; developmental care that community nurses can address within their scope of practice; training needs of community nurses pertaining to the management of developmental needs of infants and the support needed by community nurses to fulfil their responsibilities towards these infants). When constructing the questions, the researcher reviewed the literature to know what questions should be asked to cover the identified topic. The study supervisors perused the initial draft of the questions to ensure that questions were open-ended, sensitive, neutral and clear to the interviewee (Britten, 1995:251; Greeff, 2002:302-303). Although it was prepared in a way to ensure that the same information is obtained from each person, the researcher decided on the sequence of the questions during the interview. However, some of it was modified over time to include additional questions to focus attention on areas of particular importance or to modify questions that the researcher has found to be unproductive for the study (See Annexure D:404).

##### **b. Field notes**

The researcher took short notes during each interview to remind her of events influencing the study and its development, and to record specific observations as well as any inadequacies experienced by the researcher. The researcher also recorded any personal response to events that influenced her

interpretation of reality. These notes were taken to supplement the data collected with the interviews and for cross-reference of documents mentioned during interviews. The researcher typed the notes and stored it in such a manner that the researcher or any one at a later stage could retrieve it effectively. (See Annexure F:503).

#### **2.2.1.1.5 EQUIPMENT FOR DATA RECORDING**

The researcher used a battery operated micro cassette to record face-to-face interviews.

#### **2.2.1.1.6 DATA COLLECTION METHODS**

In this study, multiple sources of evidence (interviews, perusal of official documentation and a field notes) were used as any finding or conclusion in a case study is likely to be more convincing and accurate if it is based on multiple sources of evidence. Decisions regarding data collection strategies may be revised after site selection, entry into the field, and initial mapping of the field (Keen & Packwood, 1995:445; McMillan & Schumacher, 2001:437).

##### **a. Interviews**

The researcher used comprehensive, semi-structured interviews that allowed for probing to interview the participants. The interview guide approach was used where topics were selected in advance, but the researcher decided on the sequence of the questions during the interview. These topics were guided by the objectives of the study (developmental needs and support, scope of practice, training needs and support/infra structure).

In the chain of evidence (See Figure 2.4:41), the researcher indicated graphically how she kept track of the interviews to ensure validity (credibility) and reliability (dependability) of the research. The researcher maintained a chain of evidence to allow any external observer to follow the process of data collection. Furthermore, it indicates where the researcher decided to retrace

her steps, to follow up with certain participants to obtain additional information or to verify information obtained from other participants.

The interviews consisted of different phases: the preparation phase, the interview phase and the post-interview phase. The aim of the *preparation phase* was to put the participants at ease, by explaining what the discussion was about and what aims are to be achieved. The researcher also thanked the participants for their willingness to participate. A written document (consent form) that contains all the details about the study was given to them and they were given time to ask questions before they agreed in writing to participate. The researcher explained the need to use a recorder and each participant's permission was obtained. Furthermore, the researcher explained that interviews would be conducted in either Afrikaans or English and that the participants could choose the language that they felt most comfortable with. Although the vernacular of some of the participants is an African language, they were willing and comfortable with the idea of being interviewed in either Afrikaans or English. Personal and background information of the participants were obtained during this phase. This part of the interview has not been recorded, but the researcher took meticulous notes to document this information.

The *interview phase* consisted of the actual communication between the researcher and the participant. The interviews were recorded to ensure completeness of the verbal interaction. The researcher used a micro cassette recorder to record the interviews. During the previous phase, the researcher explained the need to use a recorder and each participant's permission was obtained. The researcher took notes to help with the reformulation of questions and probes, and to record nonverbal communication. The interviewer also tried to create a context in which the participants could express themselves freely and honestly. The researcher also described her preparation to address personal attitudes that could influence the study (See Table 2.8:42). This came to good use, as their interviews were highly emotive for some of the participants. During her master's studies in 'Early Childhood Intervention', the researcher came to realize how important human connectedness is between

professionals and parents with developmentally delayed or disabled children. The words of Hirshberg “trying to put yourself in the emotional shoes of another person – with all its complexity, ambiguity, and conflict” (Shonkoff & Meisels, 2000:467) indicated to the researcher how important it is to attempt to understand how the world feels to the parent, as this expands the professional’s capacity to empathize with families, and therefore, be more helpful.



Table 2.8 Researcher attitudes

| ATTITUDE OF RESEARCHER   | HOW THIS WAS ADDRESSED IN RESEARCH                                                                                                                                                   |
|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Unconditional acceptance | The researcher accepted the participant as a person without passing judgement on her or him.                                                                                         |
| Respect                  | The researcher showed respect by considering the participant's context and by accepting the uniqueness of the participant.                                                           |
| Empathy                  | The researcher showed empathy by placing herself in the position of the participant.                                                                                                 |
| Openness                 | The researcher tried to consider her own prejudices and to set it aside while the interview took place. The researcher tried not to bring her feelings and ideas into the interview. |
| Sincerity                | The researcher presented herself without any hidden agendas or ulterior motives.                                                                                                     |
| Modesty                  | The researcher tried not to make the participant feel inferior with regard to the subject being researched                                                                           |

(Poggenpoel, 2003:144).

During the *post-interview phase*, the tape-recorded data were transcribed verbatim. Each transcribed interview was copied onto a compact disc for safekeeping and a hard copy was printed for use in the data analysis. As the interviews progressed, the researcher realized that additional questions were necessary to explore all avenues of information better and the interview guides were adapted where necessary. Recurrent themes indicated that sufficient information has been collected. The researcher conducted 31 interviews over a period of five months, from October 2004 to February 2005 (See Annexure E:420. A copy of each of the categories is included. Where only Afrikaans interviews were conducted, one was selected and translated into English). A translator was utilized for the translation. A registered nurse, who is well grounded in research and has an understanding of the language used in the

health care context, translated the chosen interviews. She has the following qualifications: Diploma General Nursing; Diploma Midwifery; Diploma Nursing Education; B Cur (Nursing Administration and Community Nursing); BA (Hons) (Communication) and MA (Ancient Cultural History). She has at least 23 years of experience as a translator.

Following, a more detailed description of the interviews of the different categories:

- **Community nurses**

In total five nurses were interviewed. All of the interviews were conducted in an office at Park Street Clinic for their convenience and to minimise interruption of service rendering. Four of the interviews were conducted in English and one in Afrikaans. The duration of the interviews varied between 40 and 65 minutes. No follow-up interviews were conducted, but the researcher did phone to obtain additional information on qualifications and the period of time working in the clinic. The topics covered by the questions were guided by the objectives of the study and included among others: pre-service, post-basic training, CPD and interdisciplinary training; human rights of infants; late identification of developmental delays and disabilities; scope of practice and perceived responsibilities with regard to assessment and intervention of development of infants; domains of development; policy and guidelines pertaining to developmental needs of infants; support by management; existing infrastructure and barriers to address developmental needs of infants; interaction with other health care professionals; cultural competence; support of families and available resources for families in the community. Other people, despite a sign on the door indicating “Do not disturb”, interrupted some of the interviews. However, this had no effect on the quality of the data obtained.

- **Management**

In total four managers were interviewed; two from the local government health department and two from the provincial health department. Each of the interviews took place at a venue chosen by the participant. The main choice was the manager’s own office (for their own convenience), except for one interview that was conducted at the researcher’s office, due to the

researcher's office being more accessible. All the interviews were conducted in Afrikaans. The topics covered by the questions were guided by the objectives of the study and included among others: human rights of infants; management role and function; government policies and priorities; scope of practice and responsibilities of community nurses with regard to developmental needs of infants; standards and operating procedures manual; quality assurance; resources, training and interagency collaboration; barriers to provision of developmental care of infants; support of personnel. Three follow-up interviews were conducted after the researcher realised that the support role of managers wasn't examined in full (See Figure 2.4:41, Chain of evidence). The duration of the interviews varied between 25 and 45 minutes. The duration of the three follow-up interviews varied between 15 and 20 minutes.

- **Persons involved in the training of nurses**

In total two persons were interviewed. They are both registered nurses and the duration of the interviews was respectively 25 and 60 minutes. For their own convenience, the interviews took place at their place of work. One was conducted in English and one in Afrikaans. The topics covered by the questions were guided by the objectives of the study and included among others: reasons for CPD; policies and guidelines on training; content of the programmes; needs assessment of community nurses; shortcomings of the existing programmes; format of training; evaluation of efficacy of training; resources; responsibilities of community nurses with regard to developmental needs of infants; specific topics with regard to infant development; interdisciplinary training; guidelines for developmental management of infants; updating of knowledge; current knowledge and skills of community nurses and trainers.

- **Other health care professionals**

In total, three persons were interviewed: one speech/language therapist, one occupational therapist and one physiotherapist. The duration of the interviews varied between 20 and 30 minutes. All interviews were conducted in Afrikaans. Two of the interviews were conducted at the therapists' consulting rooms (for their own convenience) and one was done at the researcher's office (no private space available at the therapist's



consulting rooms). The topics covered by the questions were guided by the objectives of the study and included among others: experience of late identification of developmental delays and disabilities; the perceived role and responsibilities of the community nurse in a PHC clinic; importance of the education of parents with regard to infant development; assessment methods for community nurses in clinics; role of policy and guidelines in early identification and intervention; skills and knowledge of community nurse for early identification of developmental delays and disabilities; interaction between therapists and community nurses; and interdisciplinary training. The researcher experienced a technical problem with the cassette recorder during the recording of one of the interviews. The researcher, however, was still able to transcribe the interview. To exclude future problems the researcher then purchased a new cassette recorder.

- **Families (infants with typical development)**

In total, five initial interviews were conducted of which four were done in Afrikaans and one in English. Four of them were conducted at one of the other clinics in the KOSH sub-district (community nurse arranged for families to meet researcher at the clinic) and one was conducted at the researcher's own office (at the participant's request). The duration of the interviews varied between 15 and 40 minutes. The researcher initially battled with some of the participants to conduct the interviews at their level of comprehension. However, over time the researcher managed to remain at the participant's level of comprehension. The topics covered by the questions were guided by the objectives of the study and included among others: human rights of infants; knowledge pertaining to growth and development; parents' contribution to optimal development of infant; satisfaction with care at the clinic; inclusion of parental concerns; information on infant development by nurses; relationship between parent and community nurse; characteristics of community nurses; support by community nurses; referral to available resources in the community; informal support system of parents/family; barriers to effective service; inclusion of family in the assessment. The initial interview guide was changed following the first four interviews as the researcher realised that inadequate information had been obtained and thus affected the quality and

usefulness of the data. Only the last interview was done entirely according to the new interview guide. Two follow-up interviews were conducted via telephone and only those questions not initially included, were asked. This was done to extend the information initially obtained from them as well as to improve the quality of the data. (See Annexure D:404).

- **Families (infants with developmental delay/disability)**

Six initial interviews were conducted, of which five were conducted in Afrikaans and one in English. One follow-up interview was conducted. The duration of these interviews varied between 18 and 60 minutes. Four of these interviews were conducted at the participants' homes (for the convenience of the participants) and three were done at the Occupational Therapy department at one of the local hospitals (occupational therapist arranged for interviews to be conducted on the same day as the rehabilitation for the convenience of the participants). The researcher tried to include families from the African culture in this category as well. Although Afrikaans or English was not the participants' vernacular, they indicated that they felt comfortable enough with the second language to participate in an interview. The researcher tried to conduct the interview at the level of the participant's comprehension, but realized the language issue could affect the quality of the data obtained and tried to arrange for follow-up interviews with some of the participants where the interview would then be conducted in their vernacular, Setswana. However, this has not been feasible as the researcher could not get hold of an impartial, trained translator. The idea was to make use of one of the nurses in the clinic, but the researcher then realized that the participants might feel intimidated by the presence of the nurse and would therefore not speak freely; thereby once again affect the quality of the data. The researcher then decided to do a follow-up interview with one of the initial mothers, as well as to include another participant whose home language was either Afrikaans or English (See Figure 2.4:41, Chain of evidence). For one of the participants the interview was emotive and the researcher decided to rather conclude the interview and assist her with her emotions, than to pursue the interviews. The topics covered by the questions were guided by the objectives of the study and included the topics listed under the previous category, as well as:

age of infant when problem was identified; who identified this delay; how was this diagnosis conveyed; support by health care professionals during this time; information about the delay or disability; referral to other health care professionals e.g. occupational therapist; level of involvement with planning of intervention; perceived knowledge and skills of community nurses to identify developmental delays and disabilities. The initial interview guide was changed following the first four interviews as the researcher realised that inadequate information has been obtained and that the quality and usefulness of the data could be affected. The last two interviews were done according to the new interview guide (See Annexure D:404).

## b. Document study

Systematic searches of official documents (policy documents, patient/client records and training programmes) were executed to enhance understanding of the data gathered by other methods, and to enhance understanding of the data gathered by other methods to illuminate and contextualise the responses to the research questions provided during the interviews (Hewitt-Taylor, 2002:35). In Table 2.9, below, the types of documents included in the study are indicated.

Table 2.9 Types of documents included

| Documents              | Description                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Patient clinic records | The researcher drew clinic records at random but adhered to the age criteria. Therefore, the records, which did not fit the criteria, were not included. In total 50 patient clinic records were included. The researcher only used the clinic records to verify information obtained during the interviews with the community nurses e.g. nurses indicated during interviews that they do record that they have done developmental assessments. Personal information of patients was not used in any way. |

|                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|-----------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Policy documents/guidelines | <p><b>External policy (government policy).</b> No external policy documents could be found for the management of developmental needs of infants. Nurses, however, rely on other external policy documents i.e. Expanded Programme on Immunisation South Africa and Integrated Management of Childhood Illnesses, to give guidance with management of infant developmental needs. However, it is only growth that is addressed in these policies.</p> <p><b>Guidelines (compiled by nurses at primary health care clinic).</b> Nurses make use of a document containing guidelines for the assessment of motor development of infants that was compiled about 15 years ago.</p> |
| Training programmes         | <p>The researcher obtained a copy of the formal training programme of the KOSH sub-district as well as a copy of the in-service training programme compiled for the nurses working in Park Street Clinic. Neither of these programmes addressed infant development.</p>                                                                                                                                                                                                                                                                                                                                                                                                        |

These documents were included to corroborate and augment evidence from interviews with management, community nurses and personnel concerned with training. Consent to review these documents was included in the initial request to conduct research at Park Street Clinic (See Annexure B:394). These documents were kept in a manner that would ensure efficient retrieval by the researcher as well as other persons. The researcher described aspects that could influence the contents of the documents and their researchability (See Table 2.10:49).

Table 2.10 Aspects that could influence the contents of the documents and their researchability

| Aspects                   | Description                                                                                                                                                                                                                                                                                                                                                                          |
|---------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Incompleteness            | Data on the documents were often incomplete e.g. nurses indicated during interviews that they do record that they have done developmental assessments. However, no reflection of this was found in the documents.                                                                                                                                                                    |
| Lack of availability      | In some instances documents were not available in the clinic e.g. policy documents that were referred to during interviews.                                                                                                                                                                                                                                                          |
| Lack of linguistic skills | The researcher was dependent on the ability of the community nurses to formulate clearly and meaningfully when recording interventions. In most cases, English is not the first language of those compiling the records. Therefore, the researcher verified if uncertain about the meaning of an entry, with the specific community nurse whether she/he was available for comments. |

(Strydom & Delport, 2002: 322-326; Yin, 2003: 87).

As with all data collection techniques, document study also has disadvantages. Therefore, the researcher felt it was important to give attention to these aspects to be correctly critical in interpreting the contents of the documents.

### c. Field notes

The researcher kept field notes to remind her of events influencing the study and its development and to record specific observations. The researcher also recorded any personal response to events that influenced her interpretation of reality (Hewitt-Taylor, 2002:34). Short notes were taken during the interview, but as soon as possible after the interview, the researcher wrote detailed notes that included personal experience during the interview, positive aspects and any inadequacies experienced by the researcher. The researcher typed these

notes and stored it in such a manner that the researcher or any one at a later stage could retrieve it efficiently. As a precautionary measure, the researcher also made a copy of the notes on a diskette and kept it in a safe place. These notes were taken to supplement the transcribed interviews and for cross-reference of documents mentioned during interviews. Furthermore, during analysis of the interview data these notes helped the researcher to remember and explore the interviews with more insight during the identification of meanings and themes (See Annexure F:503)

#### **2.2.1.1.7 DATA ANALYSIS**

Qualitative data analysis is a process of organizing the data into categories and identifying patterns among the categories. It is an eclectic activity – there is no one “right” way. Analysis of data begins shortly after commencement of data collection and continues during data collection and beyond. The concurrent processes of data collection and analysis allow the analysis to guide data collection to prevent the collection of excess and unnecessary data (Aita & McIlvann, 1999:263; McMillan & Schumacher, 2001:463; Morse, 1998:75). Before analysis could begin, verbatim transcriptions of the recorded interviews were created. Once transcribed, the data were reviewed for accuracy by listening to the tapes while reading the transcriptions. Discrepancies were then corrected.

##### **a. General analytical strategy**

The strategy that the researcher employed, addressed the *a priori* issues embedded in the research aims and objectives, and allowed flexibility to incorporate new and hitherto unconsidered issues, which arose during data collection. A literature review was conducted to demonstrate the underlying assumptions behind the general research questions and it identified the area of knowledge that the study intended to expand. The four main concepts of the meta-theory of nursing (person, health, environment and nursing) provided the frame of reference from which data were collected. This helped to focus

attention on certain data and to ignore other data (Fouché & Delport, 2002:127, 266; Kozier et al., 1991:58; Yin, 2003:111-112).

## **b. Analytical technique**

The researcher employed a basic approach for analysing narrative data, namely content analysis. Content analysis has been defined as “A systematic, replicable technique for compressing many words of text into fewer content categories based on explicit rules of coding” (Stemler, 2001:n.p.). It is a mechanical process that relies on the creative and conceptual ability of the analyst to determine meaning, salience and connections. This approach involves a systematic process of sifting, recording and sorting material according to key issues and themes.

The five key steps involved in content analysis are:

- Getting to know the data
- Focus the analysis
- Categorize the information
- Identify patterns and connections within and between categories
- Interpretation – bringing it all together

(Taylor-Powell & Renner, 2003:2-5). In Table 2.11:52, Key steps involved in data analysis are indicated.)

Table 2.11 Key steps involved in data analysis

| Steps                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Description and illustration                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Getting to know the data:</b> Before sifting and sorting the data, the researcher must become familiar with the range and diversity of the data. By being involved in the data collection, the researcher formed hunches about key issues and emergent themes, thereby taking stock of the material as a whole.                                                                                                                                                                                                                                                 | <p>To get a feeling for the material as a whole, the researcher listened to the tapes, read the transcriptions and field notes several times, and listed key ideas and recurrent themes. The researcher also made notes of the atmosphere during the interview and the ease or difficulty of certain interviews.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Focus the analysis:</b> The process where the researcher attempts to identify the key themes/questions according to which the data can be examined. This is not a mechanical process but involves both logical and intuitive thinking on the part of the researcher. It involves making judgements about meaning, and about the relevance and importance of issues. These key issues and themes may change as the data is worked with.<br>The focus of the analysis is to look at how the case and the people in the context responded to the themes/questions. | <p>After the material has been reviewed, the researcher returned to the research notes and set up a thematic framework within which the material was sifted and sorted. The researcher drew upon <i>a priori</i> issues, issues raised by the respondents themselves and analytical themes arising from the recurrence of particular views.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Categorize the information:</b> It is the process whereby the thematic framework is systematically applied to the data in its textual form, to make judgements about the meaning and significance of the data. To bring meaning to the words before it is organized into coherent categories.                                                                                                                                                                                                                                                                   | <p>The researcher combined the following two approaches to categorize the data:</p> <ul style="list-style-type: none"> <li>• Preset categories: The <i>a priori</i> issues embedded in the research aims and objectives were used to provide direction for what to look for in the data.</li> <li>• Emergent categories: This approach allows the categories to emerge from the data. Categories are defined after working with the data.</li> </ul> <p>After reading each passage, the researcher inferred and decided on its meaning, both as it stands and in the context of the interview as a whole. The researcher read and re-read the text to identify coherent categories. This was an iterative process as definitions of categories were adjusted or new categories were identified to accommodate data that did not fit the existing categories. Main categories were broken into subcategories as this allowed for greater discrimination and differentiation. This was applied several times to refine categories to ensure that the initial research questions were being fully addressed and that the data were correctly</p> |



|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
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|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | labelled. The researcher continued to categorize until all relevant themes had been identified and labelled. After the data had been analysed, the researcher asked two independent researchers to conduct an independent analysis of the data as a verification measure. Their analysis corresponded with that of the researcher. They, however, emphasized the factors that inhibited addressing the developmental needs of infants in a primary health care clinic, whereas the researcher kept the themes, categories and subcategories positive, as guidelines were to be developed from these categories and subcategories. |
| <p><b>Identify patterns and connections within and between categories:</b> The researcher needs to build up a picture of the data as a whole and think how the categories fit together and relate. As the data are organized into categories, patterns and connections both within and between the categories, started to emerge:</p> <ul style="list-style-type: none"> <li>• Within category description: What are the key ideas being expressed within the category? What are the similarities and differences in the way that people responded?</li> <li>• Between category description: Two or more themes occurred together consistently in the data and this might suggest a cause and effect relationship.</li> </ul> | <p>The researcher thought about the following questions: What seems more important or less important. Are there exceptions that do not seem to fit? The researcher considered alternative explanations and explored conflicting themes and evidence that seemed to challenge/contradict own interpretations.</p>                                                                                                                                                                                                                                                                                                                  |
| <p><b>Interpretation – bringing it all together:</b> It refers to the process where the analyst begins to pull together key characteristics of the data and to map and interpret the data set as a whole. This is attaching meaning and significance to the analysis.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <p>The researcher developed a list of important findings discovered due to categorizing the data. The researcher asked the questions: What have you learned? What are the major lessons? What new things did you learn? The researcher reviewed the research notes; compared and contrasted the perceptions, accounts, or experiences; searched for patterns and connections and sought explanations for these internally within the data.</p>                                                                                                                                                                                    |

(Poggenpoel, 2003:148; Taylor-Powell & Renner, 2003:1-9)

#### **2.2.1.1.8 MEASURES TO ENSURE RIGOUR OF THE RESEARCH DESIGN**

Without rigour, research is worthless. A great deal of attention was therefore given to validity and reliability in this study, not only in designing the case study, but also throughout conducting the study (Yin, 2003:35). Qualitative authors Guba and Lincoln (In Morse, Barrett, Mayan, Olson & Spiers, 2002:2) substituted the terminology reliability and validity with the parallel concept of trustworthiness. This concept contains four aspects: credibility, transferability, dependability, and confirmability. However, in this study the researcher adopted Yin's approach to the case study and therefore applied the terminology as used by Yin (2003:35). The researcher indicated the tactics and verification strategies that were employed to ensure quality of the research (See Table 2.12:55, Case study tactics and verification strategies to ensure quality of research).

Table 2.12 Case study tactics and verification strategies to ensure quality of research

| Tests                                                                                                                                                                                                                                         | Case study tactic                                    | Verification strategy used in this research                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Construct validity:</b><br>Establishing correct operational measures for the concepts being studied (Yin, 2003:34)                                                                                                                         | Use multiple sources of evidence                     | Any finding or conclusion in a case study is likely to be more convincing and accurate if it is based on multiple sources of evidence. Case studies often use triangulation of data to ensure the validity of findings. In triangulation, the same fact is corroborated from at least one other source and normally by another method (Tellis, 1997:n.p.; Yin, 2003:97-101). The use of multiple sources of evidence is seen as a major strength of the case study and during the data collection process, the researcher used multiple informants (management, community nurses, personnel concerned with continuous professional development, other health care professionals and family members) to gather information; multiple measures of the same phenomenon were obtained. Furthermore, more than one data gathering method was used: interviews, document study and the researcher kept a field diary to check findings from one source against the other sources and perspectives. |
|                                                                                                                                                                                                                                               | Establish chain of evidence                          | The researcher kept all evidence in such a manner that an external observer would be able to follow the derivation of any evidence. All interviews were numbered and a graphic presentation indicated the path of the collection of evidence (See Figure 2.4:41). Furthermore, the researcher ensured that no original evidence was lost by transcribing the interview tapes verbatim. The field notes of the researcher indicated the circumstances under which the evidence was collected, e.g. time and the place of the interview.                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Internal validity:</b><br>Establishing a causal relationship whereby certain conditions are shown to lead to other conditions (Yin, 2003:34). (It is alternatively referred to as credibility by Guba and Lincoln (In De Vos, 2002:351) to | The study did not seek to associate cause and effect | Triangulation of data (See construct validity, use of multiple sources of evidence). All the raw data were made available for others to analyze. The researcher used two independent qualitative researchers to verify that all themes, categories and subcategories have been identified during the analytic process. Their findings corroborated with that of the researcher. They, however, decided to reduce the categories to include only                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |

|                                                                                                                                                                                                                                                                                                                                          |                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| indicate that the inquiry was done in such a way as to ensure that the subject was accurately identified and described).                                                                                                                                                                                                                 |                                                             | themes.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>External validity:</b><br>Establishing a domain to which a study's findings can be generalised (Yin, 2003:34). (It is referred to as transferability by Guba and Lincoln (In De Vos, 2002:352). How applicable will the data be in other contexts or with other respondents?).                                                        | Test theory by replicating findings with another case study | <p>The researcher gave a detailed description of the case context. The researcher did not specify the transferability of findings, but only provided sufficient information that can be used by others to determine whether the findings are applicable to the new situation.</p> <p>A further method employed by the researcher to strengthen the study's usefulness for other settings was by triangulating multiple sources of data to ensure that multiple measures of the same phenomenon were obtained. Furthermore, more than one data gathering method had been used: interviews, document study and the researcher kept a field diary to check findings from one source against the other sources and perspectives.</p> |
| <b>Reliability:</b><br>Demonstrating that the operations of a study can be repeated with the same results (Yin, 2003:34) (It is referred to as dependability by Guba and Lincoln (In De Vos, 2002:352). How consistent are the results? The researcher attempted to account for changing conditions in the phenomenon chosen for study). | Develop a case study protocol                               | The protocol approved by the Faculty of Health Sciences Research Ethics Committee, University of Pretoria, guided the researcher in the conducting the research. This protocol described the approach to and procedures for data analysis. The researcher also justified why these were appropriate within the context of this study. (See Annexure A)                                                                                                                                                                                                                                                                                                                                                                           |
|                                                                                                                                                                                                                                                                                                                                          | Develop a case study database                               | To address the problem of reliability, the researcher tried to minimize bias and errors in the study and meticulously documented the procedures followed. The researcher organized and stored all the study data in such a manner (typed notes were kept in a file; notes were copied onto a compact disc and were kept in a safe place; tapes were numbered and stored in a safe place) that other persons, including the researcher, could later retrieve it efficiently. The researcher used this database to compile the case study report.                                                                                                                                                                                  |

|  |                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|--|-------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  | Chain of evidence | The researcher kept all evidence in such a manner that an external observer would be able to follow the derivation of any evidence. All interviews were numbered and a graphic presentation indicated the path of the collection of evidence (See Figure 2.4:41). Furthermore, the researcher ensured that by transcribing the interview tapes verbatim, no original evidence was lost. The field notes of the researcher indicated the circumstances under which the evidence was collected, e.g. time and place of the interview. |
|--|-------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

(De Vos, 2002; Hoepfl, 1997:n.p.; Yin, 2003:34)

#### **2.2.1.1.9 DOCUMENT ANALYSIS**

Official documents (policy documents, patient/client records and training programmes) were examined to enhance understanding of the data gathered by other methods, and to illuminate and contextualise the responses to the research questions provided during the interviews (Hewitt-Taylor, 2002:35).

#### **2.2.2. PHASE TWO: DEVELOPMENT OF GUIDELINES FOR THE SUPPORT OF COMMUNITY NURSES IN EITHER TRAINING, CONTINUOUS PROFESSIONAL DEVELOPMENT OR CO-OPERATION WITH OTHER HEALTH CARE PROFESSIONALS AND MANAGERS, IN ORDER TO ATTEND TO THE DEVELOPMENTAL NEEDS OF INFANTS.**

The development of guidelines was covered in this phase. Guidelines are recommendations for the care of individuals by health care professionals. Guidelines assist the practice of health care professionals, but do not replace their knowledge and skills. Guidelines have been defined as “systematically developed statements designed to assist practitioner and patient on decisions on appropriate health care for specific clinical circumstances” (Field & Lohr, 1992:27; National Institute for Clinical Excellence (NICE), 2001:3). Guidelines are being developed to improve the quality of health care and may provide a mechanism by which health care practitioners can be made accountable for clinical activities. A key definitive attribute of guidelines is that they are based on research (Cranston, 2002:39; Duff, Kitson, Seers, Humphris & Cert, 1996:888; Scalzitti, 2001:1622; Thomas, McColl, Cullum, Rousseau & Soutter, 1999:40). Guidelines can be used as educational tools in undergraduate and postgraduate education as well as in the continuing professional development of established clinicians (NICE, 2001:1).

Guidelines make sense when practitioners are unclear about appropriate practice and when scientific evidence can provide an answer (Woolf, Grol, Hutchinson, Eccles & Grimshaw, 1999:530). Nurses need guidelines to assist them in finding “best practice” within their scope of practice to ensure higher

quality of developmental care to families with infants 0-2 years (Cranston, 2002:40; Thomas et al., 1999:41).

To ensure the validity of guidelines it is imperative that developers adhere to specified criteria. The development of a guideline should follow a logical process (Carnett, 2002:67). Guidelines that are based on a combination of sound scientific evidence and expert consensus result in more efficient and effective outcomes of care (Ibid:64). Clinicians need “simple, specific and user friendly guidelines” (Jackson & Feder, 1998:427).

### 2.2.2.1 DEVELOPMENT OF GUIDELINES

In Table 2.13, below, desirable attributes for guidelines are indicated. If these attributes are not addressed during the development process, it could result in flawed recommendations. The researcher gave attention to an applied version of the attributes throughout the development process. The attributes were applied to suit the type of guidelines developed in this study.

Table 2.13 Desirable attributes of guidelines

| Attributes                                    | Meaning                                                                                                    |
|-----------------------------------------------|------------------------------------------------------------------------------------------------------------|
| Validity                                      | Correct interpretation of the available evidence so that implementation will lead to improvement in health |
| Reproducible                                  | Given the same evidence, another guideline group would produce similar recommendations                     |
| Cost-effectiveness                            | Generating health improvements at acceptable cost                                                          |
| Reliability                                   | Given the same circumstances, another health professional would apply them similarly                       |
| Representative of key disciplines & interests | All key disciplines and interests contributed to the development of the guideline                          |
| Clinically applicable                         | Target population is defined in accordance with scientific evidence                                        |
| Clinically flexible                           | Identify where exceptions to the recommendations                                                           |

|                      |                                                                                                                 |
|----------------------|-----------------------------------------------------------------------------------------------------------------|
|                      | lie, and indicate how client preferences are to be incorporated in decision making                              |
| Clearly expressed    | Use precise definitions, unambiguous language and a user-friendly format                                        |
| Well documented      | Record all participants, any assumptions and methods and clearly link recommendations to the available evidence |
| Scheduled for review | State when, how and by whom they are to be reviewed                                                             |

(Carnett, 2002:66-67; Jackson & Feder, 1998:427; NICE, 2001:4; Royal College of Paediatrics and Child Health, 2001:5; Rycroft-Malone, 2002:150).

#### **a. Literature review**

One of the first and most important tasks of the researcher was to define the scope of the guideline to make the review more feasible (Royal College of Paediatrics and Child Health, 2001:5). During the data analysis process in the first phase of the research, data were segmented into relevant units of meaning and themes were identified. In phase two, the researcher used these themes to define the scope of the guideline (Scalzitti, 2001:1622).

An extensive literature review had been done to substantiate the research findings of Phase 1, to specify the scope and the content of the guidelines to enable community nurses to address the developmental needs of infants. One of the advantages of using a literature review is that it is easier to support the guidelines (Aldrich, Kemp, Stewart Williams, Harris, Simpson, Wilson, McGill, Byles, Lowe & Jackson, 2003:1283; Duff et al., 1996: 890; Rycroft-Malone, 2002:155; Shekelle, Woolf, Eccles & Grimshaw, 1999:594; Van Meijel, Gamel, Van Swieten-Duijfjes & Grypdonck, 2004:85).

Steps followed by the researcher in the gathering of evidence to formulate the guidelines:

- The themes to be investigated are specified in chapter 3, with the analysis of the research data.



- Research articles were investigated, findings and recommendations were compared with the findings obtained in Phase 1 and substantiation for the recommended guidelines was collected.
- Summaries, following each section of discussion of the research findings and corresponding aspects in the Transactional Model of Development in chapter 4, were used as a point of departure to develop recommendations.

#### **b. Development of recommendations**

Appropriate nursing and other literature was investigated and compared with the findings obtained in Phase 1 to develop a set of recommendations (Aldrich et al., 2003:1284). However, research findings are necessary, but not sufficient when making recommendations. Taking the findings and turning it into useful recommendations depend on the judgement, experience, and good sense of the researcher (National Health and Medical Research Council (NHMRC), 1998:17-18).

#### **c. Formulating content and format of guidelines**

Guidelines need to be easily accessible and presented with clarity. The particular audience at which it is targeted will often determine the format of the guideline. The guidelines' level of specificity and detail were aimed at community nurses working in a primary health care clinic in South Africa (Duff et al., 1996:889).

#### **d. Ensuring validity**

Guidelines should be subject to peer review prior to widespread dissemination and implementation to ensure content validity, clarity and applicability (Royal College of Paediatrics and Child Health, 2001:8; Shekelle et al., 1999:596). The completed guidelines were referred for examination to a wider group of experts involved in child health care. After comments from these experts have been taken into account, the researcher drafted the final set of guidelines.

- **Composition of the guideline validation group**

There are many sources of evidence and expert consensus is both desirable and inescapable within the development of guidelines (Mead, 2000:112). The researcher used a focus group to assist with the final development and validation of the guidelines, as it is particularly useful for exploring people's knowledge and experience (Kitzinger, 1995:299). The composition of the group utilized for the development and validation of the guidelines, is an important component in the eventual validity and acceptability of the guideline. It is important that the group is multidisciplinary as this will ensure ownership and support, and that all aspects covered by the guideline are addressed. To select the members of the group the researcher used purposeful sampling and specifically reputational-case, whereby the recommendations of knowledgeable experts (the two study supervisors) were obtained to identify suitable members (Carnett, 2002:67; Duff et al., 1996:888; McMillan & Schumacher, 2001:402; Royal College of Paediatrics and Child Health, 2001:4). Ideally, the group should have at least six, but not more than 12 to 15 members; too few members limit adequate discussion and too many members make effective functioning of the group difficult. The group, used for this study, consisted of eight professionals, who in their respective work contexts, focus on promotion of infant development and the identification of developmental delays and disabilities. Professional nurses, nursing management, personnel involved in the training of community nurses, a speech-language therapist, an occupational therapist and a physiotherapist were included.

The identified group members were informed in writing about the research (the problem statement, the objectives and the methodology). The group met only once in its entirety. The researcher first gave an overview of the completed study and then group members received a set of the recommended guidelines. Before discussion of the guidelines, they were given time to study the guidelines and an opportunity to ask questions. The two study supervisors kept notes and helped to facilitate the discussion.

The guideline validation process was completed and the guidelines were accepted (See chapter 6:351-352, Findings of validation process).

#### **e) Reviewing of the guidelines**

When guidelines are developed a date and strategy should be set for revision. This should ideally occur every three to five years or more often, where the subject matter is prone to rapid change (NHMRC, 1998:6). The researcher included a date for revision in the guidelines.

### **2.3 ETHICAL CONSIDERATIONS**

Ethics deal with “beliefs about what is right or wrong, proper or improper, good or bad” (McMillan & Schumacher, 2001:196). According to Strydom (2002:64), ethical issues can be divided into harm to participants, informed consent, deception of participants, violation of privacy/confidentiality, researcher competence and release of findings. The researcher attempted to conduct herself ethically in each of these areas. Participants were not harmed in a physical and/or emotional manner during the research and participation in the research was voluntary. This was conveyed clearly to all of them.

A letter to obtain informed consent was provided to all participants (individual interviews and focus group). In this letter the purpose of the research, possible benefits of the research, and procedures to be followed were explained. (See Annexure C:399). Furthermore, it stated that participation was entirely voluntarily and that all information obtained during the study will be confidential. Participants were not coerced or manipulated into participation and gave their written informed consent to indicate their voluntary participation in the study. Participants could withdraw from the research whenever they chose to do so.

The researcher made sure that the respect to which every participant was entitled, was not violated by clearly stipulating all the facts pertaining to the research and the researcher in the letter to obtain informed consent. The

researcher safeguarded the privacy and confidentiality of the participants. The participants were not requested to reveal their names. The researcher did not collect any data which was of a private nature and which was not necessary for this study. In addition, the participants were ensured that all information obtained during the research will remain confidential and results will be published in such a way that participants remain unidentifiable. The researcher assured all parties involved of her competence to undertake the investigation at hand. Before the study was conducted, experienced research supervisors (the two study supervisors) reviewed the research methodology.

Prior to conducting the case study, permission to carry out the research was obtained from the relevant authorities. A research proposal was submitted for approval to the Faculty of Health Sciences Research Ethics Committee, University of Pretoria (Annexure A:392). Permission was also obtained from the Town Council of Klerksdorp (Annexure B:394) as well as all the participants (Annexure C:399).

## **2.4 SUMMARY**

In this chapter a detailed description of the methodology used to execute the two phases of the research, was given. The next chapter deals with the analysis of the research.

## CHAPTER 3

### DATA ANALYSIS

#### 3.1 INTRODUCTION

The researcher described the research design and methodology used to address the research questions of this study in the previous chapter.

This chapter deals with the research findings as obtained during the data collection process. The analysis process started deductively from the pre-set aims and objectives (*a priori* reasoning) as discussed in chapter one. The strategy that the researcher employed addressed the *a priori* issues embedded in the research aims and objectives and allowed flexibility to incorporate new and hitherto unconsidered issues, which arose during data collection. To demonstrate the underlying assumptions behind the general research questions the researcher conducted a literature review through which the area of knowledge that the study intended to enlarge had been identified. The four main concepts of the meta-theory of nursing (person, health, environment, and nursing) provided the frame of reference from which data were to be collected. This helped to focus attention on certain data and to ignore other data (Fouché & Delport, 2002:127, 266; Kozier et al., 1991:58; Yin, 2003:111-112).

#### 3.2 ANALYTICAL TECHNIQUE

An important aspect of any study that employs verbatim transcriptions of interviews as its main data source is the organization of the data to bring order and understanding (Taylor-Powell & Renner, 2003:1). The researcher formed categories and searched for meaningful patterns among the categories (McMillan & Schumacher, 2001:461,466-467); she viewed a category as a group of words with similar meaning or connotations (Stemler, 2001:n.p.).

The researcher employed a basic approach for analysing narrative data, namely content analysis. The researcher employed the following definition of

content analysis “A systematic, replicable technique for compressing many words of text into fewer content categories based on explicit rules of coding” (Stemler, 2001:n.p.). It is a mechanical process that relies on the creative and conceptual ability of the analyst to determine meaning, salience and connections. This approach involves a systematic process of sifting, recording and sorting material according to key issues and themes.

As stipulated in the definition, the researcher followed specific rules to identify the categories:

- **Getting to know the data**

Despite the fact that the researcher collected the data and transcribed the interviews, she listened to and read the transcriptions and field notes several times to ensure that she was completely familiar with the data. The researcher hereby gained an overview of the richness, depth and diversity of the data.

- **Focus the analysis**

To focus the analytical process, the research aims and objectives provided direction for the researcher. The researcher organized the data of the different groups (community nurses, management, personnel involved in the training of nurses, other health care professionals, families with infants 0-2 years of age with typical development and families with infants 0-2 years of age with developmental delays/disabilities) and analysed it as a whole for each group.

- **Categorize information**

The researcher worked from the preset aims and objectives, as well as recurring themes that she did not think about, to identify categories. This was an iterative process as the categories changed as the researcher worked with the data. As the researcher read the transcriptions of each interview, text that corresponded with the identified categories was marked. The researcher then transferred these identified pieces of text onto note cards and identified the source of the text via respondent, page number and text line number. The researcher then placed the cards on the appropriate heap that represented a specific category.

- **Identify patterns and connections within and between categories**

The researcher identified several categories for each group. The list of categories was refined so that similar categories were brought together to produce a final list with reduced numbers of categories. All the different groups were included. The transcripts were then re-read alongside the agreed list to ensure that the categories covered all aspects of the content.

- **Interpretation**

Bringing it all together – this step will be discussed in chapter 4.

### 3.3 FINDINGS OF THE ANALYSIS

The researcher wrote all findings down as themes, categories and subcategories. The data were developed and demarcated, so that the researcher identified three themes. She then developed the themes further in terms of 15 categories, and discovered subcategories under each of the categories. In total, 72 subcategories were discovered. These themes, categories and subcategories are indicated in Table 3.1 below.

Table 3.1 Themes, categories and subcategories

| Themes                                                  | Categories                                                                                                               | Subcategories                                                                                                                                                                                                                                                                                                                                                                                                             |
|---------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Support by management for developmental care of infants | <ul style="list-style-type: none"> <li>• Health care governance</li> <li>• Organizational culture and climate</li> </ul> | <ul style="list-style-type: none"> <li>▪ Policies and guidelines</li> <li>▪ Induction of staff (orientation)</li> <li>▪ Role expectations</li> <li>▪ Documentation</li> <li>▪ Professional performance management (supervision)</li> <li>▪ Training</li> <li>▪ Client feedback</li> <li>▪ Acknowledgement of input and achievements</li> <li>▪ Investment in staff</li> <li>▪ Communication including feedback</li> </ul> |

|                                                   |                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|---------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                   | <ul style="list-style-type: none"> <li>• Resources and infrastructure</li> <li>• Interagency collaboration</li> </ul>                                                                           | <ul style="list-style-type: none"> <li>▪ Finances/funds</li> <li>▪ Adequate staffing</li> <li>▪ Adequate equipment</li> <li>▪ Appropriate facility</li> <li>▪ Liaison and meetings</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Developmental care of infants by community nurses | <ul style="list-style-type: none"> <li>• Rights of the infant to develop to its full potential</li> <li>• Focus on infant developmental needs</li> <li>• Professional accountability</li> </ul> | <ul style="list-style-type: none"> <li>▪ Infants cannot speak for themselves</li> <li>▪ Aim of life to develop into Independent adult</li> <li>▪ Burden on community</li> <li>▪ Parents' responsibility</li> <li>▪ Government priorities</li> <li>▪ Perception of management</li> <li>▪ Perception of community nurses</li> <li>▪ Perception of people involved in the training of nurses</li> <li>▪ Perception of other health care professionals</li> <li>▪ Perception of parents</li> <li>▪ Assessment of infant for developmental delays and disabilities</li> <li>▪ Promoting development</li> <li>▪ Barriers that nurses experience in infant developmental care</li> <li>▪ Surveillance and home visiting</li> <li>▪ Perception of scope of practice of the nurse</li> <li>▪ Competence</li> <li>▪ Evidence-based practice</li> </ul> |



|                                                                  |                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                  | <ul style="list-style-type: none"> <li>• Personal professional development</li> <li>• Family care</li> <li>• Parents' view and expectations of community nurses</li> </ul> | <ul style="list-style-type: none"> <li>▪ Ethical standards</li> <li>▪ Preservation of human dignity</li> <li>▪ Pre-service knowledge base</li> <li>▪ Identification and acknowledgement of training needs</li> <li>▪ In-service training</li> <li>▪ Continuous professional development</li> <li>▪ Formal training programme</li> <li>▪ Focus on infant development</li> <li>▪ Relationship with parents</li> <li>▪ Addressing concerns of parents</li> <li>▪ Information on resources</li> <li>▪ Recognition of cultural traditions and practices</li> <li>▪ Reflection on personal interaction style</li> <li>▪ Perception of service delivery</li> <li>▪ Accessibility</li> <li>▪ Approachability/interpersonal skills</li> <li>▪ Competence</li> <li>▪ Information and advice</li> <li>▪ Explanation of procedures</li> </ul> |
| Management of infants with developmental delays and disabilities | <ul style="list-style-type: none"> <li>• Identification of infant developmental delays and disabilities</li> <li>• Intervention for infant developmental delays</li> </ul> | <ul style="list-style-type: none"> <li>▪ Identification</li> <li>▪ Intervention</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |

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|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  | <p>and disabilities</p> <ul style="list-style-type: none"> <li>• Support to parents of infants with developmental delays and disabilities</li> <li>• Views on late identification of infant developmental delays and disabilities</li> <li>• Collaboration with other health care professionals</li> </ul> | <ul style="list-style-type: none"> <li>▪ Anticipatory guidance</li> <li>▪ Follow-up services</li> <li>▪ Effects of developmental delays and disabilities on parents</li> <li>▪ Social support</li> <li>▪ Lack of focus on infant development by community nurse</li> <li>▪ Changes in health care</li> <li>▪ Workload</li> <li>▪ Impact of HIV and poverty</li> <li>▪ Logistics</li> <li>▪ Traditional healer</li> <li>▪ Insufficient knowledge about typical infant development</li> <li>▪ Negligence/denial by parents</li> <li>▪ Lengthy process of Identification</li> <li>▪ Wait-and-see attitude</li> <li>▪ Referral and feedback</li> <li>▪ Interaction/communication with other health care professionals</li> <li>▪ Ensuring continuity of therapy</li> <li>▪ Interdisciplinary training and skills development</li> </ul> |
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Furthermore, two independent qualitative researchers analysed all interview transcripts of each group (community nurses, management, personnel involved in the training of nurses, other health care professionals, families with infants 0-2 years of age with typical development and families with infants 0-2 years of

age with developmental delays/disabilities) to verify that all relevant themes, categories and sub-categories have been identified. The researcher supplied the independent researchers with hard copies of all the transcripts as well as a copy of chapter 1. The researcher took the results from this analysis into consideration to produce the final list of themes, categories and subcategories. The analysis produced by the two independent researchers corroborated the findings of the researcher. They however, decided to reduce the number of categories and to focus only on themes. They emphasized the following inhibiting factors that prevent community nurses to manage infant developmental needs:

- Lack of integration of developmental needs of infants as a national strategy on a provincial and local level (not a priority).
- Lack of standards, protocols and guidelines in the early assessment, identification and treatment of developmental needs leads to inconsistent service delivery. No mechanisms in place to ensure quality control (checklists).
- Overall lack of competence, skills and knowledge in the comprehensive approach to developmental needs.
- Inadequate infrastructure to address developmental needs in infants (lack of resources, competent human capital, finance, space, equipment and logistics).
- Silo approach in the management of developmental needs of infants that impacts on the continuity of care (lack of partnering and co-opetition).
- Scope of practice and responsibilities of the PHC nurses not integrated totally in practice.
- Total lack of knowledge, skills and competencies regarding the developmental needs of infants contributes to a lack of knowledge and understanding within the family.
- Continuous training focuses on priority programmes of the province and only addresses the curative aspects of developmental needs in infants.
- The “customer” is uninvolved in determining priorities regarding training. Lack of a holistic approach in dealing with the infant.
- Lack of evidence-based practice and access to knowledge resources.

These themes, identified by the two independent researchers, are included in the categories identified by the researcher (See Table 3.1:67). The researcher had to develop guidelines from the identified categories and subcategories and decided to retain the initial neutral format of the themes, categories and subcategories, instead of the negative themes as suggested by the two independent researchers. A working document with the initial themes, categories and subcategories had been included, including the comments from the independent researchers (See Annexure G:506).

The researcher used quotations from the transcripts to demonstrate the specific category and subcategory under discussion. The researcher used some of the quotations more than once if she felt it was appropriate and that it could highlight the subcategory under discussion more in depth. The headings indicate the themes, and the sub-headings indicate the categories and subcategories (See table 3.1:67).

### **3.3.1 SUPPORT BY MANAGEMENT FOR DEVELOPMENTAL CARE OF INFANTS**

Community nurses would need effective support from management to deliver a developmental care service for infants, with quality client care as its principal tenet. Therefore, to make a significant impact on performance and goal achievement management must be able to inspire, challenge, motivate and unite staff in a common purpose.

#### **3.3.1.1 HEALTH CARE GOVERNANCE**

The work behaviour of management has a direct effect on patients' health and on the work performance of nurses. By means of clinical governance management monitor work performance in addition to analysing where improvements could be made. Both managers and community nurses are of the opinion that clinical governance plays a vital role in the rendering of a quality health care service. The following quotations confirm this opinion.

### **a. Policies and guidelines**

It is reasonable to assume that nurses, as part of their professional responsibility, will be familiar with and understand the policy context in which they work. The researcher, according to the responses of the community nurses, realized that this assumption might be flawed. Management as well as the community nurses neglected this aspect. From their comments, it is clear that policy documents and guidelines are something in a file in the manager's office and not something that should be applied on a daily basis to enhance clinical effectiveness.

Manager: "Yes all that I can say is ... with this new IMCI (integrated management of childhood illnesses) ... at least there is the immunisation protocol ... the cold chain for the immunisation. Then there is the IMCI chart booklet according to which they can work ..." (Free translation)

Manager: "... we do have the policies they're all available in the clinic ... I'm going to lie if I'm going to say yes ... I can't say specific if it is there."

Manager: "... yes, I can't quote them ... there are policies ... government policies ..."

Manager: "Ok, there is the Charter of Human Rights and in children's rights there must be something like that. I am not up to date, but I believe there will be something ... I don't know ... we still have the old milestones that type of stuff ... we've got a set of that ... nothing regarding development, no ..." (Free translation)

Nurse: "This, I might perhaps not tell the truth, if there are any then it must be in E... 's office, but I can't tell you specifically ... maybe there is something like that, but I definitely don't know. What we definitely have is this IMCI ... you look at his basic physical ...

the milestones, the development is not included as such ... must think clearly if there is something like that, but I don't know about anything." (Free translation)

Nurse: "I am ... not so sure ... not as far as I know ..."

Nurse: "Yes there is a policy ... the guideline ... we got our own file where we keep the policies and guidelines ... it's the guideline that they've compiled before I've started working here ... it's not an external government policy."

Nurse: "Ok I haven't actually gone through all of the policies so ... I don't know ... about any specific."

Nurse: "... there is protocols because they are on the walls. We do have something for I think IMCI ...for the development there is ... charts ... but they on the walls for I've seen it ... because I'm still new also I worked just a month here, for the milestones that shows I did see something ...the orientation that we were ... but not so deep with the protocols and I, I was never orientated on that."

The consequences of nurses not being aware of, or not implementing policies, are far-reaching and it is likely to limit the quality of care provided to infants and their families. The responses indicate that all the managers as well as the community nurses are aware of the existence of policies. However, they are not clear on the content thereof and do not know whether there is any specific policy on infant development. According to the researcher, investing in infant developmental care is a policy priority that both management and community nurses should not neglect.

## **b. Induction (orientation) of staff**

Nurses working at Park Street Clinic come to their roles from a wide variety of backgrounds. These nurses come from a hospital-based background and have no previous experience of functioning in a primary health care clinic. Therefore, effective induction would ensure that newly appointed community nurses have the opportunity to identify and fill gaps in their knowledge and skills as well as learning about their new working environment.

The researcher did not ask questions about induction *per se*, as a topic. However, two of the participants (one nurse and one manager) indicated that induction (orientation) was important. Both of them reflected that induction was important because management can use it as a vehicle to articulate clearly what is expected from personnel.

Nurse: "The orientation ... were for consultation rooms ... but not so deep with the protocols and ... with that one I was never orientated on that. Yes, I would like ... because I must know what is expected from me ... yes, we did state it ... that we need orientation. So the only orientation that was allocated, this was for the 18<sup>th</sup> ... so I don't know what are they going to orientate us with ..."

Manager: "Support is very important, especially when it is new personnel. To see that they are orientated with regard to the clinic, colleagues and to ensure that they know what is expected from them and to make sure that, you know that they can really do it."  
(Free translation)

## **c. Role expectations**

It is important for nursing staff to know what management expect from them. Not all the participants included this aspect, as the researcher did not ask them

directly about it. However, it became clear from these responses that it is an important aspect that needs more attention.

Manager: "I feel I would give in-service training, make sure that every nurse is up-to-date about what precisely is expected from her regarding the development of the child." (Free translation)

Manager: "... to find out if they know what they must do and then to make sure that they really can do it ... to say where and when a mistake was made to rectify it." (Free translation)

Nurse: "... the orientation that we ... were for consultation rooms ... but not so deep with the protocols and I, I with that one I was never orientated on that. Yes, I would like ... because I must know what is expected from me ..."

Without clear communication from management, nurses would be uncertain about what are expected from them in the clinic. There need to be a shared understanding of their responsibilities in the team.

#### **d. Documentation**

Documentation of nursing care, and specifically the promotion of infant development by community nurses, is of paramount importance and forms an integral part of quality care. The researcher's assumption has been that what the nurses have not recorded, they have not done. The researcher asked the nurses specifically about their documentation of nursing care. Most nurses indicated that they only recorded when they pick up an abnormality, although they are aware of the importance to provide comprehensive notes. However, no notes regarding the promotion of infant development were recorded.

Manager: "... I do spot checks on the Road to Health charts. Every week someone else is allocated to do such as immunisation ... I ensure that the weights are charted correctly. You pick up faults,



a child for example, came in January and will come only in March again that they don't just chart the weight and that they have the gestation period correct." (Free translation)

Manager: "... of the charts we must take five charts say for instance road to health charts to check if it is filled in completely. It is the chart of ... the children ... five of them are being evaluated at a time and then five of the patients ..."

Both these managers said they did spot checks on the cards to see if the nurses completed it correctly. The managers did not mention any other requirements for effective documentation.

Nurse: "Yes we write it then, for that visit it comes on their usual immunisation chart, on the inside there is a whole space where you can write ... no if I am satisfied then I write nothing, but if you have a problem then you will write child is lagging with motor, query lagging, child does not react to this or whatever and so forth ... yes, it is certainly important ... it is certainly important to, but to speak frankly, if there is nothing wrong, then I don't write it down, I don't do it." (Free translation)

Nurse: "Yes it must written, you write in the clinical record whatever ... findings that you have find and even if you refer you must also write it there that you did refer this child to a certain person ... yes it must also be referred in the card that everything is normal."

Nurse: "... we record for everything that we do ... because we're trying to save time we just write no abnormalities detected if there wasn't any problem of that."

Nurse: "I don't remember recording it ... (laughs) I think it is necessary."

Some of the nurses, although they realize the importance of recording all actions, were very frank about the fact that if they did not find any abnormalities that they did not record anything. Other nurses indicated that they do record their findings in full; however, during the document analysis (50 clinic records drawn randomly) the researcher found that this was not the case.

Person involved in training of nurses: “I observe and except observing, I do check their documentation if they apply what I was giving at in-service ...”

Documentation by community nurses, according to the researcher, is a shortcoming that could have far-reaching implications for both the nurse and the organization. Therefore, both management and community nurses need to direct urgent attention at documentation.

#### **e. Professional performance management (Supervision)**

The goal of performance management is to learn from experience and improve competence. Nurses must use these situations as opportunities to learn and improve. From the responses, it is clear that management and the nursing staff had very different perceptions about performance management. Management says that they visit clinics, ensure that staff knows what is expected of them and give feedback where necessary as well as general “supervision”. The nurses on the other hand experience management as being absent and they feel they do not get the necessary feedback about their performance.

Manager: “... I try to visit every clinic once a week. It is a bit of a problem, but at least once every two weeks I get round to each clinic.”  
(Free translation)

Manager: “... to find out if they know what they must do and then to make sure that they really can do it ... to say where and when a mistake was made to rectify it.” (Free translation)

Manager: "... general supervision, check ... personnel assessments of the staff, ... stock control, the TB (tuberculosis) clinic, the maternity section ... we look at the monthly statistics, I verify it ... also check the orders of the medication as well as the dry pharmacy ..." (Free translation)

Nurse: "... They stand apart from us we see them maybe once a year ... an AD (assistant director), who has a little bit more contact with the clinic has been appointed, maybe it will go better than the last month or two and ... that big gap after all received an in-between structure, so let's give it a chance to see if it will go better." (Free translation)

Nurse: "Yes we usually met with our assistant director. So she doesn't say anything whether you must keep your good work or what so that you don't know whether you are working fine ..."

Both these nurses indicated that they do not get any feedback on their performance. The one, however, is hopeful that the situation could improve and that they should give it a chance whilst the other one did not express the same positive attitude and this could affect her performance in a negative way.

Person involved in training of nurses: "I make sure by making follow-up ... sometimes when they consult I do sit where I follow what they are saying."

Person involved in training of nurses: "... with every tour, with our quality improvement, we can see ... we go to the clinics and you do an inspection, it is a tick list that says this get done, that get done ..." (Free translation)

Both these persons involved in the training programmes of nurses, indicated that they do incorporate assessment of performance management as part of

their training programmes, thereby ensuring that knowledge has been translated into competence.

Although performance management is an integral part of everyday work, it appears as if it does not receive the necessary attention. In their responses, concerning the focus on developmental needs, the managers assume (“I can’t think that ...”) or say that they have not checked:

“... I can’t think that it is left behind, if that is the case, we will have to impress it upon them at the clinic to ensure that every person is definitely doing it.”

“... I do find that I get the word that they are concentrating on it, but I can’t say, I haven’t checked ...”

#### **f. Training**

Learning and development is important to delivering high quality care in an ever-changing environment such as primary health care. Management as well as nurses indicated that it is important to ensure that nurses are equipped with the necessary skills to maximize the contribution of all staff to patient care.

Manager: “We do have in-service trainings ... if somebody’s got a lack of anything in training that’s we do that once a month ... if there is something available ... what is going on like genetics or anything, yes we do go on that ... [I feel I would give in-service training, make sure that every nurse is up-to-date about what precisely is expected from her regarding the development of the child].” ([...] Free translation)

Manager: “... the people from ... the nutrition programme there is now, we now have a dietician and she comes to the clinics and trains the staff for example to check the nutrition of the babies and also to specifically check the Road to Health charts, the importance.”  
(Free translation)

Manager: "... that there can be training and that people can be empowered to identify the thing and to do it ... you know to ensure that the people get the necessary training, even if it is just in-service training in the clinic ... and where there is an opportunity for training to send the people for training." (Free translation)

Manager: "Training we've got, council has got a training committee, but province with great gratitude they are paying and they are training our nursing personnel in all the different spheres that they can do."

Nurse: "Look we get, if you ask the necessary training you get it ..."  
(Free translation)

Nurse: "... they do that, some of us they do send them for training according their needs that they've asked."

Person involved in the training of nurses: "The training programme is for the development of staff, but it goes hand-in-hand with quality, quality improvement ... A lot of our quality improvement ... strategies, one of the very first strategies is training for all the disciplines whether it is STI's (sexually transmitted diseases), PMTC (prevention of mother-to-child transmission) or HIV (human immunodeficiency virus), training is coupled with it."  
(Free translation)

Person involved in the training of nurses: "... it is to improve the quality of care we give to clients and it's to update the staff ... it's also to let them be empowered."

By these quotations, all concerned participants indicated that learning is an essential part of quality and that it is vital for sustainable quality health care.

However, a challenge relates to the integration and retention of learning in order to improve quality of developmental care services for infants.

**g. Client feedback (feedback that clients give to nurses and management)**

To improve and extend on existing client care, the input and feedback from clients are very important. When complaints from clients about aspects of the service encounter do occur, management and community nurses must use these situations as opportunities to learn and improve, rather than blame. Responses from both management and nurses were very positive with regard to client feedback and consideration thereof.

Manager: "... frequently ... I do get informal feedback from mothers that sit in my office and from mothers complaining to a councillor and then it gets through to me and then I make contact ... if the public come here with complaints, it is just Batho Pele (directly translated it means people first, but it is principles regarding the delivery of service that clients can expect), see what is going on and then I must take remedial actions." (Free translation)

Manager: "Then to keep the clients happy by addressing complaints as well as to address needs that they have identified. If, for example, they ask for a specific service, see what we can do about it." (Free translation)

Nurse: "... also for our clients too ... we can be able to see we are ... helping them. If they do have any query or any crisis or anything to ... make us aware. We do have a questionnaire for them were they can also write and put it in the box that our supervisor can be able to see if, whether we are serving them."

Person involved in training of nurses: "... in all the clinics there is now this customer care in place, so there are these suggestion boxes.

They (clients) can put in suggestions, it is opened every month.”  
(Free translation)

From the above quotations, it is obvious that if nurses are to render quality developmental care an effective system of governance is necessary. The participants identified several factors that could impinge on quality infant developmental care: induction of newly appointed staff; lack of emphasis on policies and guidelines; lack of emphasis on effective documentation; lack of attention on performance management and insufficient focus on infant developmental care as part of the training agenda.

### **3.3.1.2 ORGANIZATIONAL CULTURE AND CLIMATE**

The way people customarily behave towards each other is important if all concerned are to achieve common goals. Therefore, the strategies that management employ to inspire, challenge, motivate and unite staff in a common purpose, namely to focus on the developmental needs of infants, are important.

#### **a. Acknowledgement of input and achievements**

The kind of relationship where everyone involved (management and community nurses) has the freedom to talk and encourage each other is vital for the quality of the work environment in which community nurses have to focus on infant developmental needs among other aspects of their daily tasks in a primary health care clinic.

Manager: “I can’t manage if I don’t get feedback and ... I must determine policy with their co-operation ... they must give their input ... to get to the decision he (the manager) must be consultative, co-operative, all that actions he must take part in with his staff and if there is someone who differs or has another idea he must listen to it ...” (Free translation)

Manager: "... the person must also be open for that which come from the side of the staff, listen to their input and include them in decision-making." (Free translation)

Manager: "Someone who works together with the staff, who doesn't keep himself to one side or above them ... participative management and if I ... take a decision about something I will call them and discuss it with them before I implement it or I will put it on the table and say to them 'listen what will you do? I leave it in your hands and then you get back to me and tell me about your decision, what will be the best option' ..." (Free translation)

Nurse: "Yes we usually met with our assistant director. So she doesn't say anything whether you must keep (up) your good work or what so that you don't know whether you are working fine or what even with the with the statistics they will do the statistics and they don't tell us whether they are there gaps whether we must improve this or that so we just working ..."

Nurse: "... they stand apart from us we maybe see them once a year ..." (Free translation)

Nurse: "... I don't know, it feels as if we are functioning alone, I mean without support. You must rely on your knowledge and take care to stay within, carry on according to the protocols. Further, I don't think you must believe or dream about support." (Free translation)

Management and community nurses reflected disparate views in their responses. Management felt they involved the staff and valued their input. In contrast, the nurses felt that they were functioning in a vacuum. Some of the nurses were very vehement in the way that they described management and their relationship with them.



## **b. Investment in staff**

A milieu should be created where opportunities for staff participation and decision making are facilitated and efforts must be sustained to unleash each community nurse's potential through mentoring, education and feedback.

Manager: "Thus I will have to stimulate her by getting someone who is already qualified in that level to give them more training and to stimulate them to look at that ..." (Free translation)

Manager: "... to build good relationships with them, to motivate them ... to act as mediator with staff conflict ... to support staff during illness and personal problems and to provide emotional support where necessary ... to be available for them in order that they don't see you as someone up there, they must thus have the confidence to approach you as manager if they have a problem. It must be somebody who is emphatic, who has understanding for somebody else." (Free translation)

Manager: "... to talk with them and if necessary to jump in and assist them ... I, for example, will call them one-by-one to have a personal interview to ask how things are at work, how she feels, what makes her unhappy, about what is she glad, does she see any change, and I think they like it." (Free translation)

Manager: "... I feel in an emergency situation one can yield a little bit for certain problem cases without causing a precedent so that it becomes a general rule in your place ... also to refer, I for example referred this one to our EAP (employee assistance programme) ... for further problem management ... we have ... the support of our social workers, all these things to which our personnel can go and ... doctor L... (Name of psychiatrist) also assist with our personnel." (Free translation)

Management believed that they were investing in their staff and provided the necessary support by means of training opportunities, investing in a good relationship, applying help-giving behaviour and supplying emotional support. Responses indicate very different perceptions amongst the nurses; some were satisfied and others became very vehement on this topic.

Nurse: "I strongly believe that ... they have to encourage ... us staff to go for training ... they have to interact with ... representatives from various companies and bring them on board to give us ... in-service training ..."

For this nurse support from management is expressed via training. No other form of support was expected by this nurse.

Nurse: "Yes I do ... their support is sufficient."

Nurse: "My little doll, if I must say nil that is now very nasty if I say it like that. The only time when you definitely hear from them is when you've perhaps made a mistake ... maybe since the new assistant director has been here a person might expect more insight ... or perhaps get more insight. I don't know it feels as if we function on our own, I mean without support ... further, I don't think you must believe or dream about support."

Nurse: "... it is nasty to say, management I personally experience them as negative. The support you get from executive management is always just criticism (laugh). Its never positive, that is true it's always about you spend too much money, you dispense too much medicine, you should have managed with less and you must be able to do a lot with everything, that is what it comes to." (Free translation)

Nurse: "I can't, one can't complain about it (support from facility manager) she's in the same vacuum than us." (Free translation)

From the last quotation, it is obvious that the community nurses have a bigger issue concerning support from the higher ranks of management than with the facility manager.

### **c. Communication and feedback**

Good communication is a key skill in any team environment and the need for two-way communication, which is open and honest, is imperative in the provision of good quality infant developmental care. Again, it appears as if there is a discrepancy between the responses from management and those from the nurses.

Manager: "... we do have ... once a month a meeting so if you've got any problem that you've detected we discuss it there ..."

Manager: "... being a manager you have to go to your level where your people should render the service and you must talk to them, you must see what they are doing ... get the area manager as well as the facility managers to give feedback on what happened there ... [I have a meeting with the co-ordinator of four clinics and that co-ordinator must then have a meeting with her clinics and I may attend all. Everyone on the ground, grass root level must know what is going on, otherwise everyone is dangerous ...]" ([...] Free translation)

Manager: "... lots of times you also get more feedback and positive feedback and criticism from way below (grass root level) and then you can see where the people know what is going on. More than what you can imagine, that which in your life you didn't think how it works or will it work, but the opposite is also true. They sometimes give criticism which makes you realize that between you and them there is a communication gap, four levels of management who perhaps didn't take the decisions correctly to the other level ..." (Free translation)

Manager: "... I told them from the start that my door is open, so in other words if S... (Facility manager) is not there they knock the whole day there and ask me stuff ... call them one-by-one to have a personal interview to ask how things are at work, how she feels, what makes her unhappy, about what is she glad, does she see any change, and I think they like it." (Free translation)

Manager: "To have a good relationship with your staff, to be available for them in order that they don't see you as someone up there, they must thus have the confidence to approach you as manager if they have a problem ... to say when a mistake was made to rectify it." (Free translation)

The managers were of the opinion that a good relationship enhances two-way communication and feedback. However, the following quotations from the nurses reflect that this was not how they experienced it.

Nurse: "... I've never heard anything from them, because that is why I was thinking maybe we must do staff satisfaction questionnaire and maybe they (management) will try to see what we lack, what we want them to do ... they will do the statistics and they don't tell us whether they are there any gaps whether we must improve this or that so we just working."

Nurse: "...sometimes we do have a, a questionnaire that is for us now where maybe we're not satisfied with something where we can put our grievances and they (management) can attend to that ..."

Nurse: "...The only time when you definitely hear from them is when you've perhaps made a mistake ... it is nasty to say, management I personally experience them as negative, the support you get from executive management is always just

criticism (laugh). It's never positive, that is true it's always about you spend too much money, you dispense too much medicine, you should have managed with less and you must be able to do a lot with everything ..." (Free translation)

It is obvious that management need to be informed about the fact that they and the community nurses have disparate views on the strategies that they (management) employ to inspire, challenge, motivate and unite nursing staff in the common goal of effective health care to clients (of which infant developmental care is a part of the whole). It was only the Park Street Clinic facility manager who is directly involved with the nurses of this clinic. The researcher interviewed one other facility manager to get the perception from a facility manager employed by the City Council of Klerksdorp. Unfortunately the assistant director (AD) who is directly involved with the nurses at Park Street Clinic withdrew from the study on the day that she was to be interviewed. The researcher, however, felt that she would like to get the input from a manager in that position and asked one of the other AD's in the KOSH area if she would be willing to participate in the study. This could be one of the reasons for the disparate views between nurses and management.

### **3.3.1.3 RESOURCES AND INFRASTRUCTURE**

Economical factors can affect the quality of health care and everyone must manage available resources with care. A national policy document, The Primary Health Care Package for South Africa – a set of norms and standards (2000:12-17), reflects core standards about the availability of prints and educational materials, equipment and supplies in the primary health care clinic. Furthermore, it stipulates core management standards about staff, finance and facilities and equipment.

#### **a. Finances/funds**

Efficient operation of a health care facility can be achieved only by adopting a business viewpoint regarding expenditures. Therefore all stakeholders,

especially the community nurses, need to be aware of the funds (budget) allocated to the clinic to promote efficiency and economy.

Manager: "... we're getting about 50% subsidy from province ... out of our capital budget we can allow for air-cons for example but province has got the policy 'no nice to haves', so it's only the bare essentials that they are providing, but they also make funds available to that regard ... They (province) are paying and they are training our nursing personnel ... budget control, meaning the subsidy that we get from province I must also manage and control that in order that the ... service can run in its entirety."

Manager: "... it is the management of your budget, the control thereof ... there is not always enough money to execute all those things. We get a shortage where you have just enough money to do certain things, to assist children with milk or things like that. We get to stages when it is not sufficient." (Free translation)

Manager: "... then finances, to manage the budget and to ensure you stay within the budget with regard to the delivery of services." (Free translation)

According to these managers, funds are not readily available but the bare necessities are covered. Therefore, this should not have a detrimental effect on the focus on infant developmental needs by community nurses.

Although community nurses are not directly involved with funds as such, some of them indicated that funds were insufficient and that this shortcoming could affect their service delivery negatively and thus their ability to attend to the developmental needs of infants in the clinics.

Nurse: "Yes, because sometimes when we do order things and then we are told ... we don't have enough money, because we are

working according to budget ... if there is not enough money, then we has to wait for the next year as the budget deteriorates.” (Free translation)

Nurse: “... I can’t remember when last one has, for instance received a poster or a pamphlet apparently there is no money for such things ...” (Free translation)

Person involved in the training of nurses: “No, when you think our training is normally funded by either the province or the district itself. And that is why our training is ... aimed specifically ... If you just think every programme manager in the department of health has her own budget, but who of us have training in financial management ...” (Free translation)

Pamphlets (learning materials), as stipulated by the core standards of the policy document, should be available in all local languages in the clinic and is therefore a valid identified shortcoming. The fact that training is aimed specifically at the priority programmes, could affect the focus of community nurses on infant developmental needs negatively, as infant developmental care is not in itself part of the priority programmes but included to a certain degree in some of the programmes.

## **b. Adequate staffing**

Adequate staffing is important for the delivery of a quality service.

Manager: “... we look at the staff establishment, how many professional nurses, how many ENA’s (enrolled nursing auxiliary) we will need.” (Free translation)

Manager: “... from the 5<sup>th</sup> of November 1995 that we can’t fill any vacant posts and province is filling all our vacant posts ... shortage of

personnel ... a shortage of personnel because if you take you have to see ... 32 to 35 patients per day ...”

From the 5<sup>th</sup> of November 1995, due to a moratorium by the government, the City Council of Klerksdorp could not fill any vacant posts at the Park Street Clinic (See chapter 2). Although the North West Province filled all vacant posts, this manager still felt that the nurse: client ratio was too high. He furthermore indicated that this contributes to stress under the community nurses, as they must attempt to deliver a quality service under pressure, (“... the stress problems come from the 38 ... per day.”).

Manager: “At my level to say ... we have a staff shortage and to bring it under the attention of my manager and to say our workload per nurse is too high.” (Free translation)

Manager: “... a big problem that we’ve had for a long time is that there was no one to test hearing. There was no one appointed at the hospital to assist us with something like that.” (Free translation)

It is not only the staff at the facility as such, that could have a negative impact on the rendering of infant developmental care. The nurses at the clinic want to refer a patient for a specific service at the hospital, but are not able to do so due to vacant posts at the hospital.

Nurse: “In that one we have enough, we have enough resources, enough staff we don’t short anything ...”

Nurse: “...yes, but it is not workload in that the entire staff of the clinic is too few, we don’t have a staff shortage anymore, we’ve got a performance problem.” (Free translation)

This nurse was very frustrated as she felt that they have adequate staff as well as the necessary resources to deliver a high quality care service to their clients, but a performance problem by some of the nurses (statistics for the



individual nurses indicate the number of clients seen per day) hampered this. Hence, the developmental needs of infants in the clinic have not been addressed to the extent that it should have been. When asked if she brought this under management's attention, she just laughed. This could indicate that there is not a comfortableness to share problems with executive management.

Parent: "... I don't actually know how many staff is here and how many nurses ... therefore I will say the staff is too small, now they don't get to everyone, to speak with everyone and all those things." (Free translation)

Parent: "... sometimes there is a lack of staff ... a shortage of staff in that maybe there will only be two nurses there ... and there are a lot of people they're waiting for those two nurses to take care of them so its really not, it's not good."

Parent: "As I told you, I don't know if they are short of staff or if they just can't finish quick." (Free translation)

Nurses from Park Street Clinic indicated that staffing was adequate at the clinic. However, one of the nurses indicated that in spite of the adequate staff they were still battling to deliver a quality service to the clients because some of the nurses were not pulling their weight (this is supported by statistics for the individual nurses). Some of the parents also indicated that they perceived an inadequacy with regard to staff at the clinics that they visit because of the number of people waiting to be helped and the time they have to wait before they are helped.

### **c. Adequate equipment**

Inadequate appropriate equipment could be the cause that nurses do not deliver services, as it should be. Minimum equipment for primary health care clinics in South Africa is stipulated in a policy document.

Manager: "... resources come from them (province) ... but province has got the policy no nice to have (no air-conditioning), so it's only the bare essentials that they are providing ..."

Manager: "You know the equipment that we have ... we have but the basic tape measures, the measuring mat regarding height ... That is what we've got, but ... as we've had in the past, toys (for assessment of development) ... yes, those things we don't have, therefore equipment is inadequate ... you know if we had guidelines according to which we can function (referring to a guideline for infant developmental care) ... to then motivate that we then also has the necessary equipment ..." (Free translation)

This manager indicated that guidelines for infant developmental care could be a valuable tool, especially when motivating for the necessary equipment that could assist community nurses in delivering an infant developmental service of high quality.

Manager: "Yes, yes we do."

Nurse: "In that one we have enough, we have enough resources ... we don't short anything."

Nurse: "Equipment is sufficient."

Nurse: "We don't have enough infrastructure ... sometimes you will find that like the scales maybe there is not one in every clinic ... you have to wait for other people for other things, there are not enough. If maybe everybody has got ... all the equipment in his or her cubicle I think it would be easier that way ... even the transport I didn't include it also maybe we want to do the home visits then sometimes you lack then they (management) don't understand so much with the need ..."

This nurse had a very positive attitude during the interview, however, the last sentence could hint at dissatisfaction with the support from management. Home visits are part of the community nurse's job description (it is also sanctioned by policy) and if transport is not available, then she has no means to fulfil this part of her job description.

Nurse: "The only problem we have actually is our telephone lines ... they do not go out so if you have to ... make a phone call, let's say to the psychologist, then it becomes a problem ... but I would say it is fine actually."

Nurse: "... basically we can't phone out anymore ... we only have certain codes, you can phone only certain places ..." (Free translation)

Person involved in training of nurses: "... we use a pool car and you must literally fight for a car to drive around in the district, for instance. That is number one, number two access to the Internet is limited ... and here there's no additional costs coupled with it to get access." (Free translation)

Although most of the staff indicated that they were satisfied with the equipment, some indicated specific shortcomings, e.g. not enough scales, limited access codes for outgoing telephone calls and lack of transport. The only shortcomings, according to the researcher, that might have a negative impact on service delivery for infant developmental care, is the limited access for outgoing telephone calls and lack of transport that could prevent them from following-up after referrals to ensure continuity of therapy and thereby improving the expected outcomes for the infants. More scales and specific toys to assess development would be nice. However, the staff could improvise and thereby enable them to assess the development of infants.

#### **d. Appropriate facility**

The facility, and more specific properties such as space, safety, comfort, ease of access, privacy as well as the aesthetic, can affect personnel functioning as well as the clients' perception of the delivery of service.

Manager: "... I would say floor space it is definitely also, a problem ... I had a request the other day from social welfare ... to make some rooms' available, consulting rooms for them. I couldn't do it because I got no facility we have no accommodation for them ..."

Nurse: "... I will say it is fine actually."

Nurse: "... here in our clinic now there is a little bit of ... infrastructure where they deter us in our daily working, because as you can see we've got few toilets. That's where the problem is and it is not easy for the female to go to the same toilet with male it's giving us a little bit of a problem ... the facility, yes it's not so good."

Nurse: "... now I will say lend itself to that end (appropriate facility), for months it didn't when T... B... (Name of manager) was here upstairs (floor space was then limited), but now it's better (manager moved to another building). It's still dirty in certain places, we received paint as a present, but it feels as if I'm not as ashamed to work here, because at one stage I was ashamed to work here. It was very inadequate with all the services squashed into one room ... we can't complain anymore." (Free translation)

At Park Street Clinic, some (management as well as community nurses) felt that the facility was sufficient while others indicated that there were certain

aspects of the facility that could be better. According to the researcher, none of these would have a serious impact on the quality of infant developmental care.

Some of the participants felt that resources and infrastructure are adequate while some felt that there are certain important things lacking. Although there were no serious identified shortcomings, it is important that management and the nurses discuss these issues collaboratively to find an efficient solution for perceived inadequate resources that could deter them in their daily functioning pertaining to infant developmental care.

#### **3.3.1.4 INTERAGENCY COLLABORATION**

Interagency collaboration is an important aspect in quality infant developmental care. In a holistic approach to infant developmental care a combination of health care providers, working in unison, will meet the users' needs better.

##### **a. Liaison and meetings**

Collaborative efforts are strengthened by networking, because it enables all stakeholders to draw upon multiple resources and competence to accomplish the desired goal of management of infant developmental needs by community nurses at primary health care level. Management from the various agencies (the Provincial Department of Health at subdistrict level, the Provincial Hospital and the Department of Health of the City Council of Klerksdorp) are currently networking (merely to address problems) and although they have formed an informal linkage and relationship they each still continues to plan and carry out their own services autonomously. Community nurses unfortunately, are not part of this networking as it is viewed as a function of the executive management and there are official channels according to which these aspects are addressed.

Manager: "... then we've got the meetings every third month with ... more the maternity section at the hospital where cases and referrals are being discussed ... you know it becomes known at the

meetings ... if there are any problems between the clinics and the hospitals ... so they are aware.” (Free translation)

Manager: “... we’ve got on management level also frequent discussions between myself, district office of health and the hospital ... there’s a very, very good relationship between district office and myself ...”

Manager: “... as I’ve said we’ve got regular meetings ...” (Free translation)

Manager: “... we report these things to management at the level higher than us and they take it to central meetings with the hospital ... so it moves up through the channels.” (Free translation)

In summary, although interagency collaboration is an important aspect for the delivery of infant developmental care and partnership opportunities are there for the taking, it is not something that management and the community nurses from Park Street Clinic could address on their own. However, networking is taking place and all stakeholders involved gave the first step in the right direction.

### **3.3.2 DEVELOPMENTAL CARE OF INFANTS BY COMMUNITY NURSES**

Investing early in infants, children and their families could prevent health, education and social problems in the future. The health care system plays a central role in promoting optimal infant health and development; community nurses specifically as they have regular access to women, infants and families thereby providing an important window of opportunity to positively influence infant health and development.

### 3.3.2.1 RIGHTS OF THE INFANT TO DEVELOP TO FULL POTENTIAL

The argument of infants' rights is based on the fact that infancy is a period when the rate of growth outpaces the growth rates at all other stages and is highly influenced by environmental supports such as nurturing parents and quality care giving. "To allow unmanaged disability and arrested development to occur in children is a violation of their basic human rights. A greater obligation to protect and help children arises from the fact that they are dependent on others for satisfaction of their rights. The support of the healthy development of the child is thus of great importance. A distinct goal in caring for children is to identify, as early as possible, developmental delays and disabilities, and to provide appropriate services and support" (See chapter 1:1).

All of the participants were of the same opinion; infants have the right to develop to their full potential. They gave various reasons why they believe infants have this right.

#### **a. Infants cannot speak for themselves**

Infants are dependent on others and this creates an obligation to help and protect them.

Manager: "Because they are not there to speak for themselves." (Free translation)

Manager: "I just think somebody must accept responsibility for it, because a child can't do it, he can't tell you I can't lift my head ... I mean he can't tell you there's a problem therefore somebody must do it on his behalf." (Free translation)

Parent: "And in the end it depends on the parents and all the people with who he gets to deal with, when he can't decide for himself if he wants to do it or not ... to take that decision for him yes." (Free translation)

The foundation for general wellbeing is established at a very early age. Community nurses can help to ensure this by providing the necessary support to parents and by making them aware of the fact that their infants are dependent on them for care and protection, as they cannot speak for themselves.

**b. Aim of life to develop into an independent adult**

Infants are the future and that future lies with parents, and all others whom these infants will have contact with throughout their lives.

Nurse: "Because the baby has also the right to live, has also the right to as I once was a baby and I was given the chance to become adult to see what I was supposed to do ... That baby also has the chance to know to the fullest potential what he was brought for ... here on earth."

Nurse: "Because they are also human beings they want to develop to a stage (adulthood) like any other child."

Parent: "It is every child's right to develop up to there (adulthood). It is a new life with the right to be healthy and to develop into an independent adult. That is surely the aim of life, so that as an adult he can bring his full part." (Free translation)

Parent: "Because he must develop in full so that one day he can do something for us as well." (Free translation)

Parent: "... I think everyone is capable of much and in the end, it counts against the child when he is an adult. He won't have the skills and things, in other words he won't live the life that he could have lived if his potential does not develop." (Free translation)



Early childhood intervention has the potential to improve physical, mental and social capacity thereby assisting with this transition from infant into independent adulthood.

### **c. Burden on the community**

All families want their infants and children to grow into persons who are well developed physically, mentally, socially and emotionally, thereby placing them in a better position to contribute to family, community and country.

Manager: "It ... is important to them (infants) I mean if they are delayed or if they are not developed then they have a handicap in the life ahead, then they become a burden for the community in the long run." (Free translation)

Nurse: "Yes, I totally agree with it, because how do they go further ... if they are for that matter not stimulated in those first two or first five years and can't develop normal, then they will be a burden for the government for the rest of their lives." (Free translation)

To prevent infants from becoming an economic burden it is important for community nurses to focus on the developmental needs of infants at an early stage, thereby enabling them to thrive.

### **d. Parents' responsibility**

Development happens as infants responds to, learns from, and seeks to affect their environments. It occurs in interaction with people and things. For this reason, parents have a responsibility to provide an environment that would foster healthy development of their infants.

Manager: "Being allowed by their parents to be developed absolutely to their capacity ..."

Nurse: "... it's also their human right, the infant you know, they ... also have the right to get whatever are they suppose to get you know from us, we adult ..."

Parent: "To assist them (infants and children) more, to show them what is correct. To talk to them, yes communication that is very important and then health, I will do everything within my power to keep them healthy to take them for their injections and to see to it that they eat healthy." (Free translation)

Parent: "I will help him to develop in full by being with him. To educate him ... yes I will ensure that he stays healthy, he gets all his injections and I check that he eats nicely." (Free translation)

Parent: "I think it's wise for every parent to read more meaningful material. Get some information anywhere ... and make sure that he takes the child to the clinic for check-ups ... and identify if there's any problem ... pertaining to the development of the child."

Parent: "... I rather believe in things like this Mothers and Miracles, and music and so forth ... I think in the end to spend time with your children and to check who is taking care of your child if you work. And there are people who for instance don't believe in the routine examinations done by paediatricians and ... while I think it is important." (Free translation)

Parent: "Every baby has the right to develop to his full potential ... with the necessary stimulation you can even help your infant that was born with a delay, to go further than his possible limits. As a parent it is your God given duty to assist your infant in every possible field, especially development." (Free translation)

From these quotations, it is obvious that all participants felt that parents have a definitive responsibility towards their infants' development. Community nurses can enhance this process by assuring that parents receive information on issues such as nutrition, safety, child-rearing practices, development and behaviour, and support.

#### **e. Government priorities**

As discussed in chapter 1, the various divisions in the department of health are responsible for programmes that impact directly or indirectly on the health of children. Each has specific programme-related goals and objectives and various national strategies and programmes stem from these goals and objectives.

The researcher asked management and persons concerned with training of nurses if enough is being done by authorities (government, province and City Council of Klerksdorp) to articulate priorities pertaining to the management of developmental needs of infants. The following quotations indicate how they perceive this articulation of priorities.

Manager: "I think with all the schemes (priority programmes) that are instituted you know there is PMCT (prevention of mother-to-child transmission), for children there are several things which they institute." (Free translation)

Manager: "... my assumption that there's more ... emphasis on the HIV/AIDS problem at this moment than on the development (of infants) ..."

Manager: "... I mean it is part of the routine at a specific facility that you ... apply ... mother and child and women's health (this manager indicates that infant development is a component of MCHW). But, I think the people do see it just as part of the routine ... No I don't believe at this stage there is really a lot of support (by

authorities) in that area (management of infant developmental needs in itself).” (Free translation)

Manager: “... no, not specifically regarding development of babies and early identification of developmental delays. Currently the biggest priority is HIV, anything concerned with HIV. In a way development of babies is addressed in some of the programmes.” (Free translation)

Person involved in the training of nurses: “If the baby and child development have anything to do with HIV. Then it is a priority for the government, and with that I mean such as ... transmission of HIV from the mother to the baby ... ARV (anti-retroviral) treatments for children things like that ...” (Free translation)

All the participants agreed that there were priorities, but according to them, the development of infants is addressed as a component in some of the programmes and that it was not a priority programme in itself. The biggest priority currently, is HIV/AIDS.

In summary, although all concerned agreed that infants have the right to develop to their full potential, they furthermore agreed that they as service providers do not uphold this right of the infant. The right of infants to develop to their full potential should provide the cornerstone for the management of infant developmental needs by community nurses.

#### **3.3.2.2 FOCUS ON INFANT DEVELOPMENTAL NEEDS**

Infant and child health care is an integrated part of primary health care and there is a critical need to not just maintain, but also to actually optimize the health of all infants and children. Community nurses are in an ideal position to focus on the developmental needs of infants. Therefore, they can play a vital role in ensuring that the health of infants is optimized. The various participants

gave several reasons for this lack of focus by community nurses on the developmental needs of infants.

#### **a. Perception of management**

Management should have knowledge of specific aspects (scope of practice, policy documents, job descriptions) regulating and prescribing service delivery by community nurses in a primary health care facility. Therefore, they should be knowledgeable about the degree that community nurses focus on developmental needs of infants.

Manager: "... I get the word that they are concentrating on it, but I can't say I haven't checked on that one. I rather at this moment concentrate on immunisation and things like that than the developmental side of ... the infant ... My assumption that there is more ... emphasis on the HIV/AIDS problem at this moment than on the development ... their aim is not, your aim is to, to develop the infant and that's not their aim at this moment, the aim is more curative."

Manager: "... we do with the immunization, we do the development with all children accordingly to the age and everything ... every baby when you see him, whether ill or whether you do immunization, and you do his full development. You weigh him, you do his head circumference, you look at his development, all those things, so I can't think, I mean every nurse knows it is her duty and it is explained on the road to health chart. Therefore I can't think (that community nurses do not focus on infant developmental needs) ..." (Free translation)

This manager felt indignant about the idea that community nurses do not focus on infant development. Even though the researcher brought it under her attention that several nurses revealed that, they do not focus on infant

development she (the manager) still felt strongly about the fact that nurses know what their duty is and that they do focus on the development.

Manager: "... I think the people do, see it just as part of the routine they won't especially go out of their way ... yes, the growth more than anything else ... on the other (other domains of development), no." (Free translation)

Manager: "... in the past a time was set apart for milestone development ... now due to the structure of health, more services were shifted off to the clinics and we have an overload of patients and we have too few hands and there is not a time to arrange specifically for milestones. We pick it up with the handling of the babies during an immunization clinic ... but, it is being done incidentally, it is not being done by appointment as it was done in the past ... it's a shame, but it is part of the work that is being done in a slipshod manner, I am very honest with you." (Free translation)

Manager: "... yes, because the services that we get is rather curative, it is chronic conditions, it is TB (tuberculosis), epilepsy and psychiatry that also. Now all sorts of services are shifted off so that the children actually bit in the dust, especially your normal, healthy baby clinics ... is not being done, indeed I am very honest, it is being treated shabbily ... it basically comes to that we don't meet our responsibilities regarding this children." (Free translation)

According to most managers, the focus on the developmental needs of infants by community nurses is not as it should be. Reasons for this lack of focus could be underpinned by the major shift in health care from a mainly hospital based to a mainly primary health care focussed health care service and with it, according to these managers, a more curative than preventative aim.

## **b. Perception of community nurses**

The essence of community nursing is promoting and preserving the health of members in the community, with no age limit defining their target audience.

Nurse: "I think all the health workers it is their responsibility ... I think if the child come you ... must observe in totality so that you can be able to refer the child ... so we are also responsible ... I think it should be done actually, ok but sometimes you, we overlook that ... We must do everything ... so that we can be able to detect even some of the things that the parents didn't bring that children for."

Nurse: "It is very important to identify, even if I mean the child can come with cough that if you do ... the ... milestones ... even nutrition. You can check something out the child didn't come with ... routine check-ups is very important or maybe the mother say the child has ear infection, don't just check the ears, check the lungs ... the milestones because I'm worried a lot with the milestones."

Nurse: "I think for prevention, community health nurse ... it's her responsibility to prevent complications."

Nurse: "On the illnesses, but not the development ... I would just establish if ... the milestones ... up to scratch and if the baby's psychological ... you know wellbeing it's OK ... but like I'm saying actually it's rare that ... I assess ... the developmental process".

Nurse: "I think it must be everybody's responsibility wherever the child lands up, but a child doesn't easily get to a physiotherapist or occupational therapist unless a community nurse refers him or diagnose or pick it up somewhere or a doctor ... but, if he

eventually lands up there then it is everybody's responsibility."  
(Free translation)

Nurse: "... I think it will differ from person to person ... a nurse how dedicated she is, how she considers her work ... not always focused to ... physical to check the milestones when you, the immunization, I talk about myself personally ... I think sometimes the milestones or the other signs and symptoms are perhaps not really noticed." (Free translation)

Although the community nurses agreed that it is their responsibility (the essence being promoting and preserving health) to focus on the developmental needs of infants, some of them felt that it should be a shared responsibility among all health care professionals. If they focus on infant developmental needs, it was inconsistent and not according to a specific guideline or protocol. Their focus was mainly on growth and nutrition, as stipulated in the priority programmes, and maybe a review of the milestones.

### **c. Perception of people involved in the training of nurses**

The changing face of health care suggests that continuing education is an important aspect in the delivery of quality health care service, including infant developmental care. However, providing continuing education for community nurses in a primary health care clinic would require professionals with in-depth knowledge of every aspect of service delivery, including infant developmental care.

The two people interviewed had very different opinions regarding infant development as part of the community nurse's function in the clinic.

Person involved in the training of nurses: "I view it since I am ... from that new course, I view it as important ... it's been taken as it's usual, it's like it's a usual thing ... you take it for granted ... they know about the infantile growth ... there is a gap ..."



This participant indicated that since she came back from a course that she had done, she regarded infant development as an important aspect of the daily task of the community nurse in the clinic. She also felt that there is a gap between the typical (what is happening on a daily basis in the clinic,) and the ideal practices pertaining to infant development. She furthermore indicated that she assumed that community nurses are knowledgeable about infant development. Moreover, she regarded her own knowledge about infant development as lacking “I do have according to what I got from that course, but I feel I still need more.”

Person involved in the training of nurses: “In a first world, yes, but not in a third world ... in a first world you see 15 patients per day ... You have enough time to do infant development ... The reality of the clinics is that you see 60 to 70 people a day and it entails crisis management ... this shopping approach (one-stop shopping approach) makes it very difficult to set time apart for something like that. However, I think it has a place; it must have a place, but in reality, I don’t think it happens like that.”

When asked if it is possible to work towards the ideal, to close the gap between reality and the ideal, she answered “Maybe, if I have worked for three months in America, then I would be able to answer that question, but not here on the ground, I don’t think so.” This indicated to the researcher that before any change concerning delivery of infant developmental care could even be anticipated, a mind shift would be necessary and the knowledge base of the professionals involved in training should be enlarged and specifically pertaining to infant development as well as early childhood intervention.

#### **d. Perception of other health care professionals**

An array of disciplines has been acknowledged as being important in the provision of comprehensive health care for infants and their families. Their input about the community nurses’ focus on infant development is therefore very valuable. Especially as indicated in chapter 1, that rehabilitation

professionals involved in early childhood care in South Africa experience it that the “diagnosis” of developmental disability is done much too late for effective intervention. Mothers and caregivers bring infants too late for evaluation of their development “due to a lack of knowledge about child development and the functional skills (milestones) children should reach at certain stages”.

Other health care professional: “... at this stage I feel it, for me the milestones are totally too broad ... the other thing is one only looks at motor development most of the time and talk a little bit about does your child chatter and you ask maybe about the hearing ...” (Free translation)

Other health care professional: “... I see that ... often when our patients are ... referred ...for bronchitis or treatment of pneumonia then ... whilst we ... treat the child for the lung problem ... one will realize, you know what is the age, that he is really far behind with his development. Sometimes a 3 month old baby cannot for instance lie on his stomach or roll ... one see it when you handle and pick up the child ... I really feel by then the child is how old and nothing has been done ...” (Free translation)

Other health care professional: “... at a primary care clinic that nurse, who is there, is the first contact person so the ... mother with a baby will always go there first, because they go there for medication or whatever ...” (Free translation)

This participant sees the community nurse as the first point of contact in health care and therefore their focus on infant development is important.

Other health care professional: “... if a nurse at one or other stage or even a doctor could tell them, but you know by now he should have been able to sit on his own and turn over on his stomach on his back and things like that then he most probably would have received help earlier ...” (Free translation)

Other health care professional: "... if a nurse ... when he received his immunization, if she then picked up that he is behind with his milestones she then could have made the parents take it to heart that this little one is a bit late and one must start looking at it and if she could tell them, type of steps, that they must realize that it is important ..." (Free translation)

Other health care professionals also felt that the focus on development by community nurses is not as it should be even though they (community nurses) are the first point of contact with health care. They totally agreed with the statement that nurses do not identify developmental delays despite the knowledge that early detection leads to better outcomes. They also felt that nurses focus mainly on growth and motor development of the infant and they either overlook all the other domains of development or address it very briefly. Furthermore, they felt that nurses do not give enough attention to enlarge the knowledge base of parents on infant development.

#### **e. Perception of parents**

Parents should be regarded as partners in the infant health care team, as these partnerships generate win-win outcomes. This can only be achieved if the input from the parents are acknowledged and respected. Hence, the researcher felt it was necessary to gain insight in their perception of the focus on infant developmental needs by community nurses.

Parent: "... I don't know if it is part of the service ... those services ... I don't know that they are to do it and all those things ... no I would really like to see it, but that I received more at the hospital." (Free translation)

Parent: "No, no (indicates that community nurses do not focus on infant development) ... because when one goes to a paediatrician or to a doctor then they always want to know more, does he sit or

does he smile ... and so forth and that is not what they are doing at the clinic.” (Free translation)

This parent compared the infant developmental care she received at the clinic with the care that she had received during her visit to the paediatrician. According to her, the care by the community nurses at the clinic lacked. This is very unfortunate as not every parent has the means to take her infant to a paediatrician for an assessment.

Parent: “... they don’t examine the child always we complain, always about that thing.” (Free translation)

Parent: “No they didn’t do that (indicate that a developmental assessment was not done).”

Parent: “No they don’t do things like that.” (Free translation)

Parent: “They don’t examine the babies, they only weigh them and that is most probably why most of our children’s problems are not identified.” (Free translation)

Parent: “Only at the hospital, but here not ever ... in the days when it were only coloureds, because then the service was very good. Then they looked well after our children. They undressed and examined them. Now they are too busy and they don’t do it any more.” (Free translation)

Parent: “... we undress them ... because they give the injections on the buttocks that is it and then it is just the drops that they drop in his mouth, but nothing physical.” (Free translation)

Parent: “No it must, yes it must be important ... so that we can know ... are our babies healthy.”

Parent: "... it is my child's health I want them to examine my child, but they haven't examined my child." (Free translation)

Parent: "We normally take them for injections immunizations and it is then there that they can detect if there is any wrong with the child."

Parent: "They must ... examine the child because, maybe you come there then the child is seriously ill and then they don't have that time to examine the children, maybe the illness took the child for a long time and then they only notice it now and then it is too late."

These parents realized the importance of having their infants' development assessed. They indicated that it was either not done or that the focus had been only on the growth of the child.

Parent: "... You know I think I would really recommend things like a clinic and examinations say for instance on a monthly basis ... so that one can enlarge the chances that it could be picked up." (Free translation)

Parent: "... I feel it shouldn't be purely medical focused, but also around my child's development. Because I, a mother don't naturally know these things unless if it is a little bit in your professional field, but irrespective of your professional field ... the average mother don't know things like that ..." (Free translation)

These parents indicated that they regard their infants' health and development as important. Moreover, they felt that community nurses should focus on infant development, as early identification and intervention is imperative to their infants' wellbeing and optimal development.

Parent: "... we were questioned with interest about the development of both the boys, their health and if there was anything about which we wanted to ask questions. Both boys were weighed, where after their progress were monitored and discussed with us ..." (Free translation)

Parent: "... if the queues are long somewhere along the way these nurses get tired and they don't really give the kids a thorough ... they don't give the kids thorough attention that's why I said I'll go to a private clinic because I know with the private clinic you have an appointment you know that at that period the nurse will be ready and she would really give your child all the attention and she'll go through it thoroughly."

These parents were in the fortunate position of attending a private clinic, where it seems as if the community nurse focused on their infants' development.

In summary, it came across that some of the parents were not aware of the fact that developmental care should actually be part of infant health care. Most of them who attended a provincial primary health care clinic, felt that the nurses did not give enough attention to their infants' development. On the other hand, most parents who attended private clinics felt that the nurses gave attention to their infants' development.

#### **f. Assessment of infant for developmental delays and disabilities**

The researcher focused on the following four elements of assessment: 1) Target of assessment (do they focus on just the child or do they include the family); 2) Context of assessment (does the assessment occur in the clinic or within naturalistic settings that are comfortable, familiar and non-threatening); 3) Methods of assessment (approaches used to assess); and 4) Assessment personnel (single source approach versus multidisciplinary team approach).

Manager: "... we do with the immunization, we do the development with

the children accordingly to the age and everything ... emotional ... [you weigh him, you do his head circumference, you look at is development all those things] ..." ([...] Free translation)

Manager: "... with the road to health chart where things are noted upon, the weight of the baby that is charted and ... you can see according to that if the child ... gained weight ... more the growth than anything else." (Free translation)

Manager: "... I mean it can be sensory, it can be motor, social behaviour what ever ..." (Free translation)

Nurse: "I don't think there is a right opportune time. The right opportune time is that time when you get contact of that baby ... you can ask the mother ... the hearing and if he can see, if that child can talk and ... the milestones and if the child ... can use ... the limbs ... those we can check."

Nurse: "... as the child comes every time I must assess whether this child is still developing in the normal way of development. I must always assess keep on assessing until the child reaches 5 years where you are going to give the last immunization ..."

Nurse: "It is very important to identify even if ... the child can come with a cough that ... you do ... the milestones ... even nutrition. You can check something out the child didn't come with ... You start with the length to see whether the child is growing, the head circumference then you compare with ... that on birth and then the weight you ... compare it ... to see if the child is developing and with the milestones, the head, the neck you just pull the child to see whether it is loose ..."

These nurses indicated that infant developmental assessment should be a continuous process during all health encounters. Community nurses should

focus on the development of the infant as well as parental concerns and encourage parents to become active partners in the process of assessment.

Nurse: “Weight ... according to age, height according to age and then any movement, speech ... to bring just monthly to this for the assessment even if the baby is not sick so that the baby can be just checked at the clinic.”

Nurse: “... when I assess the child or infant I actually chose now to follow this IMCI strategy ... actually I would just establish if you know the milestones actually you know up to scratch ...”

Nurse: “Normal development one must always just make sure if the milestones of the child have been reached ... One check the child’s state of disease, you check his physical condition, you check his nutritional status, but this I must also include I think instinctively you are focused to immediately pick up a defect. I mean we all know what a healthy baby looks like ... one must maybe be more tuned in to not only look after the physical because I personally would like to profess it is like that.” (Free translation)

Most of these nurses did not indicate domains other than physical growth, nutrition, milestones and motor development. Important aspects such as socio-emotional development, intellectual development and family functioning were not included.

Nurse: “I think first of all you check if there are any defects and say you get a or there is a defect that comes under your attention then you focus on it ... then you do what you can, I mean it makes sense, I mean if there is nothing wrong then you’ve got nothing to focus on ...”



This statement by the community nurse indicated the predominance of the medical model in service delivery. It could further indicate an absence about the awareness of a strengths perspective in working with infants and families.

Nurse: "... more about the physical things, what is the child drinking, does he eat enough, does he get all the vitamins. I think sometimes, if I want to be honest, we, I can't generalize, but everyone is not focused anymore on those things as one used to be tuned in on the development ..." (Free translation)

Nurse: "... maybe one should ... immunization chart indicate certain times, say for instance at age after birth, three months ... three times or directly after birth and then again at three months, then at 18 months or at your nine month visit that there are guidelines." (Free translation)

This nurse indicated the need for a specific guideline to assist them in infant developmental care. If they have a guideline, according to which they can operate, it would assist them in directing their focus on development as well as guide them with the assessment process in itself.

Other health care professional: "... one must actually be able to look at small things such as can he sit up from lying down, know his stomach muscles are poorly developed, his hips are not developed right ... he doesn't get rotation of his body, such type of things ..." (Free translation)

Other health care professional: "... you don't have to go and do a complete neurological examination. You can with basic simple movements and the handling of the child feel if there is hypo tone or hyper tone ... this child's head does it pull backwards when you pick him up or what ever." (Free translation)

Other health care professional: "... we have that evaluation form with the small sketches and to say at that age the child must at least have at his disposal three or four milestones ..." (Free translation)

Other health care professional: "... you see the child yourself so you know now this child is three months old and besides all the other things that you measure and check, the weight and all those things ... a child of three months must at least be able to lie on his stomach, supporting with his arms ... he shouldn't pull backwards when you pick him up, he must have an extent of head control." (Free translation)

Other health care professional: "... four or five of the most important points and then if one picks up from out of that five, for the sake of argument, that four are not according to what the evaluation form says, then you must just start to ask questions ... was it a difficult birth, was the cord around the neck? And then one can deduce from that, that you could expect problems or was this baby a prem (premature), is he going to initially develop slower than his normal full term baby or what ever." (Free translation)

These participants felt that by doing a physical assessment and obtaining a thorough history from the parent, one could deduce if there is a developmental delay or disability present.

Other health care professional: "I think ... it would be good if the nurse ... has a decent ... checklist, for different developmental milestones, at this stage it feels for me the milestones are far too broad. They, for instance look at what a baby, at the age of three months and six months and eight months and 12 months, must be able to do whilst in the first six months specific milestones happen weekly." (Free translation)

Other health care professional: "... it can be ... to detect big problems ... but if the baby have got smaller things, most likely it won't be as effective ... to do it with a checklist, but maybe if you've got a checklist and you do it long enough then eventually ... it will be part of your work procedure because it will be knowledge which you've got ... at hand." (Free translation)

Other health care professional: "... the other thing is one only looks at motor development most of the time and talk a little bit about does your child chatter and you maybe ask about the hearing, but there is no decent ... checklist that is in use that look at all the things like parent-child bonding, parent-child interaction ... development of communication. Those things remain in abeyance ..." (Free translation)

Other health care professional: "My personal opinion is that a checklist is a good thing, because in the first instance in a clinic time aspect is a big problem ... because the nurse hasn't got that in-depth knowledge about what the therapist is seeking for intervention, planning. It is just necessary that one have basic information for the sake of referral. So and ... I think a well compiled checklist can address the problem of time." (Free translation)

For these participants a checklist would be of great help to the community nurse in her assessment of infant development. However, one indicated that a checklist might not be as effective in all the cases. The community nurse would need to have the necessary knowledge at hand to enable her to realize the shortcomings of such a checklist.

Other health care professional: "I think there must be looked at what nurses use to evaluate ... in the first instance there must be a decent measuring-instrument, there must be a good questionnaire or checklist for ... more ages I can say and it must be more complete. Even if it is a short questionnaire that the parents can

fill in, I know time is limited and one can't expect that the nurse must have a whole diagnostic session about it, because basic, well placed questions can give you enough information to indicate referral is necessary ..." (Free translation)

Other health care professional: "... a complete team effort was applied, together with the family who also sat in to solve the problem and to see how one ... can do it ..." (Free translation)

The most important aspect, indicated by the other health care professionals, is the dire need for a specific assessment instrument. However, there was a difference of opinion of what this instrument should look like.

Parent: "Measure yes, that they've done at the hospital." (Free translation)

Parent: "They normally weigh them before ... we get to her ... they don't measure them ... because if one goes to a paediatrician or a doctor they always want to find out more, does he sit or does he smile or so ... and so forth and that is not what they do at the clinic." (Free translation)

Parent: "Yes there are mothers who for the first time have babies then you don't know if the child is blind or deaf and such things they must also examine." (Free translation)

Parent: "Yes he is weighed ... I don't know if the scale is coupled with that, but I haven't seen that yet ..." (Free translation)

Parent: "... yes they've measured her head and her body." (Free translation)

Parent: "Yes, yes (answer in the affirmative that the community nurse has weighed the baby) ... eh uh (no) ... no." (Indicate that the

community nurse has not measured the baby's height and head circumference)

Parent: "Yes they weigh them it's the first thing that they do." (Free translation)

Parent: "No I haven't seen, they don't do it." (Free translation)

Grandparent: "With the baby they put him just on the scale." (Free translation)

Grandparent: "Yes, because I say he must check the child, because they are nurses they know it. They must tell me 'grandmother it is so-so I see ... maybe he's fine you treat him well' or 'no, it's not right you must do this and that you see'."

From these parents and grandparents' responses, it is clear that the focus is purely on growth, and then only on the weight as few indicated that height and head circumference were part of the assessment.

Parent: "Yes she took the baby's weight ... there was a measuring tape where she measured the circumference and then the length yes ... and she also tried to see if the baby ... is able to balance ... on the floor and to see if there's any development ... and then there was, she make the toy ... she rattled it to see if there's are any ear conditions."

Parent: "Yes, yes, yes (indicated that the infant was weighed and that the length and head circumference were measured) ... didn't get a lot of attention (referring to language and intellectual abilities). (Free translation)

Parent: "They've ... placed him for instance in front of the mirror and held toys for him and so forth ..."

Parent: “Yes the first time, you know the basic information, how many children do you have and how many pregnancies I had and what type of births, but not a thing further.” (Free translation)

Parent: “They were weighed and measured and their developmental milestones were assessed. Questions were also asked about this ... their progress were monitored and discussed with us ...”

Responses from these parents, who attended a private clinic, indicated a more comprehensive assessment by the community nurse.

In summary, most participants agreed that the focus of the community nurse on the developmental needs of infants was not as it should be. From the responses, it is clear that community nurses are not well prepared regarding the elements of assessments. When the researcher questioned the nurses about their pre-service training, she asked them whether specific topics were included. These included infant developmental theories; factors that influence growth and development; ecological perspective; family dynamics; socio-cultural aspects; best practice principles of assessment and intervention; zoom lens approach to assessment; social utility approach to assessment; resource-based approach and different service delivery models. Some of them indicated that the first five topics were included. Most of them have never heard about the other topics and indicated that they would like to get more information about it.

It was the odd nurse, who indicated social behaviour, emotional development and sensory development when assessing development. They also indicated that they have no standardized guideline or specific instrument according to which they can assess the infant and each is doing her/his own thing. Assessment was done in the clinic (if it was done) and no other disciplines were involved in this process.

### **g. Promoting development**

It can be expected from community nurses, as supporters of health promotion, to devote a significant amount of their time to the promotion of optimal development. The fact that developmental problems have been identified as the new morbidity of paediatric practice, once again emphasizes the importance for the community nurse to focus on promoting the healthy development of infants.

Manager: "... we do give ... health education and everything to the mothers ..."

Manager: "That's right it comes in basically with health education ... you are going to give her guidelines in the first place about feeding of the baby ... feeding plays a very important role. If the child does not get enough feeding then he won't develop sufficiently and maybe give her education about the different stages of development and to say ... at so many months your baby is suppose to do this and this. Can your baby do this and this already ..." (Free translation)

Nurse: "... to teach the very same mother as ... the child is developing. Well to ... congratulate her to keep on doing whatever so that the child is growing well and ... the diet that she is giving it is a good diet and the way she is bringing up the child is fine, it's how it can keep it up."

Nurse: "... I can give health education to the mothers they must keep up with the standard of their taking care of the child. If there is any abnormalities they must come to the clinic and tell us what is what."

Nurse: "... the mother has to be encouraged to breast feed the baby so that they can get a full development ... I congratulate the mother

in the first place on how well the baby is being taken care of and then encourage the mother to keep up, re-educate about diet, nutrition and then the care of the baby and then to bring just monthly to this for the assessment even if the baby is not sick so that the baby can be just checked at the clinic.”

Nurse: “... I often say when a child is supposed to start sitting, put him in a box. Give education to the mother, put things a bit further if he wants to crawl, leave him that he crawls don't pick him up, know that he will go through different stages, so you give education about that to them ... let me say honestly it's not always done as wonderful and I also won't say always as comprehensive. One gives it at a next time ...” (Free translation)

Nurse: “... There must be more information available that you at least can give for the mother to take home and tell her from birth keep this, stick it to your chart and look after it well so that it can also be a guideline and report if you see there is something definitive.” (Free translation)

These nurses all indicated that imparting information is important, but they also indicated that they viewed appraisal support as part of providing information. Some of them indicated that the focus should be on developmental stages. However, none of them indicated that the content should be individualized and discussed at the level of the parents' cognitive, cultural and psychological readiness.

Other health care professional: “... I think a carefully worded checklist ... it is also something that can be given to the parents in the form of a pamphlet ... they can read through it leisurely at their time ...” (Free translation)

Parent: “She never said a thing so that I kept asking her ... questions ... the only thing that she gave me was a pamphlet were they



talked about immunization because I took him for immunization so it was stated the after effects what I should expect after the ... I think she could give more information."

Parent: "No (didn't receive any information on development) ... yes I got ... myself ... books just the Living and Loving, this type of books about babies. ... I think I also made a mistake that I now didn't ask. Maybe that is also where the problem lies, but I thought it's just automatic, it's being done automatic ... the giving of information and so forth." (Free translation)

Parent: "... I very much would like to hear about all these things, but ... I mean, see we can't ... expect that they ... individually must give attention, because then what will happen to their work ..." (Free translation)

Parent: "Not ever I tell you, it is just the basic. They only do the injection and then you go home, there's no conversation about family planning, what you can do, advice and those type of things, no nothing." (Free translation)

Parent: "Each child is different, I mean no two babies grow the same and they must point that out. Then babies cry often and especially new mothers don't know why babies cry, they can't talk so they can't say what is wrong. They must therefore teach us why babies cry so much." (Free translation)

These participants indicated their dire need to information. Unfortunately, they never voiced their need and the community nurses never anticipated this need.

Parent: "I observed it at the hospital. My eldest boy was born prematurely and he was for two months in the incubator. Whilst I sat there by him and wait, I heard what the other mothers talk and further doctor v... T... (Name of paediatrician in Klerksdorp)

taught me to notice certain things.” (Free translation)

Parent: “They must there, whilst you are still pregnant, prepare the mothers about the growth and development of babies and especially also tell them about what to do if a baby is maybe born at seven months and how those babies grow and develop.” (Free translation)

This parent indicated that information on development should also be part of antenatal care that pregnant women receive at the clinic. They would then be better prepared to know if something is not as it should be with their infant’s development.

Parent: “Not at the clinic, there they indeed ask one nothing and they only say the necessary.” (Free translation)

Parent: “They did ... yes very basic ... to a big degree, more or less ... motor development and so forth, but ... really in broad outline, things like sitting and ... transfer from one hand to the other ... never in fine detail (refer to information received from the community nurse regarding infant development).” (Free translation)

Parent: “They did the first time, for me they did, a pamphlet I think it was only one page with very, very basic ... indications ... of development.” (Free translation)

Grandparent: “No, no we ask always why this is so? (Refer to information received from the community nurse regarding infant development)” (Free translation)

Grandparent: “Not ever (refer to information received from the community nurse regarding infant development).” (Free translation)

Parent: “She didn’t tell me, no (refer to information received from the community nurse regarding infant development).”

Parent: “Advice is always welcome especially about where to get help and how to manage your child as well as where to get support groups.” (Free translation)

Most parents and grandparents were very frank about the fact that they did not receive any guidance or advice and if they received any, it was very basic. The one mother thought it was her mistake, but she added that she thought guidance and advice was given automatically. They mostly got their information from other family members or bought magazines about baby care to augment their knowledge. It was the mothers who attended a private clinic, who received guidance. Although one of the mothers, a teacher, felt it was very basic and could be better.

In summary, health education, as well as the content thereof is important. If done properly by community nurses it will contribute to promoting the development of infants.

#### **h. Barriers that nurses experience in infant developmental care**

Despite the increased awareness that the early years of life are a period of considerable opportunity for growth as well as vulnerability for harm, infant developmental care remains inconsistent. Community nurses are in a unique position to assess, identify and intervene on developmental issues. Certain conditions, systems and providers, may make it difficult for community nurses to focus on infant developmental needs. Some managers and nurses indicated that in the execution of their daily tasks they experience barriers that prevent them from focusing wholeheartedly on the development of infants.

Manager: “No, I don’t think, no, you can refer ...”

This manager felt that there are no barriers to prevent the nurses in the clinic (Park Street Clinic) to focus on the development of infants and there is always the option to refer to someone else. The viewpoint of this manager of not considering the possibility of barriers in the existing system of infant developmental services could in itself be a barrier. Several nurses, on the other hand indicated that they do experience barriers.

Nurse: "In that one, we have enough resources, enough staff, we don't short anything ... we only need the support ... nothing that prevents ..."

Although this nurse indicated that they have adequate resources, the fact that she mentioned, "we only need the support" (from management), could be perceived as a possible barrier as staff without the necessary support might not be as motivated to deliver an effective infant developmental service.

Manager: "Shortage of personnel ... the availability of funds ... I would say floor space it's definitely also a problem ... it all comes down to funds, but manpower also sure because if you ... manpower is saying one goes for training the rest must then stand in ..."

Manager: "... the guidelines according to which we ... must evaluate the baby ... there's a lack of a measuring-instrument ... then also the necessary equipment also, which at the moment is not there ... our clinic specific also ... I mean the place was, 2 years ago, extended and it's too small all ready." (Free translation)

Manager: "You know the biggest one is the number of babies and the number of nurses that are there ... yes is, is about load, do you now there are so many services. If one thinks in terms of what the service ... was 10 years ago, and which services there are made provision for today. We received more people, but time is still a factor, time and hands ratio in, in relation to your patient ..." (Free translation)

Nurse: “Here at Park Street at least the ... there is nothing because all the equipment that we need to assess the baby it’s here and ... sometimes we find that we are overloaded with babies ... sometimes you do find instead of doing a thorough examination because of the queue ... sometimes we don’t ...” (Free translation)

Although this nurse indicates that there is sufficient equipment to deliver an infant developmental service, she and the previous participant felt that the number of babies could limit the time spent with parents to discuss development and parenting issues, and thereby act as a barrier to this service.

Nurse: “... to also have the toys that the children are using to see the skills of this children how are they doing, how are they growing up ... the nurses also I think we need to have in-service training ... it’s a problem to phone outside ... we’ve got only stipulated numbers that we can phone and not the families ...” (Free translation)

Nurse: “Maybe ... lack of equipment could be one of them, maybe lack of communication ... effective communication ... at the moment I don’t think there’s anything that will hamper me except for transport for home visits if I want to make home visit, is the only one that could be.”

This nurse initially identified barriers, but at the same time thought that nothing, except transport, could hamper her in focusing on infant developmental needs. This ambivalence or uncertainty could indicate that this nurse is not sure about what is necessary to deliver an effective infant developmental service.

Nurse: “... we’ve just got certain codes that you can phone only certain places ... it impedes your contact ... how do you follow up.” (Free translation)

Nurse: “The only problem we have actually is our telephone lines you know they do not go out ... the other thing maybe could be that ... we have to kind of ... divide our patients ... You’re not ... specifically allocated for a particular ... baby or ... chronic medications ... you are also seeing ... ANC cases ... you’re not actually allocated for a specific task so as a result ... I think that serves as a barrier ...”

Nurse: “... because we must do a comprehensive service there is not for me any me ... I almost want to say specialized service in a field ... because the government’s policy is that everyone, every day, must do everything. So you must from a broken foot and plantar warts you are now with a baby ... I think if a person ... can specify that this person, for instance in this time, must work with babies, then she can fix her attention on one thing, then she can equip her and do research ... but it can’t happen like that ...” (Free translation)

These nurses viewed comprehensive service delivery as a barrier in the sense that a person cannot focus exclusively on a specific field. They feel that if they could focus exclusively on a specific field for a given period, they could then enlarge their knowledge base about that specific field.

Manager: “The ... fact that they are not trained to do it, there’s not enough ... yes training ... yes, the skills to be able to do it ...” (Free translation)

Nurse: “... you know the most important one is the knowledge, I don’t know how to assess ... for whatever, then I won’t be able to kind of come to the right conclusion ...”

Prior to working at the clinic, the nurse worked at a hospital and mostly with adult patients, hence the indication of limited existing knowledge about infant development and delivery of infant developmental care.

Nurse: "... you must sometimes call an interpreter and the interpreter that is willing to come and help you is sometimes a cleaner that also now have a lack of knowledge you know, you tell her what to say, but I think if she interprets, then I wonder how much is left out and how much is added ..." (Free translation)

Clients are mostly Setswana and not all the nurses are proficient in this language, thereby making this a very valid barrier to the delivery of a quality infant developmental service as it impedes the provision of information.

Parent: "... there are also certain cases where they also are short of staff and such things ... I think, I think yes I think that are there case, they want to make rush plans ..." (Free translation)

Parent: "... local clinics ... they there queues are normally long ... and then if the queues are long somewhere along the way these nurses get tired and they don't really give the kids a thorough ..."

Parent: "... sometimes there is a lack of staff ... a shortage of staff in that maybe there will only be two nurses there ... and there are a lot of people there waiting for those two nurses to take care of them so its really not it's not good."

Parent: "As I've told you I don't know if they are short of staff or can they just not finish quick." (Free translation)

Parent: "There are so many people and that causes that they then cannot get to the deeper part of the knowledge and work that must be addressed, they just want to finish their work." (Free translation)

These parents perceived long queues and long waiting times due to a staff shortage. Furthermore, the fact that they did not receive sufficient attention and information was equated with a barrier to effective infant developmental care.

Parent: "... became aware of the fact that there is tremendous jealousy between the different professions. That ... occupational therapists look down on speech therapists that this group looks down on those that they feel threatened by each other that they don't like it that ... there is cross reference and ... that is for me the dumbest thing, the dumbest thing." (Free translation)

This parent made a very astute observation about the jealousy between the different disciplines. In early childhood literature, it is a known fact that professional jealousy could act as a barrier to the delivery of collaborative infant developmental care. Disciplines feel threatened by each other and want to protect their professional turf (Alkema, Shannon & Wilber, 2003:223; Van Eyk & Baum, 2002:268).

In summary, several barriers were identified, among others: workload; lack of equipment; insufficient floor space; lack of funds; lack of guidelines; lack of transport; lack of telephone contact; lack of communication between professionals; language and interpreter difficulties and not enough knowledge to render the range (antenatal to gerontology) of care expected from them.

Some of the staff from Park Street Clinic indicated that there are no barriers present to prevent them from focusing on the development of infants. However, from the responses of the mothers and even some of the managers and nurses, when asked about the focus on development, it was clear that developmental assessment was either not done or that it was a very low priority for the nurses in the clinics.



## **i. Surveillance and home visiting**

Home visits are an essential component of child health supervision in many countries. In South Africa, home visiting by community nurses is endorsed by policy and is therefore seen as part of their service delivery in general.

Nurse: "... we ought to visit that home and see how they living there and how, what is the situation ... You can know more about this child and their parent ... you can refer if there is problem ... It depends on the condition of the child if I can see this child ... low socio problem they are not visited at home ... We do have a car to visit such places ... No, we are free to do it, yes."

Nurse: "To see like we said to ... to see if the child is been taken care of, if there is any food, the environment in the home and then to see if there are any needs that they needed in that house ... we do go and just investigate, find out."

Nurse: "No we don't do it at all ... not at all any more, only except the TB's (tuberculosis) that must be located, so it was discontinued." (Free translation)

Parent: "It would be good, but will they have the time to do it, because there are too many people at the clinics which must be helped." (Free translation)

Parent: "Yes it would be valuable if they can give you assistance and guidance ... directly after birth when a mother gets back home and she feels she's still unsure about everything." (Free translation)

Parent: "Nothing ... come look ... the house, so she will see how clean, how clean and healthy it looks for the child at the house." (Free translation)

Parent: “I think they are important at least in ... making home visits the nurse is able to see how you interact with your baby how you relate to your baby ... where you live how you the impact that it has on your child where you have to improve maybe you know the ... effects of the environment where you live in how it have can effect your child’s development and growth.”

Parent: “You know I think so. Something like that is wonderful ... even not just with children that do have problems. I think a system where after one had a baby, say those first three months after one had a baby.” (Free translation)

Parent: “... for me personally it wouldn’t have been so important, but that is now my personal in terms of my character and all my support networks and my knowledge, but I know several mothers have told me they’ve got a need for it and I can think it could be precious and valuable for someone ...”

The richness of informal support networks and the level of education of the parent could be an indicator of the need for home visits, as this parent rightly indicated.

Grandparent: “No they don’t go around by the house.”

Grandparent: “No they come every day, but they come for the mother (mother of baby HIV positive and ill and community nurses visit every day to administer medication, but grandmother indicated that they never check the baby).” (Free translation)

Parent: “Home visits could be of value where the mother can’t get to the clinic or if they don’t have any other support frameworks. I myself don’t have a need for this.” (Free translation)

The researcher did not include home visiting as part of her questions to management, hence the absence of responses from management. The nurses gave conflicting opinions about home visits. Some said they were doing it for surveillance purposes, and when specifically asked about it by the researcher, they assured her "... no, no we are free to do it yes." On the other hand, the answer was brief "No, we don't do it at all ...". The researcher's dilemma of who to believe was solved by the parents' responses "No they don't go around by the house." Most of the parents also indicated that they would like it if there were any possibility for home visits. They also tried to give possible reasons why this is not happening "It would be good, but will they have the time to do it, because there are too many people at the clinics which must be helped."

Although child health care is an integrated part of primary health care it is very clear from the preceding that infant developmental needs do not receive the necessary attention. To be able to optimize the health of infants and children, community nurses need to unite the physical and the psychosocial needs of infants. Therefore, a shift is needed in how nurses perceive this synergistic relationship.

### **3.3.2.3 PROFESSIONAL ACCOUNTABILITY**

Community nurses are responsible both legally and ethically for the care they provide. Nurses in South Africa must practice in accordance to the Nursing Act, no. 50 of 1978 as amended and its regulations. Although community nurses, at the Park Street Clinic, are subject to at least one annual service audit and monitoring of services and quality assurance, it is the responsibility of the individual registered nurse to act competently and ethically and be accountable for his or her own nursing practice.

#### **a. Perception of the scope of practice of registered nurses**

According to the Nursing Act, no. 50 of 1978 as amended, their scope of practice regulates the functions of registered nurses and midwives in South Africa, irrespective of their area of work and it is very important that registered

nurses do not function outside their scope of practice. The researcher asked the participants how they would define the responsibilities of the community nurse in a primary health care clinic with regard to infant development according to the scope of practice of registered nurses. Interestingly one of the managers indicated that he is not aware of the content of the scope of practice for nurses, and that as far as he knows most of the nurses are working within their scope of practice. Most of the nurses were able to identify their scope of practice, some if not all the aspects, and they indicated thereby that infant development and the identification of infant developmental delays and disabilities were part of the community nurse's scope of practice. Only one nurse indicated that the scope of practice was too broad and not specific enough concerning infant development.

Manager: "... it comes basically down on your problem identification and then you must ... draw up a plan of action ... was it implemented ... and then basically evaluate to see if it could work or not and if it does not work, then you must ... refer to a next one who can help."

Manager: "... it must be to identify at first ... what is his problem or where is the something which is outside the normal ... and then do the necessary referral ... or to give the necessary health education ... for the parents and then also that parents bring the children back say on a ... regular basis to see if there is progress." (Free translation)

Manager: "... in the scope of practice or your protocol or whatever, there will be items ... at which she must look, but I am completely honest I am not aware about what the content is, but if I must now give my own judgement ... she must know that there is a problem if she can't walk at 18 months ... in other words then she must be able to refer or ... manage it by herself ... management of the mother, counselling of the mother I would say honestly ..." (Free translation)

Nurse: “I think you will surely look at the basic progress of the development ... I think the most important there is to ... identify that symptoms or to notice it ... then it is about the management and referral and then you must have and know specific channels to refer such a child either to a paediatric department for further evaluation or to a physiotherapist ...” (Free translation)

Promotion of health and effective client advocacy to enable the client to attain the necessary health care were excluded from this nurse's responsibilities. This could be an indication that promotion of health has moved down the priority list, as they are so busy treating minor ailments that 'identify', 'manage' and 'refer' are the only items on their “recipe”.

Nurse: “... to be honest you actually know the scope of practice is not actually clear on that one ... the scope of practice is a bit broad, it is not actually ... specific ... I think that ... educating the mothers ... and community members ... regarding childhood illnesses.”

Nurse: “Within my scope of practice the infant has to have the goal the normal goal ... then breastfeeding mostly be encourage at least if up to two years if it is possible, but first six months exclusive breastfeeding. The baby has to ... full immunization, weight ... and then to see if there's any illnesses to prevent. If they do erupt or crop up then it must be treated immediately, even the health of the mother has to be taken in consideration. Home visits have to be made to see where the mother and the baby stay, if there is enough food or and environment is conducive for the baby to grow well.”

Nurse: “... maybe during immunization they must see that this child need this and this ... maybe it's a malnourished child ... they must do their home visits just to see whether the child is

growing well ... the mother can bring the child maybe every month to come and see whether their child is developing, the milestones, the nutritional, they must get their immunization that is it's our duty also ..."

Nurse: "According to my scope of practice I ... must refer ... if there is a problem to this child I must refer to other people to ... be able to diagnose to see this child needs this ... I must also be able to give the right treatment and to see if that treatment that has been given is it helping the child so that if it's not we must review and the child should be treated correctly ... and again as I've said the mother must also have the knowledge. That means you must also explain to the mother so that the mother must also have the knowledge of what to, to take care of the children."

These two nurses did not actually define their actions according to the scope of practice as such. However, they described their actions and the researcher had to read between the lines how they interpret the scope of practice with regard to the management of infant developmental care.

One of the managers indicated that he is not aware of the content of the scope of practice of nurses and as far as he knows most of the nurses are working within their scope of practice. As indicated earlier on, management, even if they are not registered nurses, should be knowledgeable about all aspects that regulate and prescribe nursing actions in a primary health care clinic. Failure to comply with this could contribute (besides legal and economic implications for the organization) to the fact that community nurses are not delivering infant developmental care, as it should be.

Most of the nurses were able to identify some of the aspects of their scope of practice, thereby indicating that infant developmental care and specifically the early identification of infant developmental delays and disabilities were part of the community nurse's scope of practice. Only one nurse indicated that the

scope of practice was too broad and not specific enough concerning infant development and this could indicate that this nurse is not able to apply the current scope of practice to the range of services expected from community nurses.

## **b. Competence**

Acquired knowledge and skills, competence in other words, enable the community nurse to care for infants along the health continuum. The anticipated outcome of applying this competence is optimal health outcomes for the infant. Community nurses serve public interest best when they constantly improve their application of competence.

Manager: "If I must say yes, then I am going to lie, because I don't reckon, not really. They will have the basic such as immunization, but the other milestones and stuff I don't really reckon." (Free translation)

Manager: "They can ... be more capacitated ... I haven't got their syllabus what they study. But the after study, the in-service training, I think that could be geared up a bit, a notch or two ... if I tell them now you must start with ... maternity services then they say they can't, they have ... a shortage of training ..." (Free translation)

This manager based his perception purely on his previous experiences, when new services had to be implemented and nurses then said they had a shortage of knowledge. The fact that he is not knowledgeable about the syllabus indicates that he has no background to judge whether the current knowledge and skills of the community nurses pertaining to infant development is adequate.

Nurse: "... basically a nurse must ... can observe or identify, but I will say it feels for me now ... that there are nurses who worked 13

or 15 years at a hospital setup, at CSD (central sterilization department) or in theatre, in other words got rusted, who are now placed back in the practice or apply for a job in the practice, which I feel, which could maybe have a refresher course again to get back in the routine here ...” (Free translation)

Nurses are transferred to the clinic without the necessary knowledge or previous exposure to community based infant developmental services to deliver this service, among other, at clinic level. This could impede the effectiveness, as well as the quality of services delivered at the clinic.

Nurse: “... I think one becomes blunt, I think there should be at least a quick briefing or a quick crash course in certain of these field if you were out of the practice and you suddenly land up here ... I wouldn't say everyone is equipped ... several might be equipped, but I think some need again a little, I speak now about me personally, I mean one gets rusted ... if one wants a specialized nurse who is equipped in these things, then one must present a short course, more like a refresher course.”  
(Free translation)

Nurse: “... I think a professional nurse is not knowledgeable, completed enough to manage ... you know an infant, especially 0-2 years ... when it comes to infants you know, the assessment of you know infants' disability, I think we are lacking ... in that area, we are lacking the necessary knowledge ...”

Nurse: “I think ... maybe things have changed I still need to have, know more information as things change now and then ...”

Nurse: “No I think I need more training ... with the recent ... recent information because you know we've did something long ago in the colleges, we don't know is it still applicable now or what ...”



These responses could indicate a lack of confidence about their existing knowledge base.

Nurse: “The nurses also I think we need to have in-service training ... not up to scratch currently ... you know what because I’ve been working with adults for long I think it will be very good if I can know more about the infant. ”

This response indicates that the nurse is aware of her own shortcomings about infant development.

Other health care professional: “... that gained experience and finished their studies and maybe done extra courses and things like that. They, they are rather good to pinpoint such things, because you see many children. You can also weigh the different children against each other ... I think your studies are also rather comprehensive regarding things like that.” (Free translation)

Other health care professional: “You know to, to learn a bit more detail of the development would be good ...” (Free translation)

Other health care professional: “I think so, because a person ... everybody’s roles, over the last couple of years, have definitely ... changed especially since primary health care are emphasized a lot. Now you won’t just give an injection or can take a blood pressure or so ... I feel you must have that knowledge or acquire it or do extra courses if it is not part of the curriculum ...” (Free translation)

Other health care professional: “I think in the first place people have too, too little information about which developmental milestones, at which stage, are important and as I say I think the information that one has, is incomplete. I just think they are in a very good position to identify these children early and they have regular

contact with the parents due to immunization ...” (Free translation)

The general feeling was that community nurses do not have at their disposal the necessary competence to render quality developmental care to infants. A further very valid issue raised, is the fact that newly appointed community nurses have never worked in a community primary health care clinic. Most of them were transferred from the local hospital where they have mainly worked with adults. None of them received any form of induction or a refresher course to fill in any gaps in their knowledge, especially pertaining to the developmental health care of infants.

Some of the other health care professionals felt that nurses do have the necessary competence and, if that is not the case, then they must attend additional courses to acquire the necessary knowledge and skills. However, it is felt that the knowledge base of the community nurse, regarding infant development, was lacking and that was perceived as a reason why identification of infant developmental delays and disabilities was made too late.

### **c. Evidence-based practice**

Evidence-based practice, the application of scientific evidence to the management of health care, is at the forefront of health care provision. As best evidence promotes the most effective practice, nurses need to understand what evidence is and how to incorporate it into their work. Initially nurses may face conflict between best practice advocated by evidence and their customary practices used in the clinic.

The researcher mentioned to the nurses that evidence-based practice is the latest development and wanted to know how they keep themselves up to date with the latest information and skills pertaining to infant development.

Nurse: “The information we get it through the symposium that we ... do attend, the courses where they teach us more about the

diseases and how to handle and to treat them and those are the things that ... equip a person ... you know I'm getting the magazine every month, especially our DENOSA (Democratic Nursing Organization of South Africa) ... magazine ..."

Nurse: "Reading the magazines, maybe watching the news ... family magazines, maybe Your Child, you see those for the pregnancy ones ..."

Nurse: "Read magazines, attend any seminars, listen to TV and sometimes they do address these subjects in the TV ... DENOSA's magazine, Hygiene, Home and Hygiene ... general magazines ... yes, whatever I get I do incorporate it ... we do have it, weekly in-service trainings, that's where we, whoever got something shares what it's got."

These nurses responded that they do acquire information. However, the manner in which this information is acquired indicates no specific goal, it is a matter of routine and they take what is on offer, whether or not this learning fits with their own career or the organization's needs.

Nurse: "... now the only information that I'm getting actually it's from the books that I'm using now that ... I'm studying now, so that's the only way which I access ... information ... I used to (read scientific journals), but now I don't have access to them."

Nurse: "... let me say if one hears or read something interesting or watch a television programme ... Further there is no other information that you can say you get on a regular basis from somewhere ... I think any information that you get, that is important, but then you start to become specialized ... but I think one has certain information interests that ... if I think about myself and E...(Name of colleague), our conversation ... our

interest are more in the medical line of the adult than that of the child ...” (Free translation)

The community nurses deem information as important, but none of them read any scientific journals. The only magazines they mentioned were the monthly magazine sent out by DENOSA (Democratic Nursing Organisation of South Africa) and Health and Hygiene, another magazine that their department receive free of charge. Some of them even mentioned the TV as a source where they get evidence-based information. They get information by chance or if they attend symposiums or courses. This could indicate that access to evidence-based literature is limited. Furthermore, they do share information during their in-service training sessions. Another aspect the researcher became aware of was that each person has a specific field of interest and not all of them are interested in the field of infant development when it comes to the acquisition of information.

#### **d. Ethical standards**

The researcher did not interview the participants *per se* about ethical standards, but in their responses, they have indicated that nurses should uphold the ethical standards of the profession.

Manager: “... it is about delivery of service, it is about service conditions ... look at the duty and the scope of practice of the nurse ... they’ve (the nurses) got this small lamp on which they swear they will render a certain service and then during that service period there are many, they let too many things distract their attention. The basic is for them ... to manage, to treat the client or patient ...” (Free translation)

The preceding quote indicates that the manager really felt adamant about the fact that the focus of community nurses is not totally on their clients and the service they should deliver to the client. He felt their focus is rather on issues

that has no relevance towards their duty and thereby implied that their ethical standards are questionable (he referred to their pledge).

Manager: "... yes, we've got a protocol according to ... every bit that we are doing ... If you've got a problem that you detect we discuss it ... Then we will have to impress it upon the clinic (the nurses) to make sure that every person definitely does it ... [Make sure every nurse is up to date with what is precisely expected from her with the development of a child ... in other words they don't do the scope of practice, definitely not, so I will look into it] ..."  
([...] Free translation)

With this response, the manager indicated that they uphold ethical standards by ensuring the quality of nursing, by adhering to the prescribed protocols and ensuring that all staff knows what are expected from them. She however, in the same response, indicated that their ethical standards could be questionable, as they do not adhere to their scope of practice.

Manager: "... important that the staff can identify or that they are empowered or have the skills to identify if they notice ... abnormality or whatever ... That they can give advice or ... health education ... We've got the clinic supervision tool that we look at specific things in all the clinics ... where child development is concerned that is the only tool at this stage which we can use to look ..." (Free translation)

According to this manager, ethical standards are ensured by upholding the knowledge of the nurses and ensuring quality of care by means of a clinic audit (supervision tool).

Manager: "... to know, to find out if they know what they must do and then make sure that they can really do it. Then to keep the clients happy by addressing complaints as well as their identified needs ... then to provide training to staff to address shortcomings and

needs ... to make sure that all the equipment is in good working condition.” (Free translation)

According to this manager, ethical standards are ensured by focusing on the clients and their needs, improving the knowledge of the staff and proper management of equipment.

Nurse: “... to make sure that you carry on according to the protocols ... I do the maximum that I can do in the best way that I can, according to my conscience and my abilities ...”

Nurse: “I think if the child comes, you ... must observe in totality so that you can be able to refer the child to ... other health workers other ... social workers or where supposed to be referred to, so we are also responsible.”

Nurse: “... if you don't respect other people's culture they're not going to ... take you seriously, but if you incorporate them and then just maybe if you know, you see this can be a danger then just explain but do incorporate the culture.”

Nurse: “...actually a continuous kind of learning process has to be embarked upon ... to enlighten most of our professional nurses ...”

Nurse: “Usually to my opinion I have to ask a second opinion from one of my colleagues then, just to come to confirm with me before ... I can refer to the relevant institution.”

These nurses try to ensure that their practice and conduct meet the standards of the profession by providing ethical nursing practice. The researcher derived from the quotations that they try to deliver a quality service; uphold their knowledge; uphold high standards of practice; have the best interest of the client at heart by referring the client to other health care professionals; respect

the culture of the client, and to seek advice from colleagues when they are unsure. However, some of the managers indicated that their level of professional conduct might not be as it should be.

#### **e. Preservation of human dignity**

A core characteristic of nursing is that nurses work in close relationships with their clients. The nurse, who is acting in regard of her client's wellbeing, expresses human dignity in actions emphasizing the inherent worth of the client; treating the client as a person; the active effort to understand the client's situation from his perspective and regarding the client as a whole being.

Although the researcher did not include questions about human dignity as such, some nurses and parents indicated that the preservation of human dignity is important to them in the nurse-client relationship.

Nurse: "... when you are talking to ... the parent you must be sensitive not to hurt them, so sometimes you sit down and ask yourself did I ... by so saying ... was I mean, hurting that particular parent ..."

Nurse: "... you have to put yourself in the shoes of that person then you have to reflect and then see if it was you who were in that position how would you be, then just be part of that person to show that you are with him or her."

Parent: "... they are always good to do it for you like nurse A..., she's a good nurse, because you go to her then she helps you and she explains you something nicely and everything ... as she handles all people and as a person ... not ugly and rude and everything and that's how I would like it to be done with me you see ... not ugly." (Free translation)

Parent: "... it is not each and every nurse who would make you feel at ease when you are with her, but I thought the one that I was interacting with was really helping."

Parent: "No not all of them ... a lovely person who always has the time to tell or show you nicely and she always ask how things are at home. Not everyone has her nature and qualities. They won't easily get one like her again." (Free translation)

Parent: "The new clinic nurse was very professional and we always felt at ease ..."

From the preceding quotations, the researcher deduced that the preservation of human dignity appears to be important in the nurse-client relationship, especially for the client. If the client does not experience that her inherent worth is respected, that she is being treated as a whole person or that there is an active effort on the nurse's part to understand her situation, from her perspective, it could impede on their relationship and thereby diminish the chances that she would share her concerns about her infant's development.

The researcher has identified several issues that need to be addressed. The most important for the researcher is that non-nursing management should become familiar with the contents of the scope of practice for registered nurses, to enable them to assess whether nurses are functioning within their scope of practice. Furthermore, rapid changes in service provision require a more highly developed workforce. Therefore, nurses' skills and knowledge need to be improved and adapted so that it can include all aspects of infant health care. Nurses need to become more involved in research, or evidence from reputable research, that can enhance their service delivery to infants. Nurses need to change their personal worldviews or their professional frames of reference to include evidence as an essential and valued component of their service delivery.



### 3.3.2.4 PERSONAL PROFESSIONAL DEVELOPMENT

It is expected of nurses to become lifelong learners and assess, maintain and document their competence in professional knowledge. The researcher got the impression that the acquisition of competence was important to the nurses, but that they relied on the in-service and formal training programmes to acquire competence.

#### a. Pre-service knowledge base

In South Africa, the South African Nursing Council regulates the training of nurses and specifically by means of Regulation R425 of 1985 (Regulations relating to the approval of and the minimum requirements for the education and training of a nurse [general, psychiatric and community] and a midwife leading to registration). For initial or basic training, nursing students enter into a programme at an approved nursing school. The Council also prescribes the content of these programmes.

Nurse: "No, I think I need more training."

Nurse: "... now that, actually I have acquired some skills from IMCI, though I strongly believe that ... a lot has to be done in ... that respect ... I think to a larger degree that can help me, but more must be done actually."

Nurse: "Yes I can say it, but it need a person to be more on this field ... the longer you are the more corrective and more I mean knowledge you require."

Nurse: "I think a person does mother craft when you do obstetrics or maternity. I think for the basis, we do after all the milestones etcetera. I think what further equipped a person more, is life. I mean in my case you, you also walked a path in life with certain things, and I think that almost equipped you more. I think if one

wants a specialized nurse who is equipped in these things then one must present a short course, more a refresher course.”  
(Free translation)

Nurse: “I think cause how I’m, maybe things have changed I still need to have, know more information ...”

Most of the nurses felt that their pre-service knowledge base did not enable them fully to deliver quality infant developmental care and indicated that further training would be required.

#### **b. Identification and acknowledgement of training needs**

Nurses need to think and reflect upon their practice, to critically assess this practice and thereby identify their own educational needs. The programme co-ordinators identified the nurses’ needs for both the in-service training and the formal training programmes. However, the nurses focused their needs on the existing priority programmes and did not indicate any other needs that they might have.

Nurse: “... you get a, fill in a thing that says done the following course or done whatever, what you would like to do, so you get a chance.” (Free translation)

Nurse: “They do that, some of us they send them for training according their needs that they’ve asked.”

From these responses, it is clear that the in-service education coordinator and the person responsible for the more formal training programmes have done an assessment of the nurses’ needs. However, it is also clear that these nurses did not even think about their own needs.

Nurse: “Not to the fullest (needs being met) ... I can still have to think to do more.”

Person involved in the training of nurses: “I think they are not honest because you’ll find that some of those insist they are, they do but they just do because it was imposed that they must do ...”

Person involved in the training of nurses: “I think it depends on the person ... no I don’t think ... what they’ve indicated that they would like to receive training in is in line with what we are presenting, they don’t think broader, that there is something broader than what we can teach them ... they’ve definitely not addressed it ... I don’t think they have (insight into their own needs).”

It seems as if these nurses find it difficult to reflect on their own learning needs. They only focus on that with which they have been presented and ignored their own developmental needs. Nurses may be unaware of their lack of knowledge and skills, not knowing what needs to be known; personal characteristics may influence self-perception and subsequent reporting.

### **c. In-service training**

If services are to be maintained and developed to meet the rapidly changing needs of the clients, staff is the key resource that requires continuous development and investment. Successful continuous development only takes place in cultures that value education as an essential and continuous process. Continuous professional development is not yet a requirement for annual registration for nurses in South Africa. The nurses at Park Street Clinic do have an in-service programme and a specific appointed person who is responsible for co-ordinating the programme.

Nurse: “Yes we do (have in-service training at the clinic) ... once a week ... sister G... (Name of nurse) she is the one who always give us in-services ... but it is not specifically based on ... the child ...”

Nurse: “Yes we do every Wednesday, we do have in-service training where one can give us ... the training ... maybe just a condition and teach us more about it or teach us about how the treatment is supposed to be given to a certain ... problem, so that’s how we do it ...”

Nurse: “Yes as I said we do have it weekly ... Whoever got something shares what it’s got ... Not this much because we have been concentrating on this integrated management not specifically infant development unless if we get somebody at that time and then that’s the discussion (focus on infant development) ... Not to the fullest (needs being met with programme) ... I can still have to think to do more ...”

#### **d. Continuous professional development**

Continuous professional development is a strategy that supports the delivery of quality health care. Community nurses, if they want to render a quality developmental care service to infants and their families, must take responsibility for the development of their competence by assessing their needs, identifying appropriate methods to meet these needs and to review their achievements against personal and institutional objectives.

Person involved in the training of nurses: “It’s ... to improve the quality of care we give to the clients and it’s to update the staff ... It’s also to let them be empowered ... We have them fortnightly, but it is best sometimes if you’ve got something you can see the need every week ... Commonly we focus on what we do in our clinics, but now lately I can say we are more focusing on STI’s and HIV ... is because of the span of the need of HIV and most of our late training ... we are being trained for STI and HIV in different forms ...”

Although continuous professional development (CPD) is not yet a requirement for annual registration it is a key process for analysing needs, identifying appropriate methods to meet these needs and to regularly review achievement against personal and career objectives.

Nurse: "So it shows that actually a continuous kind of learning process has to be embarked upon ... to enlighten most of our professional nurses to be in that ... position to manage infant illnesses."

Other health care professional: "... the other important thing for us is that we are all exposed to CPD (continuous professional development) points, we can get recognition for that and can organize small group activities and for one or other reason we just don't do it, because actually we can all benefit from such a get together ... patients and our own professional ... competence or skills can definitely also benefit from it." (Free translation)

It is obvious that the organization (nurses get the time to attend in-service training) as well as most of the nurses, value the in-service training. However, the in-service co-ordinator indicated that some of the nurses felt that in-service training and the topics discussed during in-service training were a waste of time. This feeling of wasting time could be due to several reasons. Their (the nurses) needs are not met (as some of them have indicated), they felt that they have not learnt anything new (they repeated what they have received during formal training), it lacked relevance or there is a lack of opportunity to implement new ideas (got to work according to prescribed protocols). Furthermore, it could be personally challenging if learning is viewed as an admission of un-knowingness.

Other health care professionals, previously exposed to CPD, saw it as an ideal way to enhance competence. Nurses need to take responsibility for their own professional development. To only rely on formal or in-service training, to

increase their knowledge and skills, could indicate limited knowledge about the different strategies to develop their professional knowledge and skills.

#### **e. Formal training**

The provincial department of health, at sub district level in Klerksdorp, has a specific appointed person responsible for co-ordinating and presenting formal courses. These courses are based on the priority programmes, as specified by the North West province. Besides the local training presented in Klerksdorp, nurses are also given the opportunity to enrol in training programmes presented by post-secondary educational institutions.

Nurse: "... we have a programme definitely for training, but it is over a very broad field, these days it is about different courses, I am currently busy with dispensing (course presented by educational institution) and HIV and AIDS counselling ... We have a training centre ... a person who co-ordinates it ... We try in the clinic to see that all are gradually incorporated in all the programmes ... you fill in a thing that says has done the following course ... what you would like to do, you do get a chance ..." (Free translation)

Nurse: "... some of us they do send them for training according their needs that they've asked."

Person involved in the training of nurses: "The training programme is for the development of the staff, but it goes hand in hand with quality control ..."

Person involved in the training of nurses: "... this year it is more concentrated on a need assessment which incorporated STI's, drug management, PMCT, IMCI and yes, VCT training ... done a need analysis where I've send out questionnaires for all the clinics and everyone had to indicate which training he had done

and then there was a column of ... what training they would like ...” (Free translation)

Person involved in the training of nurses: “... we have at least a one week training per month and then there is a two or three day together with. It depends on our ... planning that we do beforehand. ... We try to co-present a one week, and that is usually a PMCT Prevention of Mother to Child Transmission or a IMCI ... workshop per month and then we have a shorter workshop like STI which is two days or drug management which is two days or TB which is three days ...” (Free translation)

This comment indicates the exclusive focus on the identified government priority programmes.

All of the nurses in the clinic are exposed to formal training and the nurses felt that their needs are being met in this regard. However, as some of the managers pointed out, it takes a long time to get all the staff trained in one single programme, as only one community nurse per clinic can be taken from duty to go on training, as it may affect the delivery of service negatively. However, the fact that it takes a long time to get all the nurses trained in one programme could also affect delivery of services, and more specifically infant developmental care, negatively.

#### **f. Focus on infant development**

The focus of the training was mostly on the priority programmes. The only focus on infant development, therefore, was if the priority programmes addressed it, and then it was only a limited focus - growth and review of milestones.

Nurse: “Yes when we are doing this road to health chart it’s where we are I mean concentrating on the development of the child.”

Nurse: “But it is not specifically based on ... the child.”

Nurse: “... but it is over a very broad field, these days it is about different courses, I am currently busy with dispensing and HIV and AIDS counselling.” (Free translation)

Nurse: “Not this much because we have been concentrating on this integrated management not specifically infant development ...”

Person concerned in the training of nurses: “Commonly we focus on what we do in our clinics ... we are more focusing on STI's and HIV ... need ... to be guided ... and more exposure to infantile development and growth ...”

This limited focus on infant development could have a detrimental affect on the management of infant developmental needs, as community nurses are not empowered to deliver an infant developmental care service.

In summary, nurses need to become aware of the importance of identifying their own training needs. Furthermore, it is important that if they want to optimize infant health care delivered at the Park Street Clinic, infant development (all the domains and not just growth) be included in the training programme agenda. Finally, even though continuous professional development is not yet a pre-requisite for annual registration as a registered nurse, it could be invaluable to the nurses to partake in CPD activities, especially if it is interdisciplinary in nature.

#### **3.3.2.5 FAMILY CARE**

Family care should encompass a more ecological, holistic and family-centred approach. In family-centred care, the family rather than the individual is seen as the client and considers the strengths, vulnerabilities and patterns of family functioning in order to support families with their concerns.



### **a. Relationship with parents**

It is important for nurses to build good, trusting relationships with parents. Through this process, the nurses will gain insight in family dynamics and parents will be more willing to reveal their needs.

Nurse: "... to congratulate her to keep on doing whatever so that the child is growing is well ... the diet that she is giving it is a good diet and the way she is bringing up the child is fine ... keep it up ..."

Nurse: "... you must establish rapport, a good rapport ... to show the parent that child can still lead normal life ... the parents must be supported and encouraged ..."

This nurse indicated that it was important to get to know a family. Until a nurse gets to know a family, she cannot know what information is relevant to that family.

Nurse: "... the basic knowledge that you have, you after all convey to them, you reassure them ..." (Free translation)

Other health care professional: "... they have regular contact with the parents due to immunization ... they build very quickly a relationship with... mothers with small babies ..." (Free translation)

Parent: "The service was OK ... the nurse was fine ... she made us feel at ease ... and and the child also she ... tried to make him calm because normally when you take the child for injection it start to cry ... so she was nice anyway."

Parent: "... I am very satisfied with their service what they teach, give and everything they do for us, they never refuse you. They are

always good to do it for you, like nurse A ... she's a good nurse, because you go to her then she helps you and she explains you something nicely and everything." (Free translation)

This parent has a special bond with this one specific nurse. She later indicated that the other nurses do not have the same qualities and that one does not always have the confidence to ask questions.

Parent: "Yes, like I am with her. Greet and morning, how are you and all that. I came for such and such ..." (Free translation)

This parent indicated that respect and decency is important in the nurse-parent relationship.

Parent: "Yes, I am satisfied with their treatment." (Free translation)

Parent: "... the nurses and everyone is very sensible and they help very nicely. So I haven't experienced any problems."

Parent: "No, the nurse where I've been, she was ... friendly ..."

Parent: "You know I was really satisfied with them, they were very, very kind and calm and I could talk and ask questions and so forth. "

Parent: "... warmth, genuine interest and time and that the patient experience there is time for me ... it is not a question of five minutes, hello how are you, hello baby let's take a look we've got to run through forms, formalities, but there are genuine warmth and interest, yes and I think it is very necessary and it is worth a lot if you really get stuck and you have a relationship with a nurse I think it is the one that you will return to." (Free translation)

Parent: “Oh and you know what just the, just the warmth and interest that she extended to the child, you know it was genuine talking and soft and cuddle the baby which I think means a lot to a mother, because I think she immediately experience acceptance and genuine concern. You get a lot of trust in the nurse, because she cares, she’s got a passion ...” (Free translation)

These parents identified several characteristics that they feel should be part of a nurse-parent relationship – friendliness, warmth, interest, acceptance, concern, sensibility, kindness and calmness.

Parent: “They don’t care for us.”

This parent was very bitter and still angry about the fact that her child’s developmental disability was identified at a very late stage, where in fact, it could have been picked up directly after birth. Therefore, she did not perceive her relationship with the community nurses as very positive.

Parent: “... she was continuously very professional and we always felt at ease ... she is a very special friend of the family ... every visit was really something to look forward to ...” (Free translation)

The professional way in which the nurse conducted herself, was important to this mother.

Grandparent: “Yes they look well after him.” (Free translation)

Grandparent: “I want them to be open with me.” (Free translation)

This participant indicated that she wanted a more open relationship with the nurses, they must tell her more about what they perceive and expect from her as a caregiver of the baby.

For most nurses it was very important to congratulate parents on their parenting skills and most of the parents indicated that there was no problem with their relationship with the community nurse and that they experienced it as positive.

#### **b. Addressing concerns of parents**

Eliciting parents' opinions and concerns, and encouraging them to set an agenda for discussions of their children's development, may prove far more effective than adhering to a list of suggested topics. The researcher obtained contradicting responses from the nurses and the parents. The nurses indicated that they elicit parental concerns, whereas the parents felt, for various reasons, that they did not get any or sufficient chance to voice their concerns.

Nurse: "It's very important because it gives you the guideline where you're working."

Nurse: "The family as the origin of the child the family are the one known world in this child's life you know that's why we ought to give the response and the support to them ..."

Nurse: "I have to (address parental concerns). I, I usually want to find out how the child is at the home and then if the mother or the whoever stays with that child, how many child how many are in the family so that in that the child can get special needs if there are other special needs that she can get or to see if this child is to be taken to the institution where she can be taken better care of but if she can be taken better care of in the home stay there and then visit regularly just to make contact with the parent to see how the baby is.

Nurse: "Yes, if there's any problems, sometimes they do have financial problems, just to find out if there's anybody who can help with this need."

Parent: “Not at all (parental concerns addressed) ... I think if there could be social services at the clinic it will be good, because we all have problems and life is difficult for everyone, then if you can talk with someone about it I think it might alleviate the burden a little bit.” (Free translation)

Parent: “There are too many people in the clinic and with some of the nurses, one doesn’t always have the confidence to ask you are too scared to ask ... no the nurses are always friendly, but as I’ve said before, the half million people which are to be helped, make that you are too scared to ask, because they just want to get their work done and you feel you don’t want to waste their time unnecessarily with your questions.” (Free translation)

Parent: “Nothing they’ve only asked me if the child has a cold, because they don’t inject children that look ill ...” (Free translation)

Grandparent: “... they only check the baby ... is because of the baby, if I don’t treat the baby well they must tell me ...” (Free translation)

Parent: “No she never asked me any thing like that all she wanted to know was whether there was suitable care with my boyfriend ... I think every nurse should give you a chance to ask questions ... to say how you feel what you experience ... then your actual needs, your fears.”

Parent: “... no.” (indicated that community nurse never asked about any concerns)

Parent: “... they don’t give you time to talk you just go there, then they do what they want to do, then you go.”

When the concerns of parents are not elicited, they might not open up about problems, fears, and so forth, thereby limiting the opportunity to enlarge their knowledge base concerning infant development and nurturing parenting.

Parent: “Yes ... they ask that ... lots of times, lots of times nurse A... has done that, then she asks how is my family, because she knows our family very well.” (Free translation)

Parent: “... yes she asked me, yes she asked me.” (Free translation)

Parent: “Yes ... the one has already for me yes, she has quite a lot ... know interest, can say interest there is really interest.” (Free translation)

Parent: “She regularly asked about any problems, illnesses or worries that we might have and handled it as it emerged ...” (Free translation)

Grandparent: “Yes they talk with us, ask what does the child look like, how is the child, then we say for them ... then they do their work.” (Free translation)

Although most of the nurses indicated that they do elicit parental concerns, it does not appear as though they utilize it effectively. When community nurses do not directly elicit parents' concerns, many parents fail to share their worries. Eliciting parents' concerns, in combination with clinical judgement, could contribute to the delivery of a more effective infant developmental service.

### **c. Information on resources**

Insufficient resources could influence child development and family functioning. To meet these needs would require that families and community nurses have access to resources. Resources need not only be formal resources (e.g. professionals), parents could also utilize informal resources (e.g. family

members, friends). Professionals should therefore be knowledgeable about available resources in the community and be able to assist families to identify the necessary resources in their immediate community.

Nurse: "... no we don't have the specific places that we know of ... no I can't at the moment think specifically ... then I would try and find out ..."

Nurse: "I think you must go out to the community to maybe we can find out of those resources or maybe from our manager here ... because I don't know really ... I think, ... if you referred ... maybe then tell them because they are working with those, maybe they know the institution the resources maybe they can give them ... we have resources like this in the community maybe you can send your child there or what ..."

This nurse was unable to identify any resources in the community. However, she indicated her willingness to find out from her manager or by referring the client to other health care professionals who work with developmentally delayed/disabled infants, where they hopefully will get the necessary information about available resources.

Nurse: "I do only know about one institution where they are being referred ... I say block leader ... councillors they do divide the townships so I think the block leaders they can be the one who would be the better resource ... even the ministers ... relatives ..."

After probing during the interview, this nurse eventually concluded that ministers and relatives could be viewed as resources in the community for families. By networking with other family members, friends, neighbours and other community providers, clients can gain access to resources in their own environment.

Nurse: "... no ... I don't know ... if there is any provision for resources for infants ..."

Nurse: "You know I haven't come that far, it's only the feeding scheme that we have and to refer them to the social worker."

This nurse indicated that she has not yet, besides the feeding scheme, thought about any other resources for the family of the infant with a developmental delay or disability.

Parent: "She never mentioned anything."

Parent: "... nothing of such things was ever addressed." (Free translation)

Parent: "No, yes I would really like to know about all these things." (Free translation)

Parent: "Not ever, I tell you it is just the basic they only do the injections and then you go home, there's no talk about family planning, what you can do, advice or things like that, nothing." (Free translation)

Parent: "Nothing, yes ... yes." (Free translation)

Parent: "... not from the nurses' side. I really the, the one thing about which I received the most information from them was immunization further, further, there wasn't really." (Free translation)

Parent: "Not at the clinic, there they indeed ask nothing and they only say the necessary ... they only tell about immunization and nothing further." (Free translation)



These parents expressed a need other than just information on immunization. Immunization it seems is the only facet of infant care that receives attention. Parents need professionals who attend to their concerns and help them gain access to the necessary resources in the community as it could positively influence infant and family outcomes.

Parent: “No (indicated that the community nurse did not give her any information on resources available in the community) ... to stimulate no, no and I think it is very necessary, because if I, something like this Mothers and Miracles is incredible really and music also.” (Free translation)

Parent: “No, you know it was purely the speech therapist ...” (Free translation)

Parent: “NO ... no, no.” (Emphasized the fact that the community nurse never informed her or asked her about available resources in the community)

Parent: “No ... there was another nurse D... there at Tigane, she only said this child you must give him lots of care.” (Free translation)

Grandparent: “No I only thought why must I battle like this I haven’t got, my husband is dead ... And I battle with the other little ones here at the house, the water and lights and then I went to the doctor at the clinic ... and then I asked the doctor can’t you help me that the child can get the grant, because this child I must take him to Klerksdorp, where do I go ... it costs a lot of money and the food, he eats a lot, I buy food, but it’s not enough, then the doctor wrote me a letter.” (Free translation)

Grandparent: “No I thought I must go and fetch that money of the child ... said it myself ... then they said you want to get the grant then I said yes I went to the commissioner to do those things ... but I

haven't been back to the commissioner, because I don't have that R8.00 that I can again go to town." (Free translation)

Both these grandparents indicated, due to a lack of information and support from community nurses, that they have independently and at their own initiative, obtained help from resources in the community, e.g. disability grants. This, unfortunately, was an area where the knowledge of the nurses was totally insufficient. They openly stated that they do not know of resources and the informal network did not really feature as a resource in their responses. However, they did indicate that they would try to find out. The nurses did not realize that most resources in a community are not specialized for families of infants and children with disabilities, but are available for all families who have infants and young children. Parents also indicated that they did not receive any information pertaining to resources. They further indicated that they would really like to get more information on resources, which they could utilize to enhance their children's development.

#### **d. Recognition of cultural traditions and practices**

South Africa is a country with a cultural diverse population. Therefore, the community nurse should have knowledge and understanding of the dynamics of cultural differences if she wants to provide the best possible infant developmental care.

Nurse: "...I think that it will also ... lessen some conflict actually."

Nurse: "Yes ... you have to find out because even if you don't respect other people's culture, they're not going to ... take you seriously, but if you incorporate them and then just maybe if ... you see his can be a danger then just explain but do incorporate the culture."

Nurse: "... no I don't believe it is important ... you know sometimes they do ... like the one with the cord. They will put like cow dung and

... that cause the baby to be sick a lot and sometimes they just ... put them with the wool you see that they will stop ... circulation also ... they say they are measuring ... whether the baby is growing. No, I don't encourage that at all ..."

Nurse: "No I think it is definitely an advantage, but I think several prejudices such as cultural practices that they have, like the one that they said, the child was big already, the sangoma (traditional healer) said the eye may be squint, I mean this you must know, so I think there, there is a big role in such things about a child may be or could be handicapped ... how much knowledge must you have to help 11, 11 different cultures, I doubt, I doubt there's, there's a lot of things that we don't know, we don't see the situation the way they do, definitely not." (Free translation)

This nurse saw cultural awareness as an advantage, because as indicated in her response, culture shapes the way in which people make sense of the causes of health, disease and illness. However, the idea of becoming acquainted with so many different cultures was overwhelming to her.

Nurse: "... sometimes you need to know ... this other culture, it will at least guide you to understand why this child having this problem ... although it's their culture and you must find a way to ... tell them what is the right thing to be done about that ... you must have the, actually you must try to get the consent from them and explain it in a way that they will understand ..."

Parent: "Ok yes we have that ... they never spoke about it."

Parent: "... we put this bands (indicate legs) ... they haven't said anything to us."

Grandparent: "No they haven't said anything to me ... they leave the wool,

this one I placed the wool for the milk. Babies they must take the milk ... I place the wool ... here by the hand and by the (indicate the stomach) ... but then they got too small ... removed it myself.” (Free translation)

The researcher was amazed about the different feelings and perceptions about cultural competence amongst the nurses. Some had real insight and felt that it was very important to respect other people's culture whereas others, without flinching, indicated that they do not believe it is important. Unfortunately, the parents could not shed any further light on this issue, as they all indicated that the community nurses did not say or do anything about their cultural practices. Although knowledge and understanding of the dynamics of cultural differences is complex, the community nurses should seek to understand it if the best possible infant developmental care is to be provided for clients.

#### **e. Reflection on personal interaction style**

Reflection is a way in which nurses can examine their interaction with infants and families. If nurses reflect they conceptualize what they are observing, doing and feeling.

Nurse: “... when you are talking to ... the parent you must be sensitive not to hurt them, so sometimes you sit down and ask yourself did I done by so saying ... was I mean, hurting that particular parent. So you do introspection to find out did you do well or.”

Nurse: “At the end of a day, that I chased, a whole senseless day, through the work, if I could make contact with someone and support him ... it is important to me, then, I feel that this day I really meant something for someone.” (Free translation)

Nurse: “No not at all ... because they also need help, you must concentrate on that.”

Nurse: "... yes because you have to put yourself in the shoes of that person then you have to reflect and then see if it was you who were in that position how would you be, then just be part of that person to show that you are with him or her."

Nurse: "... actually when I knock off that's what I ... kind of reflect on ... what took place ... I usually do it."

Most nurses indicated that they do reflect on what could impact negatively via their personal interaction style on their clients. Only one nurse indicated that she is not reflecting. According to her clients need help, one cannot let personal worries, and feelings interfere with it.

In summary, the participants identified several shortcomings and urgent attention should be given to all, as it could influence negatively on the delivery of infant health care. Most parents indicated that they were satisfied with their relationship with the community nurse. Community nurses mentioned parents and family, but they almost took them for granted. Nurses should be made aware of the importance of the synergistic power in a relationship, where all participants gain in competence, abilities, resource acquisition and capability without taking any power from others. Nurses' should reflect more and become more aware of their own values and beliefs, cultural practices and professional biases and learn to recognize and take responsibility for their own reactions and interactions.

#### **3.3.2.6 PARENTS' VIEW AND EXPECTATIONS OF COMMUNITY NURSES**

It is important to explore the perceptions and expectations that parents have of the community nurse. Only by focusing on these perceptions and expectations will it be possible to try to improve on any shortcomings.

### **a. Perception of service delivery**

The extent to which parents are satisfied with service delivery would be important information for management as well as the community nurse, as they then can utilize this information to try to improve on their service delivery.

Parent: "The service was ok anyway the nurse was fine."

Parent: "... I am very satisfied with their service what they teach, give and everything they do for us, they never refuse you. They are always good to do it for you, like nurse A ... she's a good nurse, because you go to her then she helps you and she explains you something nicely and everything." (Free translation)

Parent: "I would like the clinic as in the olden days before the new clinic was even built. In the days when it was just coloureds, because then the service was very good. Then they looked nicely after our little children. They undressed them and examined them. Now they are too busy and they don't do it anymore." (Free translation)

The same parent gave the two quotations above. It is very conflicting quotations regarding her satisfaction with the service at the clinic. The parent made the first quotation during her first face-to-face interview. She made the next quotation during a second interview, which had been done via telephone. The researcher feels that the participant might have had time to think about the issues that they discussed during the first interview and the fact that it was not a face-to-face interview might have given her more confidence to say what she really felt.

Parent: "Yes, you sit for a long time, because it gets full, one sit for a very long time." (Free translation)

Parent: "Yes, I was satisfied." (Free translation)

Parent: “I’ve got nothing against them ...” (Free translation)

Parent: “So far I’ve had no, this is the third time that I came and I’ve had no problems, ok it is only the wait, but otherwise everything is well here. The nurses and everyone are sensible and they help nicely, therefore I’ve never encountered any problems.” (Free translation)

Parent: “At the moment I’ve got no problems ...” (Free translation)

Parent: “You know I was really satisfied with them, they were very, very kind and calm and I could talk and ask questions and so forth ...” (Free translation)

Parent: “... I’ve used a private clinic ... during which I received good service ... I had the confidence to ask questions about things that worried me ...” (Free translation)

Parent: “No I am not satisfied ... sometimes you stay about three to four hours.”

Parent: “Yes, they look him nicely.” (Free translation)

Parent: “The new clinic nurse was always very professional and made us feel at ease, she always answered our questions as far as possible or referred us when it was outside her field ... she is a very special friend of the family.” (Free translation)

Grandparent: “Yes, I am satisfied, because they look him nicely ...” (Free translation)

In general, parents indicated that they were satisfied with the service delivery. Some indicated they had to wait a long time and in spite of that, they were still satisfied. The researcher got the impression that if community nurses were

friendly and medicine was available, then most of the parents were satisfied. This might imply a lack of knowledge on the parents' side about the role and functions of community nurses in a primary health care clinic.

## **b. Accessibility**

With accessibility, the researcher meant that the parents see the community nurse as someone to turn to whenever support or advice is needed.

Parent: "...the nurse was fine ... she made us feel at ease you know ... It it was some kind of discussion I asked her questions and she told me you should expect this and that during the development of your child ... I think she regarded me as a competent person ... in a way I might say so because it is not each and every nurse who would make you feel at ease when you are with her but I thought the one that I was interacting with was really helping."

Parent: "I will, if I don't understand what is wrong with the child I will go back to them." (Free translation)

Parent: "There are too many people in the clinic and with some of nurses one doesn't always have the confidence to ask you are too scared to ask ... no the nurses are always friendly, but as I've said before, the half million people which are to be helped, make that you are too scared to ask, because they just want to get their work done and you feel you don't want to waste their time unnecessarily with your questions." (Free translation)

Parent: ""No not all of them. Nurse A... is a lovely person who always has the time to tell or show you nicely and she always asks how things at home are. Not everyone has her nature and qualities. They won't easily get such one again." (Free translation)



Parent: "... I think I also made a mistake that I now didn't ask. Maybe that is also where the problem lies, but I thought it's just automatic, it's being done automatic ... the giving of information and so forth." (Free translation)

Parent: "... so that I could ask questions and it wasn't if I was intimidated ... entirely comfortable." (Free translation)

Parent: "... there was a certain relationship that was established ... she was easily accessible, she's easily accessible ..." (Free translation)

Parent: "... a supportive atmosphere where you have the confidence to ask things. I think if you are in a warm atmosphere then you can ask but you are also receptive for things that you get which sometimes can be very positive for your child's later development. I personally like someone who is warm and it shouldn't be I run through number 2, number 3, we inject and off you go, but that there is real interest." (Free translation)

Parent: "We sit there then they call us, maybe call five of us ... they don't give you time to talk you just go there then they do what they want to do then you go."

Parent: "... she always made us feel at ease she answered our questions as far as possible ..." (Free translation)

Most parents indicated that they perceived the community nurse as someone to turn to, whether support or advice was needed. However, some of them indicated that other factors limited the accessibility of the community nurse, such as the high number of people in the clinic or lack of privacy because several of them saw the clinic nurse simultaneously.

### c. Approachability/Interpersonal skills

With this, the researcher wanted to know if the parents perceived the community nurses as communicative and open. She further wanted to know, if the community nurses treated the parents with kindness and respect.

Parent: “It was some kind of discussion I asked her questions and she told me you should expect this and that during the development of your child ... and I asked her questions that I felt that I needed clarity on ... and then she explained everything to me.”

Parent: “...like nurse A... she’s a good nurse, because you go to her then she helps you and she explains you something nicely and everything.” (Free translation)

Parent: “Can talk, yes, ask questions that’s right.” (Free translation)

Parent: “... with some of the nurses one doesn’t always have the confidence to ask you are too scared to ask ... no the nurses are always friendly, but as I’ve said before, the half million people which are to be helped, make that you are too scared to ask, because they just want to get their work done and you feel you don’t want to waste their time unnecessarily with your questions.” (Free translation)

Parent: “... scold a child, who cries when he is injected, that type of thing or ... patronizing ... that type of thing I absolutely hate.” (Free translation)

Parent: “... to can support someone if, when you ... find out about such a thing ...” (Free translation)

Parent: “Oh most definitely yes, yes.” (Expressed strong feelings about respect, and interest and consideration for opinions) (Free translation)

Parent: “She must definitely have interpersonal skills ... and they must also have counselling ... skills I think, to also support one when you find out about such a thing.” (Free translation)

Parent: “... I feel there must be comfortableness from her to share things with me, irrespective whether I've asked ...” (Free translation)

Grandparent: “I want them to be open with me ...” (Free translation)

Parent: “Her human relations must be good ...” (Free translation)

Most parents emphasized the following facets of approachability: interpersonal skills; openness; respect; consideration for opinions and being comfortable to share information.

#### **d. Competence**

All parents expected that community nurses should be knowledgeable about infant care. As the one grandmother indicated “... they are nurses they know it ...”

Parent: “No, I don't think they really have the necessary knowledge and skills unless otherwise if they are neglecting some of the things because some of them really don't treat ... these mothers they don't handle them well ... they should really get enough training on ... the child's development.”

Parent: “... some of them really lack ... the skills the experience and I think when it comes to ... giving birth ... really sometimes these people don't have the necessary skills they are still on training

and I think that that the process of giving birth it's very dangerous there might be some complications so it's wise if it is handled by somebody who really knows what she is supposed to do."

Parent: "I don't know if the nurses are trained in that line to do the certain examinations ..." (Free translation)

This parent indicated that she was not knowledgeable about the training that nurses receive; thereby she could not voice an opinion.

Parent: "Yes they have the knowledge." (Free translation)

Parent: "... I am not sure I almost don't think so ..." (Free translation)

Parent: "... I would rather say ... that they must have a type of specialization that if a nurse wants to run ... a baby clinic or a clinic where she specifically will work with babies, then she must specialize, must do extra courses where she is more refreshed regarding development and all the skills a child must have and that she is better equipped, has more knowledge. Knowledge that she then can share with the parent. I definitely think so." (Free translation)

Although parents are not experts when it comes to evaluating community nurses' knowledge, their perception of the level of knowledge is important. This could have a negative impact on their trust relationships with community nurses.

#### **e. Information and advice**

Most of the parents indicated that they expected nurses to give advice and information without having to ask for it, "... I thought it was automatic ..." The parents perceived this as a serious shortcoming.

- Parent: “She never said a thing so that I kept asking her about some of the questions ... I think she could give more information.”
- Parent: “I think by having workshops by work shopping the mothers ... making information available like having some kind of pamphlets.”
- Parent: “The only thing that she gave me was a pamphlet were they talked about ... immunization because I took him for immunization so it was stated the after effects what I should expect after the ... the immunization how I should treat the after effects.”
- Parent: “... I feel there must be comfortableness from her to share things with me, irrespective whether I've asked ...” (Free translation)
- Parent: “No nothing.” (Free translation)
- Parent: “Very, I would really like to know more, you know, seeing it is now the first child, I still feel a little bit unsure ... I've got ... for me the ... books ... the Living and Loving, this type of books about babies.” (Free translation)
- Parent: “... I think I also made a mistake that I now didn't ask. Maybe that is also where the problem lies, but I thought it's just automatic, it's being done automatic ... the giving of information and so forth.” (Free translation)
- Parent: “Yes it would be wonderful if it is a group, I mean we can't expect that they each give ... individual attention, because what is going to happen with their work. People just get more and more so if it is possible it would be fantastic to ... you know group presentation or so it, it could work.” (Free translation)

This was the parent's reaction when asked if group education would be acceptable while waiting for her turn. However, the fact that she felt that they cannot expect individual attention from the community nurses because it was so busy in the clinic, could indicate a lack of knowledge about the community nurse's role and functions in a primary health care clinic.

Parent: "... I don't know exactly when is, see it is basic about the information, when he must start to sit, when he must start you know those type of things." (Free translation)

This mother indicated that information, even the most basic information would be valuable.

Parent: "Not ever, I tell you, it is just the basic. They only do the injection and then you go home, there's no conversation about family planning, what you can do, advice and those type of things, no nothing." (Free translation)

Parent: "No, the knowledge that I have is not adequate, I won't be able to identify problems ... each child is different I mean no two babies grow the same and they must point that out. Then babies cry a lot and especially new mothers don't know why babies cry, they can't speak so they can't tell what is wrong. They must therefore, teach us why babies cry so much." (Free translation)

Parent: "I think it is sufficient for now because normally we take our kids to primary health care ... some, some of the things you can detect on your own but others you can't."

Parent: "I think it's wise because sometimes there are people even in rural areas where they can't get more information maybe they travel to clinics once a month or twice so if that person has got the knowledge then sometimes if she doesn't get the time she can see or identify some of the problems on her own and the

maybe take some initiative to see what she can do about the problem.”

Parent: “They did ... very basic ... to a large degree ... motor development and so forth, but ... really only in broad outline ...”  
(Free translation)

Parent: “... I rather read a lot and I myself ... studied education as well as psychology, so I after all ... yes, well it helped me in my case although ... the moment when you are personally involved ... I think partly it is a denial type of something ...” (Free translation)

Parent: “I think for me it is a new baby. Sometimes you are ignorant, say it's your first, you are ignorant. With whom do you have the first contact? You have the most contact with your nurse, because you must take your baby with certain time intervals to the clinic. ... I feel there must be comfortableness from her to share things with me irrespective if I've asked it ...” (Free translation)

This mother stated that most mothers, especially first time mothers, would value input from the community nurse and that the community nurse must feel comfortable to share information without the mother having to ask for it.

Parent: “... she did ... it was written information, shortly verbal and then also a pamphlet in the hand which also indicated the milestones and stuff ... yes I can't think that she could have done it better.”  
(Free translation)

Parent: “They did give me that once ... they said to me that my baby he's not ... they said something about his eyes not well ... they said they think there was something wrong with the baby. They said I must come here at Klerksdorp hospital so that they can see that she's not normal.”

The only time this parent felt she received information and advice was when the community nurse referred the baby, at the age of ten months, to the hospital.

Parent: “Without her input, even if it was just to confirm that we were on the right track, I would have felt very lonely, especially in the beginning with the new babies.” (Free translation)

Parent: “As a trained nursery school teacher I think I have good background knowledge to know what to expect about my children’s development, even what can be dangerous ... it is however always good to speak with other people about this to keep perspective ...” (Free translation)

Grandparent: “No ... the Klerksdorp hospital told us ... there’s a doctor of the brown people ... she told me this child when he was born he wasn’t good ... his brains won’t grow, so we must keep ourselves nicely we must not think otherwise, because this child he will just, we must care for him just like this.” (Free translation)

Grandparent: “Not ever, no it is only the other nurse at Alabama she told me I treated the child nicely.” (Free translation)

From the above quotations, it is clear that most parents do not receive any information, due to various reasons, but that they would value any information and advice from community nurses. Information from professionals is of vital significance for better outcomes for the infant and family.

#### **f. Explanation of procedures**

When parents know what is happening and why it is happening, they feel more secure and at ease. The success of a parent-professional relationship may depend on the ability to be responsive during the assessment process.



Parent: “No she didn’t explain at all.” (Free translation)

Parent: “The only thing she said was that at least the baby is growing the height she no longer was the same the length ... I think it is important (explanation of procedures) ... ok this chart she showed me .. the way that the that the baby’s weight and then she told me if this line is going beyond this one it means the baby is over weight.”

Parent: “Nothing.” (Free translation)

Parent: “(no) ... I would really like to know. With regards to immunization they explained very, very well ...” (Free translation)

Parent: “... throughout there was an explanation about what she was looking at and why ...” (Free translation)

Parents indicated that a “running commentary” about findings would be reassuring to them at the same time that the community nurse is assessing their infants. Several parents stated that there was no explanation of the procedures/assessment that the nurse carried out and identified it as another shortcoming. As one mother stated: “... everyone measures his head but no one tells ... why they are doing it ... when I got home I measured his head, now I’ve got a size, but I’ve got no idea what it means.”

Most parents indicated that they were satisfied with the service, but it is mostly related to their interpersonal relationship with the nurse. It would indeed be unwise not to take note of the several commentaries that imply that there were certain aspects of service delivery that could be better, e.g. information and advice, explanation of procedures, even the knowledge and competence of the nurse.

If community nurses want to deliver infant developmental care of a high quality, they would need to be more responsive to family priorities and preferences. They would need to change their own attitudes with regard to service delivery. They should not perceive infant developmental care as something belonging only to first world countries like America, (“... maybe if I worked in America for three months, then I would be able to answer that question ... with all respect children and infant development have a place, but if one can see, I can think why HIV and TB are priority programmes. If you see the extent, I almost want to say misery that you encounter every day in the community then you wonder if there are any healthy babies ...”). Nurses need to move away from the idea that infant developmental care is an isolated facet of infant health care, and that there is no time in busy clinics to focus on the development of infants, when there are such misery surrounding people in the community. Infant developmental care is an integral part of infant health care and community nurses must treat it as such.

### **3.3.3 MANAGEMENT OF INFANTS WITH DEVELOPMENTAL DELAYS AND DISABILITIES**

Community nurses are in a position to play a pivotal role in the system of early identification and intervention for infants with developmental delays and disabilities. How community nurses perform in this management role and the factors that influence their management decisions need urgent attention if holistic infant health care is to be delivered to the infants of South Africa.

#### **3.3.3.1 IDENTIFICATION OF INFANT DEVELOPMENTAL DELAYS AND DISABILITIES**

A distinct goal in caring for infants is to identify, as early as possible, developmental delays and disabilities and to provide appropriate services and support. Early identification allows early intervention, and together it offers substantial benefits to infants with developmental delays and disabilities. For early identification to be possible community nurses must focus on developmental surveillance of infants during all encounters with infants. They

must be particularly sensitive to parental concerns and encourage parents to become active partners in the process of surveillance. However, there is currently no 'gold standard' world wide, on how to best monitor infants' development. Moreover, in South Africa, as to date, there is no specific policy, which addresses the management of infant developmental needs by community nurses.

#### **a. Identification**

Identification encompasses all activities necessary for the detection of developmental problems. This could include reviewing milestones with parents, clinical judgement and the addressing of parental concerns. Many developmental needs and problems go unrecognised due to missed opportunities for detection thereof. In this study focus for the researcher was on timely identification and not as much on the activities itself. (The researcher felt it necessary, to give more information about the manner in which identification of the developmental delay/disability was done, to increase comprehension of the specific situation).

Parent: "He was about ten months ... they never noticed yes."

This mother took her baby for his nine months immunization, when the nurse at the clinic said that something was wrong with the baby's eyes and that she (the mother) must take him to Klerksdorp hospital, so that they can see if there were any problems. The health care professionals only identified this baby's developmental delay at the age of 10 months, although he suffered a brain injury at birth. The mother took him regularly to the clinic for all his immunizations, as well as for treatment of minor ailments. According to the mother, the community nurses never noticed in all that time.

Parent: "Oh no, we've noticed it ourselves at home."

The researcher interviewed the grandmother and she told the researcher that they (she and the mother) initially took the baby to the clinic with a fever (he

was one month old at the time). The community nurse referred the baby to Klerksdorp hospital where he was admitted and had a hernia operation. According to the doctor's notes, he was in a good, stable condition. Following the operation, they still felt that there was no improvement in his condition. They took him back to the hospital and the doctor referred him to the occupational therapy department at Tshepong hospital (extension of the Klerksorp hospital) at the age of seven months. There, they referred him and his family to the cerebral palsy support group. They took him to the clinic for all his immunizations, but none of the community nurses ever noticed that there was a delay in his development.

Grandparent: "I've seen it myself ... I spoke myself ... his head was floppy ... I then said to her (A nurse working at Klerksdorp hospital) 'no this child is not well, do you see?' ... and then they (the community nurses) themselves said no the child is not well ... they saw afterwards." (Free translation)

The baby was born prematurely and the grandmother felt, since birth, that something was wrong with the baby. She discussed it with a nurse, in the neighbourhood. At the age of four months, the grandmother took him to the clinic, where they did not want to help her, because she was not from their community. However, one of them noticed that something was wrong with the baby and referred them to the paediatric clinic at Klerksdorp hospital. From there, the doctors referred him to the physiotherapy department, who then referred him to the occupational therapy department. Although, one of the nurses noticed a possible problem with the baby, it was a very long time, before the baby ended at the occupational therapy department and he could start with rehabilitation. Before the age of four months, they took him for his immunizations, on time, and the community nurses did not notice anything.

Parent: "The clinic nurse referred us at one of our visits to an occupational therapist for a complete evaluation, who again referred us to a paediatrician who specializes in neurological development, who also referred us for the chromosomal tests ...

there are many experts in the cities, but in the countryside you bump against a wall with the doctors. You do not get straight answers and you are sent from pillar-to-post.” (Free translation)

Although, the community nurse referred the infant to an occupational therapist, at the age of 14 weeks, he was only diagnosed with dwarfism after the age of nine months.

Parent: “... I took him for his follow-up check-up to the paediatrician and told him that I am concerned ... he then said if he cannot sit properly by the age of eight months, I must take him for occupational therapy ..., which I have done ... I know at the age of 14 weeks, they (the community nurses) said he must have better head and neck control (but they did not refer the infant for evaluation) ... by the age of nine months I told them don't worry he is seeing an occupational therapist.”

The mother took the baby for a routine check-up, at age seven months and complained about the fact that the baby could not sit properly. The doctor told her to take the baby to the occupational therapist if the baby was still unable to sit properly by age eight months. The doctors diagnosed this baby with brain atrophy at age 11 months. The mother took the baby to the clinic for all his immunizations, and although the nurse assessed his development and noticed a lack of proper head and neck control, she did not refer him for further assessment.

Community nurses should accept accountability and responsibility for timely identification of developmental delays and disabilities as part of their daily health care services to infants and young children. However, the responses from these parents could indicate that there is a shortcoming regarding the knowledge and skills of community nurses, concerning infant development and the process of developmental surveillance. It could also be the lack of an effective instrument that could be used by them for developmental surveillance of infants in the primary health care clinic. However, it also indicates other

possible reasons for late identification or management of the developmental delays, e.g. wait-and-see approach, pillar-to-post situation with doctors in the countryside, not having been referred to the correct health professional, thereby creating another pillar-to-post situation (insufficient knowledge about role and functions of other health care professionals)

### **3.3.3.2 INTERVENTION FOR INFANT DEVELOPMENTAL DELAYS AND DISABILITIES**

Community nurses are in a crucial position to identify infant developmental delays and disabilities early, because they are in regular contact with them. Furthermore, they can provide the necessary intervention or refer, if they feel that they are not suitably equipped to handle the problem.

#### **a. Intervention**

Developmental surveillance is based on the premise that early identification will result in intervention that will be of benefit to the infant. Intervention provides families with services and support within or outside of the clinic.

Nurse: "... try to gather information, maybe something that is in the family you see ... and if you are not sure just refer ..."

Nurse: "... if it's ... delayed, maybe milestones or speech, let me say for speech, we refer them to the speech therapist in Klerksdorp hospital."

Nurse: "... now I must start teaching the mother, finding out how is she bringing up this child and help to teach her maybe where I can see she is lacking and also if there is something that she need me to refer. ... Because of the problem, I must refer this mother to and if there's something that you may as the health worker I need to do ... to see to it that child develops well, I must also do that to see that child is developing well."

Nurse: “The first that we refer, it’s to paed, the paediatric department, it is at Klerksdorp hospital and from there I think they do the referrals to either physiotherapy or whatever. ... One would first want to clear it out, you write this and this did you diagnose and then you refer, ok if he has a squint eye then you refer to the eyes, I mean one knows that after all, but I think sometimes there are motor losses, then you must rather refer to the doctor, maybe he wants to determine 10 other things before you side skip him and go to physio (physiotherapy).” (Free translation)

Nurse: “Depending on the type of you know disability I will refer ...”

The only interventions indicated by the nurses, were that of referral and limited health education (anticipatory guidance). They referred to the paediatric clinic at Klerksdorp hospital, because they felt it was appropriate to first refer the baby to a doctor. They felt that they could not side step the doctor. From there (Paediatric Clinic), they could refer the baby for therapy if they think it was necessary.

Parent: “Then he said if by eight months he still can’t sit properly, then I must take him ... for occupational therapy ... and that I’ve done ...” (Free translation)

Parent: “You know she referred me, she specifically mentioned speech therapy, speech therapists that can help one in terms of child development and how she can evaluate the child and tell you if there are developmental milestones that were not attained ...” (Free translation)

Parent: “The nurse that referred me she said to me I must come. She gave me a date ... So I got there then she told me that my, she thinks when the baby was born she, she what ... the brain (sustained a brain injury during birth).”

Parent: “She referred us to an occupational therapist ...” (Free translation)

Grandparent: “No they only told me we must just take to Klerksdorp hospital.” (Free translation)

Grandparent: “No they (community nurses at the clinic) just said I must go back to the hospital. They made me a card like this (showed appointment card).” (Free translation)

The parents indicated that they themselves took action or if the nurses referred them, they went from pillar-to-post, to get to somebody who could diagnose the infant and refer them for the proper treatment or therapy. This could indicate that community nurses are not aware of the role and functions of the different therapists; therefore, they prefer to refer to the paediatric clinic, where the onus would be on the doctor to decide what action he/she should take. This could further indicate uncertainty on the part of the community nurse, which might be due to a lack of skills and knowledge.

### **3.3.3.3 SUPPORT TO PARENTS OF INFANTS WITH DEVELOPMENTAL DELAYS AND DISABILITIES**

Community nurses need to be aware of the enormous effect the disability may have on each member of the family and of the significant role they have to play regarding facilitating the process of adaptation, providing family support, facilitating access to local services, and co-ordinating services.

#### **a. Anticipatory guidance**

Community nurses in the primary health care setting are supposed to offer parents guidance and support in promoting infant's development, through the provision of anticipatory guidance. If used properly this can be a mechanism for strengthening an infant's development.



Nurse: “What we can do maybe, share something, the skills how you must you must, must handle a child like this ...”

Nurse: “... now I must start teaching the mother, finding out how is she bringing up this child and help to teach her maybe where I can see she is lacking ...”

Nurse: “And again as I’ve said the mother must also have the knowledge that means you must also explain to the mother so that the mother must also have the knowledge of what to take care of the children.”

Parent: “... she did not, she only mentioned it is not her field ... and that one refers to an expert ...” (Free translation)

Grandparent: “No we always ask why this is so ... no, they didn’t show us they just told us we must give lots of care.” (Free translation)

Grandparent: “No they didn’t say anything.” (Free translation)

The nurses indicated that they do give anticipatory guidance, but the parents on the other hand indicated that they never received any guidance or any assistance on how to take care of their infants so that the impact on their daily lives will be less severe. As supporters of health promotion, it can be expected from community nurses to devote a significant amount of their time to the promotion of optimal development of infants.

#### **b. Follow-up services**

Follow-up by community nurses could indicate genuine concern and interest in the infant and family. Furthermore, if community nurses followed up on the clients that they have referred, they could ensure that clients have started with therapy. With follow-up, community nurses could enhance the continuity of therapy by encouraging the parents to persevere with therapy. The researcher

wanted to know what happened to parents and their infants after the community nurses referred them.

Nurse: “No, I haven’t kept track because from them, we don’t actually get feedback.”

Nurse: “Yes we follow up and find out how is the parents and the baby is and they also if they have any problems ...”

Nurse: “Yes we ask, we, especially if you are very interested, its exceptional cases or whatever the circumstances, you ask them to come and tell you, because you don’t always get feedback ... sometimes you will phone afterwards and ask at paed’s, but we don’t know the people any more. I must tell you honestly there were times when you exactly knew the doctor to whom you send this patient that you knew his name and you could phone him.” (Free translation)

Nurse: “Because we usually ask them if maybe you send to the hospital at least they (family) must ... give us the report back from the hospital what did they say about the child ... we need because you cannot just send them and do not know what did, what did they do.”

Nurse: “You know most of the times, to say the truth, we don’t try t keep track, but if that family come to the clinic again, we do ask them ... I think it’s because we are to busy, I can put it that way, because the transport it’s available for us to keep track ... it’s a problem to phone outside.”

Parent: “... with my next visit to the clinic she asked me ... do I remember we spoke about it and asked what happened ... with the problem, did I get someone and what were the results.”  
(Free translation)

Parent: “No (The mother stated that the community nurses never came to visit her at the house after she was referred to follow-up) ... they just asked me what happened and I told them the Klerksdorp hospital send me to the Baragwanath.” (Mother indicated that the community nurse asked, with their next visit at the clinic, about what happened with the infant)

Grandparent: “No (The community nurses didn’t come to the house to find out what happened after the infant was referred to the hospital) ... yes (The only time they see the community nurses is when they go the clinic) ... they don’t go around to the house.”

Parent: “... I told her, the nurse what happened in the end, what his diagnosis was and so forth ... she felt very guilty that she didn’t take it as serious earlier on.” (Free translation)

Nurses and parents alike indicated that follow-up was minimal. The community nurses expected the parents to keep them informed about the situation. The community nurses have no means other than doing a home visit to contact the parents, but their workload prevented them from doing so. This could have a negative effect on the developmental outcomes for infants and their families, as the continuity of care is not assessed.

### **c. Effects of developmental delays and disabilities on parents**

Community nurses need to be aware of the enormous impact that developmental delay or disability may have on families and that family members may experience many emotional reactions. Furthermore, it is very important that community nurses know that coping responses differ from person to person. The researcher wanted to know how the parents experienced the delay or disability, and to whom did they turn when they felt they needed support.

Parent: “You know very upset and angry. Angry at the people who never noticed it and who worked with him and never made us aware of it.” (Free translation)

Parent: “You know sometimes ... I feel sorry for him, I feel it is potential that he had, which was sort of taken from him ... so sometimes, but I really resolved that I won’t, it won’t help to sit on a heap and feel sorry for myself and him. I’ve decided I rather want to try and do for him ... as much as I possibly could yes.” (Free translation)

Parent: “... so yes, we feel we’ve been left in the lurch.” (Free translation)

Parent: “I stopped working and that is one thing I feel bad about I was simply too busy to take him to things like music where I took all my other children, I just didn’t have the time and then I also felt bad about that, because its extra stimulation which he could have received, which he didn’t have and maybe could have helped that his problem was picked up earlier by other people ...” (Free translation)

Parent: “I will like her to try to (too overcome to add any thing) ... it was very difficult at that moment.”

Grandparent: “... she (the nurse) must also say that I can also come right ... that the heart and then I must believe it is the truth, he will come right.” (Free translation)

This aspect really needs urgent attention. Some of these parents have not yet accepted or worked through their mixed-up emotions. The community nurse must be able to either assist these people herself, or see to it that they are referred to professionals who can assist them with the acceptance of their infant’s condition.

#### **d. Social support**

Instrumental (resources to meet basic needs, equipment or adapting materials); informational (information on services, the developmental delay/disability itself, resources, and child development and intervention strategies); appraisal (acknowledgement of extra care that parents provide for infant) and emotional support (informal social networks, support groups) are necessary for maternal and infant wellbeing and has been acknowledged as critical resources for families of infants with developmental delays and disabilities.

Nurse: "We only reassure the parent at primary level. From there we refer them to ... the different departments at the hospital ... if we're to ... support parents here I don't think you'll have ample time to do that ... we refer them to people ... with the necessary skills."

Nurse: "Emotional support and then to show the parent that child can still lead normal life that ... the parents must be supported and encouraged and not to feel self-pity even for the child ..."

Nurse: "We usually, you refer them ... if its delayed maybe milestones or speech let me say for speech we refer them to the speech therapist in Klerksdorp hospital and then maybe if there is a support group for mothers with a child children like that at least if you involve them they will know that I'm not alone at least we share information with the mothers. What we can do maybe share something the skills how you must ... handle a child like this because the other they were talking you must just try to be patient with something like that, I think the support groups ..."

Nurse: "I ... can almost say empathy and the rest is to get him structure and to reassure him and to say let us do this, it's going to take this long or it is for the sake of your child ... Let me put it this

way I will make the time and use it to give that one support or to encourage him. ... That is for me the seriousness.” (Free translation)

Nurse: “I congratulate the mother in the first place on how well the baby is being taken care and then encourage the mother to keep up.”

Parent: “No madam that’s the first time from today that I’ve now such things with madam, now that madam now discuss with me here.” (Free translation)

Parent: “... nurse A specifically has told me I raise her nicely.” (Free translation)

Parent: “No she didn’t (asked about informal support networks) ... I think it is Important because some of us have no knowledge at all ... and find out if there is any kind of support that you are getting as a mother on home or rent or whatever and try and see what she can do to help.”

Inadequate income is a source of anxiety in itself and prevents parents from accessing other resources, such as hired help. To prevent or reduce this type of anxiety, community nurses have to assess this need.

Parent: “Yes it is very difficult because normally ... some of the mothers are still young they don’t even have a clue they don’t know anything ... so at least if there is some one out their maybe a mother, aunt or whomever it is easier ... it’s easier to grow a child in that way than when you are just on you’re own and you don’t get any support.”

Informal support, especially which is available from within the immediate family, has been shown to be related to wellbeing. This fact should encourage community nurses to assess the family’s available support networks.

Parent: "... invited me and asked, perhaps its good to belong to a support group to belong to a support group for breast feeding, because it provides one with a lot of support and yes mothers share their experiences with each other, is very supportive for you in that situation ..." (Free translation)

Parent: "... it is good that there is emotional support for the mother I think it is stressful for a lot of mothers it is very difficult for them ... so I think ... that support, because a lot of mothers get a little support ..." (Free translation)

Parent: "So at least if you come together as groups if you share your ideas your angers your fears what you've experienced during the process ... I've experienced this and this but I didn't know how to handle this so if somebody experienced the same problem that I had and managed to overcome that problem then it might be easier if that person explains to me how she overcome the problem, where she went ... who helped her."

Support groups could be a source of emotional support for parents. It could provide parents with the opportunity to discuss their concerns, feelings, resources and maybe provide them with the necessary strategies to cope with their daily stresses and concerns.

Parent: "I think she regarded me as a competent person ... I think if ... there was anything she thought was wrong with the baby she would have explained to me ... I am not doing this correctly ... you should do it like this, so she was pleased ... with how I was taking care of my baby."

Enablement is an important part of providing support. Nurses' actions can have both positive and negative outcomes for the recipient of the help. Effective enablement would encourage a family to acquire the skills they need to help themselves, thus becoming more independent and less reliant on others. An

example of this is promoting the use of the family's informal support system and not replacing it with formal supports.

Parent: "She was very sympathetic and she ... had encountered a similar type of experience with her own child and she could more or less console me and tune me positively and so she was very sympathetic ..." (Free translation)

Parent: "... I rather think people are very inclined to accept that because it is one's fourth child ..." (you do not need any information or support) (Free translation)

Parent: "... well A... (laughs) A... and, and then the family, that's (all) ..." (Free translation)

Parent: "... but she definitely gave me peace of mind that I don't go into this state and think something big is wrong with my child ..." (Free translation)

Parent: "... she must not just provide book-learning, but also the necessary moral support when they need it, for instance ... after the parents received the bad news about their child's health." (Free translation)

Emotional support from professionals has been found to reduce stress, promote wellbeing and promote positive parent-child interactions. Community nurses could be helpful just by responding in a friendly way to parents and by being sensitive. They furthermore can help parents to identify and build informal networks to ensure emotional support and enhance wellbeing.

Parent: "You know information at any stage, I can't tell you ... you get this terrible shock and no one can tell you, well he has not explained ... what atrophy is ... he couldn't give me an idea of could have caused it. He could not even give us an idea, ok not



that it was his job, but starting with him no one could give us information. No one knows, you hear this terrible thing that happened to your child and you don't have an idea about what it is." (Free translation)

It is natural that families, as soon as their infant is diagnosed with a disability, may want to learn more about the disability. Information will help the family better understand the disability and make accommodations accordingly. However, the experience of this participant indicates this is not such an easy feat. She went from pillar-to- post before she eventually received any information about her son's condition.

Parent: "You know I think she didn't do it directly for me ... I merely think the reason for that was because I am relatively personally known to her and she knew what my support network, which is very supportive in nature, looked like and my husband is also a very supportive role, she therefore just mentioned you know we can't without other people and then we laughed, yes you know how we do it just now ..." (Free translation)

Parent: "She just told me that I must accept it my baby will not be like other babies ... eh uh (no) (felt too overcome to answer) ... she never, she just said that I must accept it ... I will like her to try to (too overcome to add any thing) ... it was very difficult at that moment."

This parent became very emotional during the interview, thereby indicating that she still was in dire need of emotional support. Community nurses could help parents, like these, by providing support, empathy and education. They could also link them with other parents, facing similar situations.

Parent: "Never ... they just referred me to Klerksdorp hospital ... nothing else" (the community nurse did not refer her to any support

group or assisted her with the identification of resources in the community or informal support networks)

Grandparent: "You know us coloured people ... we are not people who feel sorry for the other one, you must just do without ..." (Free translation)

For this grandmother, the concept of informal networks where friends and neighbours help each other is peculiar. Community nurses should provide families with information about available services to empower them to better provide for their families.

Grandparent: "(No) they said nothing to me." (Free translation)

Grandparent: "... it's only the other nurse at Alabama she told me I treat the child nicely." (Free translation)

Grandparent: "(No) never, (No)." (Free translation)

Community nurses tend to elicit information about health, childcare and family structure more regularly than they inquire about the family's social relations and life situation. Some of the parents did not receive any support at all, or their support was insufficient to deal with the problems. The parents' perceived support (informational, instrumental, emotional and appraisal) as a necessary element in the parent-nurse relationship. Some parents do not have immediate family to turn to, and there the community nurse could fill a huge gap. The researcher felt that the nurses are not knowledgeable about the support concept. Their focus was more on emotional support and appraisal support (they did not indicate this form of support directly, but the researcher felt that they are supporting parents in this way) than any other type of support. One of the nurses even indicated that they do not have the time to support parents, they only reassure them, and if there is a need for support, the nurse has to refer them. Only one nurse indicated that she would employ support groups and sharing of information as means of support.

The preceding responses and discussions indicate that various shortcomings, pertaining to the management of infants with developmental delays and disabilities are occurring. To enhance quality of developmental care to infants and their families, community nurses need to give urgent attention to all of the preceding aspects.

#### **3.3.3.4 VIEWS ON LATE IDENTIFICATION OF INFANT DEVELOPMENTAL DELAYS AND DISABILITIES**

Most of the community nurses felt the statement, made by other health care professionals, that the diagnosis of developmental disability is done much too late for effective intervention, is not true and furthermore felt that infants are referred for intervention. They gave several possible reasons for the late identification of developmental delays and disabilities.

All of the other categories of participants also gave reasons that could contribute to the late identification of developmental delays and disabilities.

##### **a. Lack of focus on infant development by community nurses**

Infant and child health care is an integral part of primary health care and there is a critical need to not just maintain, but also actually optimize the health of all infants and children. Community nurses are in an ideal position to focus on the developmental needs of infants.

Nurse: "... sometimes I can also say we health workers we overlook some of the problems of the children because some parents they can't see, but we can be able to detect when we are ... giving this children their immunization that this child is lacking something."

Nurse: "... I think sometimes the milestones or other signs and symptoms are not being noticed ... one is not always focused to do the physical, to check the milestones when you do the

immunization ...” (Free translation)

If community nurses focus on the development of infants, it is only the physical development and a review of the milestones. However, other domains of development do not get any consideration and this could indicate a shortcoming in their knowledge base about infant development.

Nurse: “I think it should be done ... but sometimes we overlook that ...”

Manager: “... I rather at this moment concentrate on immunisation and things like that than the developmental side ... of the infant.”

Manager: “... more the growth than anything else.” (Free translation)

Parent: “They don’t examine the babies, they only weigh them and that is most probably why most of our children’s problems aren’t identified early.” (Free translation)

Parent: “... no one, no one noticed it ...” (Free translation)

Parent: “They never noticed yes.”

It appears as though the community nurses’ focus on infant development is insufficient, thereby preventing better outcomes for infants with developmental delays or disabilities. The focus in itself is also very narrow and aspects such as socio-emotional development, intellectual development and family functioning among others, do not feature in the assessment of infant development.

## **b. Changes in health care**

With transformation of the health system in South Africa, as described in chapter 2, several measures to improve access to health care were introduced, amongst others free primary health care for every citizen, provided by the

community nurses at the clinic. These changes required community nurses in the clinic to integrate preventive and promotive care with a wide variety of curative services. Currently curative services constitute the bulk of their work in the clinic.

Manager: "...in the past a time was set apart for milestone development and to do it. Now due to the structure of health more services were shifted off to the clinics and we have an overload of patients and we have too few hands and there is not a time to arrange specifically for milestones ..." (Free translation)

Nurse: "... because we must deliver a comprehensive service ... because it is government policy that everyone must do everything, every day ... from a fractured foot and plantar warts you now end up with a baby and then back to that thing. If one can specify that somebody spend this period of time with babies then she can focus her attention on one thing and she can equip herself ... but it cannot happen like that because we must do everything the whole day ..." (Free translation)

Nurse: "... you are not actually specifically allocated for a particular ... baby or doing chronic medications then, you are also seeing ANC cases you also doing so many things ..."

These responses indicate that the community nurses feel frustrated by the current situation of service delivery in the clinic, where all of them have to deliver all the services, every day. They feel that their focus and knowledge about infant development could improve if they could restructure the way in which they deliver services.

Other health care professional: "... everybody's roles in health care have definitely ... changed over the last few years, especially because of the emphasis on primary health care ..." (Free translation)

From these responses, it is clear that the transformation of the health system brought along a shift in the focus of health care delivery, thereby reducing the amount of time spent on promotive and preventive services such as the management of infant developmental needs.

### **c. Workload**

With the introduction of free health services for children, less than six years and pregnant women by the South African government, the caseload that nurses have to handle at PHC clinics, have increased.

Nurse: "I sometimes think workload ..." (Free translation)

Parent: "... there are so many people and that causes that they can't get to the deeper part of the knowledge and work that must be addressed, they just want to finish their work." (Free translation)

Parent: "Definitive I would say ... I think it is because there are so many people they certainly can't then give all, a 100% attention, because it is ... it gets very full here." (Free translation)

Parent: "... because they are so busy and they have little time for it and now all the people from J... from K... now they don't get the chance to go over it with the people ... the staff is a bit small and now they don't get to everyone to talk to them and all those things." (Free translation)

From these responses, it is evident that the parents in particular feel that they have to wait long, and that the staff at the clinic, is inadequate to attend to all their needs.

#### **d. Impact of HIV and poverty**

According to research, there is a relationship between poverty and disability. Poverty could be a cause of disability through lack of knowledge of prevention, lack of access to health care, poor nutrition to mention but a few consequences. The HIV/AIDS pandemic has become a major drain on the available resources of poor families and therefore an important factor in the creation and perpetuation of poverty. Therefore, both poverty and the HIV/AIDS pandemic have major implications for the developmental outcomes of infants affected by it.

Nurse: "... another problem I think that enters here, it's not always the mother who brings the child, the mother is dead due to HIV, now it's the aunt and next time it's the grandmother, so the children at home they also follow an unstable road ... he gets his basic needs, but he doesn't get that attention, specific attention and knowledge attention." (Free translation)

Grandparent: "No I thought I must go and fetch that money of the child ... said it myself ... then they said you want to get the grant then I said yes I went to the commissioner to do those things ... but I haven't been back to the commissioner, because I don't have that R8.00 that I can again go to town." Free translation)

Grandparent: "No I only thought why must I battle like this I haven't got, my husband is dead ... and I battle with the other little ones here at the house, the water and lights and then I went to the doctor at the clinic ... and then I asked the doctor can't you help me that the child can get the grant, because this child I must take him to Klerksdorp, where do I go ... it costs a lot of money and the food, he eats a lot, I buy food, but it's not enough, then the doctor wrote me a letter." (Free translation)

Grandparent: "... you must tell them I have HIV ... they must give me the pills when I go in labour ... they come (to the house) but it is for the mother (to bring her medication)

This participant is looking after her HIV positive daughter as well as her developmentally delayed grandchild. In her previous response, she indicated that she has applied for a disability grant for her grandchild. However, she does not have the means to go back to the authorities to submit the application. This indicates how interrelated poverty, HIV and disability could be.

From these responses, it is clear that community nurses are very much aware of the impact of HIV/AIDS on the family and that it could lead to infants not getting the necessary attention for optimal development. The parents indicated that they battle to make ends meet and in most instances, the whole family came to rely on a single disability grant. Community nurses can do much more than just assist with anti-retroviral drugs. They can assist these families to attain the necessary financial resources, increase their knowledge about health practices, disease and disability and further help them to identify their informal network system, and refer them to appropriate institutions and organizations in the community that could support them in an ongoing manner.

#### **e. Logistics**

Logistical barriers that could prevent parents from taking their infants to a clinic for the necessary health services include money, distance from clinic and availability of health services. If parents stay too far away from the clinic to walk, they would need transport to get to and from the clinic and for some, money could then be an issue. If parents are dependent on a mobile health service, they have to fit in with the schedule of the mobile health service.

Nurse: "They say they bring the child late ... in our area ... they've got this problem of the mobile clinics where they don't come to, they don't reach the farms. Therefore, that's the cause ... bringing



the child late to the clinic ... then the other thing it could be transport ... to reach the clinic ... they take a long time to come, this is due to transport, lack of money, all those things.”

Nurse: “Sometimes it could be that maybe they didn’t have any transport ... or ... maybe stay ... in the farms ... far from the health centre and others maybe they don’t have, they think they have to pay as we say that lack of information then they are afraid they have to pay something ...”

According to these nurses, aspects such as transport, money and dependency on a mobile clinic could play a role in late identification of infant developmental delays and disabilities. Community nurses could refer these people to the appropriate institutions and community organizations to get the necessary support that would enable them to get access to infant health care. Furthermore, community nurses delivering the mobile clinic services should make sure that the service delivery is reliable, that time intervals between service dates are not too long and that service points are accessible to all clients in that area.

#### **f. Traditional healers**

In South Africa with its great population diversity, there is also a traditional healing system. Traditional healers appear to be acceptable to a large proportion of the population and are often the first point of contact with health care in certain cultures. They may also be physically, socially and culturally more available and accessible than western health care.

Nurse: “... if they say that mothers cannot ... detect the problems early ... that one can be the case, because ... it can be pending again as to who is the mother, as the grandmothers who detect the problem and then decides maybe to take the baby to a traditional healer ...”

Nurse: "... The sangoma (traditional healer) said the eye might be squint ..." (Free translation)

This nurse indicated that with certain cultures, if the traditional healer says it should be like that, due to whatever reason, you just have to accept the child's disability and the outcome is that the parents do not take the child for remedial actions.

Nurse: "... we diagnosed a child with tonsillitis and then the child returned more ill than before and the mother acknowledged the fact that they didn't give the medicine that I gave them, that they took the child to the sangoma (traditional healer) instead ..." (Free translation)

This nurse indicated that it is more acceptable and expected of certain cultures to take the infant to a traditional healer than to a clinic or doctor who make use of western medicine. Hence, the possibility that community nurses diagnose developmental delays and disabilities at a later stage.

Due to the large proportion of the population who consult traditional healers, it is important for community nurses to respect these people's choice and to realize that when families are confronted with the stress of an infant who is displaying a problem, turning to familiar cultural resources might provide comfort. When community nurses display a sense of mistrust in the use of traditional medicine, they could be the cause that parents withhold information about its use. Furthermore, community nurses need to educate people on the causes of illness, as their choice of treatment is based on their understanding of the causes of illness.

Management, parents and other health care professionals offered various views on late identification to the researcher. Nurses and management need to review these and find ways to prevent or minimize further late identification of developmental delays and disabilities.

### **g. Insufficient knowledge about typical infant development**

Each visit provides an opportunity for the community nurse to offer information in a manner that will educate and support parents and strengthen parenting capacity. Informed parents are more likely to parent in a way that meets the developmental needs of the infant.

Nurse: “As I say there may be some exceptions, but the community health nurses they do educate their people, but there may be some exceptions. I do not deny that one, in other places they are not properly educated.”

Other health care professional: “The mothers sometimes they also don’t know that the child must react otherwise, the child is like that and they have known the child like that since birth. So they don’t know that something can be done about it or that the child is not at his motor development as he should be ...” (Free translation)

Other health care professional: “... it is not always something that parents remember, because nobody ever asks about it, but every one asks, when did your child begin to sit, when did your child begin to walk and never about development of communication ...” (Free translation)

Other health care professional: “... If a nurse at one or other stage or even a doctor could tell them, but you know by now he should have been able to sit on his own and turn over on his stomach on his back and things like that then he most probably would have received help earlier ...” (Free translation)

Other health care professionals feel that community nurses are in an ideal position to engage parents in guidance about infant development, thereby increasing the parents’ awareness about healthy parenting behaviours and practices, as well as possible delays in development.

Parent: “Some of the things you can detect on your own, but others you can’t.”

Parent: “... no it did not give me entrance to everything, because there are too many people (the researcher wanted to know if contact with the clinic nurse has given her entrance to knowledge, skills and resources in the community) ... With the previous one my mother helped me a lot and I learned a lot, but she is not here any more, now it is my sister who helps.” (Free translation)

Parent: “I cannot ... no nothing ... from my mother.” (Free translation)

This parent indicated that she would not be able to identify developmental delays and disabilities with the knowledge that she has on hand. She further said that the community nurse did not provide any information or advice on the development of her infant and the little bit of knowledge that she has, she had received from her mother.

Parent: “... she then made me aware of smaller things ... such as muscle tone that she ... indicated which I, it is something that I didn’t know enough of, I didn’t realize.” (Free translation)

This parent thought she had a sufficient understanding of infant development as she was a teacher and psychology had been one of her subjects. However, the information that the speech therapist gave her, made her aware that her existing knowledge about infant development, is insufficient.

Parent: “I know which milestones, at which age my children are supposed to reach, but there are some things that you do not notice, or do not want to notice.” (Free translation)

Parents bemoan their lack of knowledge, as they feel it could contribute to their infants not developing to their fullest, or them not being able to detect delays in development timely. If community nurses enlarge parents’ knowledge base

about infant development, it could assist in minimizing the possibility of late identification of developmental delays and disabilities.

#### **h. Negligence/denial by parents**

Negligence continues to be one of the most important health threats to the healthy and normal development of infants all over the world. Negligence or the careless taking care of the infant occur in the family environment and is not in the best interest of the infant. Denial could be seen as the first stage of grief. Although people are aware that developmental delays and disabilities do occur, most proceed through life thinking, "it will not happen to my child". When it does, they respond with disbelief or denial.

Nurse: "I think the negligence of the parent you know to bring their children for a problem so that it can be identified."

Nurse: "Sometimes the (parents), they don't go ..."

This nurse indicated that parents sometimes do not take their infants to the relevant institutions after the community nurse has referred them, thereby implying carelessness.

Other health care professional: "... so these parents have already waited too long, the child is already 11 months and he can't crawl yet."  
(Free translation)

Parent: "I was aware, from very earlier on, that T...'s development was not according to what the books indicated and that he was behind his age group with certain things ... even a teacher deny that her child has got problems." (Free translation)

If community nurses suspect negligence on the part of parents, it is their responsibility to report concerns about possible neglect to social services or legal authorities. By means of educating parents on healthy and safe parenting

behaviours and practices, visiting the home to survey the home environment and enhancement of social support, the community nurses could help to reduce the occurrence of negligence.

Community nurses can do much to assist parents with denial: they can counsel them in the clinic, they can maintain frequent contact with the family through phone calls and visits, or they can initiate referral to other health care professionals if they feel that they do not have the necessary counselling skills to assist parents in such a situation.

#### **i. Lengthy process of identification**

In spite of the knowledge that early identification leads to better outcomes for infants and their families, numerous infants are diagnosed late. Sometimes the possibility of a developmental delay has been identified at an earlier stage, but it could still be a lengthy process before a definite diagnosis is reached.

Parent: "... and then an enormous long-winded road which are followed before this child was eventually diagnosed properly and by that time a lot of precious time was lost ..." (Free translation)

Parent: "... there are lots of experts in the cities, but in the country you come up against the doctors. You do not get straight answers and you get send from pillar to post." (Free translation)

These responses indicate that parents felt frustrated with the delay in diagnosis. However, it appears as if other health care professionals are co-responsible for this type of delay.

#### **j. Wait-and-see attitude**

When health care professionals do not have the necessary knowledge and skills, they sometimes employ a wait-and-see attitude.

Other health care professional: "... but the most people will say you know this child normal, a little bit late with his development, wait until he is three years old and that is a shame because one can start with therapy before the age of three and it is too late if they are three years and older ..." (Free translation)

Parent: "... the neurologist told us that there are several children with the same type of problem as my child who are only diagnosed at two or three years, because ... it's the whole time wait-and-see, wait-and-see ..." (Free translation)

Parent: "... there was no progress ... she just carried on and on and ... I said, after about two and a half months, to her shouldn't I take this child to a neurologist or someone, shouldn't I do something else?" (Free translation)

As indicated by these responses, a wait-and-see attitude could contribute to late identification of developmental delays and disabilities. Furthermore, it could lessen the effectiveness of intervention. Community nurses need to acquire the necessary knowledge and skills to prevent situations of wait-and-see. If they still feel, they do not have the necessary skills for intervention they then need to refer, in good time, to other professionals to ensure better developmental outcomes for infants and their families.

From these responses and discussions, it is evident that various reasons exist for late identification of infant developmental delays and disabilities. Community nurses can do much to prevent late identification of infant developmental delays and disabilities, and by doing that increase developmental outcomes for infants and their families.

### **3.3.3.5 COLLABORATION AND CO-OPERATION WITH OTHER HEALTH CARE PROFESSIONALS**

Infants with developmental delays and disabilities need support that crosses institution and professional boundaries. Therefore, effective collaboration is of particular importance to them. Collaboration is perceived as working together towards a common goal.

#### **a. Referral and feedback**

In infant developmental care, community nurses are often confronted with situations where they need to refer clients to other health care professionals. To ensure that these clients do not fall through the cracks, an effective referral system is imperative.

Manager: “You know I refer, I’ve never even, personally, spoke with those people, because we refer to the hospital and that’s it ... I think it is bad it (feedback) doesn’t always happen, no it doesn’t always happen, here and there, but it is rather the exception.” (Free translation)

Manager: “You know at this stage, with the occupational therapists, I’ve never really seen anyone refer to an occupational therapist ... you know in general your back referral from hospitals are very poor, we maybe get ...” (Free translation)

Nurse: “Depending on the type of ... you know disability I will refer ... regarding the feedback, we don’t get any feedback, actually we don’t usually.”

Community nurses could assist other health care professionals with the continuity of therapy, if they receive feedback from the other health care professionals, following referral. However, referral should then be directly to the other health care professional to promote two-way communication.



Nurse: “Mostly we do refer to the paediatricians first ... maybe we can say that there’s no two way communication with the or interpersonal communication with other like you said physiotherapists ... I won’t say we send them late, maybe as we as I say we don’t have the open communication with our colleagues from other department, so we don’t know what is happening there, but people are send to my knowledge at the same time.”

Nurse: “The first that we refer, is to paedes, the paediatric department at Klerksdorp hospital and from there I think they refer to either physiotherapy or whatever ... (Free translation)

Nurse: “Because if you detect something, then you can just refer to them, maybe it can go with the milestones ... something to do with the bones, then you can refer to the physiotherapist, maybe they can help with the exercises or what.”

Nurse: “... we start to refer the child to the doctor then the doctor will refer the child further if maybe see that this need to be referred further ... you can also to refer the baby directly to a occupational ... but then it’s also ... good also to refer to the doctor to assess also and refer to the, to the occupational, but you can also go straight to the occupational, that’s how we are doing it.”

Some of the nurses indicated that they first refer to the doctor at the paediatric clinic at the local hospital. This could indicate a lack of knowledge or understanding of the roles of other health care professionals.

Other health care professional: “... maybe it is a child who is only a little behind with the milestones, so then you can give feedback to the nurse, this mother has got a home exercise programme, must come back to see me in 6 weeks time ...” (Free

translation)

Other health care professional: "... if there's no feedback from the other disciplines to the clinic, then ... you don't have continuous, I don't know what is the right word now, but in any case I feel there must with a referral form or whatever to the concerned therapist or where ever, which institution they refer to, definitely be requested that there must be feedback from there ..." (Free translation)

Other health care professional: "... which says you seek urgent feedback after the first treatment session or evaluation session or whatever, because now it can happen that the nurse thinks this child must, for arguments sake, receive speech therapy because there are feeding problems, the speech therapist again feels occupational or social or physio must be included and the nurse is unaware about those other referrals, inter-disciplinary referrals. So it is very important that feedback is given to and fro." (Free translation)

Other health care professional: "...not to make a diagnosis or to treat, but merely to decide if a referral is necessary." (Free translation)

Parent: "... she referred me to Klerksdorp hospital ... the doctor ... not here to Baragwaneth hospital." (The parent was referred to the paediatric clinic at Klerksdorp hospital and was seen by a doctor, who then referred her to Baragwaneth hospital, from where she was referred to the occupational therapy department at Klerksdorp hospital)

Parent: "Yes, then they send the child to the Klerksdorp hospital." (Free translation)

Although the nurses do refer to other health care professionals via an official referral system, agreed upon between the clinic and the hospital, there is no contact whatsoever between them. Nurses stated that they prefer to refer to the doctor at the paediatric clinic, because they feel it would not be correct to sidestep the doctor. Further referral to other health care professionals would then be the decision of the doctor. This could lead to a pillar-to-post situation, which could aggravate the situation of late identification of developmental delays/disabilities or a delay in starting with therapy and thereby, developmental outcomes of the infant and the family. Referral channels need to be clarified if the best interest of the client is to be maintained by all parties involved.

Feedback from other health care professionals seems to be a big shortcoming. The other health care professionals acknowledged this shortcoming and said that all concerned with a specific referral should try their utmost best to communicate with each other for the benefit of the client. This lack of feedback could also have a negative impact on continuity of therapy.

#### **b. Interaction/communication with other health care professionals**

Communication with other health care professionals is a crucial contribution to effective developmental outcomes for infants.

Manager: "... I also think another thing is that the nurse ... they know about this other people, but they, I don't think they think they can refer straight to such a person, they must first go through the MOPD (medical officer at paediatric department) of the ... paediatric clinic and then those people refer them further." (Free translation)

Manager: "... we got a psychiatric department, we've got our physio department we've got social workers ... either at the hospitals or ... situated in the PC Pelser building."

This manager mentioned some of the departments that are at their disposal. However, knowledge about the service does not automatically indicate effective interaction and communication between health care professionals.

Manager: “Yes it could be better if a person ... yes, it could, and yes it is a lack. It could be better I think it is more if you have a person, you know more about she’s ... got a stature, then it could be better and there could be better co-operation if a person knows, but listen this is that nurse and this is that, if there’s a relationship, at the moment there is no relationship.” (Free translation)

This manager felt that personal contact between health care professionals could enhance inter-professional interaction and communication. If you could put a face to a name, it could definitely contribute to communication that is more effective.

Manager: “... I had a request the other day from social welfare ... to make some rooms available consulting rooms for them. I couldn’t do it because I got no facility, we have no accommodation for them ...”

Manager: “... you work with the community service doctors ... we’ve got a Psychologist at the PC Pelser building and she goes from clinic to clinic, introduces her and tell them what they must refer to her ... I mean it was an eye opener to them, because they didn’t know who, what, what she sees or if they get a patient then they don’t know what to do with the patient ...” (Free translation)

Manager: “... we now have a dietician and she comes to the clinics and trains the staff for example to check the nutrition of the babies and also to specifically check the road to health charts, the importance.” (Free translation)

Interaction with other health care professionals has been established within the provincial department of health at district level. However, at an interagency level, Park Street Clinic and the hospital, interaction and communication is not indicated as clearly. It is also more difficult to establish interaction and communication between two separate agencies.

Nurse: "... maybe we can say that there's no two way communication ... interpersonal communication with other like you said physiotherapists ... I say we don't have the open communication with our colleagues from other department, so we don't know what is happening there, but people are send to my knowledge at the same time."

It is clear from the response that community nurses upon referral of a client do not make the effort to establish contact either in person or via telephone. For their clients' benefit, community nurses need to make the effort to interact and communicate with other health care professionals.

Nurse: "... you know a professional nurse ... maybe trying to ... sort all the problems all alone, sometimes it's impractical so you need the expertise of social workers of psychologists of you now you have to be in touch so that a client is keeping, is kind of integrated."

Nurse: "You know according to me, it would be better if maybe, lets say once a month, if it was possible for the nurse and the social worker and you know to meet ... and discuss the problems of the children, because sometimes you find that this child doesn't grow well because of the low socio problem at home and so if ... we all meet and see where we can help ... this child to grow well."

From these two responses, it is clear that community nurses realize the benefits that effective interaction and communication holds, not just for the

client only, but for their professional development as well. However, it is clearly not yet part of their daily routine.

Other health care professional: “I think it is of cardinal importance, but I think it doesn’t happen at all. Even for those of us who know that it must happen, it doesn’t happen ... and not always to the advantage of the patient. I think there must be better co-operation between therapists who is doing the intervention and the nurse who is doing the identification thereof ...” (Free translation)

Other health care professional: “... where one is perhaps not always doing your share to make ... contact with other disciplines and especially to make contact with the nurse ...” (Free translation)

Other health care professional: “... I think that therapists make life difficult for the nurse, we’ve never really communicated with each other, the disciplines have never worked together ...” (Free translation)

From these responses, it is clear that other health care professionals realize that they are also to blame for poor communication between the different professionals and that it could be detrimental to the outcomes for the client.

Other health care professional: “Communication is always an important thing ...” (Free translation)

Other health care professional: “... the communication, it definitely comes in there, because you (community nurses) are most of the times the first contact person and then communication with other disciplines is very important ...” (Free translation)

Although this health care professional realized the importance of two-way communication, between the community nurse and other health care professionals she, however, placed the onus on the nurse to establish

interaction and communication. Effective collaboration can only be established if all participants take equal responsibility for communication and interaction.

Other health care professional: “You know it is really important, because lots of time, it happens that the parents don’t pitch up again at say for instance me and then a person can always refer back or speak to the nurse to find out if the parents still pitch up there ...” (Free translation)

Other health care professional: “... I come from a team approach. I’ve worked at a rehabilitation hospital where I worked together with a physio and a speech and a social worker and, and the nurses, worked closely with them.” (Free translation)

Other health care professional: “... it would be absolutely utopia if everybody could work together and share information and communicate with each other, because ... lot gets lost and one even I here in my private practice I am rather isolated. I see the children and that is that and one doesn’t know what happened further if they don’t finish here.” (Free translation)

The previous two commentaries are from the same health care professional, comparing her current work situation with her previous work situation. Her current work situation describes the reality (isolation) in which most health professionals’ function, whereas the previous situation describes the utopia (inter-disciplinary approach) that she is craving.

Other health care professional: “... one must learn to communicate with other disciplines without this professional jealousy, one places walls and barriers there that is not to the advantage of our patients and for sure not to the advantage of our own professional skills ...” (Free translation)

Other health care professional: “We don’t want to share, because we feel a little bit threatened ... but that is also because we don’t have contact with each other ...” (Free translation)

Parent: “... C... can’t stand H... apparently and it is absolutely a question that she feels threatened by H... and she feels that H... is interfering on her field ... I see it now how the stuff overlaps.” (Free translation)

Parent: “... became aware of the fact that there is enormous jealousy between the different professions. That ... occupational therapists look down on speech therapists, that this group look down on that, that they feel threatened by each other ...” (Free translation)

Before interaction and communication with other health care professionals would be effective and to the clients’ benefit, community nurses as well as other health care professionals, must feel secure in their own roles and have confidence in their own abilities. Some professionals may find these experiences very threatening.

Parent: “... they work together ... they talk weekly to each other about S... specific, and the one says what she observes and what she needs and the progress.” (Free translation)

Parent: “They work together, their personalities complement each other and it is clear to me that they work towards the same goal and that is to develop him ... but it would have been wonderful to me, if a doctor here and a nurse could sit down with them and talk and plan ... his future, yes.” (Free translation)

This is a very astute remark by this parent. She is amidst the situation and it is her experience that effective interaction and communication, between the two professionals involved in her son’s rehabilitation, is to her son’s benefit.



Moreover, she would like to add the community nurse and doctor to the team, as she could envision the added benefits to her son's development.

The participants gave several reasons for this shortcoming. Amongst others: professional jealousy; being uninformed about role and function of other health care professionals; cannot refer directly to therapist. However, all were of the same mind that this is a big shortcoming and not to the client's best interest. If community nurses have their client's best interest at heart, they would take it upon themselves to establish and maintain communication and interaction with other health care professionals.

### **c. Ensuring continuity of therapy**

Continuity of therapy is important for better developmental outcomes for the infant and the family.

Manager: "... the future treatment on the child."

This manager indicated that community nurses could assist with the continuity of therapy if they are aware of what the future treatment of the client entails.

Other health care professional: "... so that nurse knows if the mother comes in with the baby. If she didn't go back in that period to the other disciplines, then she must address it with her or tell her you must go back there ... otherwise there is no continuity and then the child is lost anyway ..." (Free translation)

Other health care professional: "... I think if the nurse has contact with the therapist then she will realize that these people are going to different therapists and you know at the end of the day it is not good for that child, because every time the therapy is interrupted and started again ... there's no continuity." (Free translation)

The therapists see this as an aspect that the community nurse could address. This, however, is a situation where everyone must try their utmost best to communicate with each other, to ensure the continuity of therapy. Collaboration of health care professionals is vital to the outcome of the intervention.

#### **d. Interdisciplinary training and skills development**

This type of learning requires a commitment from all to work towards a common goal. It may further require from community nurses to work across traditional professional boundaries, as it implies the transfer of skills and sharing of expertise. It can take many forms, e.g. guest lectures, small group activities or shared practicum experiences. For this to be possible, nurses would need to establish connections with experienced practitioners from a range of disciplines.

Manager: "With physical contact by getting together and to say listen I am this and that or to invite her to the clinic and maybe ask her to come and give an in-service training session ..." (Free translation)

Manager: "... the people from the nutrition, the nutrition programme there is now, we now have a dietician and she comes to the clinics and trains the staff for example to check the nutrition of the babies and also to specifically check the road to health charts, the importance." (Free translation)

Manager: "... if one can do it I believe it could work, just to give an example ... we've got a psychologist at the PC Pelser building and she goes from clinic to clinic, introduces herself and tell them what they must refer to her ... I mean it was an eye opener to them, because they didn't know who, what, what she sees or if they get a patient then they don't know what to do with the patient ..." (Free translation)

Nurse: "... when we were in the hospital we had rather more ... here there is no ... they sometimes came to the clinic, but now there, I think there is a lack we don't have that ... we got the information from the physiotherapists ... it would be interesting to have it again." (Free translation)

Nurse: "They can yes, it's, we really need it."

Nurse: "It is important to know ... maybe they must give us the in-services or maybe we can go for a specific course where they will tell but you know something that you read from ... a wall you cannot say is better if somebody is telling you what and what they expect."

Nurse: "... I think that is ... you know, an excellent thing actually and it has to be maintained because I mean tasks have to be divided you cannot just have ... a professional nurse fortunate saying maybe trying to, you know, sort all the problems all alone sometimes it's impractical so you need the expertise of social workers of psychologists of you now you have to be in touch so that a client is keeping is kind of integrated."

Nurse: "I think so ... like we said the paediatricians, social workers ... even those, the caregivers, what school teachers, kindergarten teachers can also even the parents can be also involved."

Other health care professional: "... I also think that ... training sessions to say precisely what each type of therapist is doing ... correct referrals is very important, because I feel the information regarding that is not always sufficient. A person does not always ask what the different disciplines are doing." (Free translation)

Other health care professional: "... I think if there was regular contact, shared information sessions ... information inputs then a person

might just have a good frame of reference to repeat the information to the parents and make co-operation and decision-making so much more effective.” (Free translation)

Other health care professional: “... because we don’t know about each others’ skills and we won’t change it unless we start to share information ...” (Free translation)

Other health care professional: “... I spoke to the teachers or principal of the nursery school ... tell them what an occupational therapist is doing and why, what they must look out for referrals to the occupational therapist ... and I think with nurses one can really try the same way.” (Free translation)

Other health care professional: “... if one has a session where you sit down with the nurses and explain nicely to them why it is important that a baby rolls, sit, crawl all those type of things. I think it also make it easier for the nurse ...” (Free translation)

Other health care professional: “... there are certain things that one can show and tell the nurse that she can use and show to the parents again, because a lot of our therapy we show the parents in any case, because the parent must exercise with the child at home ...” (Free translation)

Other health care professional: “... the people are extreme, if I think about the courses that I want to attend, how severely they protect the content that you receive there and how little of that you actually may convey to other people. It is actually bad for me, because the more people who can use it, the better for the patient ...” (Free translation)

As there are currently no other health care professionals based in the Park Street Clinic, community nurses need to identify the resources in the

community that could assist them with the delivery of holistic health care to infants. They then need to meet with these other health care professionals in order to explore their mutual goal of better outcomes for infants with developmental delays and disabilities. Responses from both nurses and other health care professionals suggested that collaboration is not taking place between them. Several reasons for this were mentioned and several suggestions for rectifying the problem were put on the table.

Collaboration with other health care professionals seems to be a big shortcoming and that is not in the best interest of the client. Nurses need to find a way to see to it that collaboration becomes the *modus operandi* in identifying and achieving positive infant and family outcomes.

### 3.4 DOCUMENT ANALYSIS

To enhance understanding of the data gathered by other methods and to illuminate and contextualise the responses to the research questions, provided during the interviews, official documents (policy documents, patient/client records and training programmes) have been examined (Hewitt-Taylor, 2002: 35).

As infant development is incorporated as part of some of the priority programmes, there is currently no specific policy available to guide community nurses in this regard. It also became clear during the interviews that community nurses do not utilize policy documents, as they should. One of the community nurses offered several reasons for this shortcoming. It should not be a lengthy document, anything more than two pages is not read. It should be printed in a font that is easy to read, otherwise they lose interest, and it should be completed in full before it is distributed for use in the clinics. The community nurse used the IMCI protocol as an example. It is a lengthy document and according to her, after every IMCI course presented, it is changed and they find it difficult to adapt to all these changes.

The clinic records revealed that some of the nurses were honest about them not documenting, when they do not find anything wrong. With the 50 records that the researcher has drawn, no entries were found regarding assessment of the infant's development. This revealed a discrepancy between the records and the responses of some of the community nurses.

When the researcher examined the training programmes, it became clear that the focus was on the priority programmes as indicated by the community nurses and personnel involved in the training of nurses. Infant development only featured recently in the in-service programme of Park Street Clinic, as several of the newly appointed staff members were not well grounded in infant development, as they have worked mostly with adult patients in a hospital. The in-service programme co-ordinator indicated that she herself only became aware of the importance of infant development after she recently attended a course: Syndromic approach to treatment of HIV positive children. However, it was only pertaining to growth.

### 3.5 SUMMARY

The findings presented in this chapter demonstrate the following:

- Developmental needs of infants and their families are currently not being addressed by community nurses in Park Street Clinic;
- Community nurses can deliver infant developmental care within their scope of practice. However, due to several reasons, infant developmental care is not included to its fullest potential;
- Community nurses need additional training to equip them to deliver holistic infant health care, and specifically infant developmental care;
- Management need to review their commitment and type of support to community nurses if infant developmental care, as part of community nurses' responsibilities, is to be effective and of high quality;
- An in depth understanding of the process of collaboration with other health care professionals is required to equip all stakeholders with appropriate knowledge, but in particular management and community nurses, if any change in the current situation is to take place and thereby improve the

health outcomes of infants and their families; and

- Other health care professionals can be an invaluable source of learning for community nurses.

In this chapter, the researcher presented the analysis and ensuing findings of the study. A thorough discussion of the findings will be dealt with in the next chapter by means of relevant models, theoretical overview in Nursing Science and literature.

## CHAPTER 4

### CONCEPTUAL FRAMEWORK AND DISCUSSION OF RESEARCH FINDINGS OF PHASE ONE

#### 4.1 INTRODUCTION

In the previous chapter, the research findings were organized into fewer content categories according to key issues and themes.

In this chapter, the researcher will describe the research findings by means of a selected model, overview of Nursing Theory and related literature. The Transactional Model of Development (Sameroff & Chandler, 1975:187-244) was utilized to provide a conceptual framework for understanding the research findings. This conceptual framework was adopted from a non-nursing health oriented discipline and was applied to the nursing context.

#### 4.2 CONCEPTUAL FRAMEWORK

The Transactional Model of Development (Sameroff & Chandler, 1975:187-244) may facilitate the interpretation of the research examining outcomes associated with the management of infant developmental needs by community nurses. The researcher 'borrowed' this model from the Disciplines of Child Development and Early Childhood Intervention to address developmental delays and disabilities. Hence, a critical review of nursing theory is given as well as an explanation of why it is acceptable to borrow theories from other disciplines. This is followed by a description of the application of the meta-paradigm of nursing that underlies the researcher's assumptions, to the findings obtained in Phase one of the research.

##### 4.2.1 CRITICAL REVIEW OF NURSING THEORY

Theory may be described as the goal of all scientific work. Kerlinger (1986:9) defines a theory as "a set of interrelated constructs (concepts), definitions, and



propositions that present a systematic view of phenomena by specifying relations among variables, with the purpose of explaining and predicting the phenomena.”

Theories of nursing are defined in different ways and in its simplest view it is the creation of relationships among two or more concepts to form a specific view of a phenomenon (Higgins & Moore, 2000:179). A nursing theory attempts to describe or explain the phenomenon called nursing. It defines the body of nursing knowledge, promote further knowledge development, establish nursing as a discipline, and aim to give direction to nursing practice (Sousa & Hayman, 2002:n.p.). A complete nursing theory is one that describes the context, content, and process of nursing. Context is the environment in which the nursing act takes place, content refers to the subject of the theory, and process is the method by which the nurse acts in using the theory (Hickman, 1995:2).

McEwen (2002:25), Raudonis and Acton (1997:138) all state that the use of theory offers structure and organization to nursing knowledge. It defines and clarifies nursing and the purpose of nursing practice to distinguish it from other caring professions by setting professional boundaries. It is also a framework for development of new knowledge and validation of old knowledge. It also indicates in which direction nursing should develop in future (Colley, 2003:33-34; Ruddy, 1998:245).

Various nursing theories have been developed over the years and most nursing scholars credit Florence Nightingale as the first modern nursing theorist (McEwen, 2002:26). Nursing theories offer alternative ways in which to organize and describe the content of the discipline (Stevens Barnum, 1994:2). Nursing professionals apply theory to describe, explain, predict, or prescribe nursing practice. A descriptive theory identifies the properties and workings of a discipline. An explanatory theory examines how properties relate and thus affect the discipline. A predictive theory calculates relationships between properties; as well as how these relationships occur, and a prescriptive theory identifies under which conditions relationships occur (Colley, 2003:34).

The nursing profession recognizes four levels of theory, including meta-theory, grand theory, middle range theory, and practice theory; each of these levels has defining characteristics and purposes (Colley, 2003:34; Higgins & Moore, 2000:179-181; McEwen, 2002:36-39; Riddlesperger, Beard, Flowers, McLendon Hisley, Pfeifer & Stiller, 1996:601).

Nursing theory is important because it helps nurses to decide what they need to know. Furthermore, by describing nursing explicitly, it helps to distinguish what should form the basis of practice. Nursing theory provides nurses with a sense of identity and it assists patients and other health care professionals to recognize the unique contribution nurses make to the health care service (Colley, 2003:34). Nursing theory should provide the principles that underpin practice. Ways in which theory have influenced nursing practice include amongst others, standards for nursing care, distinctive nursing processes, enhanced professional status for nurses, improved communication between nurses and guidance for research and education (McEwen, 2002:26; Colley, 2003:34).

Nursing theories are either unique to the discipline of nursing or borrowed from other disciplines. Unique nursing theory is the result of discipline-specific knowledge derived through asking questions and viewing phenomena unlike other disciplines. These theories clearly identify with the nursing meta-paradigm and concepts. Borrowed theory is knowledge developed by other disciplines and adapted to the discipline of nursing. The value of a borrowed theory is that it allows nursing to interpret, add and validate it in a nursing context. Once a borrowed theory has been adapted to nursing, it emerges as nursing theory because it comprises shared knowledge employed in a distinctive way. Therefore, the proponents of using borrowed theory feel that the use of knowledge generated by other disciplines is not borrowed, but shared. They furthermore believe that shared theory enhances nursing scholarship and that nursing depends on the theories from other disciplines for its theoretical foundations. Borrowed theories have been a source of ideas and if they deal with all four meta-paradigm concepts (person, health, environment,

and nursing), they could also legitimately be considered nursing theories (Sousa & Hayman, 2002:n.p.).

According to Janhonen (2000:145) it is important to participate in interdisciplinary collaboration and the purpose of collaboration is “to discover something that no one has or could ever think of on one’s own.” Interdisciplinary collaboration strengthens the interpretation and understanding of human phenomena, but these phenomena should be selected according to their appropriateness from the perspective of nursing (McEwen, 2002:40; Sousa & Hayman, 2002:n.p.; Timpson, 1996:1031).

#### 4.2.1.1 META-PARADIGM OF NURSING

Assumptions underlying this research are embedded in the meta-paradigm of nursing which presents the most global perspective of the nursing discipline. The meta-paradigm is the most abstract and universal of the four levels of theoretical thinking and addresses issues related to the conduct of inquiry (Higgins & Moore, 2000:180). In 1984, four concepts (person, health, environment and nursing) have been conceptualized and formalized as the meta-paradigm of nursing (McEwen, 2002:40; Thorne et al., 1998:1258). These meta-paradigm concepts served as an organizing framework around which conceptual development proceeded. For definitions of each concept, see chapter 1.

The Transactional Model of Development (Sameroff & Chandler, 1975:187-244) used in this research as point of reference, relates to the meta-paradigm of nursing as it coincides with all four concepts: person, health, environment and care (nursing). In the Transactional Model of Development, the development of the infant is seen as a product of continuous dynamic interaction between the infant and the experience provided by his or her family and social context. In comparison, in the meta-paradigm of nursing, there is also dynamic interaction between the **person** (recipient of care), the nurse, and the environment. In the transactional model, there is an acknowledgement of promotive factors that aid in the general development of infants. In

comparison to the meta-paradigm concept of health, the transactional model also seeks to maintain, promote and restore the development (meta-paradigm concept of **health**: promotion of optimal development, early identification of developmental delays and disabilities, and appropriate interventions) of infants and their families and this is done by focusing on the child-rearing regulatory system. The Transactional Model includes the environment of the infant in such a way that the experiences provided by the environment are not independent of the infant and this correspond with the meta-paradigm concept of **environment** where there is also a focus on the constant interaction between the person (recipient of care) and the environment. The infant, by his or her previous behaviour, may have been a strong determinant of current experiences. Therefore, it helps infants to attain their developmental potential by adjusting the infant to better fit the regulatory system, or to adjust the regulatory system to better fit the infant, and this coincide with the meta-paradigm concept of **nursing** which has as its objectives the promotion of health, prevention of illness, alleviation of suffering, restoration of health and optimum development of health potential and includes all aspects of the nursing process (Sameroff, 1993:6; Sameroff & Fiese, 2000:142; Sameroff, 2004:6-8).

#### **4.2.2 CLARIFICATION OF CONCEPTS RELATED TO THE TRANSACTIONAL MODEL OF DEVELOPMENT**

Before the actual description of the Transactional Model of Development, certain concepts need to be clarified to enhance comprehension of the model. These concepts include infant development, prevention of developmental delays and disability and/or further deterioration, ecological risk and promotive factors affecting infant development, and developmental regulation.

##### **4.2.2.1 INFANT DEVELOPMENT**

It is essential for anyone working with infants and families to understand how infants develop as well as the influences, intrinsic and extrinsic, that could disrupt this development. Infancy is a time of tremendous growth and

development in every way: physical, cognitive, emotional and social. Development unfolds through a complex and interactive process that could be enhanced or disrupted by both biological regulation and early life experiences (Shonkoff & Marshall, 2000:35). Development involves change that is cumulative and systematic. It refers to the refinement, improvement, and expansion of existing skills that is orderly. The result is a consistent modification in behaviour, which contributes to a higher level of functioning in the infant. Furthermore, infants develop at different rates and this creates variation among individuals. This understanding of individual differences, provides the foundation for recognizing normal variations as well as extreme differences among infants and thus for identifying those who may have special needs (Hooper & Umansky, 2004:40-41; Figure 4.2:240).

The domains of development are not distinct, but combine in an integrated, holistic way to yield the growing infant. Each of these domains influences and is influenced by the others. Infants' physical achievements (reaching, sitting, crawling and walking) have a powerful impact on their understanding of their surroundings (cognitive) and their social relationships. When infants think and act more competently, adults stimulate them more with games, language and expressions of delight at the infant's new achievements (emotional and social). These enriched experiences promote all aspects of development. The powerful effect of early experience is apparent in the development of infants who lack rich and varied stimulation in their homes. Furthermore, abnormal development in one domain often impedes progress in others (Berk, 2003:5,139,163).

According to Meisels and Atkins-Burnett (2000:234), it is important to view the development of all infants on a continuum. By doing so, all infants born with a disability or developmental delay can be viewed from the perspective of infants who are not yet functioning as expected in given areas, rather than infants who are unable to acquire the skills of typically developing infants. In this study, in which the management of infant developmental needs by community nurses is the focus, both typical and atypical infant development is relevant.

#### **4.2.2.2 PREVENTION OF DEVELOPMENTAL DELAYS AND DISABILITY AND/OR FURTHER DETERIORATION**

Since disease/disability evolve over time and pathological changes becomes less reversible as this process continues, the ultimate aim is to halt or reverse this process as early as possible, thereby preventing further damage (Stanhope & Lancaster, 1984:153). Prevention efforts are divided into primary, secondary and tertiary prevention. Primary prevention is practiced prior to the disease. Secondary prevention is practiced after the disease has been identified, but before it has caused disability. Tertiary prevention occurs after disability has been experienced and the goal is to reduce further deterioration (Sameroff & Fiese, 2000:136). However, these distinctions among prevention categories are more applicable to biological disease than to development. To understand prevention from a developmental perspective one needs to keep the following in mind:

- The child's level of competency, at any point in early development, is not linearly related to the child's competence later in life.
- Secondly, to complete an equation that predicts later development, one needs to add the effects of the child's social and family environment that act to foster or impede the child's developmental trajectory (Sameroff & Fiese, 2000:136-37).

#### **4.2.2.3 ECOLOGICAL RISK AND PROMOTIVE FACTORS**

The quality and the context of an infant's environment are important. It is therefore essential to understand that the environment can encompass influential factors and significant relationships that affect overall infant development over time. The influence in these relationships is transactional (Osofsky & Thompson, 2000:54; Figure 4.2:240). Risk factors are elements that might increase the likelihood of negative infant developmental outcome. Susceptibility to negative developmental outcomes is related to risk factors (Mohr, 1999:123). Furthermore, it is the number, rather than the nature of risk factors that is the best determinant of outcome; attention to the full array of

contextual factors provides a better picture of the child's development (Sameroff & Fiese, 2000:137). Risk factors encompass both biological and environmental factors and include among others: maternal age (especially teenage mothers) and parity; paternal factors (age and substance abuse); maternal nutrition; exposure to toxins and substances during pregnancy; maternal illness and infections; parental psychopathology; prematurity and low birth weight; child abuse and neglect and violence (Hooper & Umansky, 2004:56-77; Osofsky & Thompson, 2000:60-67).

Protective factors appear to be the positive pole of risk factors and a better term would rather be promotive factors. Promotive factors are elements that modify, ameliorate or alter infants' responses to environmental hazards that predispose them to a maladaptive outcome. Promotive factors are related to resiliency, the ability to adapt successfully after exposure to adverse events (Mohr, 1999:123). Families with many promotive factors do better overall. In the repertoire of environmental influences on child development, contextual variables in the parents, the family, the neighbourhood, and the culture at large could be presented as a continuum, aiding in development at the one end and inhibiting it at the other (Mohr, 1999:123; Sameroff & Fiese, 2000:140-141). Promotive factors can be found within the infant, in the family and in the community. Promotive factors that have been observed in infants who cope well in adverse situations, include average intelligence and positive temperamental characteristics (such as very active, affectionate, cuddly and easy to deal with). These infants are successful in eliciting positive attention from other people and are able to recover quickly from discomfort (Werner, 2000:117-123). Within the family, the educational level and gainful employment of the mother have been found to be powerful promotive factors. Other promotive factors in the family include family size, birth order and affectional ties with alternative caregivers, adaptive parenting, socialization practices, required helpfulness and faith. Promotive factors in the community include among others, the availability of friends and caring neighbours (Werner, 2000:123-126).

#### 4.2.2.4 DEVELOPMENTAL REGULATION

If developmental problems are to be understood, it is important to understand how infants and their parents influence each other over time. Besides the physical world where the talents of infants unfold, these infants are embedded in social relationships with others who provide the nurturance for both physical and psychological growth. In the regulation model, as illustrated in Figure 4.1 below, the developmental changes between the individual and context are represented as an expanding cone.

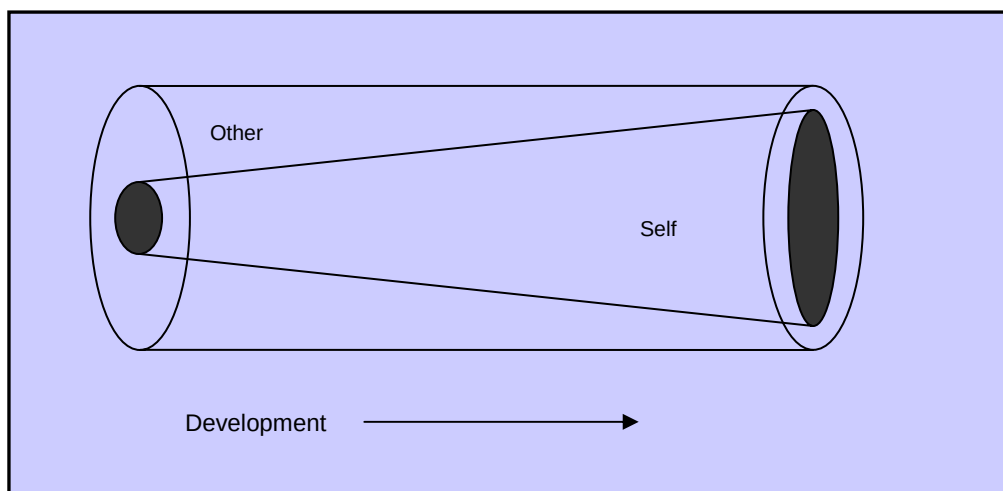


Figure 4.1 Changing balance between other-regulation and self-regulation as an infant develops into an adult (Sameroff & Fiese, 2000).

The balance of other-regulation and self-regulation, changes as the child is able to take on increasing responsibility for his or her own well-being. Initially, the infant could not survive without the parents providing nutrition and warmth. Later, the child is able to help him- or herself when cold or hungry, although the parents still have to provide for the family. Eventually, the child reaches adulthood and with the start of the next generation becomes part of the other-regulation of the new infant. Parents are regulated as well, not only by the laws and customs of society, but also by the relationships in which they are involved. An example of such regulation is regulation of the mother during pregnancy and during delivery by the doula programme. A doula is a trained non-professional who provides emotional, physical and informational support



to the family before, during, and after delivery (Sameroff, 2004:11-12; Klaus, Kennell & Klaus, 2002:16-20).

#### **4.2.3 TRANSACTIONAL MODEL OF DEVELOPMENT**

This model has been selected to interpret the data obtained in the study and to serve as a framework for the development of guidelines (chapter 5) for community nurses to manage the developmental needs of infants. First, an overview of the Transactional Model of Development is given. Thereafter, it is used to interpret and discuss the findings of the research. From 4.2.3.1, research findings are discussed by employing this model and relevant literature (nursing and other) to substantiate the importance of the categories (as identified in chapter 3), to provide effective developmental care to infants as well as to justify the utilization of the Transactional Model of Development, as a framework for the management of infant developmental needs. Furthermore, the researcher indicated the corresponding concept of the meta-paradigm of nursing where applicable.

Sameroff and Chandler (1975:187-244) proposed a Transactional Model of Development, to explain the developmental outcomes for infants exposed perinatally to various risks, among others, anoxia, prematurity and socioeconomic influences. The Transactional Model of Development posits that developmental processes reflect the transactions between individuals and environments in which they alter each other, and that these transactions affect subsequent interactions in an ongoing manner. This model goes beyond a unitary model, which explains outcome either entirely by biological or environmental factors. With the research that they reviewed, Sameroff and Chandler (1975:189-190) exposed the contradiction between the belief that nature or nurture predicted developmental outcomes and the evidence that nature and nurture were inseparable.

In the Transactional Model of Development, how a child turns out, is not a function of the infant alone or of experience alone. It is rather a product of the combination of the individual and his or her experience. The Transactional

Model of Development embeds the infant in an environment of social relationships that will enhance some early characteristics and impede others. The Transactional Model of Development views the development of the infant as a product of the continuous dynamic interactions between the infant and the experience provided by his or her family and the social context. The experiences from the environment are not viewed independently from the infant. Therefore, Sameroff and Chandler (1975:228-230) supported the notion that infants with high-risk births ended up with later developmental problems, not because of damage to the brain at birth, but rather of the negative effect such infants had on their caregivers.

Because transactions are located in the way the parent and the infant think about each other, one must comprehend their interpretive frameworks to intervene effectively. Understanding how infants and their parents influence each other over time is a necessary prologue to recommendation for appropriate interventions. Evidence of transactions can be found at all points in development, e.g. the establishment of the unique infant-caregiver attachment relationship where the infant plays a role in eliciting parent interactions (Sameroff & McKenzie, 2003:17-18). In order for a genuine transaction to occur, the parents must be influenced by the infant's behaviour, to do something they would not have done if the infant behaved otherwise (Sameroff, 1993:7).

In line with the Transactional Model of Development (Sameroff & Chandler, 1975:187-244), Sameroff and Fiese (1990:134-144) presented a format for identifying targets of intervention, as well as strategies of intervention: the Transactional Model of Intervention. By examining the strengths and weaknesses of the regulatory system, targets can be identified. In some cases, small alterations in infant behaviour may be all that is necessary to re-establish a well-regulated developmental system. In other cases, changes in the parent's perception of the infant may be more effective. Lastly, to improve the ability of parents to take care of the infant may be a more effective form of intervention. These categories of intervention have been labelled remediation, redefinition and re-education.

The Transactional Model of Development represents an appropriate conceptual framework to address the management of infant developmental needs by community nurses. The researcher borrowed this model from the fields of Child Development and Early Childhood Intervention, because it indicates the requirements necessary for successful intervention to support child development (typical and atypical development):

- Child development has multiple contributors (among others, socio-economic disadvantage, parent-child relationship and parenting skills) at multiple levels of the child's ecology: micro-, meso-, exo- and macrosystem. (See Figure 4.2:240; Figure 4.5:246).
- At each of these levels, multiple processes are represented in family thought and cultural symbols and are enacted in family interactions and social services (See 4.2.3.1.1:247; 4.2.3.1.2:276; Figure 4.2:240).
- Intervention processes are targeted at a particular problem for a particular infant in a particular family in a particular community (Barrera & Rosenbaum, 1986:113-115; Osofsky & Thompson, 2000:54; Sameroff & Fiese, 2000:135; Thomas, Guskin & Klass, 1997:201; Van Doesum, Hosman & Riksen-Walraven, 2005:160).

Following, Figure 4.2 that indicates the intertwining of the Transactional Model of Development and the meta-paradigm concepts of nursing in the management of infant developmental needs by community nurses.

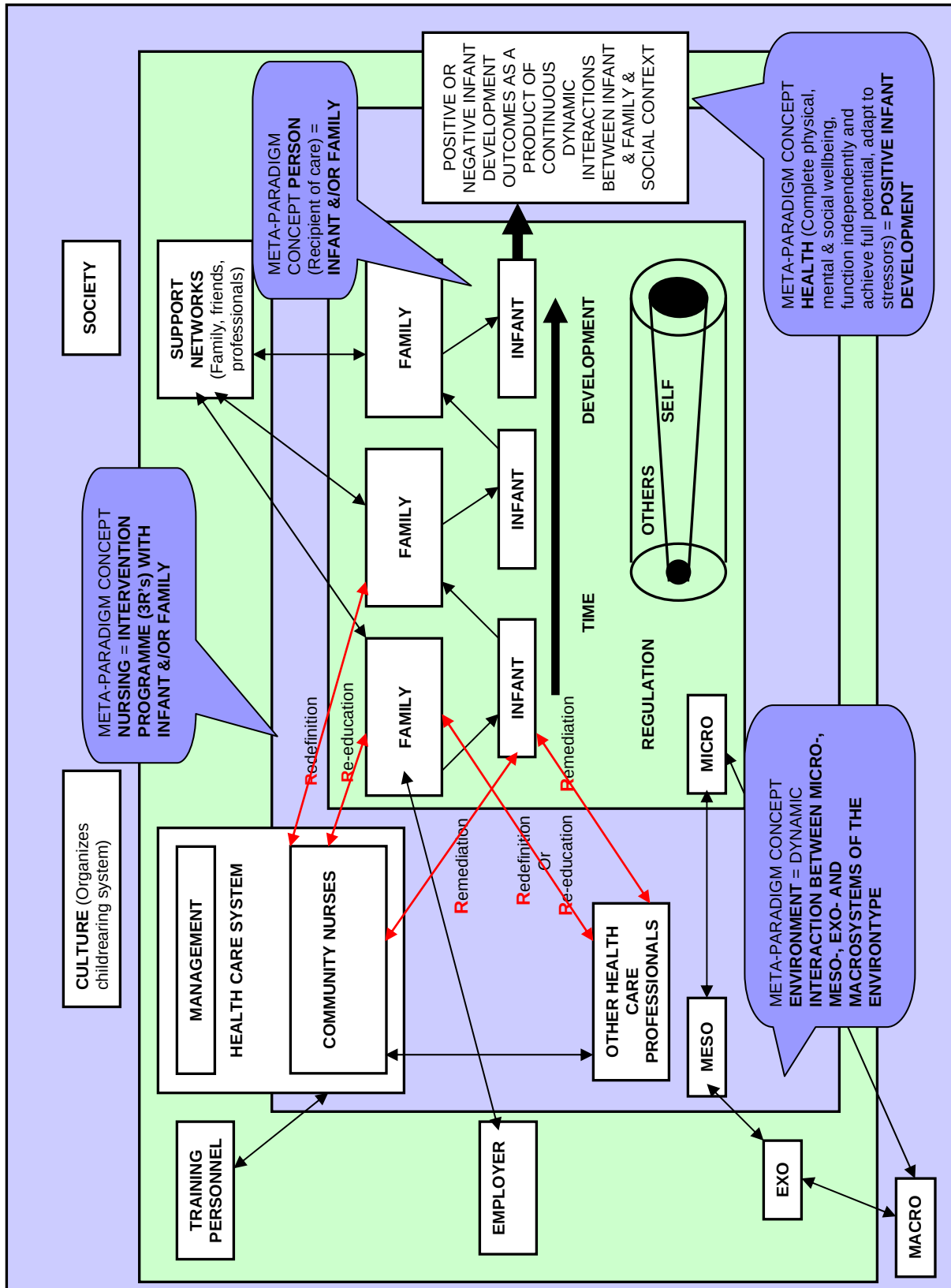


FIGURE 4.2 Diagram that indicates how the Transactional Model of Development and the meta-paradigm concepts of nursing are intertwined in the management of infant developmental needs by community nurses.

The role of the environment in affecting child development has been emphasized in the transactional model, indicating that it is an ecological model. Infant and environmental characteristics are therefore addressed simultaneously in the transactional model. Outcomes are seen as a combination of an individual and his or her experience provided by the family and social context. Equal emphasis is placed on the effects of the infant and the environment, so that experiences provided by the environment are not viewed as independent of the infant. Infants are thus viewed in a holistic, organizing framework (Mohr, 1999:121; Sameroff, 2004:7-8; Sameroff & Fiese, 2000: 141-143; Thomas et al., 1997:200; Veddovi, Gibson, Kenny, Bowen & Starte, 2004:582). Figure 4.3 below, illustrates the transactional process with reciprocal effects between the infant and the parent across time.

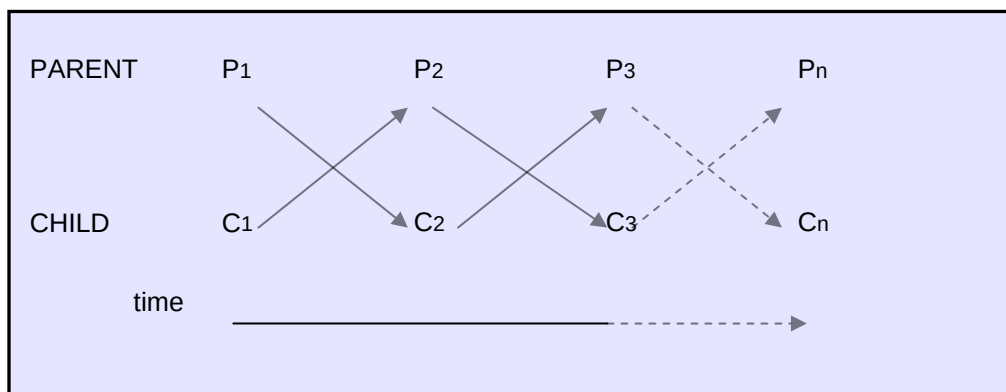


Figure 4.3 Transactional process with reciprocal effects between the child and the parent across time (P = parent; C = child; n = number of transactions between parent and child over time) (Sameroff, 2004:8).

The series of transactions illustrated (See Figure 4.4:242), is an example of how developmental achievements are rarely sole consequences of immediate or distal antecedents. The causal chain between peri-natal problems and early childhood problems is not only extended over time, it is also embedded in an interpretive framework. For example, a mother's anxiety is based on an interpretation of the meaning of a complicated childbirth, and her avoidance is based on an interpretation of the meaning of the child's irregular feeding and sleeping patterns (Sameroff, 2004:9).

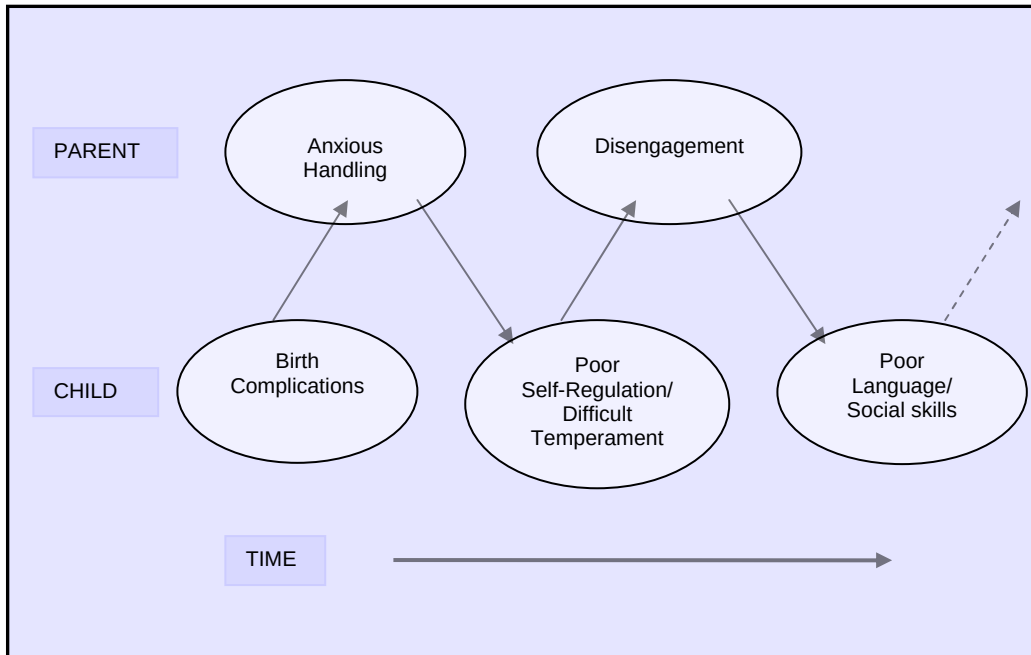


Figure 4.4 Transactional process linking peri-natal complications and early childhood language problems (Sameroff, 2004:9; Sameroff & McKenzie, 2003:17)

There is a need to understand this interpretive framework. What follows is a description of this interpretive framework and the ultimate goal of this description is to offer a theoretical basis for the design of future intervention strategies that can be targeted at a level of developmental regulation appropriate to the desired change in an infant's development (Sameroff & Fiese, 1990:123-124).

#### 4.2.3.1 THE ENVIRONTYPE

Just as there is a biological organization, the genotype, which regulates the physical outcome of each individual, there is a social organization, the envirotype, that regulates the way human beings fit into their society. This organization operates through family and cultural socialization patterns. If one is interested in manipulating the infant's development, as in the case of prevention or intervention programmes, it is important to identify the sources of regulation of human development. Each infant's envirotype contains these regulatory patterns and this envirotype is composed of subsystems that not

only transact with the infant but also with each other (Sameroff & Fiese, 1990:124-125). Bronfenbrenner's (In Thomas, 2005:352-355) Model of Human Ecology is used to explain how the world that surrounds the infant, help or hinder continued development. This environment is examined at four levels beyond the infant. These levels include:

- The *Microsystems* are “a pattern of activities, roles, and interpersonal relations experienced by the developing person in a given face-to-face setting with particular physical, social, and symbolic features that invite, permit, or inhibit engagement in sustained, progressively more complex interaction with, and activity in, the immediate environment” (Thomas, 2005:352). It is the most basic unit of analysis and the level closest to the infant and it includes the immediate settings in which the infant exists, e.g. family, neighbourhood or childcare environments. Relationships at this level have impact in two directions, away from the child and towards the child. The quality of this system is indicated by its ability to provide a context that is able to sustain and enhance development (Garbarino & Ganzel, 2000:78). Aspects of the microsystem that influence infant development are adaptive parenting, presence or absence of family violence, family cohesion, parental characteristics and parenting skills (Mohr, 1999:122).
- The *Mesosystems* “comprises the linkages and processes taking place between two or more settings containing the developing person. Special attention is focused on the synergistic effects created by the interaction of developmentally instigative or inhibitory features and processes present in each setting” (Thomas, 2005:354). This level refers to the interconnections between the infant's different microsystems and its richness is measured in the number and quality of those connections. An example is the extended family or the connection between the infant's day caregiver and his or her parents (Garbarino & Ganzel, 2000:79).
- The *Exosystems* “comprises the linkages and processes taking place between two or more settings, at least one of which does not contain the developing person, but in which events occur that indirectly influence processes within the immediate setting in which the developing person lives” (Thomas, 2005:354). This level consists of contexts in which the infant does not function directly but which nevertheless affect the infant's

development e.g. the parents' workplace and community based resources (the health care system), crime and violence in the community. Both risk and opportunity can be experienced. For instance if the parent is treated in a manner that impoverishes (risk) or enhances (opportunity) their behaviour in the microsystem they share with their infant, e.g. policies set forth by parents' employers about long and inflexible hours, could restrict parents' availability to their infant and in turn influence the infant's development. On the other hand, flexible hours could assist in the infant's development. Another way in which risk and opportunity flow from the exosystem is the decisions that are made in those settings that affect the day-to-day experience of infants and their families. When funds for services are suspended, it affects infant development negatively. When funds are increased or new services for mothers and infants are initiated it affect infant development positively. The ecological perspective forces people to focus on the concept of risk beyond the narrow confines of individual personality and family dynamics (Garbarino & Ganzel, 2000:79-80).

- The *Macrosystems*. This is the overarching system and is comprised of the cultural milieu. It is the source of influence most remote from the infant's immediate experience, but affects the infant through the assumptions about how things must be done. Elements could include such items as the presence or absence of policy and legislation designed to protect the rights of children, or the availability of health care and other social services. The effects of assumptions defined by the macrosystem have a ripple effect throughout all the levels (Garbarino & Ganzel, 2000:80-81; Mohr, 1999:122).

These systems are illustrated to indicate the influence that they have on each other, as well as on the infant and family (See Figure 4.2:240; Figure 4.5:246).

In the meta-paradigm of nursing, the corresponding concept is the **environment**. In nursing, the environment refers to both the internal and external conditions, circumstances and influences that affect the person. However, in this context the focus is more on the external environment, which constitutes the physical, social and economic relationships of a person. The environment includes the immediate (micro- and mesosystems) as well as the



larger environmental contexts (exo- and macrosystems) and there is a constant interaction between a person (infant) and this environment (indicates bi-directionality of interactions; subsystems that not only transact with the infant but also with each other) (Thorne et al., 1998:1262). In this research, the infant's environment encompasses the parents and extended family, community nurses, management, other health care professionals as well as persons involved in the training of community nurses.

In Figure 4.5:246, the structure of the environment in the Ecological Systems Theory is illustrated. The microsystem includes relations between the developing infant and the immediate environment; the mesosystem, connections between immediate settings; the exosystem, social systems that affect but do not contain the infant and the macrosystem, the values, laws and religion that affect activities and interactions at all inner layers.

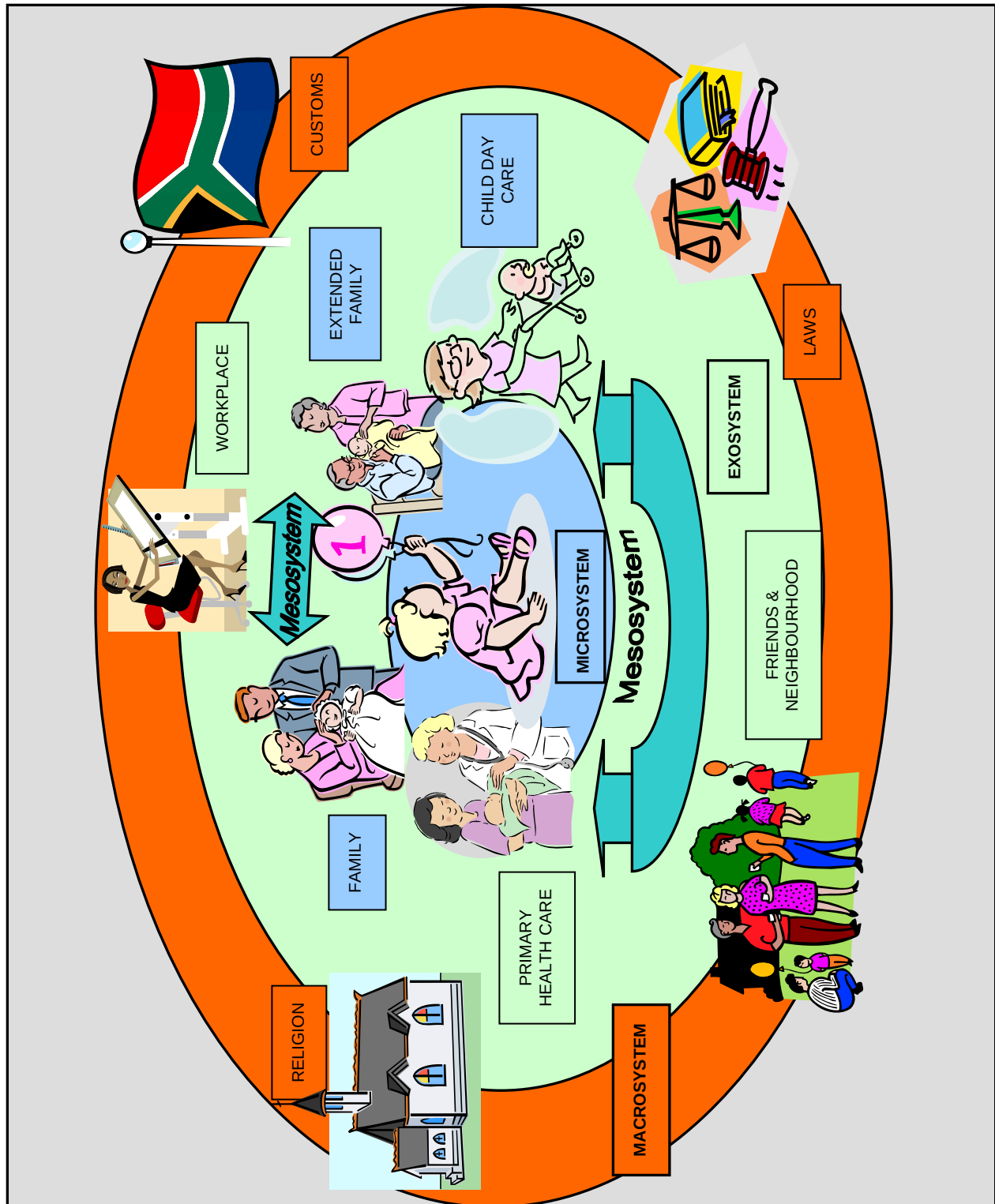


Figure 4.5 Structure of the environment in the Ecological Systems Theory (Berk, 2003:28).

If one wants to manipulate human development, one needs to be able to identify the sources of regulation of human development. The levels of environmental factors are contained within the culture, the family and the individual parent. Developmental regulations are carried within codes: the cultural code, the family code and the individual code of the parent. These codes regulate physical, cognitive and social-emotional development and enable the infant to fill a role defined by society. The experiences of the developing infant is partially determined by 1) beliefs, values and personality of the parents; 2) the family's interaction patterns and transgenerational history and 3) socialization beliefs, controls and supports of the culture. Changes in the abilities of the developing infant are major triggers for regulatory changes and different parents, different families, and different cultures may be sensitive to different behaviour of the infant as a regulatory trigger (Sameroff & Fiese, 1990:125-126).

**From this point onward, the categories and subcategories identified through analysis in chapter 3 are discussed by utilizing the Transactional Model of Development and related nursing literature. An overview of the specific section of the Transactional Model of Development is given before any discussion is presented. In cases where the meta-paradigm of nursing is addressed, it will be indicated in bold letters. Any reference to the categories and subcategories will also be typed in bold letters, to enhance interpretation.**

#### **4.2.3.1.1 CULTURAL CODE**

The cultural code organizes a society's childrearing system and incorporates elements of socialization and education. These processes are embedded in sets of social control and supports, which are based on beliefs that differ in the amount of community consensus ranging from norms to fads. For example, in most cultures formal education starts when most children have developed the cognitive ability to learn from structured experiences. Furthermore, due to certain cross-cultural differences, certain changes in infant behaviour are ignored or emphasized. For example, some parents believe that prenatal

experiences will enhance their infant's cognitive development and therefore, start with stimulation during pregnancy (Sameroff & Fiese, 2000:144). The cultural code therefore regulates development so that an individual may fill a role in society.

Thus, society has a commitment to ensure the healthy development of every infant and it requires far more than standing on the sidelines and wishing parents the best in their efforts. It requires helping parents to obtain health care that focuses on infant development and to stand alongside parents in their efforts to ensure the wellbeing of infants (Thompson, 2001:31). The health care system is therefore, through society's commitment, very much a part of the infant and family's environment.

Health care takes place in a relatively well-defined context. Many people participate in this context. This care context can be viewed as a hierarchy containing systems on different levels, which interact and influence each other. These systems need to be managed and this implies adding at least one hierarchical level, the management level, to oversee and support the community nurse in her management of infant developmental needs in the primary health care clinic (Sandelin Benkö & Sarvimäki, 2000:515-518) (See Figure 4.2:240). From the research findings, it is clear that community nurses and management have disparate views on how they view support by management to community nurses.

#### **a. Health Care Governance**

Health care governance can be seen as a framework to help management to continuously improve the quality of care and to safeguard standards of care, delivered by community nurses (Tait, 2004:724; Wilkinson, Rushmer & Davies, 2004:106; Table 3.1:67). Management must be able to inspire, challenge, motivate, and unite staff in a common purpose: the quest for improved quality (Drach-Zahavy & Dagan, 2002:20; McSherry, 2004:137). Health care governance is furthermore concerned with instilling confidence in both public

and community nurses, to ensure the clients receive the right care, at the right time, from the right person in a safe environment (McSherry, 2004:141).

For health care governance to be effective, change is necessary at three levels in the organization:

- Individual community nurses. They need to embrace change through reflective practice where the client is at the centre of their thinking.
- Teams. Intervention teams need to become truly transdisciplinary.
- Management. They need to put systems for support of community nurses in place to ensure the quality of care provided (Tait, 2004:724).

According to McSherry (2004:139) in order to ensure successful health care governance, certain essential qualities are necessary: commitment, respect, experience, approachability, being an agent of change, supportiveness and being a good listener. Management can by listening, empowering, valuing, and involving staff, enhance changes in the primary care service delivery. Management must be appropriately prepared to lead and manage this process. This requires intellectual growth from management and literature indicates that they need to pursue training and development to prepare them for effective leadership. Unless management take cognisance of and are competent in, among others, strategic planning development that implicates on clinical practice, they would not be able to create work environments that benefit community nurses and ultimately clients (Murphy, 2005:131-132, 135).

In a health care context, policies may be defined as “the direction given by any body sanctioned by government, through health departments” (Tolson, Maclaren, Kiely & Lowndes, 2005:662). The consequence of community nurses not being aware of or not implementing policies, are far reaching. It is therefore, paramount for management to devise strategies, as part of health care governance, to prioritize and share information about the implementation of **policies and guidelines**, to ensure the quality of service provision (Tolson et al., 2005:662, 670). To enhance this process, they must constantly familiarize themselves with health care delivery policy documents (Murphy, 2005:131).

As part of health care governance, effective **induction** would ensure that newly appointed community nurses had the opportunity to identify and fill gaps in their knowledge as well as learn about their new working environment (Scottish Executive Health Department, 2004:n.p.). In accordance, **role expectations** are also important in health care governance. Role, as defined by Katz and Kahn (In Bower, Jerrim & Gask, 2004:337) indicates, “Recurring activities of an individual, appropriately interrelated with the repetitive activities of others so as to yield a predictable outcome.” The nursing manager should communicate the specific role expectations to each individual community nurse, as it represents the standards used to evaluate the specific community nurse in order to bring about conformity with those expectations. Role clarity has been identified in the literature, as key to successful role implementation (Micevski, Korkola & Sarkissian, 2004:n.p.)

Another important component is the evaluation of nursing **documentation**. According to literature, nurses often leave essential facts related to the care of the client, unrecorded. Nurses are responsible for maintaining records and are accountable if documentation is not accurately completed and informative. Documentation is the only way that the nurse can legally communicate the care that has been delivered. It is therefore crucial for the quality of nursing care and it is a prerequisite for quality assurance within nursing (Kärkkäinen & Eriksson, 2005:203; Nilsson & Willman, 2000:199; Owen, 2005:48).

**Professional performance management (supervision)** is conducted for the purpose of quality improvement in health care and the emphasis is on the identification of opportunities for improvement and continual development (Rhydderch, Edwards, Elwyn, Marshall, Engels, Van den Hombergh & Grol, 2005:367).

In health care governance, management must be aware of the processes, which communicate that knowledge is essential to care delivery (client orientated and sustainable care). Thus, management need to help community nurses to be users of knowledge by developing a **training** strategy. This training strategy should include at least:

- Commitment to continuous professional development
- A training needs analysis of individual community nurses
- Identification of necessary knowledge and skills required of the person working within a specific role
- Identification of key people required to support and enable staff to gain the skills to meet the identified needs (Clarke & Wilcockson, 2001:271; Rutherford, Leigh, Monk & Murray, 2005:103).

It is imperative for management to include **client perceptions** in their framework of health care governance. In this age of 'accountable consumerism' in which clients demand service excellence, management need to identify the issues that are important to clients and their perceptions of quality if they truly want to focus on improvement (Drain, 2001:31).

If the transactional model is implemented as a frame of reference for delivery of health care, management will realize that early experiences matter. Therefore, they need to do everything in their power to support community nurses in the management of infant developmental needs, thereby ensuring that infants' experiences with health care promote positive developmental outcomes.

## SUMMARY

### HEALTH CARE GOVERNANCE (HCG)

- HCG is a framework to help management improve the quality of care and management must have the necessary qualities and be appropriately prepared to lead and manage this process.
- To improve the quality of care and to safeguard standards of care, the formulation of principles for health care governance is necessary. An emphasis on the following aspects is essential:
  - Policies and guidelines
  - Induction of staff
  - Role expectation
  - Documentation
  - Professional performance management
  - Training
  - Acknowledgement of client perceptions

#### b. Organizational Culture and Climate

Culture represents the shared beliefs and values within an organization and it is perceived as an important factor in health system reform and quality improvement (Tait, 2004:725; Table 3.1:67). Culture is defined by Drennan (In Wilson, McCormack & Ives, 2005:28) as “the way things are done around here” and includes a shared understanding of actions and beliefs that are obtained through group socialization and learning. Managers must provide a sense of direction, they must coach and mentor their subordinates individually and collectively to ensure productivity (**investment in staff**) (Drach-Zahavy & Dagan, 2002:26). An organization’s effectiveness is often reliant on a culture that values its staff and the contribution they make. Managers, if they want to be effective as leaders, have to acknowledge staff contributions (**input and achievements**) (Rutherford et al., 2005:103). Furthermore, there need to be effective two-way **communication and feedback**. If communication is not in place, the staff is at a disadvantage and it is more difficult for them to perform their duties effectively (McGillis Hall, McGilton, Krejci, Pringle, Johnston,



Fairley & Brown, 2005:185; Murphy, 2005:133). According to McGillis Hall et al. (2005:181-185) little empirical research exists that examines the area of the supportive relationship between nursing staff and managers in health care settings. However, they have identified various qualities that define a supportive manager:

- Respect and trust
- Praise, recognition and positive reinforcement
- Role-modelling and helping behaviour
- Personal caring behaviour
- Absence of personal defensiveness

In addition to organizational culture, the climate, how it 'feels' to work in a place, is just as important as it influences employee motivation. Leaders who manage the organizational climate can tap the full potential from their employees. On the other hand, if the climate is not managed, the workers will be less than average or mediocre. The relevance of creating an environment with a positive climate cannot be overestimated, as this will eventually have an effect on the quality of the health care service context in which community nurses relate to infants and families (Snow, 2002:393-395). Possible ways in which to improve organizational climate is described in Table 4.1 below.

Table 4.1 Ways to improve organizational climate

| <b>Ways to improve organizational climate</b> |                                                                                                                                             |
|-----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|
| To increase flexibility                       | Reduce rules and red tape<br>Encourage new ideas<br>Establish minimum lines of authority<br>Organize for maximum efficiency                 |
| To increase responsibility                    | Encourage calculated risk-taking<br>Delegate additional tasks and authority<br>Foster job authority<br>Hold people accountable for outcomes |
| To increase standards                         | Encourage challenging goals<br>Give feedback, information, and assistance to improve performance                                            |

|                             |                                                                                                                                                                                                               |
|-----------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                             | Make sure that performance measures are clear and adequate                                                                                                                                                    |
| To increase rewards         | <p>Increase recognition</p> <p>Decrease unwarranted threats and criticism</p> <p>Reward employees in proportion to the quality of their performance</p> <p>Provide professional development opportunities</p> |
| To increase clarity         | <p>Clarify job expectations</p> <p>Connect job expectations to mission objectives</p> <p>State policies and procedures</p> <p>Make sure that lines of authority are clear</p>                                 |
| To increase team commitment | <p>Resolve conflicts quickly</p> <p>Foster co-operation</p> <p>Resolve issues that interfere with task completion</p> <p>Encourage interaction among team members</p>                                         |

(Snow, 2002:396).

## SUMMARY

### ORGANIZATIONAL CULTURE AND CLIMATE

- **Organizational culture and climate is perceived as an important factor in health system reform and quality improvement.**
- **It is, therefore, imperative to create a positive organizational culture and climate in the health care environment, as it allows and encourages community nurses to operate at their full potential.**
- **A supportive relationship between management and community nurses is important, as this will eventually have an effect on the quality of the health care service context in which community nurses relate to infants and families. Furthermore, awareness of the qualities that define a supportive manager, contributes to this supportive relationship.**

### **c. Resources and Infrastructure**

Managers, in an era of limited resources, need to ensure that the necessary **infrastructure, human and financial resources** are available to allow nurses to perform their job effectively (Murphy, 2005:132; Table 3.1:68). Limited resources and the pace of change in health care can be a potential obstacle to success in improving the quality of care (Jorgensen Huston, 2003:296). The Primary Health Care Package for South Africa, a set of norms and standards (National Department of Health, 2000:12-15), encompasses core standards pertaining to clinic **facilities**, equipment, staff and financial resources. Each clinic therefore, has to strive towards fulfilling these preset requirements. However, in this study there was no consensus among both community nurses and management about the necessary infrastructure and resources. Management, nevertheless, need to address constraints timely to ensure that lack of resources and infrastructure do not impede the delivery of a quality health care service to infants and their families. Once again, the health care context has an important influence on outcomes: families' experience the service as poor and dissatisfied clients are less likely to return with their infants to the clinic or to seek treatment at all, thereby compromising the infant's health and development (Drain, 2001:31).

#### **SUMMARY**

##### **RESOURCES AND INFRASTRUCTURE**

- **Management need to ensure that the necessary infrastructure, human and financial resources are available to enable community nurses to manage infant developmental needs effectively as limited resources can be a potential obstacle to success in improving the quality of care.**
- **Be cognizant of the influence of the health care context on health outcomes. Identify and address constraints timely to ensure that it does not impede the delivery of a quality health care service to infants and their families.**

#### d. Interagency Collaboration

Interagency collaboration or joining to work together in partnership is viewed as a strategy to assist with co-ordination of health care. Collaboration is a vehicle through which different organizations can pool their intellectual and institutional resources and it can vary along a continuum from a simple co-operative understanding to co-ordinated ventures. A lack of collaboration between agencies has been seen as the reason that people 'fall through the gaps' and do not receive the health care services that they need. Infants have complex issues relating to health, development and behaviour and they do not fall neatly into one of the service categories into which the services are divided. (Alkema, Shannon & Wilber, 2003:223; Chaudry, Polivka & Kennedy, 2000:76; Salmon, 2004:156; Van Eyk & Baum, 2002:262; Table 3.1:68).

Although professionals working with infants and children understand and agree that collaboration should occur between agencies, this appears not to happen in practice. In South Africa, according to the White Paper for the Transformation of the Health System in South Africa (National Department of Health, 1997) appropriate referral mechanisms would facilitate appropriate interaction between community, clinic and hospital-based care. The focus therefore, is only on interaction (**liaison and meetings**) between different organizations and not on collaboration. However, it is expected from management to collaborate with other agencies that provide infant health care in the community. In the words of Boswell & Cannon (2005, n.p) "It takes a community of individuals all working together to be successful. An understanding of the process of collaboration enables leaders to develop and manage the environment to meet the needs identified within the community."

The Transactional Model of Development focuses on the context of the care giving environment of the infant (Meyer, Lester, Boukydis & Bigsby, 1998:49-50). Changes in the external environment (health care system that collaborates with other agencies to deliver a more effective service) of the infant may lead to improvements in the ability of the infant to grapple with developmental challenges.

## SUMMARY

### INTERAGENCY COLLABORATION

- Collaboration is a vehicle through which organizations can pool their intellectual and institutional resources, therefore management need to understand the process of collaboration to enable them to develop and manage the environment to meet the health care needs identified within the community.
- A lack of collaboration could be the reason that people ‘fall through the gaps’ and do not receive the health care services that they need. Hence, it is expected of management to implement interagency collaboration as a strategy to provide and co-ordinate health care to infants in the community.

#### e. Rights of the infant to develop to full potential

There is global consensus that children's rights need special attention, as had been indicated by the research findings. The widespread belief of the importance of good care and protection of children is embedded in the culture of all societies. This belief is endorsed by the human rights argument, which stipulates that children have a right to life and to develop to their full potential. Furthermore, the fact that infants are dependent on others for satisfaction of their rights, as they **cannot speak for themselves** creates a greater obligation to protect them (Meyers, 1993:37; Table 3.1:68). The Convention on the Rights (CRC) of the Child (Meyers, 1993:37), adopted unanimously in 1989 by the United Nations (UN) General Assembly, recognized among its 10 principles:

“The child will enjoy special protection and will have at its disposal opportunities and services dispensed under the law and through other means, allowing physical, mental, moral, spiritual and social development in a healthy and normal way, with liberty and dignity.”

The CRC guarantees the rights of children to the three P's: protection (from maltreatment, neglect, and all forms off exploitation), provision (of food, health

care, education, social security) and participation (in all matters concerning them). The UN Committee stresses four underlying guiding principles: 1) the best interests of the child, 2) non-discrimination, 3) the right to life, survival, and development and 4) respect for the views of the child. Of these, the 'best interest' principle is seen as the most fundamental. At the World Summit for Children in 1990, Heads of State signed a declaration asking all world leaders to commit themselves to the protection of the rights of the child and improvement of children's lives, particularly enhancing children's health; promoting optimal growth and development in childhood; strengthening the role of women and respecting the role of the family (UNICEF, 1990).

On 16 June 1994, President Nelson Mandela pledged the government's commitment to South Africa's children. A holistic plan, National Programme of Action for Children (NPA), had been developed and it endeavours to improve and promote the rights and issues of children in South Africa (NPA, n.d.:5). The Constitution of South Africa (1996) devotes a special section to children and a range of children's rights is specified, including the right of every child to basic nutrition, shelter, basic health care services and social services.

Infants are the future and that future lies with parents, and all other with whom these infants will have contact with throughout their lives. Development happens as infants respond to, learn from, and seek to affect their environments. It occurs in interaction with people and things. For this reason, **parents have a responsibility** to provide an environment that would foster healthy development of their infants. All families want their infants and children to grow into persons who are well developed physically, mentally, socially and emotionally (**develop into an independent adult**). Therefore, placing them in a better position to contribute to family, community and country, they should not become a **burden on their community** (Meyers, 1993:21, 38-39).

As discussed in chapter 1, the various divisions in the Department of Health are responsible for programmes that affect the health of children directly or indirectly. From the literature, it is obvious that there must be a focus on the rights of children, morally and legally. Meyers (1993:37) indicated that

“Allowing disability and arrested development to occur each year in millions of children, when it could be prevented, is a violation of basic human rights. The fact that children are dependent on others for satisfaction of their rights creates an even greater obligation to help and protect them.”

The Transactional Model of Development focuses on the biological, psychological, and social factors. These factors influence each other and define the complex world in which the child develops (Thomas et al., 1997:200). Therefore, utilization of the transactional model would enable community nurses to address all the issues as stipulated in the principle by the United Nations General Assembly, as well as the three P's, namely protection, provision and participation. This coincides with the meta-paradigm concept of **nursing**. In South Africa, according to the patients' rights charter, as set out in The Primary Health Care Package for South Africa (National Department of Health, 2000:10-11) community nurses are to acknowledge the rights of patients in the delivery of health care. By targeting effective anticipatory guidance, they could assist parents in promoting optimal infant developmental outcomes (Halfon, Regalado, Sareen, Inkelas, Peck-Reuland, Glascoe & Olson, 2004:1926).

#### **SUMMARY**

##### **RIGHTS OF THE INFANT TO DEVELOP TO FULL POTENTIAL**

- **Acknowledge the rights of the infant (protection, provision and participation) to develop to full potential. Community nurses have specific responsibilities and priorities in protecting these rights by enhancing infants' health through delivery of quality health care.**
- **Parents have a responsibility to provide an environment that would foster healthy development of their infants and community nurses have co responsibility by ensuring that parents have the necessary knowledge to provide an environment conducive to healthy development.**

#### **f. Focus on infant developmental needs**

There is a concern about the extent (**focus**) to which infants receive basic preventive services apart from immunizations, as many early emerging developmental delays and disabilities go undetected and, therefore unaddressed by service systems (Carter, Briggs-Gowan & Ornstein Davis, 2004:118; Magnusson et al., 2001:118; Zuckerman, Stevens, Inkelas & Halfon, 2004:1522; Table 3.1:68). Most participants in the study echoed this concern (**perceptions**). The literature indicates that timely assessment of infant development makes it possible to identify and manage developmental delays and disabilities at the earliest possible point of manifestation and to prevent or diminish loss of developmental potential. It can furthermore, help to identify developmental risk factors and target effective anticipatory guidance to assist parents in promoting optimal developmental outcomes (Carter et al., 2004:118; Halfon et al., 2004:1926; Magnusson et al., 2001:118).

The early years matter as it is a period of considerable opportunity for growth, and vulnerability to harm (Shonkoff & Marshal, 2000:35; Simeonsson, 2000:4). Research confirms that nurturing relationships, early environments and early experiences matter as it plays a critical role in infants' development (Klein & Rye, 2004:340; Thompson, 2001:22; VanLandeghem et al., 2002:1). The most resilient infant will be at risk for later developmental problems when such relationships are dysfunctional. On the other hand, the infant with extensive neurological vulnerabilities may still have an opportunity to thrive when such relationships are nurturing and supportive of adaptive development. It is imperative to identify biological risk factors and to reduce the deleterious effects. If it cannot be rectified, community nurses must have the necessary understanding of human adaptation to intervene (Sameroff & McKenzie, 2003:16; Shonkoff & Marshall, 2000:50). Changes in family structure, work patterns and other aspects of society that places increasing demands on families can in turn, have a negative impact on infant development. These challenges can further be compounded when families are of low-income, headed by a teen parent, experience substance abuse or have mental health problems (Sices, Freudtner, McLaughlin, Drotar & Williams, 2004:274).



However, development is notorious for its self-righting quality when biologic l or environmental conditions are restored to normal. Therefore, community nurses have a vital role in infant development, as they have regular access to infants and their families, which provide them with an important window of opportunity to assess and **positively influence infant health and development (promoting development)** (DiPietro, 2000:460; Miles Curry & Duby, 1994:40; VanLandeghem et al., 2002:5).

The goal of **assessment** is to acquire information and understanding, thereby enabling the community nurse to facilitate the infant's development and functional development within the family and community (Meisels & Atkins-Burnett, 2000:232). Developmental assessment has been defined as "a process to deepen understanding of a child's competencies and resources, and of the care giving and learning environments most likely to help a child make fullest use of his or her developmental potential. Assessment should be an ongoing, collaborative process of systematic observation and analysis. This process involves formulating questions, gathering information, sharing observations, and making interpretations in order to form new questions" (Meisels & Atkins-Burnett, 2000:232). To accept this definition of assessment, community nurses need to be knowledgeable about assessment, specifically the principles and elements of assessment.

Currently, the best approach to identify infants at risk is not clear. Infant development is a dynamic process and because of this and the fact that health care providers are reluctant to provoke parental anxiety, many infants with developmental delays, especially mild delays, are denied the opportunity to benefit from early intervention (Dworkin, 1989:1000; King & Glascoe, 2003:625). Romanczyk, Gillis, Noyes-Grosser, Holland, Holland & Lyons (2005:216) point out that an important, yet challenging part of the early identification process is the decision of which method should be used e.g. clinical procedure, screening instrument or assessment.

The infant's functional capacities should be examined in a variety of contexts and all areas of infant development should be considered. Perspectives from multiple sources, including other professionals and the parents should be obtained to produce a more complete, informed, and multidimensional profile of the infant. Assessment should begin with the establishment of a reliable relationship with the parents that is based on respect and trust. Parents play a vital role in helping the community nurse understand how familial and cultural contexts influence the infant's repertoire of skills. Community nurses need to find an effective way of adapting their recommendations that is culturally acceptable to meet the needs of the infant. Thereafter, it moves through multiple means of data collection and it results in the creation of a plan of action. The relationship between an infant and his caregivers forms the basis of the infant's ability to organize and respond to his or her world. Professionals should also determine the level of family involvement that would be the most beneficial for the family. Community nurses require an understanding of infant growth and development. They should be able to identify skills or behaviours with no functional application. Knowledge about what motivates the infant, what is frustrating and what is satisfying, as well as the availability of experiences for eliciting, supporting, and extending skills and abilities is necessary. The identification of strengths and competencies alerts the community health nurse to the available personal and ecological resources that the infant could call upon to meet subsequent challenges. A complete assessment includes information about how to facilitate the infant's development and the supports needed to help the infant exhibit desirable behaviours. Furthermore, assessment is an ongoing process and incorporated into the intervention so that the two functions become virtually seamless (Meisels & Atkins-Burnett, 2000:232-237).

Elements of assessment should include the following:

- *Target of assessment.* The infant should be viewed in relation to his or her family and caregivers.
- *Context of assessment.* Assess the infant within the context of the family that is familiar, comfortable and non-threatening. Information about the home environment, parent-child interactions, and family social support

networks should be included in the assessment. Furthermore, cultural competence is of paramount importance to ensure the validity of the assessment.

- *Methods of assessment.* Approaches that make use of everyday experiences that enable children to show what they know, what they can do, and what they are experiencing are currently more acceptable.
- *Assessment personnel.* In best practice, multidisciplinary teams observe and share perspectives on the child's development as it gives a more complete picture of the child's strengths and abilities.
- *Fusion of assessment and intervention.* Information from multiple sources throughout various time points reflects a wide range of child experiences and caregiver interpretations. The formal act of assessment is seen as the first step in the process of acquiring information. Furthermore, assessment without intervention is of limited value (Meisels & Atkins-Burnett, 2000:237-251).

Although developmental surveillance is a powerful identification tool, several **barriers** to effective implementation have been identified that are currently applicable to the South African context. Time constraints seem to be the most obvious barrier according to the community nurses who participated in the study. In a very busy clinic, the community nurse will simply not have enough time to perform all of the necessary steps for comprehensive developmental surveillance. It will not be successful for those infants receiving infrequent care by different providers at different times. The efficacy of this strategy is dependent on the community nurse's knowledge and experience. Inadequate training regarding developmental issues compromises the community nurse's skills in early identification, for instance not eliciting parental concerns properly can be a significant factor leading to missed early identification (Rydz et al., 2005:6)

Hendrickson, Baldwin and Allred (2000:1-17) have done a study to indicate factors perceived by mothers that prevent families from obtaining early intervention services for their children with special needs. The major barriers identified were a lack of knowledge by the primary health care providers

regarding the developmental delays that the children were experiencing and a lack of appropriate referral information. Other barriers that were identified include family discord, parents chose to wait, different parental beliefs and values about early intervention (parents who believed their children were affected less severely, were less likely to seek early intervention assistance).

Research by Barrera, Doucet and Kitching (1990:143-144,155) indicates that intervention during **home visits** could have a profound effect on improving the home environment, the infant's cognitive development, and increase in mother responsiveness during social interactions, social competency and adaptation. Another study (Koniak-Griffin, Verzemnieks, Anderson, Brecht, Lesser, Kim & Turner-Pluta, 2003:128) indicates that home visitation could provide early intervention services to improve pre-natal care and to offer instruction in parenting skills. They furthermore demonstrated notable improvement in both maternal and infant outcomes. Nurse-visited mothers had homes more conducive to infant development. These studies indicate the benefits of home visiting by nurses. According to The Primary Health Care Package for South Africa – set of norms and standards (National Department of Health, 2000), community nurses are to conduct home visits regularly. However, according to the research findings, home visits are done inconsistently and not for the purpose of developmental surveillance of infants.

The role of the community nurse in the primary health care clinic is to enhance the adaptation of the client system (infant, family) to its environment (Anderko, Uscian & Fisher Robertson, 1999:169). Developmental care emerges from interactions, especially a reciprocal action-reaction between the infant and professionals, as well as the infant and parents. The infant communicates developmental needs to the immediate environment through these interactions (Aita & Snider, 2003:227). The Transactional Model of Development focuses on the interaction of the infant and its environment (mother-infant interaction) and the interactive processes within the infant (biological and psychological). These interactions mutually influence one another. The first couple of years lay a crucial foundation for the health and development of infants and much of the development that occurs in this time is in the context of their interactions with

family (Blann, 2005:263; Wickberg, 2000:33). Community nurses have a vital role in facilitating development of early parent-infant relationships. They are ideally placed to promote positive outcomes for infants through intervention, where amongst others information on parent-infant relationships is shared with parents in their daily practice (Davis, Mohay & Edwards, 2003:579; Johnson, Kent & Leather, 2005:28).

It is evident that community nurses have a part in the ecology of the infant and need to manage the infant in the context of the care-giving environment, which includes the parents and family, the extended family and friends, the community, and the culture (See Figure 4.2:240). The coinciding meta-paradigm concept is **environment**, which infers that both internal and external conditions, and circumstances and influences affect the person. Internal conditions, circumstances and influences could be genetic, intellectual, spiritual or the disease process. The external constitutes the physical, social and economic relationships of a person. The environment includes the immediate as well as the larger environmental contexts and there is a constant interaction between a person and this environment (Thorne et al., 1998:1262).

The corresponding concept for the infant in the transactional model is **person** in the meta-paradigm. It refers to the recipient of care that includes physical, spiritual, psychological and socio-cultural aspects of care. Reference to person as recipient of such care does not exclude the family or even the community. The person as an open, holistic and adaptive system that is in constant interaction with the environment during the phases of the life span is envisaged. Through adaptation to changes, experiences to grow occur (Grant MacEwan College, 2001:17; McEwen, 2002:41; Salve Regina University, 2002:7).

Furthermore, in the meta-paradigm of nursing, **health** is seen as the intrinsic right of the person and it is a dynamic, interactive process that can be presented as a continuum with death/disease/disability on the one end and a high level of wellness on the other end. Health is a goal of nursing and the emphasis is rather on health promotion and disability prevention than on

disability and treatment. Health means a person can function independently and achieve his/her full life potential. It also indicates successful adaptation to life's stressors and is a reflection of the whole person: mind, body and soul (Gilbert et al., 2002:4; McEwen, 2002:41; Thorne et al., 1998:1261).

The concept **nursing** includes the care of both the well and the sick; it seeks to maintain, promote and restore the health of individuals, families and communities. Therefore, it helps individuals to attain their human potential by reducing and ameliorating the effects of disability and disease. The focus is thus on strengths and potentials and to promote harmony between the individual and the environment. To assist with this facilitation of optimal health, nursing also employs effective communication and collaboration with other health care providers (Feeley & Gerez-Lirette, 1992:802; McEwen, 2002:42; Salve Regina University, 2002:6; Thorne et al., 1998: 1265).

#### **SUMMARY**

##### **FOCUS ON INFANT DEVELOPMENTAL NEEDS**

- **Timely assessment of infant development makes it possible to identify and manage developmental delays and disabilities at the earliest possible point of manifestation and prevent or diminishes loss of developmental potential, thereby enlarging the extent to which infants receive basic preventive services beyond immunizations, as well as fixing the focus on developmental needs,**
- **It is important for community nurses to consider the various contexts and domains of development as well as to obtain perspectives from multiple sources, including the parents.**
- **Assessment must begin with the establishment of a good working relationship with the parents. The family needs to be included in the assessment to amplify insight in how the familial and cultural contexts influence the infant's repertoire of skills.**
- **Skills and knowledge about infant growth and development should be included in community nurses' knowledge base to support them in the process of promoting infant development.**

- The best approach to perform developmental surveillance must be developed to assist community nurses in primary health care clinics to identify infants at risk.
- Ensure sustainability of developmental surveillance in the current health care context by addressing barriers to effective implementation of infant developmental surveillance.
- Home visiting demonstrate positive outcomes for both infant and mother.

#### g. Professional accountability

Community nurses are responsible both legally and ethically for the care they provide. Nurses in South Africa must practice in accordance with the Nursing Act, no. 50 of 1978, as amended, and its regulations. The regulation **scope of practice**, R2598 of 1984, as amended, regulates the practice of registered nurses and midwives, irrespective of their area of work and it is very important that registered nurses do not function outside their scope of practice. Most community nurses in this study could identify the scope of practice from a developmental care aspect and agreed that developmental care is part of their responsibility (See Table 3.1:68). However, their practice did not reflect developmental care as part of their service to infants and their families. The current regulations relating to the scope of practice of registered nurses, including community nurses recognize the ecology of health by focusing on the individual, the family, groups and the community in the execution of a nursing regimen as well as an environment in which the physical and mental health of a client is promoted (See Figure 4.2:240). Therefore, the Transactional Model of Development would be applicable within the registered nurse's current scope of practice. Although there is no specific mentioning of interaction per se, it is implied by the nursing regimen, as nursing interventions in the case of infant developmental care, could not be instituted without interaction between the nurse and the infant, and/or family.

Although the final responsibility for the quality of care rests with the chief executive of the work place, it is the responsibility of the individual registered nurse to act **competently and ethically** and to be accountable for his or her own nursing practice. By virtue of their professional accountability and contracts of employment, community nurses have a responsibility to enhance their nursing practice (McSherry, 2004:145; Tait, 2004:723).

The assumptions that underpin the practice of health care have changed from a framework where practice had been based on experience, to one where practice is based on evidence. Information is considered as evidence if it is derived through research. Nurses need to know how to find evidence and develop skills to do it. They need to understand the way in which evidence can be used in clinical reasoning; they need to take a personal responsibility for the change to **evidence-based practice** through professional development; and lastly to know what strategies can be used in this professional development (Cusick & McCluskey, 2000:161; Dale, 2005:48). On a personal practical level, community nurses may face “conflict between best practice advocated by research-based evidence and the custom-and-practices used in their work place setting” (Spouse, 2001:13).

Everything done by community nurses in the primary health care clinic must be able to stand the test of legislative bodies and public judgements on propriety and professional codes of conduct. Accountability and a code of conduct are about ensuring that community nurses know to whom they are accountable and for what practices (McSherry, 2004:140). A core characteristic of nursing is that nurses work in close relationship with their clients. The nurse who is acting in regard of her client’s well being, expresses **human dignity** in actions, emphasizes the inherent worth of the client; treats the client as a person; puts in active effort to understand the client’s situation from his perspective and regards the client as a whole being (Fagermoen, 1997,434, 439).

The Transactional Model of Development emphasizes relationships, and by bolstering parents’ wellbeing and self-esteem, parent-infant interactions could be influenced positively (Osofsky & Thompson, 2000:69). In the meta-



paradigm of nursing, the concept **nursing** has as its objective, caring that encompasses all of the professional values, roles, core competencies and knowledge that the cultural congruent professional nurse employs to facilitate optimal health (McEwen, 2002:41; Thorne et al., 1998:1261).

#### SUMMARY

##### PROFESSIONAL ACCOUNTABILITY

- **Community nurses are responsible for their professional accountability, and specifically by:**
  - **Practicing in accordance with the Regulation Scope of Practice (R2598, 1984, as amended).**
  - **Acting competently and ethically**
  - **Being personally responsible to change to practice that is based on evidence**
  - **Being able to stand the test of legislative bodies and public judgements regarding propriety and professional codes of conduct**
  - **The expression of human dignity in their actions.**

#### h. Personal professional development

In South Africa, the South African Nursing Council regulates the training of nurses and specifically, by Regulation R425 of 1985 (Regulations relating to the approval of and the minimum requirements for the education and training of a nurse [general, psychiatric and community] and a midwife leading to registration). The Council furthermore, prescribe the content of training programmes (See Table 3.1:69). Therefore, all community nurses undergo **pre-service training** as prescribed by the South African Nursing Council. However, rapid changes in service provision towards a more responsive service require from nurses to acquire new knowledge and skills to enable them to deliver an effective care service (Tennant & Field, 2004:167).

During the interviews, the community nurses indicated a lack of knowledge about infant development care and this lack coincided with their inconsistent

**focus on infant development.** Dworkin (1989:1006) emphasizes a sound knowledge of the basic principles, processes, and domains of child development; familiarity with the roles and skills of professional colleagues; familiarity of community resources; knowledge of parental behaviour and responses to infants' developmental problems and an understanding of the developmental surveillance process. Community nurses best serve public interest and specifically that of the infant when they constantly improve their application of competence and thereby increasing their focus on infant development. Community nurses need to be able to recognize their own limitations and **training needs**, they need to look at their practice with fresh eyes to be able to plan on how to meet such needs best (Spouse, 2001:15,17; Tennant & Field, 2004:168).

Bruder and Dunst (2005:25) researched personnel preparation in recommended early intervention practices. They postulated that preparation for personnel, serving infants and young children and their families, demands a focus that is different from the preparation of personnel serving older children. Bailey, Simeonsson, Yoder and Huntington (1990:n.p.) recommended a stronger emphasis and commitment on both pre-service and **in-service training programmes** to include content that will enable those serving infants and young children to meet the developmental needs of the population.

Bruder and Dunst (2005:26-27) identified the following content areas as being important for professionals working with infants and their families:

- *Family-centred practice.* Infants are developing and learning within the context of their families, which requires that services be targeted at families as well. Community nurses must be prepared to treat families with dignity and respect. They must be culturally and socio-economically sensitive to family diversity. They must provide choices to families in relation to their priorities and concerns. They must fully disclose information to families to enable them to make informed decisions. They must focus on a range of informal resources as sources of parenting and family support, and employ empowering and competency enhancing help-giving practices.

- Conceptualization and implementation of *transdisciplinary models of service delivery*. The primary purpose is to pool and integrate the expertise of team members to provide more efficient and comprehensive developmental care to infants.
- *Service co-ordination*. The role of the service coordinator is to assist the family to obtain the services and assistance they need.
- *The development of the Individualized Family Service Plan (IFSP)*. The IFSP is a planning document that shapes and guides the day-to-day provision of services. This plan is developed with the assistance of the family and is the culmination of the assessment process.
- *Natural environments*. Interventions should be integrated into an infant's everyday routine and activities. It should be at those places where the infant would be, such as the home or day care centre.

Pre-service training programmes need to include the necessary content to enable those serving infants and young children to meet the developmental needs of the population. However, given the difficulty in changing university programmes e.g. lack of faculty with necessary expertise in infant or family issues; competing priority areas in personnel preparation such as sports medicine and requirements imposed by professional associations or university policies limiting options for development of new programmes. To include this content, an important priority is a significant investment in in-service and continuing education programmes to empower staff in this regard (Bailey et al., 1990:n.p.; Bruder & Dunst, 2005:26; See Figure 4.2:240).

According to Spouse (2001:12-17), **work-based (in-service) learning** requires investment in staff at all levels. An environment where learning is valued should be created and time should be protected for in-service training and discussions about practice. Structures should be in place to support and facilitate life-long learning and **continuous professional development**. The necessary knowledge and skills to be effective in professional practice is not static and needs refreshment and development on a continuous basis. Learning in the work place requires that community nurses share their expertise, to identify their learning needs and plan how such needs can be

met. Management should also focus on academic outreach by giving information to community nurses on **formal training programmes** (Cusick & McCluskey, 2000:166).

From the preceding, it is evident that community nurses need to focus on infant development, as part of their routine health care to infants. Due to the nature of infant developmental care, community nurses need to maintain current information regarding the latest research and knowledge in this field. This will enable them to embrace the concepts of the Transactional Model of Development where developmental outcomes are a consequence of reciprocal interactions between the infant and the care-giving environment (Hanft & Anzalone, 2001:68). The Transactional Model of Development will direct the focus of community nurses on social control and supports based on beliefs that differ in the amount of community consensus as well as cross-cultural differences as this might have consequences for infant development; certain infant behaviour/development are either ignored or emphasized (Sameroff & Fiese, 2000:144) .

#### **SUMMARY**

##### **PERSONAL PROFESSIONAL DEVELOPMENT**

- **Community nurses best serve public interest and specifically that of the infant, when they constantly improve their application of competence. To empower staff, a significant investment in in-service and continuing education programmes is important. It is necessary to create structures to support and facilitate life-long learning and continuous development of community nurses.**
- **It is important for community nurses to be able to recognize their own limitations and training needs.**
- **Content in training programmes that will enable community nurses to meet the developmental needs of infants should be included.**

#### i. Views on late identification of developmental delays and disabilities

From the research findings, it is evident that various reasons are accountable for late identification of developmental delays and disabilities (See Table 3.1:70).

Since the election of the ANC in 1994, a major **transformation of the health care delivery system** took place (See chapter 1); the consequent introduction of free health services for children under six and pregnant women by the South African government increased the caseload that nurses have to handle at PHC clinics. Due to this, patients flock to clinics to receive free medication for minor ailments (Baez, 2000:n.p.; Geyer, 1999:n.p.; National Department of Health, 2001). Therefore, the **workload** of nurses in PHC clinics increased, with the result that they are too overloaded to devote time to developmental surveillance. This essential aspect of the wellbeing of children is therefore overlooked. Many developmental needs and problems go unrecognised due to missed opportunities for detection thereof (Baez, 2000:n.p.; Haber, 1991:1; Wright et al., 2001:18).

Furthermore, a **lack of focus on infant development** by community nurses seems to contribute to late identification of infant developmental delays and disabilities. This has already been discussed (See 4.2.3.1.1:260).

Consulting **traditional healers** was also cited as a possible reason for late identification of infant developmental delays and disabilities. According to the World Health Organization, some 80% of South Africans consult traditional healers as their first contact for advice and/or treatment of health concerns. It is clear that traditional healers play an influential role in the lives of many South Africans (Richter, 2003:10). Traditional healers are physically, socially and culturally more available and accessible than western health care to many South Africans. Health views determine the use of a health care system and at the core of these views are culturally determined beliefs and values. Traditional healers treat all age groups and all problems, using medicines that are either natural or ritual, or both, depending on the cause of the disease. They also

deal with traditional ailments and these types of ailments usually do not respond to western medicine. There are five such culture-bound syndromes: spirit possession, sorcery, ancestral wrath, neglect of cultural practices and defilement. (Muller & Steyn, 2002:81; Pretorius, 2002:88-91). As indicated by some of the participants, these culture-bound syndromes might be the cause of late identification as the person must accept his or her fate and appease the ancestors. Only when they visit the primary health care clinic for another reason, the developmental delay or disability is identified and most of the times it is then considered as a late identification by the rehabilitation therapists.

The prevalence of **HIV and poverty** in South Africa were also indicated as contributing factors in the late identification of infant developmental delays and disabilities. It is estimated that about 600 people in South Africa die of HIV-related illnesses each day; 5.3 million (21.5%) of South Africa's population are living with HIV and 13% of all the people in the world living with HIV can be found in South Africa. Until 1998, South Africa had one of the fastest expanding epidemics in the world, but the level of HIV prevalence is now growing more slowly. However, the problem is still a huge one which affects numerous South Africans on a daily basis (Barry, 2004:n.p.; Noble, Barry & Fredriksson, n.d.:n.p.). With its high toll of death and disability, HIV/AIDS has become a major drain on resources and therefore an important factor in the creation and perpetuation of poverty (Emmett, 2005:69). The increase in deaths means an increased burden on families, households and hospitals. The increase means every household will suffer and there will be a reduction in household income (Zulu, 2005:n.p.). The epidemic has further contributed to high numbers of orphaned children. According to a recent population-based survey by the Human Sciences Research Council, 13% of South African children have lost one or both parents (US Agency for International Development, 2003). Some of the participants in the study indicated that the latter definitely has an effect on the developmental outcomes of infants and late identification of developmental delays and disabilities. With so many orphans raised by the extended family or even the eldest child in the family, it is possible that limited access to health care and lack of knowledge about infant development could contribute to late identification.

Poverty is widespread in South Africa and it is estimated that 53% of the population lives under absolute poverty (below a nationally defined poverty line). Poverty is strongly characterized by race, geographical area, gender and age. Ninety-five percent (95%) of the poor are black Africans, with 75% of them residing in rural areas. Women, children, the elderly and those with disabilities bear the brunt of poverty (Shamapande, 1998:n.p.). Poor people lack the means to protect themselves and it often prevents them from taking full advantage of, for instance, free health care. Health is not only important in its own right as a contributor to the quality of life, but it may also be seen as a means to increase income. A healthy and well-nourished person can be more productive in the workplace than someone who is ill and undernourished, and thus have the potential to earn more, thereby ensuring continued health and nutrition (Emmett, 2005:72-75). Poverty can make it difficult for families to take appropriate action when an infant becomes ill e.g. no money to pay for transport to primary care clinic. In turn, lack of knowledge of health and child-rearing practices can lead to temporary impairments becoming permanent, such as hearing loss due to lack of appropriate treatment (Emmett, 2005:91).

**Logistical barriers** that could prevent parents from taking their infants to a clinic for the necessary health services include money, distance from clinic, availability of health services and lengthy waiting periods (Creel & Perry, 2003:n.p.). If parents stay too far away from the clinic to walk, they would need transport to get to and from the clinic and for some money could then be an issue. If parents are dependent on a mobile health service, they have to fit in with the schedule of the mobile health service. If it is a very busy clinic, clients have to wait for lengthy periods for care.

If community nurses utilize the Transactional Model of Development, they will know to focus in their assessment on the four levels of the environment that not only transact with the infant and the family but also with each other (Mohr, 1999:120). Thereby, the community nurse will be able to identify factors experienced by the family that might have contributed to late identification of infant developmental delays and disabilities. The coinciding meta-paradigm

concept is that of **environment**, which has been described in detail, at the beginning of this section (See 4.2.3.1:242).

### **SUMMARY**

#### **VIEWS ON LATE IDENTIFICATION OF DEVELOPMENTAL DELAYS AND DISABILITIES**

- **It is important for health care professionals to identify possible factors that might prevent early identification of infant developmental delays and disabilities, to enable them to institute measures to overcome it.**

#### **4.2.3.1.2 FAMILY CODE**

First, an overview of the specific section of the Transactional Model is given before any discussion takes place.

Family codes organize individuals within the family, just as cultural codes regulate the fit between individuals and the social system. Family codes provide a source of regulation that allows a group of individuals to form a collective group and to produce members that fulfil a role within the family. Ultimately, new members are incorporated through marriage, birth and remarriage (Sameroff, 1993:10-11; Sameroff & Fiese, 1990:127).

To fully comprehend the effects of family interactions and beliefs on child development, it is important to identify the central tasks of the family. Family life takes place in a variety of domains and Landesman, Jaccard, and Gunderson (In Sameroff & Fiese, 2000:144) proposed six domains in which family life takes place: 1) physical development and health, 2) emotional development and wellbeing, 3) social development, 4) cognitive development, 5) moral and spiritual development and 6) cultural and aesthetic development. Due to changes in the family over time, the family code regulates development so that the tasks of the family may be fulfilled. Infant development is regulated by the family through a variety of forms that vary in their degree of explicit representation.



- **The represented and practicing family**

Experience is organized through the beliefs that families hold and the ways in which they interact with each other. In represented families the internal representation of relationships are highlighted as well as how working members provide a sense of stability. To understand the represented family it is important to understand how they impart values and make sense of personal experiences. The practicing family, on the other hand, stabilizes and regulates family experiences through observable interactions. Family practices are momentary exchanges that are repeated over time. The family code is a cause and a consequence of what families do on a regular basis and how family values are imparted to children. One way to access the family code is by exploring family stories and rituals, as both are integrated into the developmental demands of raising children and reflect transactional processes over time (Sameroff & Fiese, 2000:145).

- **Family stories**

Family stories deal with how families make sense of their world, express rules of interaction, and create beliefs about relationships. Family stories can be examined by thematic content or by the process of storytelling itself. Parents use stories to highlight expected developmental tasks of family members. The themes of the stories change over time. As the child gets older, it changes from belonging to personal success and achievement. Furthermore, the coherence of family stories indicates to children that the world can be mastered and understood (Sameroff & Fiese, 2000:145).

- **Family rituals**

Family rituals organize family life and are associated with both the practicing and the represented aspect of the family code. Family rituals vary from highly organized events (baptism) to less organized events (family dinnertime). Rituals are part of the daily family life and are sensitive to the developmental changes in the family. The stability of family rituals as well as the meaning associated with family rituals is related to family adaptation (Sameroff & Fiese, 2000:146).

Both the practicing and the represented family code affect behaviour over time. Family practices come to have meaning over time and become part of the

symbolic aspect of the represented family. The represented family in turn, may affect how the family regulates and interprets its practices. A transactional understanding of such processes may help with the identification of problematic developmental processes (Sameroff & Fiese, 2000:146-147).

#### **a. Family care**

Family nursing is a distinct speciality that sees the family as the client instead of the individual and it is based on concepts regarding family behaviour. “Family theory is a set of perspectives from the family’s point of view that helps the nurse address the important health issues of the child-rearing family” (Pillitteri, 1999:23). The term family can be used broadly to define the social environment within which parenting is conducted. This term is therefore used to describe a range of social relations. Many types of families exist and a family type may change over time as it is affected by birth, work, death, divorce and the growth of family members (Franck & Callery, 2004:266; Pillitteri, 1999:25; Table 3.1:69).

The family, as a group, has certain functions and roles. These values are passed on from generation to generation. An important part of family assessment is to identify the roles that family members must assume as it helps the community nurse to work effectively with the family. Various family tasks are essential for the family to perform to survive as a unit. These tasks differ in degree from family to family. Landesman, Jaccard and Gunderson (In Sameroff & Fiese, 2000:144) proposed various domains in which family tasks take place: 1) physical development and health, 2) emotional development, 3) social development, 4) cognitive development, 5) moral and spiritual development, 6) cultural and aesthetic development. Duvall and Miller (In Pillitteri, 1999:27) added the tasks of allocation of resources, maintenance of order, division of labour and reproduction, recruitment, and release of family members.

Family-centered care has become widely accepted as part of the philosophy of care giving in infant health care, because of the growing recognition of the

family's importance to an infant's recovery and the impact of an infant's illness on the family. However, authors from different professional perspectives refer to different definitions and use diverse literature to underpin the case for family-centered care. In most clinical settings, the philosophy of family-centered care means that families have a central position in the care environment, as it is the constant in an infant's life (Cookfair, 1996:995; Franck & Callery, 2004:265-266; Tomlinson, Thomlinson, Peden-McAlpine & Kirschbaum, 2002:162). The most important aspect of this concept focuses directly on the **nurse-family interface (relationship)** and the nurse's sensitivity to the immediate emotional, role and practical demands of the family. For nurses to deliver effective care and to build trust, their perceptions of parents' needs should be congruent with families' perceptions (Tomlinson et al., 2002:162).

Family-centered child health nursing considers the strengths, vulnerabilities and patterns of family functioning in order to support child-rearing families and to encourage healthy coping strategies for families facing a crisis. This means that health assessment should include consideration of social, emotional and financial resources as well as the physical environment of the home and community. Furthermore, the community nurse should elicit **parental concerns**. Besides gaining precious information, eliciting parental concerns might be instrumental in the process of building positive relationships (Glascoe, Altemeier & MacLean, 1989:958). The quality of the working relationship between parents and community nurses are very important. Parents play a vital role in helping community nurses understand how familial and cultural contexts influence the infant's repertoire of skills. Community nurses need to take into account the **cultural context** of the parents. Together with the family, the community nurse needs to adapt professional recommendations to meet the needs of the infant in a manner that is culturally acceptable to the family (Meisels & Atkins-Burnett, 2000:236). A further important aspect is the power **relationships between community nurses and families**. Because nurses often have a difficult time in relinquishing control, they need to focus on power as the ability to get things done and not to control events and resources. By sharing power with the family, all the participants can gain in competence,

abilities, resource acquisition and capability without taking any power from others (Tomlinson et al., 2002:163; Turnbull et al., 2000:642).

Community nurses need to assume that the family is embedded within a number of ecological systems, in addition to that provided by the health care system. These other systems can and do influence infant development. Sources of informal supports in the community could influence infant and family outcomes positively (See Figure 4.2:240). Therefore, community nurses need to assist families in addressing their needs within the context of the existing and potential relationships with available and accessible community **resources** and sources of support (Wolery, 2000:196). Furthermore, nurses can enhance family care by reflective practice intervention. **Reflection on personal action** is thinking back over what had been done in order to discover how specific actions have contributed to the outcome. Greenwood (In Peden-McAlpine, Tomlinson, Forneris, Genck & Meiers, 2005:496), cites “the purpose of reflective practice as the creation of actions that reflect the values and beliefs of people involved.”

The Transactional Model of Development focus on patterns of interaction between infant and family, as well as between family and systems outside of the family; identification of family tasks and the family environment that supply the necessary experiences to the infant (Sameroff & Fiese, 2000:143-144). Therefore, the Transactional Model of Development is in accordance with the elements of family care in nursing. The coinciding meta-paradigm concept is that of **nursing** which seeks to maintain, promote and restore the health of individuals, families and communities and therefore helps individuals to attain their human potential by reducing and ameliorating the effects of disability and disease. The focus is thus on strengths and potentials and on promoting harmony between the individual and the environment (McEwen, 2002:42; Salve Regina University, 2002:6).

## **SUMMARY**

### **FAMILY CARE**

- **Accept family-centered care as the philosophy of care giving in infant health care, because it considers both the strengths and vulnerabilities of family functioning in the support of infant development within families.**
- **The working relationship between parents and community nurses are very important as parents play a vital role in helping community nurses understand how familial and cultural contexts influence the infant's repertoire of skills. By addressing parental concerns, community nurses can enhance this relationship.**
- **Community nurses need to share power with the family. Thereby all participants can gain in competence, abilities, resource acquisition and capability without taking any power from others.**
- **Community nurses need to assist families in addressing their needs in the context of existing and potential relationships with available and accessible community resources and sources of support.**
- **Community nurses can enhance family care by means of reflective practice intervention.**

#### **b. Identification of developmental delays and disabilities**

According to Miles Curry and Duby (1994:40), the long-term problems of infants at risk for developmental delay have been well established. A growing body of literature has supported the benefits of early identification and intervention. Community nurses can play a vital role in the identification of such developmental delays and disabilities. All encounters between the community nurse and the infant should be viewed as an opportunity for developmental surveillance. Encounters for developmental surveillance should not be restricted to well-child visits (as indicated by the community nurses in the study), but should also be performed during visits for minor ailments (Miles Curry & Duby, 1994:42; Table 3.1:69).

The monitoring of infants' development should be one of the most fundamental activities of child primary health care. The reason is that developmental delays should be **identified** at the earliest possible point of manifestation as the outcome could be improved by preventing loss of developmental potential. Community nurses are in a crucial position to identify infant developmental delays and disabilities early because they are in regular contact with them. They can also monitor development over time. Furthermore, they are often aware of underlying social and familial factors at work in the infant's immediate environment (Dworkin, 1989:1007; Halfon et al., 2004:1926; Magnusson et al., 2001:118; Rydz, Shevell, Majnemer & Oskoui, 2005:5; VanLandeghem et al., 2002:2). Developmental surveillance is the means by which primary health care providers identify infants who have developmental delays or are at high risk of developing such delays (King & Glascoe, 2003:624). Dworkin (1998:1006) defined developmental surveillance as "a flexible, continuous process whereby knowledgeable professionals perform skilled observations of children throughout all encounters during child health care." To be effective, developmental surveillance must be incorporated into comprehensive child health care. In recent years, the concept of children's development has been broadened to include appropriate development of the social, behavioural and emotional skills necessary for success in later years (Dworkin, 1989:1006; King & Glascoe, 2003:624). Therefore, to be successful, development should be viewed in the context of the infant's overall well being and not be isolated from other domains pertaining to infant health and wellbeing (Rydz et al., 2005:5). Assessment has been discussed in full (See 3.3.2.2:114).

The Transactional Model of Development will direct the community nurse's focus on the various systems that need to be addressed during assessment. It will provide the necessary theoretical framework to guide the community nurse to conceptualize the factors that determine high-risk infant developmental outcome. It will enhance the community nurse's role in supporting the disabled infant and his or her family because of the focus on the continuous dynamic interactions between the child and the experiences provided by his or her family and social context. Furthermore, the emphasis on the environment would assist the community nurse in identifying resources in the family's

environment (Osofsky & Thompson, 2000:60-68; Sameroff & Fiese, 2000:142; Wolery, 2000:196). From the latter, it is evident that the four meta-paradigm concepts of nursing are applicable. By incorporating developmental surveillance in her daily practice, the community nurse focuses on the infant and the family (**person**). Developmental surveillance is a dynamic interpersonal process (**nursing**). Developmental surveillance has as its goal identification of developmental delays or infants at high risk of such delays (**health**: maintain, promote, and restore health of individuals and families) and it focuses on various contexts of development as well as the underlying social and familial factors at work in the infant's immediate environment (**environment**) (See Figure 4.2:240).

#### **SUMMARY**

##### **IDENTIFICATION OF DELAYS AND DISABILITIES**

- **View all encounters as an opportunity for developmental surveillance to identify infants who have developmental delays or are at high risk of developing such delays. Therefore, community nurses need to incorporate developmental surveillance into comprehensive child health care.**
- **The Transactional Model of Development provides the necessary theoretical framework to guide the community nurse to conceptualize the factors that determine high-risk infant developmental outcome. It enhances the community nurse's role in supporting the disabled infant and his or her family because of the focus on the continuous dynamic interactions between the child and the experiences provided by his or her family and social context. Furthermore, the emphasis on the environment assists the community nurse in identifying resources in the family's environment.**

### c. Social support and follow-up services

Although the birth of a baby is one of life's most happy experiences, it can cause anxiety. This anxiety can stem from the change in role that occur from being a non-parent and responsible only for oneself to having responsibilities for caring for a new baby. Besides this natural anxiety, it can be a nightmare for parents whose child is born with a disability (Pelchat & Lefebvre, 2004:124; Warren, 2005:48). The parents may view the presence of a child with a disability as a tragedy because society views people with disabilities as a burden (See Table 3.1:70). Parental reactions after receiving the diagnosis of impairment in a child can range from fear, denial, anger, frustrations, guilt, grief and mourning. These are just the beginning of chronic stress, sadness and consequently ongoing distress and dysfunction in the family (Kearney & Griffin, 2001:582-583). After receiving the diagnosis, the parents progress through a predictive sequence of stages before they are able adapt to the situation (Cookfair, 1996; Pelchat & Lefebvre, 2004:124). These stages have been compared to that proposed by among others, Elizabeth Kubler-Ross in her theory of grief, ranging from initial shock to eventual acceptance or adaptation (Wittert, 2004, n.p.). Community nurses therefore, need to be aware of the enormous **effect the disability may have on each member of the family**. Disability in one family member may affect relationships, regular routines, finances, work and living arrangements of the other family members.

Community-based nurses have a significant role to play in the care of disabled children and their families in facilitating the process of adaptation, providing family support, facilitating access to local services and co-ordinating services. They need to assess parents' own appraisals of their situation; the resources available in the family and the coping strategies used, and then respond to this identified need and help parents mobilize resources and build upon their strengths (Kirk, 1999:351; Pelchat & Lefebvre, 2004:125; Sloper, 1999:91).

Adaptation strategies are important for every individual member of the family. Adaptation is the capacity of a family to feel competent and confident about making use of available resources and skills to manage daily tasks, to be self-



directed and to act independently. Everyone in the family must regain equilibrium and this difficult experience has ramifications for the entire family. Community nurses need to be aware of the various family members' perceptions of the situation and the degrees of importance they assign to various aspects of the disability, as it influence the family's adaptation. Knowledge about these perceptions will enable community nurses to determine whether the strategies are beneficial or contrary to adaptation (Pelchat & Lefebvre, 2004:126-127).

**Support**, according to Finfgeld-Connett (2005:6) is "an interpersonal process that is context specific and involves the exchange of information." It consists of facts, advice, words of reassurance, positive affirmation and empathy. People must first recognize the need for support and they must be willing to accept it. Support can be formal (professionals) or informal (family, friends and the like) and the functional elements thereof have been conceived as instrumental, informational, emotional and appraisal support (McWilliam & Scott, 2001:57-59; Warren, 2005:480).

- *Instrumental support* helps with tasks in the guise of physical assistance or services and may be especially important to the family's adaptation (Warren, 2005:480).
- *Informational support*. Parents always want more information about the disability of the child, services and resources, child development and intervention strategies (McWilliam & Scott, 2001:57).
- *Emotional support*, particularly the support provided by partners and significant others are seen as important. Professionals provide emotional support by facilitating parent groups and assistance with identification of social networks. Emotional support has been found to reduce stress, promote well being and promote positive parent-child interactions (McWilliam & Scott, 2001:59).
- *Appraisal support*. The family feels that the professionals perceive them as being competent and acknowledge their expertise in the care taking of the disabled child (Arborelius & Bremberg, 2003:171).

An important attribute of social support is advocacy. Community nurses serve as advocates by motivating and empowering families to act on their own behalf and to maintain as much control over common strategies used in advocacy (Finfgeld-Connett, 2005:6).

From the research findings, it is evident that there is no form of **follow-up services** after referral. Some of the community nurses indicated that they ask the parents to inform them about the outcomes of the referral. As the community nurse acts as the mediator between intervention services and the parents, she needs to follow-up on the referral to ensure the continuity of care and thereby, positive outcomes for clients (Stanhope & Lancaster, 1984:357,750).

#### **SUMMARY**

##### **SOCIAL SUPPORT AND FOLLOW-UP SERVICES**

- Knowledge about formal and informal support resources in the community is important for the community nurse to be able to facilitate access to resources in the community.
- The developmental disability may have an enormous effect on each member of the family. Community nurses play a significant role in facilitating the process of adaptation, providing family support, facilitating access to local services, and co-ordinating services. Community nurses need to determine the most beneficial strategy for adaptation.
- Community nurses act as advocates for infants and their families by motivating and empowering families to act on their own behalf to gain and maintain control over their own wellbeing.
- It is important for community nurses to have knowledge about the functional elements of support to enable them to provide appropriate ongoing support to the family
- Ensure the continuity of care and positive outcomes for clients by following-up on referrals.

#### **d. Collaboration and co-operation with other health care professionals**

Collaboration with other health care professionals is an important strategy to ensure that clients have access to holistic and comprehensive health care services (See Table 3.1:70; Figure 4.2:240). Collaboration of this nature can enhance intellectual resources and allow individual health care providers to fulfil their optimal potential within their respective professions (Pringle, Levitt, Horsburgh, Wilson & Whittaker, 2000:764). Research findings indicate that collaboration of this nature with other health care professionals, besides the doctor or paediatrician, is virtually non-existing.

Infants with developmental delays and disabilities often require the expertise of numerous professions and without collaboration, there would be no **continuity of care** (Stanhope & Lancaster, 1984:789; Stayton & Bruder, 1999:61). According to Kesby (2002:359), “continuity of care is achieved when all appropriate care and treatment interventions are provided in a planned, co-ordinated and consistent manner by staff working across professional/agency boundaries and through the required period of time. This should be integrated with informal care and agreed and experienced by patients/users, their carers and their families.”

Communication (**referral and feedback**) between community nurses and the various other health care workers is the key ingredient in effective co-ordination and collaboration. The referral process is a means whereby the community nurse assists the family with an infant with a developmental delay or disability, to use resources in the community and to co-ordinate care. After the community nurse has established a need for a referral, she must explore resource availability and then facilitates the referral. As she acts as a mediator between the family and other health care professionals, the community nurse needs to follow up on the referral to ensure the continuity of care and positive outcomes for clients (Stanhope & Lancaster, 1984:357,750).

Various approaches of collaboration and co-operation are outlined in the literature:

- *Unidisciplinary* working is where one professional or one profession attempts to deliver a service to infants and their families and meet all their needs. The approach has its basis in the medical model and the inherent assumptions operating in this model is that the client is the passive receiver of care and one professional can adequately meet all the needs of the client (Briggs, 1997:90).
- *Multidisciplinary* working is individual health care professionals working next to each other with limited **interaction and exchange of information** or expertise. The infant and family enjoy the benefit of getting many different opinions. Links are weak to moderate and arrangements are usually informal (Briggs, 1997:90; Harbin, McWilliam & Gallagher, 2000:392; Watson, Townsley & Abbott, 2002:372).
- *Interdisciplinary* working is where health care professionals from different agencies assess needs of infants and families separately, but meet together to discuss the findings and set goals. It is unlikely that the needs of other family members will be addressed. Families might be invited to attend meetings. Service co-ordination will be achieved to some extent, but professionals still tend to practice within their own areas of expertise. Therefore, most professionals do not fully understand the exact nature of each other's professional practice (Briggs, 1997:93; Watson et al., 2002:373).
- *Transdisciplinary* working is a more holistic approach where the focus of service delivery is the infant and the family. Team members have a collective understanding of infants, families and their team's interactions. It allows for flexible definitions of role and responsibility. This flexibility in duties, roles and responsibilities enriches the team and the family while simultaneously empowering individual members. The concepts of role extension and role release are key elements to transdisciplinary working. Team members must first improve their own knowledge base and clinical skills to enhance their self-confidence in order to become full, active members of the team. Role release involves the infusion of information unique to the specific profession into the collective knowledge base of the team. Several professionals are concerned about the concept of role release, as they fear the elimination of their position. A second fear is the

loss of professional identity, autonomy and authority as roles are shared, and skills and information intermingled. Family members are seen as equal partners who set the goals for delivering and measuring the quality of the services they want and need (Briggs, 1997:94-98; Watson et al., 2002:372).

Janhonen (2000:145) feels it is important to participate in interdisciplinary co-operation, as this type of co-operation is beneficial to everyone. According to her, there are preconditions for effective interdisciplinary co-operation: 1) giving up unnecessary normative aspects, shake off feelings of inferiority or superiority, 2) be tolerant, and 3) be approving of creativity and open to different ideas. Furthermore, one has to have the courage to disagree openly and be able to justify one's point. The purpose of this type of interdisciplinary collaboration is to "discover something that no one has or could ever think of on one's own" (Janhonen, 2000:145).

Interdisciplinary collaboration helps to develop a community of mutual interest, understanding and respect. It gives access to information and resources that would otherwise not have been available. However, how can practitioners be motivated to collaborate in this way? It could be achieved by means of **interdisciplinary training**. Interdisciplinary training has been defined as "learning together to promote collaborative practice" (Cooper, Carlisle, Gibbs & Watkins, 2001:229). Different professional groups learn with and from each other to increase collaborative practice and to improve the effectiveness of care delivery (Cooper, Braye & Geyer, 2004:180).

From a transactional point of view, interactions that enhance competence of community nurses could have a beneficial effect on the infant's development, as the community nurse would be more knowledgeable in the management of infant developmental needs. According to the corresponding meta-paradigm concept of **nursing**, to assist with the facilitation of optimal health, nursing also employs effective communication and collaboration with other health care providers (Salve Regina University, 2002:6).

## **SUMMARY**

### **COLLABORATION AND CO-OPERATION WITH OTHER HEALTH CARE PROFESSIONALS**

- Collaboration ensures that the client have access to holistic and comprehensive health care, as community nurses are more aware of the necessity of good communication to ensure continuity of care and positive client outcomes.
- Collaboration and co-operation between community nurses and other health care professionals give access to information and resources that would otherwise not have been available.
- Infants with developmental delays and disabilities often require the expertise of numerous professions and communication between these professions is the key ingredient to collaboration. Community nurses need to follow up on referrals to ensure the continuity of care.
- With the trans-disciplinary approach, team members have a collective understanding of infants, families and their team's interactions and it allows for flexible definitions of role and responsibility.
- With interdisciplinary training, community nurses learn with and from other professional groups to increase collaborative practice and to improve the effectiveness of care delivery.

#### **4.2.3.1.3 INDIVIDUAL PARENTAL CODE**

An overview of the specific section of the Transactional Model of Development is given first, before any discussion takes place.

Parental behaviour is influenced by the family context. When functioning as part of a family, individual behaviour is altered and it is done frequently without awareness of the change. Each parent's past participation in family coded interactions, conditions his or her interpretation of the cultural and family codes. These individual interpretations further condition the parent's responses to his or her own child. Both health and pathology can be embedded in these

parental responses and the effect of parental deviance has long been recognized as a contributor to poor developmental status of children. To improve the outcomes of infant development, parents' care-giving behaviour need to be facilitated. It is important to note the context of cultural and family codes in which parental behaviour is rooted (See Figure 4.2:240; Figure 4.4:242). Furthermore, it is important to recognize the parents as the main regulating agency of infant development, but it is equally important to recognize that the behaviour of parents is itself embedded in regulatory contexts (Sameroff, 1993:11; Sameroff & Fiese, 2000:147-148).

#### **a. Parents' view and expectations of community nurses**

Several studies in the literature focused on the parents' view (**perception**) and expectations of the community nurse (Fägerskiöld & Ek, 2003:119-128; Fägerskiöld, Wahlberg, & Ek, 2001:139-147; Hallberg, Lindblad, Råstam & Håkansson, 2001:151-159; Walizer, 1996:537-539; Warren, 2005:479-488; Table 3.1:69). Child health care is an integral part of primary health care and families with infants visit the clinic for various reasons e.g. immunization, minor ailments, chronic conditions and nutritional support. How parents view the child health services and specifically the community nurse, are important as it can provide insights to improve delivery of service. It is evident in the research findings that parents in general, feel that they are treated well but the service regarding infant development is insufficient.

The following expectations (except explanation of procedures) of the community nurse, expressed by mothers, were identified by the latter studies:

- **Support.** The mothers expected various forms of support. Informational support, such as normal infant development; appraisal support, such as the mother is taking good care of the infant; emotional support, such as addressing feelings of helplessness and instrumental support, such as the nurse had sufficient time to listen and facilitate discussion of some issues.
- **Approachability.** The community nurse should be communicative and open. A kind reception and respect were also important to mothers.

- **Accessibility.** The nurse should be someone to whom a mother, and especially a new mother, can turn to whenever support is needed.
- **Competence and advice.** The nurse should be knowledgeable about various aspects pertaining to infant growth and development, as well as prevention and treatment of minor ailments. Mothers expected nurses to give advice on various topics.
- **Parent support groups.** Support groups give exposure to other mothers as the mothers sometimes felt isolated with their infants. They want to hear about the other mothers' parenting experiences.
- **Explanation of procedures.** The research findings indicated a lack of information to parents about the procedures carried out by the community nurses. The parent-nurse relationship is considered a cornerstone of quality infant nursing care. Therefore, good communication skills are essential to explain procedures in a layperson's terms, as the manner in which information is communicated to parents may lead to client dissatisfaction. Furthermore, the desire for information depends on the individual coping style of the parent. Persons who desire high levels of information are termed 'monitors' and persons, for whom too much information can lead to increased distress, are called 'blunters'. Information given by community nurses should facilitate the delivery of enough information to the monitors, without pressurizing the blunters

(Cork, Britton, Butler, Young, Murphy & Keohane, 2003:583; Espezel & Canam, 2003:34; Wisselo, Stuart & Muris, 2004:300).

A good relationship would be required to enable the community nurses to fulfil the mothers' expectations and to find out what the mother desires. This relationship should be based on the Collective Empowerment Model, "in which all participants increase their capacity and mastery over the resources needed to achieve mutually desired outcomes." (Turnbull et al., 2000:641-642). The essence of this model is synergistic power. This type of power is not about control but about capacity building, with partners gaining in competence, abilities, resource acquisition and capabilities without taking any power from others.



The Transactional Model of Development embeds the infant in an environment of social relationships that will enhance some early characteristics and diminish others. New mothers' confidence in infant care is important to facilitate adaptation to motherhood (Warren, 2005:480). The Transactional Model of Development views the development of the infant as a product of the continuous dynamic interactions between the infant and the experience provided by his or her family and social context. By focusing on these transactions, the community nurse would be able to identify dysfunctional relationships and by means of timely intervention facilitate positive infant development. (Sameroff & McKenzie, 2003:16). If the community nurse has a good relationship with the mother and fulfils her expectations, then the richness of this relationship could furthermore enhance the development of the infant.

Coinciding meta-paradigm concepts include **person** (infant and family), **environment**, **health** and **nursing**, which have been discussed previously (See 4.2.3.1.1:265).

#### SUMMARY

##### PARENTS' VIEW AND EXPECTATIONS OF COMMUNITY NURSES

- Parents' view of child health care services is important as it can provide insights to improve delivery of service to infants and their families.
- Various parent expectations of the community nurse have been identified: support, approachability, accessibility, knowledge and advice, and support groups.
- A good relationship between parent and professional, based on the Collective Empowerment Model, is essential if the community nurse wants to find out what the parent desires.
- Explanation of procedures is vital to increase client satisfaction. If community nurses are cognizant about the individual coping style of the parents, it enables them to facilitate the delivery of information without adding to parental distress.

## **b. Views on late identification of developmental delays**

Parents in the study expressed various views as possible reasons for late identification of developmental delays and disabilities. Each visit provides an opportunity for the community nurse to offer information in a manner that educates and supports parents and strengthens parenting capacity. Parents who are informed are more likely to parent in a way that meets the developmental needs of the infant (See Table 3.1:67). According to Reich (2005:145) interventions designed to increase **parental knowledge** of typical child development and effective parenting strategies have been associated with, amongst others, overall better child outcomes. Parents that are more knowledgeable are therefore more likely to notice problems in their infant's development and attend to it sooner, thereby minimizing the possibility of late identification.

Parents also indicated that a **lengthy process**, before identification of developmental delay or disability is eventually made, as well as that of a **wait-and-see attitude** by health care professionals, contribute to late identification of developmental delays. Sometimes professionals lack the necessary competence to identify developmental delays and disabilities and parents are referred from one health care professional to the next, until one eventually identifies the developmental delay or disability. Furthermore, parents often visit their paediatrician or doctor with concerns about their infants' development, just to hear "let's just keep an eye on this", and this wait-and-see attitude of the doctors amplifies the magnitude of late identification of developmental delays and disabilities (Hendrickson et al., 2000:9).

**Negligence** continues to be one of the most important health threats to the healthy and typical development of infants all over the world. Negligence or the careless taking care of the infant occurs in the family environment and is not in the best interest of the infant. Neglect includes failure to meet a child's basic physical and medical needs, emotional deprivation and desertion. Neglect is often seen among families with physical, psychological, or substance abuse

problems. Acute or chronic depression, especially maternal, is often present. Drug or alcohol abuse by one or both parents frequently results in chronic impoverishment and a distortion of priorities in family life. Desertion by the father may precipitate neglect. The care provider who is alert to clues and able to provide support in such settings goes a long way toward preventing tragic events (Beers & Berkow, 1999:n.p.).

**Denial** could be seen as the first stage of grief. Although people are aware that developmental delays and disabilities do occur, most proceed through life thinking, “it will not happen to my child”. When it does, they respond with disbelief or denial. Denial buffers the individual against what is sometimes a bleak reality. Denial may be exhibited, among others, by means of: 1) physician shopping, 2) attributing the symptoms of the actual problem to a minor condition and 3) delay in agreeing to treatment. Acceptance of the family’s emotional reactions in a non-judgemental manner is important and one of the most supportive interventions is active listening (Kearney & Griffin, 2001:588; Pillitteri, 1999:1088).

The Transactional Model of Development posits that the quality and the context of an infant’s environment are important. It is essential to understand that the environment can encompass influential factors and significant relationships, such as that between infant and parent that affect overall infant development over time. The Transactional Model of Development provides the service provider with an overview of the systems involved in particular that of the family and the culture as parental behaviour is rooted in these codes (Sameroff & Fiese, 2000:147-148).

## **SUMMARY**

### **VIEWS ON LATE IDENTIFICATION OF DEVELOPMENTAL DELAYS**

- Each visit provides an opportunity for the community nurse to offer information that educates and supports parents and strengthens parenting capacity. A lack of knowledge about the typical development of infants and child-rearing practices has been associated with late identification of developmental delays and neglect.
- Sometimes professionals lack the necessary competence to identify developmental delays and disabilities and parents are referred from the one health care professional to the next, thereby causing a lengthy process before identification of a developmental disability is identified. Furthermore, this lack of knowledge often initiates the wait-and-see attitude amongst health care professionals.
- Negligence continues to be one of the most important health threats to the healthy and typical development of infants. Knowing which settings are conducive to neglect helps to identify at-risk families.
- Denial could be seen as the first stage of grief and acceptance of the family's reactions in a non-judgmental manner is important. To be able to support the family in denial, it is important for community nurses to be aware of ways in which denial could manifest.

#### 4.2.3.1.4 SELF-REGULATION AND OTHER-REGULATION

An overview of the specific section of the Transactional Model of Development is given before any discussion.

The concept of developmental regulation has been described (See 4.2.2.4:236). However, to complete the picture, an elaboration on the complexity of regulatory processes reflected in their time span, purposiveness, level of representation and the nature of the infant's contribution is needed. Developmental regulation is divided into three categories based on these considerations: macroregulations, miniregulations and microregulations. These three sources of regulation are organized at different levels of the environment.

- *Macroregulations* are purposive major changes in experience that continue for long periods of time, such as weaning. It is the most extensive type of regulation and occurs within the cultural code. It is a series of points in time when the environment is restructured to provide different experiences to the infant, e.g. weaning or toilet training may be initiated at different times in the infant's developmental trajectory, based on different cultural codes. This type of regulation provides the basis for socialization in each culture and it is responses to behaviours from the infant that are distinct events and are expected of all members of a culture. In addition to actual laws aimed at regulating child health and education, many cultural codes are passed on to individual members of society through customs, beliefs and mythology (Sameroff & Fiese, 2000:148).
- *Miniregulations* are care-giving activities that occur on a daily basis and include dressing, feeding or disciplining and are operational within a shorter time span. It occurs within the family code in which less formal interactions shape the care-giving behaviour of family members. Families develop their own codes that are then transmitted to other members of the family. These regulations are susceptible to a wide range of individual variability while still conforming to the cultural code. The infant's contribution to miniregulations could be seen in instances where the caretaking behaviours of the family have been restructured to incorporate an infant with cerebral palsy, for

example, into daily routines through the alteration in miniregulations (Sameroff & Fiese, 2000:148).

- *Microregulations* operate on the shortest time span and are momentary interactions between infant and caregiver. This has been referred to as attunement (behavioural synchrony) on the positive side, or coercion on the negative. It occurs at the individual level in which differences in personality and temperament regulate reactions to the child. The infant's contribution to microregulations could be seen in the effects of infant activity on maternal responsivity (Sameroff & Fiese, 2000:148).

During infancy, the common pathway of these regulations is through the behaviour of the parents, and especially the primary caregiver, in their relationships with the infant. These regulations, although described independently, are in constant interaction and even transaction with each other (See Figures 4.1:236; Figure 4.2:240). The family develops its child rearing routines based on the transactions between the cultural and family codes, that is, between social norms and family traditions. The style of each family member contributes to the way in which the regulations are to be carried out in relation to the individuality of each child (Sameroff & Fiese, 1990:131-133).

#### **a. Anticipatory Guidance**

Health literacy is according to research, a stronger predictor of health status than socio-economic status, age or ethnic background. Inadequate health literacy can act as a barrier to utilize health care successfully (Speros, 2005:633-634). The World Health Organization (Speros, 2005:635) offers a definition of health literacy: "Health literacy represents the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand, and use information in ways that promote and maintain good health." Health literacy is thus viewed as the outcome of health education/anticipatory guidance efforts. This indicates that it is essential for community nurses to assess their clients' health literacy. Community nurses can increase the likelihood of comprehension by "using plain, lay language and avoiding medical jargon, speaking slowly, using pictures and visual images,

limiting the amount of information communicated in one encounter, asking clients to recall essential information, and creating a trusting and shame-free therapeutic environment” (Speros, 2005:638). Dines (1994:219) and Cantrell (1998:90) suggest that community nurses are well placed to undertake **anticipatory guidance** (health education) due to their closeness to their clients and their families.

Anticipatory guidance is defined as the provision of information with the expected outcome a change in attitude, knowledge or behaviour (Dworkin, 2000:330). It consists of the information that community nurses give families about what they should expect in their infant’s development and what they should do to promote this development (Nelson, Wissow & Cheng, 2003:630).

There is limited literature that specifically discusses the community nurse’s role in anticipatory guidance. Bakewell-Sachs and Gennaro (2004:401) indicated in their study that teaching and preparing parents to parent the post-NICU premature infant during the infant’s stay are meant to provide anticipatory guidance. Thereby, information is provided that will help parents to successfully parent the infant following discharge. However, they feel there is a gap between what parents believe they need to know and what nurses believe parents need to know. Nurses need to evaluate what parents want to know and then provide information about those topics. Mothers with unmet informational needs are more anxious and less confident in their care giving. It is known that positive parenting results in improved outcomes for preterm infants. Therefore, it is essential that community nurses help parents to become competent caregivers by providing anticipatory guidance. There are numerous missed opportunities for anticipatory guidance and parents indicate that they would like more information. The content of anticipatory guidance should be individualized and it should be discussed at the level of the parents’ cognitive, cultural and psychological readiness. By eliciting parents’ concerns during the interview, the community nurse can encourage the parents to decide on the list of topics that they would like to discuss (Bakewell-Sachs & Gennaro, 2004:401; Dworkin, 2000:634).

Unfortunately lack of time, knowledge and skills have been identified as barriers to providing anticipatory guidance in the primary health care clinic. The Transactional Model of Development with its ecological nature and the emphasis on the here-and-now interactions of children and their caregivers could help the community nurse in her focus on eliciting parental concerns and thereby guiding anticipatory guidance from the parents' perspective. To understand and address infant developmental problems the community nurse needs to understand how infants and their parents influence each other over time. By focussing on the regulatory processes, the community nurse would be able to identify where there is a lack of knowledge about child rearing or misinterpretation of infant behaviour and then intervene by means of anticipatory guidance to augment this lack of knowledge or correct the misinterpretation (Sameroff & Fiese, 2000:148-150). The corresponding meta-paradigm concept **nursing** encompasses caring that the nurse employs to facilitate optimal health (development). **Environment**, in nursing, refers to both the internal and external conditions, circumstances and influences that affect the person. **Person** refers to both the infant and the family and the concept **health** means a person that can function independently and achieve his/her full life potential (Feeley & Gerez-Lirette, 1992:802; Gilbert et al., 2002:4; Grant MacEwan College, 2001:17; McEwen, 2002:41-42; Salve Regina University, 2002:7).



## **SUMMARY**

### **ANTICIPATORY GUIDANCE**

- It is essential for community nurses to assess their clients' health literacy and develop strategies that will enhance comprehension of the parent. Community nurses can increase client comprehension in various ways: by using plain language, speaking slowly, using visual images, limiting the amount of information communicated in one encounter, asking clients to recall information, and to create a trusting therapeutic environment.
- Community nurses need to elicit parents' concerns during the interview, thereby encouraging the parents to decide on the list of topics that they would like to discuss.
- It is essential for community nurses to be knowledgeable about the Transactional Model of Development to enable them to focus on the regulatory processes to identify parental lack of knowledge about child rearing or misinterpretation of infant behaviour.
- Community nurses need to provide individualized anticipatory guidance to parents about their infant's development to promote the infant's development, thereby helping them to become competent caregivers. Discuss it at the level of the parents' cognitive, cultural, and psychological readiness.
- Identify barriers to anticipatory guidance and institute measures to overcome it.

#### **4.2.3.2 TRANSACTIONAL MODEL OF INTERVENTION**

An overview of the specific section of the Transactional Model of Development is given before any discussion.

The Transactional Model of Development can be utilized especially for identifying targets and strategies of intervention. This model holds that the infant and his or her care-taking environment tend to mutually alter each other. One can often see a three-part sequence in which, firstly, infants stimulate their

parents, either through their appearance or their behaviour; secondly, the parents impose some meaning on the input; and thirdly, the parent then react with some form of care giving. Where relationships are problematic, intervention should be focused at one or more of these parts. These parts have been labelled remediation, redefinition, and re-education (Sameroff & Fiese, 2000:149; Sameroff & MacKenzie, 2003:19; Figure 4.2:240). In Figure 4.6 below, the three R's of intervention within a Transactional Model of Development are indicated.

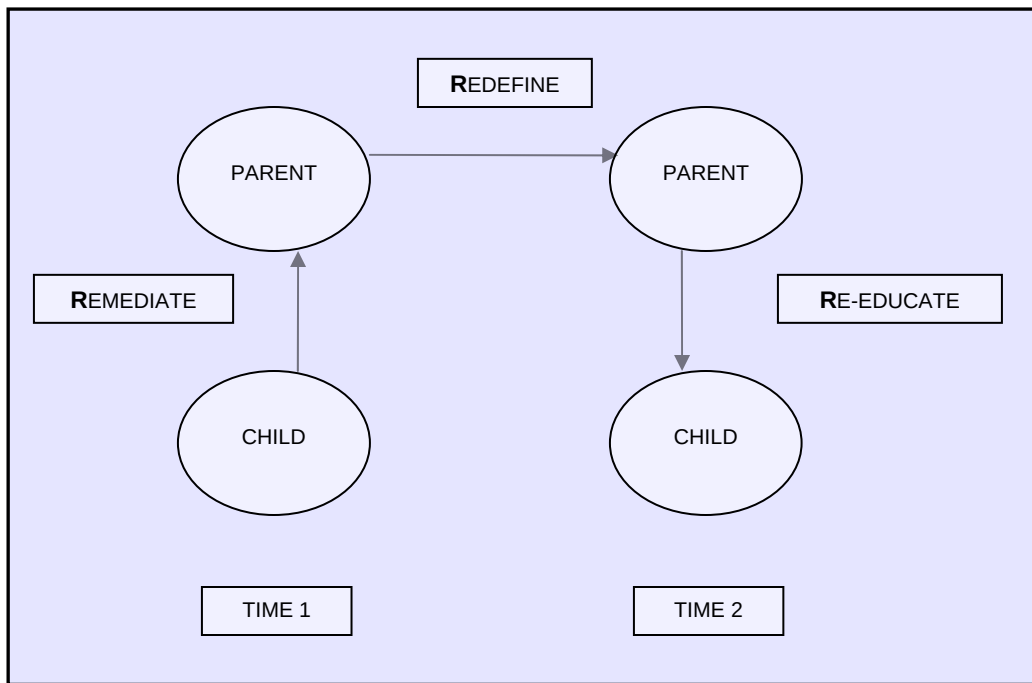


Figure 4.6 The 3-R's of intervention within a Transactional Model of Development (Sameroff & McKenzie, 2003).

#### 4.2.3.2.1 REMEDIATION

In the case of remediation, the child is defined as developmentally atypical. Therefore, remediation changes the way the child behaves toward the parent, with eventual changes occurring in the parent for example, through supplemental feeding for malnourished infants. It is not aimed at changing the family or cultural codes. A professional person implements it outside of the

family system (Sameroff & Fiese, 2000:149-151; Sameroff & MacKenzie, 2003:19).

#### **4.2.3.2.2 REDEFINITION**

Redefinition is indicated when the parents' representation of the child inhibits appropriate care giving. Redefinition changes the way the parent interprets the child's behaviour. By being difficult or wilful, the child may deter a parent from positive interactions. Positive interactions could be facilitated by refocusing the parent on other, more acceptable attributes of the child (Sameroff & Fiese, 2000:151; Sameroff & MacKenzie, 2003:20). Difficulty in care-giving could arise from various sources, including failure of the parents to adapt to a disabling condition in the child, failure of the parents to distinguish between their emotional reactions to the child and the child's actual behaviour and maladaptive patterns of care that extend across generations. Redefinition interventions may be aimed at augmenting the parents' experience of care giving as well as distinguishing the current relationship between mother and child from the mother's own upbringing. For example, to help the mother realize that preterm babies, although small, have cognitive and emotional needs and patterns of normal development similar to full-term babies. Community nurses can make use of anticipatory guidance to achieve this (See 4.2.3.1.4:298). Thereby, the infant's behaviour is redefined to fit the mother's expectation for normal development and the mother might be able to engage in more reciprocal interaction (Sameroff & Fiese, 2000:152; Sameroff & MacKenzie, 2003:20).

Redefinition interventions often incorporate the represented aspects of the family code. Family stories offer one way to assess the parent's current beliefs about their child. If a belief that the child is deviant is changed, then normative care giving can begin and the parents can use the skills that are already part of their repertoire. However, when the parents do not have the necessary skills or knowledge base for effective parenting, then re-education is indicated (Sameroff & Fiese, 2000:152).

#### **4.2.3.2.3 RE-EDUCATION**

Re-education refers to teaching parents how to raise their children. These parents have a healthy acceptance of their infants, but lack certain care-giving skills or knowledge. It is frequently the case with teenage mothers, parents who abuse alcohol or has limited education. Re-education efforts are directed toward the individual family and it provides information about specific care giving skills. The community nurse can utilize anticipatory guidance to enhance the lack in parents' knowledge about care giving (See 4.2.3.1.4:298). It is typically aimed at the practicing aspect of the family code. Furthermore, it is assumed, that once parents have the necessary knowledge, their care giving will enhance development in line with the cultural code (Sameroff & Fiese, 2000:153-154; Sameroff & MacKenzie, 2003:20).

#### **4.2.3.2.4 SPECIFICITY OF INTERVENTION**

Remediation, redefinition, and re-education have been described as efforts for targeting specific aspects of the transactional process. Development is part of a system that is influenced by various aspects of the cultural, family and parental context. Spillover effects from one area of functioning to another, such as between family practices and family representations have been documented in interventions with families. Therefore, when choosing a form of intervention it needs to be aligned with resources and characteristics of individual families and infants. When resources for intervention are limited, it is beneficial to consider the most cost-effective form of intervention that would affect multiple domains of adaptation. The three forms of intervention can be placed in a transactional diagnosis scheme (Sameroff, 2004:20-21).

#### **4.2.3.2.5 TRANSACTIONAL DIAGNOSIS**

Intervention efforts can be focused according to problem identification. A decision tree can be described for choosing the appropriate form of

transactional intervention. A transactional diagnosis decision flowchart based on the three R's intervention model is applied (See Figure 4.7 below)

First, a decision needs to be made if remediation is appropriate, or viable. If there is nothing that needs to be changed in the infant, then the parents' knowledge of the developmental agenda and their reactions to the infant need to be examined. When there is evidence that parents have care-giving skills but they do not use them with their infant, redefinition is necessary. When there is evidence of a lack of knowledge about adaptive childrearing, re-education is indicated (Sameroff, 2004:22-23).

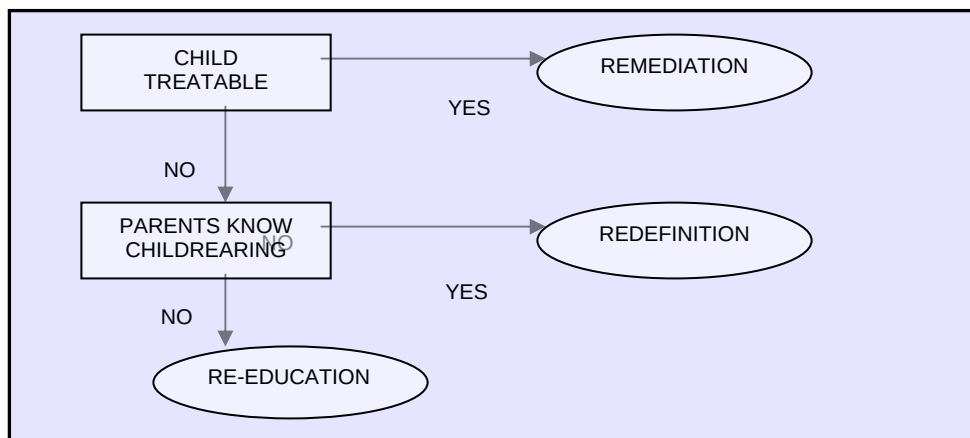


Figure 4.7 Transactional diagnosis decision flowchart, based on the three R's intervention model. (Sameroff, 2000:14).

#### a. Intervention for developmental delays and disabilities

According to Blann (2005:265), nurses have a long history in participating in early intervention programmes and community nurses can play a vital role in the provision of early intervention services to infants and families with special needs. For intervention to be successful, it must adhere to certain design and helping principles. The first principle is the importance of a theoretical underpinning, such as the transactional model. Theoretical frameworks help providers make sense of what they are observing and learning about families and decide how and where to intervene. It contributes to a shared understanding among staff. When a provider is working from a coherent theory, it communicates to the client that an honest effort is being made on the

part of the provider to make sense of what she is observing (Halpern, 2000:377).

A clear mission and boundaries are important, as one cannot be everything to everyone. If providers try to do this, they might not be able to sustain the intervention. Then the idea is that intervention has to start where the family is developmentally (what parents are capable of investing in and contributing towards the helping relationship and in their own lives). A related principle is that interventions have to begin with parents' own perception of their own situation. As a provider, one needs to link the help-giving agenda to whatever the parents' are experiencing.

The relationship that providers build with families is very important because they cannot know what information would be relevant to the family unless they really get to know them. The principle of working from a strengths perspective does not deny family vulnerabilities and needs. One helps parents to acknowledge what their problems are, at the same time that they are recognizing all the positive things they are doing. Lastly, it is very important for providers to not only view the infant in the family context but also to not lose the infant when using a family-centered lens (Halpern, 2000:377-378).

There need to be a balance between the provider's own world view, mission and priorities and those of families; between the needs of parents and those of infants; between a recognition of strengths and a recognition of vulnerabilities and between doing for a family and encouraging them to do it for themselves. Providers need to convey to parents that they are a meaningful resource, but that they should not promise more than they can deliver. Providers should also convey to parents the importance that change is gradual, fragile and reversible and that it should be measured in small units. Change is also difficult because "people are embedded in social milieus that reinforce existing views of self, ways of coping, and relating" (Halpern, 2000:379).

As the infant's current functioning changes from moment to moment, assessment should be continuous so that it can be incorporated into the

intervention so that the two functions become almost seamless. Assessment and intervention should be interactive processes in which each informs the other as re-assessment could reflect on the effect of intervention and every intervention provides information that could be part of assessment to create a new intervention (King & Glascoe, 2003:626; Romanczyk, Noyes-Grosser, Holland & Lyons, 2005:220; Meisels & Atkins-Burnett, 2000:232-237).

If community nurses utilize the Transactional Model of Diagnosis and Intervention, because it pinpoints intervention at each of the mentioned levels, it could be beneficial to infants and families, as the form of intervention is aligned with available resources and characteristics of individual families and children (Sameroff, 2004:21). The corresponding concept in the meta-paradigm is **nursing**. This includes the care of both the well and the sick and seeks to maintain, promote and restore the health of individuals, families and communities and therefore helps individuals to attain their human potential by reducing and ameliorating the effects of disability and disease. The focus is thus on strengths and potentials and to promote harmony between the individual and the environment. Nursing has as its objective, caring that encompasses all of the professional values, roles, core competencies and knowledge that the cultural congruent professional nurse employs to facilitate optimal health (Grant MacEwan College, 2001:17; McEwen, 2002:41; Salve Regina University, 2002:7).

## **SUMMARY**

### **INTERVENTION FOR DEVELOPMENTAL DELAYS AND DISABILITIES**

- The transactional diagnosis decision flowchart to choose the appropriate form of intervention should be applied.
- For effective and sustainable intervention efforts, community nurses need to adhere to the following principles:
  - Theoretical underpinning to make sense of what they are observing and learning about families and to decide how and where to intervene.
  - Clear mission and boundaries. One cannot be everything to everyone.
  - Start where the family is developmentally.
  - Start with the parents' own perception of their own situation.
  - Build a good relationship with the family.
  - Work from a strengths-based perspective.
  - View the infant in the family-context but do not lose the infant when using a family-centered lens.
  - Do not promise more than what can be delivered.
  - Convey to parents that change is gradual, fragile and reversible and it is measured in small units.
  - Assessment and intervention are interactive processes in which each informs the other.

## **4.3 SUMMARY**

In this chapter, the researcher described the conceptual framework used in this research. The researcher first gave an overview of the importance of nursing theory as well as a description of the meta-paradigm of nursing that underpins the researcher's assumptions in this research. Furthermore, the researcher gave a description of the transactional model that had been applied for understanding the research findings. Moreover, the researcher applied it within the nursing context by means of appropriate nursing and other literature.



In the next chapter, the researcher will discuss Phase two of the study, the development of guidelines for the support of community nurses in either training, continuous professional development, or co-operation with other health care professionals and managers, in order to attend to the developmental needs of infants.

## **CHAPTER 5**

### **THE DEVELOPMENT OF GUIDELINES FOR THE SUPPORT OF COMMUNITY NURSES IN EITHER TRAINING, CONTINUOUS PROFESSIONAL DEVELOPMENT, OR CO-OPERATION WITH OTHER HEALTH CARE PROFESSIONALS AND MANAGERS, IN ORDER TO ATTEND TO THE DEVELOPMENTAL NEEDS OF INFANTS.**

#### **5.1 INTRODUCTION**

In the previous chapter, the researcher described the research findings of phase one by means of a relevant borrowed model, nursing theories and literature (nursing and other). The researcher utilized the Transactional Model of Development to provide a conceptual framework for understanding the research findings. Literature (nursing and other), was used following each section of the Transactional Model of Development, to substantiate the relevance and importance of the categories and subcategories (as identified in chapter 3) regarding the provision of effective developmental care to infants, as well as to justify the utilization of the transactional model as a framework for the management of infant developmental needs. Furthermore, the researcher indicated the corresponding concept of the meta-paradigm of nursing where applicable; after each category, the researcher presented a summary. With these summaries as a point of departure, guidelines were developed (phase two) for the support of community nurses in either training, continuous professional development, or co-operation with other health care professionals and managers, in order to attend to the developmental needs of infants.

#### **5.2 DEVELOPMENT OF GUIDELINES**

Guidelines are recommendations to improve the quality of health care delivery by health care professionals. It provides a mechanism by which health care practitioners can be made accountable for clinical activities. A key definitive attribute of guidelines is that they are based on research. Guidelines help to translate scientific information into statements that could change practice

(Cranston, 2002:39; Duff et al., 1996:888; Lia-Hoagberg, Schaffer & Strohschein, 1999:397; Scalzitti, 2001:1622; Thomas et al., 1999:40). Guidelines can be used as educational tools in undergraduate and postgraduate education, as well as in the continuing professional development of established clinicians (NICE, 2001:1). Guidelines make sense when practitioners are unclear about appropriate practice (Woolf et al., 1999:530). Guidelines are necessary to support community nurses in finding “best practice” within their scope of practice to ensure higher quality of developmental care to families with infants 0-2 years (Cranston, 2002:40; Thomas et al., 1999:41).

Guidelines need to be presented with clarity. The format of guidelines is often determined by the particular aspect of care and by the audience at which it is targeted. The intended audience is a very important determinant of the format and content of the guideline (Duff et al., 1996:889). The guidelines’ level of specificity and detail, in this study, are aimed at community nurses working in a primary health care clinic in South Africa.

To ensure the validity of guidelines, it is imperative that developers adhere to specified criteria. The development of guidelines should follow a logical process (Carnett, 2002:67). Guidelines that are based on a combination of sound scientific information and expert consensus result in more efficient and effective outcomes of care (Ibid:64). Guidelines should be simple, specific and user friendly (Jackson & Feder, 1998:427).

Desirable attributes for guidelines were described (See Table 2.13:59). The researcher gave attention to these attributes throughout the development process, because if appropriate attention is not given, it can result in flawed recommendations.

### **5.2.1 REVIEW OF THE LITERATURE**

One of the first and most important tasks of the researcher was to define the scope of the guideline to make the review more feasible (Royal College of

Paediatrics and Child Health, 2001:5). During the data analysis process, in the first phase of the research, the researcher segmented data into relevant units of meaning and identified themes. In phase two, the researcher used these themes to define the scope of the guidelines. (Scalzitti, 2001:1622).

An extensive literature review had been done to substantiate the research findings of phase one, to specify the scope and the content of the guidelines to enable community nurses to eventually address the developmental needs of infants. One of the advantages of using a literature review is that it is easier to support the guidelines (Aldrich et al., 2003: 1283; Duff et al., 1996: 890; Rycroft-Malone, 2002:155; Shekelle et al., 1999:594; Van Meijel et al., 2004: 85).

Steps followed by the researcher in the gathering of evidence to formulate the guidelines:

- The themes to be investigated were specified in chapter 3, with the analysis of the research data.
- Research articles were investigated; findings and recommendations were compared with the findings obtained in phase one; and substantiation for the recommended guidelines had been collected.
- Summaries, following each section of discussion of the research findings and corresponding aspects in the Transactional Model of Development in chapter 4, were used as a point of departure to develop recommendations.

### **5.2.2 DEVELOPMENT OF RECOMMENDED GUIDELINES**

After substantiation for the guidelines had been obtained (described in chapter 4), literature was analyzed and synthesized to develop a set of recommendations (Aldrich et al., 2003:1284). Evidence is necessary, but not sufficient when making recommendations. Taking the evidence and turning it into useful recommendations depend on the judgement, experience and good sense of the researcher (National Health and Medical Research Council (NHMRC), 1998:17-18).

After the researcher developed the guidelines, a focus group was utilized to discuss and finalize the recommended guidelines. A key feature of a focus group is the active interaction among participants to explore a set of issues (guidelines) (Kitzinger, 1995:299; Webb & Kevern, 2001:800). The researcher relied on the recommendations of knowledgeable experts, in this study the two study supervisors, to identify suitable members for the focus group. The main aim was to include all professional groups represented in the case study: community nurses, nursing management, personnel involved in the training of community nurses and other health care professionals. Besides the researcher and the two study supervisors, the group had eight members. The study supervisors contacted the identified members. The researcher then informed them in writing, about the research (See Annexure C:399). In Table 5.1 brief information on each of the participants is given concerning their qualifications, occupation, years experience and their specific involvement in infant developmental health.

First, the researcher presented a brief, but detailed overview of the research to enable group members to comprehend the reason for that specific guideline, as well as the rationale for each specific guideline. Furthermore, they could draw on this information to assist them in their final decision about the format of the guidelines. The group discussed each guideline and sub-guideline and accepted the recommended guidelines in principle. However, they suggested certain amendments pertaining to the grammatical structure of the guidelines and sub-guidelines and where appropriate, the researcher implemented the changes.

Table 5.1 Descriptive information of the focus group participants

| Professional qualifications                                                                                                                                                                                             | Occupation                        | Employer                           | Professional experience | Years involved in education | Involvement in infant developmental care                                                             |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|------------------------------------|-------------------------|-----------------------------|------------------------------------------------------------------------------------------------------|
| M Occupational Therapy                                                                                                                                                                                                  | Occupational therapist & lecturer | University of Pretoria             | ± 28 years              | 18                          | Lectures paediatric occupational therapy on pre- and post graduate level Focus on early intervention |
| Dipl. General Nursing Science, Dipl. Community Nursing Science, Nursing Administration, Nursing Education, Dipl. Midwifery                                                                                              | Senior professional nurse         | Phedisong Clinic, Odi Sub district | 15 years                | -                           | Renders comprehensive primary health care services, including infant health care                     |
| Dipl. General Nursing, Midwifery, Psychiatric Nursing, Community Nursing, Intensive Care Nursing, Primary Health Care Nursing<br>BA (Cur) Nursing Administration & Nursing Education<br>MA (Cur) Intensive Care Nursing | Senior tutor                      | SG Lourens Nursing College         | 27 years                | 10                          | Facilitates IMCI short courses for students. Input from a lecturer's point of view                   |
| Dipl. General Nursing, Midwifery, Community Nursing<br>B (Cur) Ed et Admin – Nursing Education & Administration                                                                                                         | Chief professional nurse          | Jubilee Community Hospital         | 24 years                | -                           | Renders comprehensive primary health care services, including infant health care                     |

|                                                                                                                              |                           |                                                                |          |    |                                                                                                                                 |
|------------------------------------------------------------------------------------------------------------------------------|---------------------------|----------------------------------------------------------------|----------|----|---------------------------------------------------------------------------------------------------------------------------------|
| BSc. Physiotherapy<br>M Ed<br>PhD<br>Clinical specialization course                                                          | Lecturer in Physiotherapy | University of Pretoria                                         | 32 years | 30 | Lectures paediatric physiotherapy<br>Involved in Kangaroo care at academic hospital                                             |
| B Communication Pathology<br>MA (AAC)                                                                                        | Speech language therapist | University of Pretoria                                         | 4 years  | 3  | Consult infants with severe disabilities<br>Lecturing at post-graduate level                                                    |
| Dipl. General Nursing, Midwifery, Child Health Nursing, Health Management & Nursing Education<br>M Community Nursing Science | Chief professional nurse  | Department of Health, North West Government, Moretele District | 20 years | 1  | Coordinator maternal, child & women's health.<br>Gave input from a management perspective.<br>Part time lecturer in paediatrics |
| BCur (Hons)<br>BCur I et A<br>MEd<br>PhD                                                                                     | Lecturer                  | University of Pretoria                                         | 23 years | 12 | Not directly involved with infants. Lecturer in education management.<br>Gave input from this perspective.                      |

Following, is a description of the **recommended guidelines**. Ten main guidelines were identified. After each guideline, a rationale and actions are given. To ensure full understanding of the rationale, if necessary, the researcher elucidated it with additional information. To ensure a comprehensive set of guidelines and where appropriate, the researcher developed sub-guidelines in addition to the main guideline.

#### **5.2.2.1 SET OF RECOMMENDED GUIDELINES**

**Guideline 1: Nursing management implements health care governance, as a shared responsibility of management and community nurses, to optimize the management of infant developmental needs and quality of care by community nurses.**

##### **a. Rationale**

Health care governance (HCG) is a framework through which health care service organizations are “accountable for continuously improving the quality of their services and safe guarding high standards of care by creating an environment in which excellence in care will flourish” (Arya & Callaly, 2005:241; Onion, 2000:405). According to the literature, HCG is a clearly outlined framework that clarifies concepts of accountability, clinical practice improvement, management of risks, and monitoring and evaluation of clinical standards and quality improvement (Arya & Callaly, 2005:242). Shared governance is a system of management and leadership whereby community nurses are empowered in decision-making processes (Scott & Caress, 2005:4).

Shared HCG should address the dimensions of quality as outlined by the World Health Organization (2000). Community nurses need to be competent, do the right thing the first time and doing it better next time (perform appropriately). They need to be well educated to meet the needs of their clients. Waste and duplication of effort should be eliminated. The environment in which health care is provided must be safe to all, as accidents have several



consequences, all of which are negative and detrimental to the facility's reputation. It is always more pleasant to have care provided in an aesthetically acceptable environment. A facility that pays attention to amenities (cleanliness, décor or service) that relate to client comfort and wellbeing is certainly a quality facility. Services need to be equitable and accessible to all. It should be available, acceptable and affordable and be sensitive to a multiplicity of cultures, beliefs and educational backgrounds. Personnel interaction is extremely important and health care providers cannot provide holistic care to the client without relying on teamwork. Interpersonal relationships therefore, play a tremendous role in shaping the processes of care and ensuring positive outcomes for the client. Furthermore, care should be initiated, rendered, evaluated, improved and continuously monitored.

## **b. Actions**

Nursing management:

- accepts responsibility for the HCG process and show their commitment to HCG and quality improvement by supporting this initiative as a key strategic and operational priority within the service structure, thereby supporting community nurses in the quest for improved management of infant developmental needs;
- acquires the necessary knowledge to effectively implement this process; to ensure there is minimal duplication of effort, and decision making is streamlined, thus allowing community nurses to dedicate themselves more diligently to the delivery of infant developmental care;
- holds community nurses accountable to deliver a quality infant developmental care service, by including this facet of infant health care as a key performance aspect in the personal performance management of community nurses;
- provides clear leadership and direction at both clinical and organizational levels so that there is no role confusion or role diffusion concerning integration of infant developmental care into the comprehensive health care delivered to infants and their families. To elucidate role clarity, newly appointed community nurses attend induction to identify and fill gaps in

their knowledge, as well as learn about their new working environment before they enter into their practice role;

- confronts entrenched practices and re-engages staff that have become disenchanted and disillusioned, for whatever reason, in the management of infant developmental needs;
- establishes a bottom-up approach to lead continuous quality improvement of services to ensure an environment in which excellence of infant developmental care can flourish. They help community nurses to be users of knowledge by developing a training strategy that includes:
  - commitment to continuous professional development by providing opportunities for community nurses to attend seminars, workshops and conferences that include the management of infant developmental needs in the programme content,
  - a training needs analysis of individual community nurses (not only focused on government priority programmes),
  - identification of knowledge and skills that are necessary and required of the person working within a specific role,
  - identification of key people, required to support and enable staff to gain skills to meet the identified needs (with suitable preparation for the role);
- engages community nurses in service-wide programmes (e.g. clinical documentation audits and induction of staff), and individual-specific programmes (e.g. all staff develop an annual individual plan in which they identify their goals, as well as plans to reach these goals), thereby maximizing efforts to support community nurses in their delivery of infant developmental care;
- ensures consistent application of policies and procedures pertaining to infant developmental needs, by appointing a sub-committee that is responsible for development, updating, reviewing and dissemination of these policies and procedures;
- incorporates client feedback in the HCG process, to facilitate the holistic management of infant developmental needs by community nurses.

**Guideline 2: Nursing management creates a positive organizational culture and climate, in which community nurses can reach their full potential to manage infant developmental needs optimally.**

**a. Rationale**

Organizational culture is defined as “ways of thinking, behaving, and believing that people have in common” (Ingersoll, Kirsch, Merk & Lightfoot, 2000:11). This shared understanding is obtained through group socialization and learning. A culture of excellence positively influences job satisfaction, enhances self-esteem and achievement of organizational goals (Wilson et al., 2005:28). The desirable culture is seen as being one that is open and honest and that has a no blame approach (Wilkinson et al., 2004:110).

Organizational climate influences group behaviour and encompasses the value base and expectations of workers. It is the perception of how it ‘feels’ to work in a particular environment. It is directly linked to productivity, job satisfaction, client satisfaction, staff retention and organizational commitment. These are also the most overlooked aspects when determining the performance of a particular work team. Leaders are primarily responsible for creating the climate in their organization or their work units. The following dimensions can be measured: flexibility, responsibility, standards, rewards, clarity and team commitment (Snow, 2002:39-394; Wilson et al., 2005:28).

It is evident from the literature that workplace culture and climate are multifaceted and assert a major influence on individual and group behaviour, client care, the change process, job satisfaction and ultimately organizational success (Wilson et al., 2005:28).

## **b. Actions**

Nursing management:

- trains in, and is knowledgeable about, aspects such as organizational culture and climate that could have a negative effect on organizational commitment to manage infant developmental needs;
- develops a method to measure the dimensions of organizational culture and climate and if warranted, develop strategies to address issues timely, before the context in which infant developmental care is delivered, is affected negatively
- coaches and mentors staff individually and collectively, to support them in their management of infant developmental needs;
- focuses explicitly on effective two-way communication and feedback, because if it is not in place, community nurses are at a disadvantage and it is more difficult for them to effectively promote positive infant developmental outcomes;
- fosters a supportive relationship by focusing on the following qualities that define a supportive manager:
  - respect and trust,
  - praise, recognition and positive reinforcement,
  - role-modelling and helping behaviour,
  - personal caring behaviour,
  - absence of personal defensiveness.

**Guideline 3: Nursing management evaluates, prioritizes and addresses existing infrastructure and resource (financial and human) constraints in a timely manner, to enable community nurses to deliver sustainable quality developmental care to infants and their families.**

## **a. Rationale**

Infrastructure and resources play a critical role in the improvement of the quality of health care, especially in an era of limited resources. Infrastructure and resource strategies need to be developed or re-examined to ensure more

effective and equitable provision of health services. Therefore, plans to strengthen sustain and maintain appropriate health care infrastructure and resources to deliver essential health care, need to be a priority (O'Brien-Pallas, Baumann, Donner, Tomblin Murphy, Lochhaas-Gerlach & Luba, 2001:121; WHO, 1998:n.p.).

## **b. Actions**

Nursing management:

- utilizes a bottom-up approach, so that all staff are involved in the identification of resource and infrastructure constraints that negatively affect the delivery of quality infant developmental care;
- develops innovative plans to prioritize and address constraints, which if left unattended, affect the sustainability of effective infant developmental care by community nurses.

**Guideline 4: Nursing management pursues interagency collaboration to obtain the necessary intellectual and institutional resources to enable community nurses to provide sustainable quality infant developmental care.**

## **a. Rationale**

The need for partnerships between health care professionals within geographical communities is becoming increasingly important as new health care needs and issues are identified. Collaboration is perceived as working together towards a common goal. The elements of networking, leadership and vision are all important as relationships between stakeholders are developed. A lack of collaboration between agencies could be the reason that infants fall through the gaps and do not receive the necessary health care services that they need. Infants have complex issues relating to health, development and behaviour and they do not fall neatly into one of the service categories into which services are divided. No one professional discipline can be expected to

have the knowledge and skills required to deal with them (Boswell & Cannon, 2005:n.p.; Watson et al., 2000:374).

Working together is a continuum that includes unidisciplinary, multidisciplinary, interdisciplinary, and transdisciplinary working. There are opportunities for services and professionals at each point along the continuum to work together to improve the quality of services delivered to infants and their families.

Research indicated that transdisciplinary working, offers the most benefits to infants and families (Watson et al., 2002:374). See Family code, 4.2.3.1.2:242-246).

Collaboration has a number of positive outcomes for health care: enabling the provision of the best quality and most effective care for infants who require multiple services; saving money by reducing overlap and duplication between services; and providing a means for managers to share their responsibility for community care and reduce organizational stress (Salmon, 2004:157; Van Eyk & Baum, 2002:262).

However, these benefits of collaboration come with many operational and philosophical challenges. Among others, developing a unified mission with mutually recognized goals, understanding and integrating professional perspectives and capitalizing on the individual strengths of multiple stakeholders (Alkema et al., 2003:223).

## **b. Actions**

Nursing management:

- recognizes the necessity to work collaboratively with other agencies in the community, to ensure the delivery of holistic infant developmental care by community nurses;
- understands the process and the necessity of collaboration with the various agencies and if not, actively obtains the necessary information to enable this process;

- fosters strong relationships with other agencies by focusing on personal contact and networking, mutual respect and credibility, and accessibility and sharing of information, to ensure that community nurses are in a position to deliver and sustain developmental care to infants and their families;
- decides together with prospective partners what form the collaboration will take on and devise protocols accordingly to reduce overlap and duplication between services focused on developmental care for infants and their families;
- identifies and addresses the barriers to collaboration to ensure the continuity of developmental care to infants and their families.

**Guideline 5: Community nurses engage in infant developmental care in such a way that it is a central focus of each contact that the community nurse has with the infant.**

#### **a. Rationale**

Developmental disability is an important health problem as it carries an appreciable burden to the individual, family and society. The importance of promoting typical development of infants and children is increasingly apparent in the literature. The monitoring of infants' development should be one of the most fundamental activities of infant primary health care. The reasons for it are: delays in development are common; early intervention is effective for infants with developmental delays; infants at risk of poor developmental outcomes also benefit from early intervention and community nurses are uniquely positioned to identify and refer infants with developmental delays in a timely manner to other health care professionals (King & Glascoe, 2003:624-625; Rydz et al., 2005:17).

Developmental care will result in infants being identified at a younger age, when intervention has its maximum benefit to alter their developmental trajectories favourable. (Pinto-Martin, Sonders, Giarelli & Levy, 2005:163,167; Rydz et al., 2005:4).

## **b. Actions**

- Infant development and developmental surveillance are included in the content of all training programmes (pre-service and in-service) to ensure community nurses have the necessary knowledge and skills to identify developmental delays and disabilities timely, when intervention has its maximum benefit to alter the developmental trajectory of infants favourably.
- Community nurses, by becoming more evidence-based orientated in their daily practice will recognize the importance of developmental care as a priority in the daily care of infants.
- Community nurses identify strategies to incorporate a more comprehensive developmental service in their daily care of infants.
- Community nurses include the Transactional Model of Development in the theoretical framework that underpins the delivery of developmental care to infants to ensure that they have the necessary knowledge to deliver a quality infant developmental care service.
- Community nurses focus on relationships between parent and infant, and family and service providers, to ensure sustainability and acceptance of infant developmental services.

**Sub-guideline 5.1: Community nurses acknowledge and incorporate the right of infants to develop to their full potential, in their health care delivery to infants and families.**

## **a. Rationale**

There is global consensus that children's rights need special attention and the importance of good care and protection of children is embedded in the culture of all societies (Meyers, 1993:37). The Constitution of South Africa (1996) devotes a special section to children and a range of children's rights is specified, including the right of every child to basic nutrition, shelter, basic health care services and social services.



## **b. Actions**

Community nurses:

- have the best interests of the infant at heart and guarantee the rights of infants according to the three P's: protection (from maltreatment, neglect, and all forms of exploitation), provision (of food, health care, education and social security) and participation (in all matters concerning them) in their daily developmental care to infants;
- acknowledge and incorporate the right to life, survival and development of the infant in their daily developmental care to infants and families to ensure that the infant is well developed physically, mentally, socially and emotionally, thereby placing them in a better position to eventually contribute to family, community and country;
- have a responsibility to see that parents have the necessary knowledge to provide an environment conducive to the healthy development of their infant.

**Sub-guideline 5.2: Government priority programmes address the scope of infant development comprehensively.**

## **a. Rationale**

The World Health Organisation recognizes the importance of infant development and acknowledges that supporting the development of infants should become a greater priority in health programmes (WHO, 1999).

However, many early-emerging developmental delays and disabilities go undetected and therefore unaddressed by service systems (Carter et al., 2004:118; Magnusson et al., 2000:118; Zuckerman et al., 2004:1522).

Timely assessment of infant development makes it possible to identify and manage developmental delays and disabilities at the earliest possible point of manifestation and to prevent or diminish loss of developmental potential. It can furthermore, help to identify developmental risk factors and target effective anticipatory guidance to assist parents in promoting optimal developmental

outcomes (Carter et al., 2004:118; Halfon et al., 2004:1926; Magnusson et al., 2000:118).

## **b. Actions**

Community nurses:

- use every contact with the infant and family to assess and positively influence infant health and development;
- have the necessary understanding of human development to identify biological risk factors and to reduce its deleterious effects on infant development;
- have the necessary knowledge about assessment, specifically the principles and elements of assessment, at their disposal to identify infant developmental delays and disabilities;
- establish a good working relationship with families to amplify insight in how familial and cultural contexts influence the infant's repertoire of skills;
- employ home visiting, as means to provide early intervention services to improve infant and parent outcomes;
- identify and address barriers to developmental care in a timely manner to ensure sustainability of infant developmental care.

**Guideline 6: Community nurses ensure that their professional practice, regarding developmental care to infants and their families, meets the standards of the profession.**

## **a. Rationale**

Community nurses are responsible, both legally and ethically for the care they provide. Nurses in South Africa must practice in accordance to the Nursing Act (1978) and its regulations. The Draft Charter of Nursing Practice (2004), which is to replace the current Regulations Scope of Practice (SANC Regulations No. R 2598, 1984 as amended), stipulates the code of conduct and ethics of nursing; standards for nursing practice; competencies for nursing practice; scope of the profession of nursing and midwifery; conditions for practice and

education and training for nursing practice. Although the final responsibility for the quality of care rests with the chief executive of the work place, it is the responsibility of the individual registered nurse to act competently and ethically and to be accountable for his or her nursing practice. By virtue of their professional accountability and contracts of employment, community nurses have a responsibility to enhance the provision of their service to the public (McSherry, 2004:145; Tait, 2004:723).

#### **b. Actions**

- Community nurses deliver infant developmental care in accordance with their scope of nursing practice, specifically clinical practice and quality of practice, as stipulated in the Draft Charter of Nursing Practice (2004).
- Community nurses uphold the mandate given by the people of South Africa, by accepting and demonstrating accountability and responsibility for own professional judgment and actions in the daily delivery of developmental care to infants and their families, as stipulated in the Draft Charter of Nursing Practice (2004).
- Ethical infant nursing practice of community nurses is based on the ethical principles and standards, code of conduct, and values fundamental to nursing, as stipulated in the Draft Charter of Nursing Practice (2004).
- The assumptions that underpin the practice of health care have changed from a framework where practice was based on experience to one where practice is based on evidence and community nurses need to take a personal responsibility for this change to evidence-based practice.
- Community nurses consult with more experienced nurse practitioners when infant developmental care requires expertise beyond their current competence.
- Community nurses consult with other health care professionals when the developmental needs of infants and their families fall outside the scope of nursing practice.

**Guideline 7: Community nurses accept responsibility and accountability for their own continuous professional development pertaining to the developmental needs of infants and their families.**

**a. Rationale**

Community nurses serve public interest and specifically that of the infant, best when they constantly improve their application of competence and thereby increasing their focus on infant development. Community nurses need to be able to recognize their own limitations and training needs; they need to look at their practice with fresh eyes to be able to plan how to meet such needs best (Spouse, 2001:15&17; Tennant & Field, 2004:168).

**b. Actions**

- Community nurses assume responsibility for lifelong learning and maintenance of competence concerning infant development.
- Community nurses identify own individual limitations and learning needs to enhance professional knowledge to improve developmental care delivered to infants and their families. Formulate, implement and evaluate individual learning plans to address the identified needs.
- Organizations support lifelong learning by ensuring that time and necessary resources are available for staff development.
- Organizations encourage community nurses to participate in evidence-based learning by subscribing to scientific journals that contain evidence on how to improve infant developmental care.
- To enhance delivery of developmental care to infants and their families, specific content can be included in all education programmes (pre-service, in-service and CPD). This includes: infant development; developmental vulnerability; adaptive and maladaptive parenting; protective factors and individual resilience; theoretical frameworks for intervention and specifically the Transactional Model of Development; elements of assessment and intervention (infant, family and community); human ecology of early risk;

cultural differences as sources of developmental vulnerabilities; family-centered care; service delivery models for developmental care of infants, specifically infants with developmental disabilities and family-professional partnerships (collective empowerment model).

**Sub-guideline 7.1: The providers of continuous professional development (CPD) programmes for community nurses have the necessary expertise and competence to present courses in infant developmental care.**

**a. Rationale**

The nurse educator role requires specialized preparation and every individual engaged in the academic enterprise must be prepared to implement that role successfully. A core of knowledge and skills is essential if one is to be effective and achieve excellence in the role. It is critical that all nurse educators know about teaching, learning and evaluation. The nurse educator's role is essential to the ongoing professional development of the community nurse (National League for Nursing, 2002:267).

**b. Actions**

- Appoint educators with the necessary competence in infant developmental care to implement this role successfully.
- Educators engage in lifelong learning activities to maintain and expand expertise, to ensure that community nurses increase their competence in infant developmental care.
- Educators focus on evidence-based learning by including scientific journals that contain articles on infant developmental care in the programme content.
- Educators support and employ inter-professional education to prepare community nurses to have a more holistic approach to their infant developmental care.

**Sub-guideline 7.2: Community nurses are proactive and involved in their own continuous professional development regarding infant developmental care.**

**a. Rationale**

CPD is defined as “an individual who takes responsibility for the development of his/her own career by systematically analysing development needs, identifying and using appropriate methods to meet these needs and regularly reviewing achievement compared against personal and career objectives” (Cusick & McCluskey, 2000:163). Although continuous professional development is not yet a requirement for annual registration for nurses in South Africa, CPD provides a learning framework for community nurses to adapt to the changing paradigm of evidence-based health care (Cusick & McCluskey, 2000:163).

**a. Actions**

- Each community nurse identifies individual learning needs pertaining to infant developmental care.
- Community nurses develop a specific professional development plan, which includes the specific strategies and time limit to meet learning needs.
- Community nurses review achievements against personal and organizational objectives concerning management of infant developmental needs.

**Guideline 8: Community nurses embrace family-centered care as their philosophy of care to infants and families.**

**a. Rationale**

A family-centered care approach in service delivery is considered best practice. In family-centered care, nurses respond to family priorities, empower

family members, employ a holistic (ecological) approach to the family, and demonstrate insight and sensitivity to families (Harbin et al., 2000:396). In this approach the strengths, vulnerabilities, and patterns of family functioning are considered in order to support child-rearing families and to encourage healthy coping strategies for families facing a crisis. This means that health assessment should include consideration of social, emotional, and financial resources as well as the physical environment of the home and community (Glascoe et al., 1989:958).

## **b. Actions**

Community nurses:

- become well-grounded about the dimensions of family-centered care to increase the possibility of a more holistic approach in the delivery of infant developmental care;
- become more active in cultivating a working relationship with parents to enhance positive developmental outcomes for their infants. Eliciting parents' view and expectations of the community nurse will assist in this process and promote excellence in service delivery to infants and their families;
- employ the Collective Empowerment Model as means to empower family members to activate the intrinsic competencies in all families and to utilize the natural and formal resources in the environment of the family, to support and sustain their identified goals for positive infant developmental outcomes;
- become familiar with the available resources in the community to assist families in addressing the developmental needs of their infants, in the context of available and accessible community resources;
- respect and support family decision making in the management of infant developmental needs;
- are cultural competent in the provision of infant developmental services, and are aligned to meet the needs of the infant in a manner that is culturally acceptable to the family;

- include reflective practice intervention in the delivery of infant developmental care to enhance the quality of family-centered care.

**Guideline 9: Community nurses ensure efficient management of infant developmental delays and disabilities.**

**a. Rationale**

The long-term problems of infants at risk for developmental delay have been well established. A growing body of literature supports the benefits of early identification and intervention. Community nurses can play a vital role in the management of such developmental delays and disabilities (Miles Curry & Duby, 1994:42).

**Sub-guideline 9.1: Community nurses focus on early identification of developmental delays and disabilities.**

**a. Rationale**

The monitoring of infants' development should be one of the most fundamental activities of child primary health care. The reason is that developmental delays should be identified at the earliest possible point of manifestation as the outcome could be improved by preventing loss of developmental potential. Community health care providers are in a crucial position to identify infant developmental delays early because they are in regular contact with them. They can also monitor development over time. Furthermore, they are often aware of underlying social and familial factors at work in the infant's immediate environment (Dworkin, 1989:1007; Halfon et al., 2004:1926; Magnusson et al., 2001:118; Rydz et al., 2005:5; VanLandeghem et al., 2002:2).



## **b. Actions**

Community nurses:

- incorporate developmental surveillance into comprehensive health care to infants and view all encounters as an opportunity for developmental surveillance to ensure early identification of developmental delays and disabilities thereby, increasing the possibility of intervention to have a positive effect on infant and family outcomes;
- become knowledgeable about aspects of developmental surveillance, elements and principles of assessment and utilize the Transactional Model of Development as theoretical framework to conceptualize the factors that determine high-risk infant developmental outcome, thereby optimizing early identification of infant developmental delays and disabilities by community nurses.

**Sub-guideline 9.2: Community nurses are knowledgeable about formal and informal support resources in the community to facilitate access for families.**

## **a. Rationale**

According to Dunst and Trivette (Wolery, 2000:194) informal support, and by extension resources, positively influence infant and family outcomes. Support, according to Finfgeld-Connett (2005:6) is “an interpersonal process that is context specific and involves the exchange of information.” It consists of facts, advice, words of reassurance, positive affirmation and empathy. Support can be formal (professionals) or informal (family, friends and the like) (McWilliam & Scott, 2001:57-59).

## **b. Actions**

Community nurses:

- become knowledgeable about the resources available in the community for infants and their families to be able to assist families in the identification of the necessary resources to meet their needs;
- become knowledgeable in the functional elements of support to institute the correct type of support for the family in need;
- develop an eco-map for each family to identify available and accessible resources and sources of support.
- build community capacity by recognizing the strengths and assets of a community by demonstrating how these strengths address infant and family desires and by eliminating barriers using other resources.

**Sub-guideline 9.3: Community nurses act as advocates for infants and their families.**

## **a. Rationale**

Advocacy is defined as “pleading the cause of another” (Stanhope & Lancaster, 1984:750). Nursing has as its end purpose the welfare of other human beings. Nurses act as advocates when they act in the best interest of the client. The nurse is seen as a resource person who gathers information to assist clients and families in their efforts to become informed about their rights. The nurse as advocate supports the client's right to participate in the decision making process and act as a buffer to prevent others from undermining the process.

## **b. Actions**

Community nurses:

- share information on developmental delays and disabilities with local organizations to increase their awareness of the needs of members in their community;

- present the client's concerns about his or her infant's developmental delay or disability when necessary in a succinct and convincing manner;
- identify resources to be utilized for the client's benefit leading to positive outcomes for both the infant and the family;
- identify sources of information on specific developmental delays and disabilities so that family members can be better informed about the infant with a developmental delay or disability;
- link families with family organizations who will help them advocate for their infant with a developmental delay or disability;
- assist clients toward assertive behaviour in personal health practices to improve developmental outcomes for their infants;
- motivate and empower families in the delivery of infant developmental care to act on their own behalf to gain and maintain control over their own well-being.

**Sub-guideline 9.4: Community nurses acknowledge the effect of developmental delays and disabilities on the family and determine the most beneficial strategy to facilitate the process of adaptation.**

#### **a. Rationale**

Parental reactions after receiving the diagnosis of impairment in a child can range from fear, denial, anger, frustration, guilt, grief and mourning. These are just the beginning of chronic stress, sadness and consequently ongoing distress and dysfunction in the family (Kearney & Griffin, 2001:582-583). After receiving the diagnosis the parents progress through a predictive sequence of stages before they are able to adapt to the situation (Cookfair, 1996; Pelchat & Lefebvre, 2004:124). These stages have been compared to that proposed by amongst others, Elizabeth Kubler-Ross in her theory of grief, ranging from initial shock to eventual acceptance (adaptation) (Wittert, 2004, n.p.).

Community nurses therefore, need to be aware of the enormous effect the disability may have on each member of the family and they have a significant role to play in facilitating the process of adaptation, providing family support,

facilitating access to local services and co-ordinating services (Kirk, 1999:351; Pelchat & Lefebvre, 2004:125; Sloper, 1999:91).

## **b. Actions**

Community nurses:

- are aware and sensitive to stages of grief and adjustment of a family with an infant who has been diagnosed with a developmental disability;
- become well-grounded in counselling and communication skills to ensure the necessary and ongoing support for families with a developmental delayed/disabled infant;
- bolster parental perceptions of control, support and coping to improve parental emotional well being and behaviour, thereby promoting positive developmental outcomes for both parents and the infant;
- provide information on the diagnosis, prognosis and daily care of the infant, with a developmental delay or disability in the family environment to facilitate the family's adaptation;
- boost parental self-esteem and confidence by acknowledging and respecting the expertise of the family in caring for the child and promote family interaction by including siblings and extended family in the daily care-giving of the developmental disabled infant;
- facilitate access to parent support groups to ensure the family receives the necessary support, thus, enhancing the family's well being and increasing the likelihood of positive developmental outcomes for the infant;
- mediate between families and the various health care professionals to promote continuity of care and support.

**Sub-guideline 9.5: Community nurses focus on anticipatory guidance in the management of infant developmental delays and disabilities.**

**a. Rationale**

Anticipatory guidance is seen as the cornerstone of child health services. It is the information health care professionals give to families about what they should expect in their child's development, what they should do to promote this development, and the benefits of these healthy lifestyles and practices. Research indicates that anticipatory guidance improves infant and family functioning (Nelson et al., 2003:630,634). Dines (1994:219) and Cantrell (1996:90) suggest that community nurses are well placed to undertake anticipatory guidance due to their closeness to their clients and their families.

**b. Actions**

Community nurses:

- include individualized anticipatory guidance in every contact session with infants and families to promote infant development;
- assess client's health literacy to increase the likelihood of comprehension of anticipatory guidance and they use plain lay language and avoid medical jargon, speak slowly, use pictures and visual images, limit the amount of information communicated in one encounter, ask clients to recall essential information, and create a trusting and shame-free therapeutic environment;
- utilize the Transactional Model of Development to focus on the regulatory processes to identify parental lack of knowledge about child rearing or misinterpretation of infant behaviour to provide the necessary anticipatory guidance to rectify the identified shortcoming, thereby improving infant developmental outcomes;
- elicit family concerns and base anticipatory guidance topics on these concerns or ask open-ended questions to prompt parents to raise issues on which they wish to receive guidance;

- utilize pre-visit questionnaires and checklists to help identify specific developmental concerns and risks to ease the workload;
- are guided by developmental needs of the family and community, population risks and morbidity, and the scientific evidence previously summarized to choose topics for discussion.

**Sub-guideline 9.6: Community nurses apply best-practice principles in early intervention efforts to promote positive outcomes for the infant and the family.**

#### **a. Rationale**

According to Blann (2005:265), nurses have a long history in participating in early intervention programmes and community nurses can play a vital role in the provision of early intervention services to infants and families with special needs. However, for intervention to be successful it must adhere to certain design and helping principles.

#### **b. Actions**

Community nurses:

- create a family-centered therapeutic process by encouraging family members to participate in the intervention process;
- apply the transactional diagnosis decision flowchart for choosing the appropriate form of intervention. Family decision making is respected and supported by community nurses in early intervention efforts;
- support care-givers/parents of a developmentally delayed or disabled infant by showing understanding for their concerns and frustrations, and discuss and explain procedures with family;
- adhere to the following principles for effective and sustainable intervention efforts to enhance positive infant developmental outcomes:

- utilize a theoretical underpinning to make sense of what are being observed and learned about families and to decide how and where to intervene.
- decide on a clear mission and boundaries for intervention efforts.
- start where the family is developmentally.
- build a good relationship with the family.
- work from a strengths-based perspective.
- view the infant in the family-context, but do not lose the infant when using a family-centered lens.
- do not promise more than what can be delivered.
- convey to parents that change is gradual, fragile and reversible and it should be measured in small units;
- view assessment and intervention in the management of infant developmental delays and disabilities as interactive processes in which each informs the other.

**Guideline 10: Community nurses implement and promote interdisciplinary collaboration in the delivery of infant developmental care.**

#### **a. Rationale**

Infants with developmental delays and disabilities often require the expertise of numerous professions and without collaboration there would be no continuity of care (Stanhope & Lancaster, 1984:789; Stayton & Bruder, 1999:61).

Collaboration with other health care professionals is an important strategy to ensure that clients have access to holistic and comprehensive health care services. Collaboration of this nature can enhance intellectual resources and allow individual health care providers to fulfil their optimal potential within their respective professions (Pringle et al., 2000:764).

## **b. Actions**

Community nurses:

- acquire knowledge about the roles and functions of other health care professionals to facilitate the referral process of infants with developmental delays and disabilities, thereby ensuring timely intervention;
- institute a referral process that initiates feedback and communication between health care professionals to assist the community nurse in the management of infant developmental needs;
- follow up on referrals to ensure the continuity of care and thereby positive developmental outcomes for both parents and infants.

**Sub-guideline 10.1: Community nurses establish and sustain interdisciplinary/ transdisciplinary working teams, to address infant developmental delays and disabilities.**

## **a. Rationale**

Infants with complex problems, such as developmental delays and disabilities, do not fall neatly into the service categories into which the services are divided (e.g. health, social). No one professional discipline can be expected to have the knowledge and skills required to deal with these infants. The need for interdisciplinary collaboration has been clearly recognised to address the needs of these infants in a holistic manner (Salmon, 2004:157).

Transdisciplinary working allows for flexible definitions of role and responsibility and thereby enriches the team and the family while simultaneously empowering individual members. Team members must first improve their own knowledge-base and clinical skills to enhance their self-confidence in order to become full, active members of the team. Role release involves the infusion of information unique to the specific profession into the collective knowledge base of the team (Briggs, 1997:94-98; Watson et al., 2002:372).



## **b. Actions**

Community nurses:

- include parents in the interdisciplinary/transdisciplinary teams to ensure that interventions start where families are developmentally and that it begins with parents' own experience of their situation;
- are confident in their own role to deliver infant developmental care and respect the expertise and roles of other health care professionals;
- acquire the necessary knowledge to perform as a member of an interdisciplinary/ transdisciplinary team;
- and other health care professionals develop a unified mission with mutually recognized goals for the team, and find common ground among team members to determine what contribution each of the members can provide in infant developmental care;
- establish effective communication and a common language for use among team members to ensure an effective service to infants and their families;
- identify barriers to collaboration and address it timely to ensure sustainability of the management of infant developmental needs.

**Sub-guideline 10.2: Community nurses engage in interdisciplinary education to enhance their knowledge and skills to facilitate a more holistic approach to infant developmental care.**

## **a. Rationale**

The impetus for inter-professional education initiatives originated in the World Health Organization Alma Ata in 1978, which stated the need for a more holistic approach to health care (Mandy, Milton & Mandy, 2004:154). Inter-professional training has been defined as “learning together to promote collaborative practice” (Cooper et al., 2001:229). Different professional groups learn with and from each other to increase collaborative practice and to improve the effectiveness of care delivery (Cooper et al., 2004:180). However, it would be naïve to assume that learning together is without its difficulties. It is

necessary therefore to consider carefully how such learning opportunities are planned and structured (Fowler, Hannigan & Northway, 2000:187).

## **b. Actions**

Community nurses:

- improve communication and working practices across professional and organizational boundaries to initiate interdisciplinary education to enhance their competence to ensure a more holistic approach to infant developmental needs;
- obtain support from management to ensure sustainability of interdisciplinary education;
- join other health care professionals with a view to assign the initial planning process to a designated planning team and acquire the necessary infrastructure support, such as space for group meetings and teaching equipment;
- join other health care professionals to form small (no more than eight), but diverse (no fewer than four) groups to enhance interaction to allow members to learn from one another and develop a common conceptual understanding;
- recognize the effect of cognitive factors such as attitudes toward each other, to help understand the complexity of interdisciplinary relations in delivery of infant developmental care;
- recognize the effect of emotional factors such as perceptions of interdisciplinary education and its effects, to help understand the facilitation processes involved in developing this type of intervention;
- recognize social-environmental variables, such as social norms and influences of peers and gatekeepers, to help understand the development of stereotypes;
- identify and address barriers to collaboration and shared learning to ensure that community nurses reap the benefits of other health care professionals' expertise and competence and thereby, increasing the effectiveness of infant developmental care.

The researcher decided to make use of the acronym, **DEFINE HOPE**, to name the set of recommended guidelines. This acronym indicates that there is 'hope' to enhance positive developmental outcomes for infants and their families and to prevent late identification of developmental delays and disabilities:

- D** – **D**evelopmental care focus
- E** – **E**stablish infrastructure and resources
- F** – **F**amily-centered care
- I** – **I**nterdisciplinary collaboration
- N** – **N**etworking with other agencies
- E** – **E**thical nursing and professional accountability
  
- H** – **H**ealth care governance
- O** – **O**rganizational culture and climate
- P** – **P**ersonal professional development
- E** – **E**fficient management of developmental delays and disabilities.

### 5.3 ENSURING VALIDITY

Guidelines should be subject to peer review prior to widespread dissemination and implementation to ensure content validity, clarity and applicability (Royal College of Paediatrics and Child Health, 2001:8; Shekelle et al., 1999:596). The recommended guidelines were referred for examination to a group of professionals who, in their respective work contexts, focused on promotion of infant development and the identification of developmental delays and disabilities. The same focus group that was utilized to assist with the final development of the guidelines validated the guidelines.

### 5.4 SUMMARY

In this chapter, the second phase of the study, the development of guidelines to support community nurses in either training, continuous professional development, or co-operation with other health care professionals and

managers was discussed in order to attend to the developmental needs of infants. The researcher also indicated the measures that had been employed to ensure validity of the guidelines.

In chapter 6, a summary of the main findings of the research is given. The researcher discusses the research findings of phase one, the validation of the recommended guidelines, recommendations to enhance the management of infant developmental needs by community nurses and possible limitations of the study.

## **CHAPTER 6**

### **VALIDATION OF GUIDELINES, CONCLUSIONS AND RECOMMENDATIONS**

#### **6.1 INTRODUCTION**

In chapter 5, the management of infant developmental needs by community nurses was addressed by developing guidelines with appropriate actions. The recommended guidelines, that envision enhanced management of infant developmental needs by community nurses, were subjected to a validation process to ensure that it could be implemented in practice.

This chapter contains conclusions regarding the management of infant developmental needs by community nurses. These include the responsibilities of community nurses according to the scope of practice of registered nurses, with regard to the management of developmental needs of infants in Park Street Clinic, Klerksdorp, and the development of guidelines for the support of community nurses to address the developmental needs of infants 0 - 2 years. The research is also evaluated in terms of limitations and strengths. This is followed by recommendations regarding the contributions that this research could make to the field of nursing.

#### **6.2 SUMMARY OF MAIN FINDINGS**

The purpose of this research was to describe the responsibilities of community nurses according to the scope of practice of registered nurses, with regard to the management of developmental needs of infants in a primary health care clinic in South Africa, and to develop guidelines for the support of community nurses to address the developmental needs of infants 0 - 2 years.

Data to determine the responsibilities of community nurses regarding the management of infant developmental needs were obtained by means of comprehensive, semi-structured interviews with various stakeholders, e.g. community nurses, management concerned with nursing issues, personnel in

training and continuous professional development of nurses at the clinic, families with infants 0-2 years of age with typical development, families with infants 0-2 years of age with an identified developmental delay or disability; and other health care professionals (speech/language therapists, occupational therapists and physiotherapists). These interviews indicated the following:

- Developmental needs of infants and their families are currently not addressed optimally by community nurses in the Park Street Clinic, although all of them agreed that infants have the right to develop to their full potential.
- Community nurses did not agree with the statement made by other health care professionals, that the diagnosis of developmental disability is done much too late for effective intervention. They furthermore felt that infants are referred for intervention. They gave several possible reasons for the late identification of developmental delays and disabilities.
- Management need to review their commitment and type of support to community nurses if infant developmental care, as part of community nurses' responsibilities, is to be effective and of high quality.
- According to the community nurses the current organizational culture and climate is not conducive to address the developmental needs of infants and their families.
- Expressed constraints concerning infrastructure and resources (human and financial) in the Park Street Clinic, should not have a detrimental effect on the focus on infant developmental needs by community nurses.
- Parents indicated that they are not knowledgeable about the role and function of the community nurse therefore they are not aware of the fact that developmental care of infants and their families should be part of the comprehensive child health care delivered by community nurses.
- Besides competence, the parents identified several characteristics that they feel should be part of a nurse-parent relationship: friendliness, warmth, interest, acceptance, concern, sensibleness, kindness and calmness.
- For various reasons parents felt that they did not get any, or sufficient chance to voice their concerns. Most of the parents indicated that they expected nurses to give advice and information without having to ask for it, "... I thought it was automatic ..." The parents perceived this as a serious

shortcoming.

- Parents indicated that a “running commentary” about findings would be reassuring to them whilst the community nurse is assessing their infants. Several parents stated that there was no explanation of the procedures/assessment that the nurse carried out and identified it as a shortcoming.
- The only interventions indicated by the nurses, were that of limited anticipatory guidance to the parents/family members and/or referral. Community nurses are not aware of the role and functions of the different therapists and therefore they prefer to refer to the paediatric clinic where the onus would be on the doctor to decide what action he/she would take.
- Follow-up by nurses following referral is minimal, if not non-existing. This could affect continuity of care negatively, thus, minimizing positive developmental outcomes for infants and their families.
- Community nurses do not have the necessary knowledge about the formal and informal support resources in the community. Therefore, they are not able to facilitate access to local resources to optimize the development of infants and their families.
- Community nurses do not have sufficient knowledge about the functional elements of support to enable them to provide appropriate, ongoing support to families.
- An in depth understanding of the process of collaboration with other health care professionals is required to equip all stakeholders with appropriate knowledge, if any change in the current situation is to take place and thereby improve the health outcomes of infants and their families.
- Referral channels are not what it should be. It should be clarified, if the best interest of the infant and its family is to be maintained by all parties involved.
- Feedback from other health care professionals, to community nurses, seems to be a big shortcoming.
- Other health care professionals can be an invaluable source of learning for community nurses.
- Community nurses need additional training to equip them to deliver holistic infant developmental care.

Arising from the foregoing, the following guidelines are recommended:

- Nursing management implements shared health care governance as a responsibility of management and community nurses, to optimize the management of infant developmental needs and quality of care by community.
- Nursing management creates a positive organizational culture and climate in which community nurses can reach their full potential, to manage infant developmental needs optimally.
- Nursing management evaluates, prioritizes and addresses existing infrastructure and resources (financial and human) constraints in a timely manner, to enable community nurses to deliver sustainable quality developmental care to infants and their families.
- Nursing management pursues interagency collaboration to obtain the necessary intellectual and institutional resources to enable community nurses to provide sustainable, quality infant developmental care.
- Community nurses engage in infant developmental care in such a way that it is a central focus of each contact that the community nurse has with the infant.
  - In their health care delivery to infants and families community nurses acknowledge and incorporate the right of infants to develop to their full potential.
  - Government priority programmes address the scope of infant development comprehensively.
- Community nurses ensure that their professional practice regarding developmental care to infants and their families, meets the standards of the profession.
- Community nurses accept responsibility and accountability for their own continuous professional development pertaining to the developmental needs of infants and their families.
  - The providers of continuous professional development (CPD) programmes for community nurses have the necessary expertise and competence to present courses in infant developmental care.



- Community nurses are proactive and involved in their own continuous professional development regarding infant developmental care.
- Community nurses embrace family-centered care as their philosophy of care to infants and families.
- Community nurses ensure efficient management of infant developmental delays and disabilities.
  - Community nurses focus on early identification of developmental delays and disabilities.
  - Community nurses are knowledgeable about formal and informal support resources in the community to facilitate access for families.
  - Community nurses act as advocates for infants and their families.
  - Community nurses acknowledge the effect of developmental delays and disabilities on the family and determine the most beneficial strategy to facilitate the process of adaptation.
  - Community nurses focus on anticipatory guidance in the management of infant developmental delays and disabilities.
  - Community nurses apply best-practice principles in early intervention efforts to promote positive outcomes for the infant and the family.
- Community nurses implement and promote interdisciplinary collaboration in the delivery of infant developmental care.
  - Community nurses establish and sustain interdisciplinary/transdisciplinary working teams to address infant developmental delays and disabilities.
  - Community nurses engage in interdisciplinary education to enhance their knowledge and skills to facilitate a more holistic approach to infant developmental care.

### **6.3 VALIDATION OF THE GUIDELINES**

In chapter 5, the development of the guidelines was described. Furthermore, the researcher indicated that the guidelines were to be evaluated. In this section, the researcher will discuss the entire process of the validation of the guidelines.

A number of desirable attributes for guidelines are indicated in the literature (See Table 2.13:59). On recommendation of the study supervisor, the researcher adapted these attributes to compile the criteria for evaluation of the guidelines. When the focus group (See Table 5.1:314) reconvened for the validation process, the researcher discussed the development of the recommended guidelines. Furthermore, the rating scale and definitions of the criteria, according to which the guidelines were to be evaluated, were also discussed with the group. Time was given for questions. Some of the group members had a problem with one of the criteria, that of reproducibility, as they felt that they had no insight into the raw data and analysis thereof. The group in its entirety, then decided to exclude that criterion and to rate the guidelines only according to the remaining five criteria. The group then evaluated the guidelines at the hand of the specified criteria. The criteria and rating scale, according to which the recommended guidelines were evaluated, are indicated in Table 6.1.

Table 6.1 Criteria and rating scale for evaluation of recommended guidelines

| CRITERIA                                                                                                                                                            | RATING SCALE             |              |                 |                             |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------|-----------------|-----------------------------|
|                                                                                                                                                                     | STRONGLY<br>AGREE<br>(1) | AGREE<br>(2) | DISAGREE<br>(3) | STRONGLY<br>DISAGREE<br>(4) |
| <b>Valid:</b><br>Correct interpretation of available evidence so that implementation of the guidelines will lead to improvement in promotion of infant development. |                          |              |                 |                             |
| <b>Reproducibility:</b><br>Given the same evidence, another researcher would produce similar recommendations.                                                       |                          |              |                 |                             |
| <b>Cost-effectiveness:</b><br>The guidelines should generate health improvements at an acceptable cost.                                                             |                          |              |                 |                             |
| <b>Reliability:</b><br>Given the same circumstances, another health professional would apply them similarly.                                                        |                          |              |                 |                             |

|                                                                                                                                             |  |  |  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|
| <b>Applicability:</b><br>Target population identified in accordance with evidence, as well as a clear description of the target population. |  |  |  |  |
| <b>Clarity:</b><br>Guidelines should be precise, unambiguous and user-friendly.                                                             |  |  |  |  |

(Adapted from Carnett, 2002:66-67; Jackson & Feder, 1998:427; NICE, 2001:4; Royal College of Paediatrics and Child Health, 2001:5; Rycroft-Malone, 2002:150).

In Table 6.2, below the ratings of the main guidelines are indicated. The number of participants who indicated the specific rating, is indicated (e.g. 3 participants indicated that they strongly agree, by marking 1; 4 participants indicated that they agree, by marking 2; 1 participant indicated that she disagrees by marking 3 and no participants indicated that they strongly disagree).

Table 6.2 Rating of guidelines

|              | VALID |    |   |   | COST-EFFECTIVENESS |    |   |   | RELIABILITY |    |    |   | APPLICABILITY |    |   |   | CLARITY |    |   |   |
|--------------|-------|----|---|---|--------------------|----|---|---|-------------|----|----|---|---------------|----|---|---|---------|----|---|---|
|              | 1     | 2  | 3 | 4 | 1                  | 2  | 3 | 4 | 1           | 2  | 3  | 4 | 1             | 2  | 3 | 4 | 1       | 2  | 3 | 4 |
| GUIDELINE 1  | 3     | 4  | 1 | - | 1                  | 6  | - | 1 | 1           | 4  | 3  | - | 1             | 6  | - | 1 | 4       | 3  | - | 1 |
| GUIDELINE 2  | 4     | 3  | - | 1 | 2                  | 5  | - | 1 | 1           | 4  | 3  | - | 2             | 5  | - | 1 | 4       | 3  | - | 1 |
| GUIDELINE 3  | 3     | 3  | 1 | 1 | -                  | 5  | 2 | 1 | 1           | 5  | 2  | - | 3             | 4  | 0 | 1 | 2       | 5  | - | 1 |
| GUIDELINE 4  | 2     | 5  | - | - | -                  | 6  | 1 | 1 | 2           | 5  | -  | - | 3             | 4  | - | - | 2       | 5  | - | - |
| GUIDELINE 5  | 4     | 3  | - | 1 | 1                  | 3  | 2 | 1 | 3           | 2  | 2  | 1 | 3             | 4  | - | 1 | 4       | 3  | - | 1 |
| GUIDELINE 6  | 5     | 2  | 1 | - | 2                  | 5  | 1 | - | 2           | 4  | 1  | - | 2             | 5  | - | - | 2       | 5  | - | - |
| GUIDELINE 7  | 3     | 4  | 1 | - | 1                  | 4  | 2 | 1 | 2           | 4  | 2  | - | 2             | 5  | 1 | - | 2       | 5  | - | - |
| GUIDELINE 8  | 4     | 3  | 1 | - | 2                  | 5  | - | 1 | 3           | 3  | 2  | - | 2             | 5  | - | - | 3       | 4  | 1 | - |
| GUIDELINE 9  | 4     | 3  | - | 1 | 1                  | 6  | - | 1 | 2           | 5  | -  | 1 | 2             | 5  | 1 | - | 3       | 4  | - | 1 |
| GUIDELINE 10 | 5     | 2  | - | 1 | -                  | 7  | - | 1 | 1           | 6  | 1  | - | 2             | 5  | - | - | 3       | 4  | 1 | - |
| TOTAL (n)    | 37    | 32 | 5 | 5 | 10                 | 52 | 8 | 9 | 18          | 42 | 16 | 2 | 22            | 48 | 2 | 4 | 29      | 41 | 2 | 5 |

In Table 6.2, (n) indicates the total number of participants for a specific rating. The red blocks indicate the highest number of participants for that specific rating of the guideline. Most participants indicated that they either agree or strongly agree with the specific criteria for each guideline. Some participants felt that some of the guidelines did not meet the criteria as defined by the researcher. They were, however, by far the minority and the focus group accepted that the guidelines were valid, cost-effective, reliable, applicable, and clear, as indicated by the outcomes of the ratings.

The complete set of validated guidelines, **DEFINE HOPE**, is presented in a separate booklet format (See Guidelines for the support of community nurses in the management of infant developmental needs, 2005:12-13).

## **6.4 DESCRIPTION OF THE GUIDELINE DOCUMENT – DEFINE HOPE**

Following, is a descriptive overview on the outline of the guideline document, **DEFINE HOPE**.

### **6.4.1 INTRODUCTION**

It is important to orientate the reader of the guideline regarding the purpose and objectives, for whom the guideline is intended, as well as who had developed the guideline.

#### **6.4.1.1 PURPOSE AND OBJECTIVES**

This section briefly states why the guideline was written and what it is intended to achieve.

#### **6.4.1.2 FOR WHOM IS THE GUIDELINE INTENDED?**

This section explicitly identifies the intended users of the guidelines.

#### **6.4.1.3 WHO HAS DEVELOPED THE GUIDELINE?**

It is important to identify the person responsible for development of the guidelines, including the qualifications of the developer, so that those who consult the document are convinced of the competence of the developer, as expertise is germane to the creation of guidelines (ACC/AHA Task Force on Practice Guidelines, n.d:n.p.). The researcher complied with this by identifying herself, as well as supplying a list of her qualifications.

The developer is a community nurse, with 25 years of experience in a primary health care environment. Her main interest, however, is the wellbeing of infants. This interest, in optimizing the development of infants, led to her being the first community nurse in South Africa to obtain a Master's degree in 'Early Childhood Intervention' at the University of Pretoria. After exposure to professionals in the field of Early Childhood Intervention who stated that the "diagnosis" of developmental disability is done much too late for effective intervention and that mothers and caregivers bring infants too late for evaluation of their development, due to a lack of knowledge about child development and the milestones infants should reach at certain stages, the developer felt a need to explore the truth value of this statement. This led to the commencement of the PhD study 'Management of developmental needs of infants by community nurses,' with the aims:

- To describe the responsibilities of community nurses are, within their scope of practice, with regard to the management of developmental needs of infants at a primary health care level, and
- To develop guidelines for the support of community nurses in either training, continuing professional development or co-operation with other health care professionals and managers in order to attend to the developmental needs of infants.

#### **6.4.2 DEVELOPMENT OF THE GUIDELINE**

In this section, the researcher indicated the nature of guidelines and explained the benefits of guidelines.

#### **6.4.2.1 BACKGROUND**

The researcher felt it necessary to give a brief overview of the background and rationale of the research study to enhance the reader's understanding as to why the guideline document had been developed.

#### **6.4.2.2 ASSUMPTIONS UNDERPINNING THE GUIDELINES**

By focusing the reader's attention on the assumptions that underpin the guidelines, the researcher indicated that the research, from which the guidelines originated, focused on the four concepts of the meta-paradigm of nursing: person, health, environment and nursing.

#### **6.4.2.3 CONCEPTUAL FRAMEWORK FOR THE DEVELOPMENT OF THE GUIDELINES**

By giving a brief overview of the Transactional Model of Development, the researcher indicates to the reader that it is an appropriate conceptual framework for community nurses to address the management of infant developmental needs. Furthermore, the researcher indicates how the Transactional Model of Development coincides with the four concepts of the meta-paradigm of nursing: person, health, environment and care (nursing) (See Figure 4.2:240 and 6.4.2.1:314).

#### **6.4.2.4 CLARIFICATION OF CONCEPTS**

In this section, the researcher clarified certain concepts, as common usage of these concepts varies. This was done to facilitate the reader's understanding of the Transactional Model of Development and thereby increase comprehension of the respective guidelines.

#### **6.4.2.5 METHODOLOGY**

The researcher gives a brief description of the strategy used to investigate the phenomena, the methods used to collect the data, as well as the technique utilized to analyze the data.

#### **6.4.2.6 REVIEW OF THE LITERATURE**

By explaining why and how the literature review had been done, the researcher increases comprehension about the scope of the guideline.

#### **6.4.2.7 DEVELOPMENT OF THE GUIDELINES**

In this section, the researcher gives an overview of the guideline development process. A focus group had been utilized to assist the researcher in the final stages of the development process. The researcher indicates who were included in this focus group and why they were included.

#### **6.4.3 VALIDATION OF THE GUIDELINES**

Here, the researcher indicates how she went about to obtain validation of the guidelines. Furthermore, the necessity and importance of this process is highlighted.

#### **6.4.4 NAMING OF THE GUIDELINES**

By utilizing the acronym, DEFINE HOPE, the researcher makes it easier for the reader to remember the ten main guidelines of the guideline document.

#### **6.4.5 SET OF RECOMMENDED GUIDELINES**

In this section, the researcher condensed each guideline in a sentence or two and separated it from the text by placing it in a text box. Each guideline is further enhanced by a rationale and descriptive information to ensure comprehension, as guidelines are intended for use in real world settings and should therefore be practical and feasible to implement.

#### **6.4.6 SCHEDULE FOR REVIEW**

Guideline developers need to maintain guideline content so that is up-to-date with best practices in the field of infant developmental needs. Therefore, it is advisable to review guidelines within one year following publication.

### **6.5 IMPLICATIONS FOR NURSING**

The main findings of the research imply that infant developmental care is not included to its fullest potential, in the health care delivered to infants and their families. Moreover, community nurses do not fulfil their responsibilities, according to the scope of practice of registered nurses, with regard to the management of developmental needs of infants in Park Street clinic in Klerksdorp. Community nurses need a greater understanding of what infant developmental care comprises and therefore, need additional training to equip them to deliver holistic infant developmental care.

Management need to review their commitment and type of support to community nurses if infant developmental care, as part of community nurses' responsibilities, is to be effective and of a high quality. Community nurses and other health care professionals must recognize the nature and potential of inter-professional collaboration to ensure positive outcomes for infants with developmental delays and disabilities. Furthermore, other health care professionals can be an invaluable source of support and learning for community nurses in the management of infant developmental needs.



These findings have implications at the following levels:

- **Research**

- After applying the guidelines in practice (Park Street Clinic), a follow-up study should be conducted to determine whether application of the guidelines actually improved the quality of infant developmental care delivered by community nurses.
- Research indicates that transdisciplinary working is likely to offer most benefits for infants with developmental delays and disabilities. As this is a new concept for community nurses in South Africa, research could be conducted on the effect of joint working, in a primary health care clinic, on infants with developmental delays and disabilities and their families. These infants and their families are likely to have specific needs, which may or may not mean that particular approaches to joint working are more effective in improving outcomes for infants and their families.
- As transdisciplinary working or joint working is a new concept for community nurses this could, if put to practice, lead to insecurity about their primary roles and responsibilities that could affect motivation to a large extent. The relationship between joint working and motivation to deliver quality infant developmental care should be further investigated.
- In the present study, the participants were restricted to people who could speak or comprehend either Afrikaans or English. It would be interesting to conduct another study where participants from other language groups could be included to broaden the focus and to include perspectives from other cultures.
- To improve the continuity of developmental care provided to infants and their families, research could be conducted into referral and management procedures that would aid communication between health care professionals, thereby, assisting service providers to improve the quality of developmental care to infants and their families.
- If specific content regarding infant developmental care is included in the curriculums of under- and postgraduate students, as well as the content of continuous professional development programmes, research could be conducted to see if training that is more comprehensive has a

positive effect on the quality of developmental care to infants and their families.

- **Education**

- To enhance delivery of developmental care to infants and families, there is an essential need for community nurses to have a full understanding of the following: Infant development; developmental vulnerability; adaptive and maladaptive parenting; protective factors and individual resilience; theoretical frameworks for intervention and specifically the Transactional Model of Development; elements of assessment and intervention (infant, family and community), human ecology of early risk; cultural differences as sources of developmental vulnerabilities; family-centered care; service delivery models for developmental care of infants and specifically infants with developmental disabilities; family-professional partnerships (Collective Empowerment Model) and ways to implement the specific theory on developmental care in practice. Therefore, it should be included in the curriculum of both under- and postgraduate students, as well as to be included in the content of continuous professional development programmes.
- Community nurses should be educated in the role and function of other health care professionals to enhance co-operation amongst all health care professionals, thereby enhancing positive infant developmental outcomes.
- Other health care professionals should be incorporated in education programmes of community nurses to ensure a more holistic approach to infant developmental care.
- Community nurses should take ownership of their own continuous professional development; they need to identify their own needs and limitations and implement the necessary steps to augment any shortcomings.

- **Practice**

- There is a need to test the guidelines, as presented in this research, in the primary health care clinic, to see whether the application thereof actually improve the delivery of developmental care to infants and their families.

- Community nurses working in a primary health care clinic need to reflect on the developmental care that they deliver to infants and families, so that they can devise strategies to rectify shortcomings such as insufficient anticipatory guidance and parental concerns not being elicited.
- Families need to be incorporated as members of the transdisciplinary team and their involvement and contributions should be encouraged and respected by all team members. Community nurses need to educate parents/families, as to what their rights are as members of such a team. Furthermore, they should be educated about the role and function of the other members of the team, to enhance co-operation and continuity of care.
- For the purpose of quality improvement, infant developmental care should also be incorporated in the professional performance expectations of community nurses. Furthermore, the emphasis should be on the identification of opportunities for improvement and continuous development of community nurses.
- The awareness of management needs to be raised regarding the importance of their commitment and type of support to community nurses if infant developmental care, as part of community nurses' responsibilities, is to be effective and of a high quality.
- Management and community nurses need to institute joint working with other health care professionals to ensure the delivery of holistic infant developmental care.
- Community nurses and other health care professionals need to make a concerted effort to follow-up after referral of clients, as well as give feedback to ensure the continuity of care.
- Barriers to the implementation of effective infant developmental care by community nurses must be assessed, so that strategies to overcome these barriers can be implemented.
- Community nurses need to become knowledgeable about the resources in their community that could promote early child development.

## 6.6 LIMITATIONS OF THE STUDY

Several **limitations** of the study should be acknowledged. Although multiple-case designs are preferred over single-case designs, the researcher selected a single case study design, but she justified her choice with a strong argument. The research was confined to one primary health care clinic, in one province of South Africa, therefore it is accepted that the research findings are not generalizable (transferable) to similar groups. However, the researcher did not specify the transferability of findings, but only provided sufficient information that can be used by others to determine whether the findings are applicable to their situation. All the participating community nurses, except one, were women. This gender division can briefly be explained by the fact that in western societies, occupations such as nursing are almost exclusively female (Lindholm, Sivberg & Udén, 2000:334). Participants were bound by language restrictions on the part of the researcher. Therefore, the opinions from those who were not proficient in either Afrikaans or English were excluded. This was decided upon to ensure that language problems did not influence the effectiveness of the interviews. In relation to the qualitative approach used in this study, a further limitation could be attached to the interpretation of the data, in that the researcher's own perception of developmental care may have influenced the classification of themes and therefore the interpretation. Despite these limitations, it is possible to suggest how the research findings may be applied to enhance the delivery of developmental care to infants and their families, and to make recommendations for further research.

## 6.7 SUMMARY

The study demonstrated the importance for community nurses (as well as management concerned with nursing issues, personnel involved in the training and continuous professional development of nurses at the clinic, and other health care professionals, e.g. speech/language therapists, occupational therapists and physiotherapists), to identify and address the developmental needs of infants and their families in a holistic and timely way to ensure positive outcomes for infants and their families.

In chapter 3, the shortcomings concerning the responsibilities of community nurses with regard to the management of infant developmental needs were identified in the analysis of the data. In chapter 4, the researcher discussed the responsibilities of community nurses at the hand of literature (nursing and other). Furthermore, the researcher developed guidelines for the support of community nurses to address the developmental needs of infants 0 - 2 years (chapter 5). This implies that the aims of the research, stated in chapter 1, namely to describe the responsibilities of community nurses, within their scope of practice, with regard to the management of developmental needs of infants at a primary health care level; and to develop guidelines for the support of community nurses in either training, continuing professional development, or co-operation with other health care professionals and managers, in order to attend to the developmental needs of infants, were achieved.

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**ANNEXURE A**  
**ACCEPTANCE BY THE FACULTY OF HEALTH SCIENCES RESEARCH**  
**ETHICS COMMITTEE, UNIVERSITY OF PRETORIA**



**ANNEXURE B**

**OFFICIAL REQUEST AND APPROVAL: KLERKSDORP CITY COUNCIL**











**ANNEXURE C**  
**INFORMED CONSENT**

**Community Nurses**

**Management, personnel involved in training, other health care  
professionals**

**Family with infant with typical development/developmental delay or  
disability**

**Focus group participants**

## INFORMED CONSENT FOR COMMUNITY NURSES

Dear participant

### The management of developmental needs of infants by community nurses

I am a PhD student at the Department of Nursing Science, University of Pretoria. You are invited to volunteer to participate in my research project on the management of the developmental needs of infants in a community health centre in Klerksdorp.

This letter is to help you to decide if you would like to participate. Before you agree to take part in this study you should fully understand what is involved. If you have any questions on any aspect that is not clear to you, do not hesitate to contact me. You should not agree to take part unless you know what is expected of you. Your participation in this study is voluntary and you can refuse to participate or stop at any time without stating a reason.

**The purpose of this study is:** 1) to determine the responsibility/function of the community health nurse, according to her scope of practice, with regard to the management of developmental needs of the infant in the primary health care clinic in South Africa, and 2) to develop guidelines to assist community health nurses in finding "best practice" within their scope of practice to ensure higher quality of developmental care to families with infants 0-2 years. The study protocol for this research project was submitted to the Research Ethics Committee of the University of Pretoria, Faculty of Health Sciences. The committee has granted written approval.

### The possible benefits of this study:

- Support and guidance of community health nurses in the management of developmental needs of infants.
- The empowerment of families on how to support the development of their children, and
- The early detection and intervention of developmental delays and disabilities.
- Maximizing children's developmental and functional abilities within their families and communities.

You will be requested to do an interview with the researcher. The duration of the interview may vary between 30 and 45 minutes. The topics covered in the interview will be guided by the objectives of the study. Type of question that could be asked during the interview:

- Developmental needs and support – As a community health nurse do you think infants and their families could benefit from developmental surveillance of infants by community health nurses? Scope of practice – Do you regard infant developmental surveillance as part of the community health nurse's responsibility and functions? How would you define the scope of practice of community health nurses with regard to developmental surveillance of infants?
- Training needs – Do you think your current knowledge base is sufficient to support you with the developmental surveillance of infants? If not, what training would you like to receive? Describe your current knowledge base.
- Support/infra structure – Do you feel the existing system has got the necessary infra structure to support you as a community health nurse to include developmental surveillance in your current daily tasks?

The interviews will be recorded to ensure completeness of the verbal interaction. The researcher may need to do a follow-up interview to verify some of your information. There will be no risk or discomfort involved during this study. All information obtained during this study will be confidential. Results will be published or presented in such a fashion that participants remain unidentifiable.

I sincerely appreciate your help.

Yours truly

R Leech (018) 468 2972 (H) (018) 468 7908 (W) 0824414576 E-mail address: [rl4@linkmax.co.za](mailto:rl4@linkmax.co.za)

### CONSENT TO PARTICIPATE IN THIS STUDY

I have read or had read to me in a language that I understand the above information before signing this consent form. The content and meaning of this information have been explained to me. I have been given the opportunity to ask questions and am satisfied that they have been answered satisfactorily. I hereby volunteer to take part in this study. I have received a copy of this informed consent agreement.

Participant signature \_\_\_\_\_ Date \_\_\_\_\_  
Person obtaining informed consent \_\_\_\_\_ Date \_\_\_\_\_  
Witness signature \_\_\_\_\_ Date \_\_\_\_\_

**INFORMED CONSENT (Management, personnel involved in the training of nurses, other health care professionals)**

Dear participant

**The management of developmental needs of infants by community nurses**

I am a PhD student at the Department of Nursing Science, University of Pretoria. You are invited to volunteer to participate in my research project on the management of the developmental needs of infants in a community health centre in Klerksdorp.

This letter is to help you to decide if you would like to participate. Before you agree to take part in this study you should fully understand what is involved. If you have any questions on any aspect that is not clear to you, do not hesitate to contact me. You should not agree to take part unless you know what is expected of you. Your participation in this study is voluntary and you can refuse to participate or stop at any time without stating a reason.

The purpose of this study is: 1) to determine the responsibility/function of the community health nurse, according to her scope of practice, with regard to the management of developmental needs of the infant in the primary health care clinic in South Africa, and 2) to develop guidelines to assist community health nurses in finding "best practice" within their scope of practice to ensure higher quality of developmental care to families with infants 0-2 years. The study protocol for this research project was submitted to the Research Ethics Committee of the University of Pretoria, Faculty of Health Sciences. The committee has granted written approval.

The possible benefits of this study:

- Support and guidance of community health nurses in the management of developmental needs of infants.
- The empowerment of families on how to support the development of their children, and
- The early detection and intervention of developmental delays and disabilities.
- Maximizing children's developmental and functional abilities within their families and communities.

You will be requested to do an interview with the researcher. The duration of the interview may vary between 15 and 30 minutes. The topics covered in the interview will be guided by the objectives of the study. The interviews will be recorded to ensure completeness of the verbal interaction. The researcher may need to do a follow-up interview to verify some of your information. There will be no risk or discomfort involved during this study. All information obtained during this study will be confidential. Results will be published or presented in such a fashion that participants remain unidentifiable.

I sincerely appreciate your help.

Yours truly

R Leech (018) 468 2972 (H) (018) 468 7908 (W) 0824414576 E-mail address: rleech@lantic.net

**CONSENT TO PARTICIPATE IN THIS STUDY**

I have read or had read to me in a language that I understand the above information before signing this consent form. The content and meaning of this information have been explained to me. I have been given the opportunity to ask questions and am satisfied that they have been answered satisfactorily. I hereby volunteer to take part in this study. I have received a copy of this informed consent agreement.

Participant signature \_\_\_\_\_ Date \_\_\_\_\_

Person obtaining informed consent \_\_\_\_\_ Date \_\_\_\_\_

Witness signature \_\_\_\_\_ Date \_\_\_\_\_

## INFORMED CONSENT FOR FAMILIES

Dear participant/s

### The management of developmental needs of infants by community health nurses

I am a PhD student at the Department of Nursing Science, University of Pretoria. You are invited to volunteer to participate in my research project on the management of the developmental needs of infants in a community health centre in Klerksdorp.

This letter is to help you to decide if you would like to participate. Before you agree to take part in this study you should fully understand what is involved. If you have any questions on any aspect that is not clear to you, do not hesitate to contact me. You should not agree to take part unless you know what is expected of you. Your participation in this study is voluntary and you can refuse to participate or stop at any time without stating a reason.

The purpose of this study is: 1) to determine the responsibility/function of the community health nurse, according to her scope of practice, with regard to the management of developmental needs of the infant in the primary health care clinic in South Africa, and 2) to develop guidelines to assist community health nurses in finding "best practice" within their scope of practice to ensure higher quality of developmental care to families with infants 0-2 years. The study protocol for this research project was submitted to the Research Ethics Committee of the University of Pretoria, Faculty of Health Sciences. The committee has granted written approval.

The possible benefits of this study:

- Support and guidance of community health nurses in the management of developmental needs of infants.
- The empowerment of families on how to support the development of their children, and
- The early detection and intervention of developmental delays and disabilities.
- Maximizing children's developmental and functional abilities within their families and communities.

You will be requested to do an interview with the researcher. The duration of the interview may vary between 30 and 45 minutes. The topics covered in the interview will be guided by the objectives of the study. Type of questions that could be asked during the interview:

- Developmental needs and support: 1) Do you think as a family with a child under the age of 2 you could benefit from health education on how to promote the optimal development and functional abilities of your child? 2) Do you think early detection of developmental delays and disabilities is important? 3) As a family with a child with a developmental disability do you think you could benefit from support given by the community health nurse at the clinic? 4) What type of support would be beneficial to your family?

The interviews will be recorded to ensure completeness of the verbal interaction. The researcher may need to do a follow-up interview to verify some of your information. Furthermore, the researcher would like to look at your child's clinic record to assess the recording of nursing actions. No personal information of you or your child will be used or made public during this study. There will be no risk or discomfort involved during this study. All information obtained during this study will be confidential. Results will be published or presented in such a fashion that participants remain unidentifiable.

I sincerely appreciate your help.

Yours truly

R Leech (018) 468 2972 (H) (018) 468 7908 (W) 0824414576 E-mail address: rleech@lantic.net

### CONSENT TO PARTICIPATE IN THIS STUDY

I have read or had read to me in a language that I understand the above information before signing this consent form. The content and meaning of this information have been explained to me. I have been given the opportunity to ask questions and am satisfied that they have been answered satisfactorily. I hereby volunteer to take part in this study. I have received a copy of this informed consent agreement.

Participant signature \_\_\_\_\_ Date \_\_\_\_\_

Person obtaining informed consent \_\_\_\_\_ Date \_\_\_\_\_

Witness signature \_\_\_\_\_ Date \_\_\_\_\_

## INFORMED CONSENT: FOCUS GROUP PARTICIPANTS

Dear participant

### The management of developmental needs of infants by community nurses

I am a PhD student at the Department of Nursing Science, University of Pretoria. You are invited to volunteer to participate in my research project on the management of the developmental needs of infants in a community health centre in Klerksdorp, North West.

The letter is to help you to decide if you would like to participate in a focus group discussion on the guidelines that I have compiled for the management of the developmental needs of infants by community nurses. If you have any questions on any aspect that is not clear to you, do not hesitate to contact me. Your participation in this study is voluntary and you can refuse to participate or stop at any time without stating a reason.

The purpose of this study is: 1) to determine the responsibility of the community nurse, according to her Scope of Practice, with regard to the management of developmental needs of the infant in the primary health care clinic in South Africa, and 2) to develop guidelines to assist community nurses in finding "best practice" within her Scope of Practice to ensure a higher quality of developmental care to families with infants 0-2 years of age. The study protocol for this research project was submitted to the Research Ethics Committee of the University of Pretoria, Faculty of Health Sciences. The Committee has granted written approval.

The possible benefits of the study:

- Support and guidance of community nurses in the management of developmental needs of infants
- The empowerment of families on how to support the development of their infants
- The early detection and intervention with developmental delays and disabilities
- Maximizing infants' developmental and functional abilities within their families and communities

You will be requested by dr. C. Uys, on my behalf, to participate in a focus group discussion. The purpose of the discussion is to validate the guidelines developed by the researcher. Participants of the focus group will include members from each category of people that were included in the first part of the study:

- Community nurses (working with infants 0-2 years of age)
- Other health care professionals, e.g. speech language therapist, physiotherapist and occupational therapist (working with infants 0-2 years)
- Management from Local Authority/Provincial primary health care clinics (Head of Department, Assistant Director and facility manager)
- People involved in training of community nurses (in-service training and continuous professional development)
- Parents of infants 0-2 years of age with typical development
- Parents of infants 0-2 years of age with developmental delays or disabilities

The guidelines will be e-mailed to you for your perusal before the focus group discussion. The discussion will be tape recorded to ensure completeness of verbal interaction. The duration of the focus group discussion will be approximately 3 hours, between 09:00 and 12:00 on the given date.

I sincerely appreciate your help.

Yours truly

Ronéll Leech

Contact details: rleech@lantic.net  
0824414576  
018 4687908 (w)

**ANNEXURE D**  
**INTERVIEW GUIDE**

**Community nurses**

**Management**

**Personnel involved in the training of nurses**

**Other health care professionals**

**Family with infant with typical development**

**Family with infant with developmental delay or disability**



## INTERVIEW GUIDE: COMMUNITY NURSES

### SCOPE OF PRACTICE:

1. “Infants and young children have a human right to develop to their full potential. To allow unmanaged disability and arrested development to occur in these children is a violation of their basic human rights”. Do you agree with this statement?
2. According to the scope of practice of registered nurses, nurses have a responsibility to:
  - ◆ Diagnose health needs, develop and execute a nursing regimen to meet these needs
  - ◆ Prevention of disease and the promotion of health
  - ◆ Facilitation and attainment of optimum health for all
  - ◆ The promotion of physical and mental health for all
  - ◆ Provision of effective patient advocacy to enable patients to obtain the necessary health care

How would you define, according to the latter, the responsibility of community nurses with regard to the management of normal and special developmental needs of infants?

3. Do you think prevention and early detection of developmental delays and disabilities are the responsibility of community nurses or should it be the responsibility of other health care professionals e.g. occupational therapists?
4. Do you see the primary health care clinic as the ideal setting for routine developmental surveillance? If yes, why? If not, why?
5. To what extent do health check-ups in the primary health care clinic contribute to the discovery of developmental delays and disabilities?
6. It is the experience of rehabilitation professionals that many developmental delays and disabilities are not identified, despite the knowledge that early detection and intervention lead to better outcomes. What is your opinion on this?
7. They further add to this that mothers and caregivers bring infants too late for evaluation of their development due to a lack of knowledge about child development. What is your opinion on this?
8. Do you function according to specific policies and guidelines? Which policies? Which guidelines?
9. In your daily care to infants do you assess each infant's development, even if the reason for the visit is a minor ailment? If you don't assess the infant when do you think is the most opportune time to assess the infant's development?
10. Do you record that you've done a developmental assessment?

11. According to literature there is currently no “gold standard” to assess an infant’s development. Which techniques do you employ to assist you in this task? Which components of development do you assess? Do you focus on deficits or strengths of the infant and the family?
12. Is there consensus among the nurses working in this clinic as to how developmental assessment should be done?
13. Do you include the family in your assessment of the child? If yes, why and how? If not, why?
14. If there is no developmental delay or disability present, what type of action will you take? How do you go about to promote the normal development of the infant?
15. If you suspect a developmental delay/disability what type of actions will you take to address the issue?
16. Is there a formal referral system in place? To whom do you refer? Do you think this system is effective? If not, what could be done to improve it?
17. South Africa is a country with a diverse population. Do you think cultural competence is of great importance in the management of developmental needs of infants? Do you incorporate any cultural traditions, values or customs in your interventions?
18. To what extent does management support you in the execution of your daily tasks? Do you think this support is enough? If not, what support would you expect from management?
19. In the execution of your daily tasks does the current infrastructure contribute to a job done well or deter you in your daily functioning? Please explain your answer?
20. In the current scenario of service provision, do you think there are any barriers that could prevent community nurses from managing developmental needs of infants? In your opinion what could be done to overcome these barriers?

#### KNOWLEDGE, SKILLS, TRAINING AND CONTINUING PROFESSIONAL DEVELOPMENT

1. Where and when did you complete your training?
2. Did you complete any post-basic courses after your initial training? Which course?
3. Do you think that the knowledge base you acquired during your pre-service training is sufficient to assist with the management of normal and special infant developmental needs in your current practice?
4. During your pre-service training which of the following aspects were included:
  - Child developmental theories
  - Factors that influence growth and development
  - Ecological perspective

- Family dynamics
- Socio-cultural aspects
- Best practice principles of assessment and intervention
- Zoom lens approach to assessment
- Social utility approach to assessment
- Resource-based approach
- Different service delivery models, e.g. family-focussed community based model and collective empowerment.

If it were not included would you like to know more about it?

5. The latest “buzzword” is evidence-based practice. Do you keep yourself abreast of the latest information pertaining to infant development? In which way do you acquire knowledge? Do you focus on scientific studies when you read articles in professional journals? Do you incorporate this information in your daily practice? Do you share any of this information with your colleagues?
6. Do you have a formal programme for continuing professional development?
7. Who is responsible for this programme?
8. In this programme, are your individual needs assessed at any time?
9. Do you feel your needs are being met with this programme? If not, what could be done to rectify this?
10. What is your view on interdisciplinary training? Do you feel that the knowledge and skills of other health care professionals could assist with the management of infant developmental needs? In what way do you think can interdisciplinary training be achieved?

#### SUPPORT OF PARENTS

1. Do you provide any form of support to families with children with developmental delays/disabilities? What type of support?
2. Are you responsive to family priorities, preferences and concerns? Do you listen with empathy and understand the family's point of view?
3. In your current work scenario do you feel you have the time and flexibility to provide support to families? Do you think this function is the responsibility of the community nurse or is it the function of other health care professionals' e.g. social workers?
4. Do you do any home visits? What are your reasons for doing home visits?
5. Are you familiar with the type of resources available in the community for families with children with developmental delays/disabilities? Do you have any contact with these resources yourself?
6. Do you assist the family in identifying community resources? How do you go about

to identify the necessary resources for the specific family?

7. Do you assist the family in establishing rapport with these community resources?
8. After referral of a family to these resources do you keep track of the family in any way?
9. The ability to develop and maintain strong, positive relationships with families requires an adequate understanding of one's own personal style and factors that influence personal behaviour. Do you ever reflect on your own styles and interaction with families?

## INTERVIEW GUIDE: MANAGEMENT

1. "Infants and young children have a human right to develop to their full potential. To allow unmanaged disability and arrested development to occur in these children is a violation of their basic human rights". Do you agree with this statement?
2. Do you think this point of view is recognized and supported by government policies? Which policies address this issue? Do you have a copy of the policies? May I, at a later stage please examine these policies?
3. Pertaining to the management of developmental needs of infants do you think enough is being done by authorities to articulate priorities, build consensus and manage change?
4. Does the service provided at this clinic focus on the development of infants? In what way? If not, why not?
5. Do you think prevention and early detection of developmental delays and disabilities are a responsibility of community nurses or should it be the function of other health care professionals e.g. occupational therapists?
6. According to the scope of practice of registered nurses, nurses have a responsibility to:
  - a. Diagnose health needs, develop and execute a nursing regimen to meet these needs
  - b. Prevention of disease and the promotion of health
  - c. Facilitation and attainment of optimum health for all
  - d. The promotion of physical and mental health for all
  - e. Provision of effective patient advocacy to enable patients to obtain the necessary health care

How would you define, according to the latter, the responsibility of community nurses with regard to the management of normal and special developmental needs of infants?
7. Do you have clearly stated and well-defined standards according to which services are provided? May I at a later stage examine this document?
8. Do you have an operating procedures manual that guides nurses in their service provision? Is the development of infants included as a specific topic in this manual?
9. How do you assure the quality of infant health care?
10. Resources, training and interagency collaboration are essential to provide a successful service to infants. What is the role of management regarding:
  - Resources
  - Training

- Interagency collaboration

11. In the current scenario of service provision, do you think there are any barriers that could prevent community nurses from managing developmental needs of infants? In your opinion what could be done to overcome these barriers?

Would you like to add any comments?

|                                        |
|----------------------------------------|
| <b>FOLLOW UP INTERVIEW: MANAGEMENT</b> |
|----------------------------------------|

1. Could you briefly describe your role and function regarding the management and supervision of the clinic?
2. Do you see support of staff as an important aspect of your management role? Why? How would you describe a supportive manager?
3. Despite the fact that the development of infants is regarded as their human right, nurses give insufficient attention to infant development in their service delivery to infants. How would you as a manager help to narrow the gap between ideal practice and reality?
4. With reference to our previous interview you indicated that infant development is acknowledged and supported by government policies but that the executors don't agree. Could you explain to me what you meant by that? (BI 1)
5. You mentioned that there must be a mind change, if I could quote ... What did you mean with that mind change? (BI 2).
6. With the question about the responsibility of the nurse regarding infant development you did not really define your answer. Could you briefly indicate what these responsibilities should be? (BI 3)
7. You also indicated that you are satisfied with the fact that most of the nurses are functioning within their scope of practice. Why is it that you refer to the majority and not everyone? Are some of them functioning outside their scope of practice and if so what is being done about it? (BI 4)
8. According to you there are 80% of complaints and 20% of gratitude. Why is the % of complaints so high? (BI 5)
9. You also mentioned that the knowledge of the nurses are not up to scratch and could be bettered by a notch or two. Why according to you should it be better and what could you as a manager do to address this shortcoming?

|                                        |
|----------------------------------------|
| <b>FOLLOW-UP INTERVIEW: MANAGEMENT</b> |
|----------------------------------------|

- 1 Briefly describe your role and function with regards to management and supervision in the clinic?
- 2 The support of personnel, is that important to you? Why? How would you describe a supportive manager?
- 3 How do you ensure that the nurses in the clinic carry out their tasks in the same manner?
- 4 With regards to the previous interview you agreed that optimal development is the right of each infant, but you did not really motivate your answer. Why did you agree with that statement?
- 5 Despite the fact that the development of infants is regarded as their human right little attention is paid by the nurses to this aspect in their service delivery. Why do you think that is? What can you do as a manager to correct this?
- 6 According to the current scope of practice how would you define the responsibility of the nurse with regard to the management of these developmental needs of infants?
- 7 We did not really address the question whether authorities are doing enough to build consensus and to manage change sufficiently. Could we discuss it again?
- 8 Could you show me the policy, standards and protocol documents that address infant development?



### OTHER HEALTH CARE PROFESSIONALS

1. Many stakeholders are involved in infant health surveillance in different settings. However, the degree to which they focus on infant developmental services is inconsistent. It is experienced by rehabilitation professionals that the “diagnosis” of developmental delay and disability is done much too late for effective intervention. What is your opinion and experience in this regard?
2. How do you perceive the responsibilities of community nurses in a primary health care clinic with regard to the management of developmental needs of infants?
3. Do you think the community nurse has the necessary knowledge and skills to identify early developmental delays and disabilities in infants? What would be the solution to rectify this lack of knowledge and skills?
4. There is currently no “gold standard” for developmental surveillance. What would be the most effective way for nurses in a primary health care clinic to assess the different domains of development?
5. Do you think clinical practice guidelines could be a useful tool to assist community nurses with developmental surveillance and timely referral for intervention?
6. Since developmental interventions are outside of the primary health care clinic, linkages between the clinic and community based systems can be inconsistent and incomplete. Do you think feedback loops are important in the ongoing care of at-risk infants?
7. Due to a scarcity of trained health care professionals, especially in rural areas, what is your opinion on role release and role extension (looking at the child and family through the lenses of different disciplines) to assist the community nurse in meeting the developmental needs of infants? The therapist could then act as a consultant, supervisor or mentor.

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| <b>INTERVIEW GUIDE – FAMILIES INFANTS WITH TYPICAL DEVELOPMENT</b> |
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1. Do you think every baby has the right to develop to his or her fullest potential?  
Why?
2. How do you think parents can help their baby develops to his or her fullest potential?
3. Your knowledge with regard to growth and development do you think it is sufficient? This knowledge, will it enable you to identify any problem pertaining to growth and development at an early stage? Where did you obtain this knowledge?
4. The nurse at the clinic where you took your baby, did she at any time offer you any information on growth and development of babies? What was the format of this information? Do you think it was sufficient? Do you know when they assess a baby which areas of development must be included in the assessment?
5. Are you satisfied with the service that the nurse rendered at the clinic that you attended with your baby? Were there times when you felt frustrated with the service?
6. How would you describe your relationship with the nurse at the clinic?
7. Except for clinical competence what other characteristics do you think a nurse should have?
8. Please describe your last visit at the clinic briefly?
9. What were your feelings about this visit? Were there any shortcomings or barriers?
10. Did the nurse examine your baby during this visit? Please describe this examination of your baby? Did the nurse at any time explain why she was doing what?
11. Did the nurse at any time ask if you had any concerns or experienced any stressful situations? If you mentioned that you had concerns were you satisfied with how it was managed?
12. During the visit did the nurse just focus on the baby or did she ask any information about the family? Did ask if you had an informal support system? Did she encourage you to utilize this support system?
13. Did the nurse refer you to any other health care professionals e.g. speech therapist, physiotherapist?
14. Did the nurse tell you about any resources in the community that could be valuable to your baby's development?
15. Do you think the nurse saw you as a person that is competent to look after your baby?
16. Did the nurse ever visit you at home? Do you think a home visit could be valuable?

17. Do you think your contact with the nurse exposed you to knowledge, skills and resources?
18. Do you think the nurse has the necessary knowledge and skills to identify developmental delays and disabilities in the clinic?
19. Do you have any comments?

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| <b>INTERVIEW GUIDE: PERSONNEL INVOLVED IN THE TRAINING OF NURSES</b> |
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1. Do you have a training programme?
2. How often do you have training sessions?
3. Do you think this is sufficient to help the staff develop skills that they can use in rapidly changing environments?
4. Do you have any policies or guidelines for continuing development?
5. What topics do you focus on during training sessions? How do you decide on the content of the programme? Are there any prescriptions from province that you have to adhere to or do you just focus on current and perceived needs of the nurses to guide you in this decision?
6. Do you take the needs of the nurses in to consideration when you compile the programme?
7. How do you assess the needs of the nurses? What is your opinion of professionals' perceptions of limited competence? Do you think they are aware of their own limitations?
8. What is the format of your training sessions?
9. Why Do you ever make use of other health care professionals to present training?
10. Do you think that the provision of information will translate directly into effective outcomes? How are you going to ensure the efficacy of your training efforts? Do you evaluate skills against an established list of criteria for mastery that you use in this evaluation?
11. Do you have the necessary resources to ensure that information can be translated into effective practices?
12. Have you ever addressed infant development as a topic during any of your training sessions? Have the nurses ever identified infant development as an area where there is a perceived lack of knowledge?
13. Do you view infant development as an important aspect of nurses' daily tasks? Do you think the government view infant development as important? Why?
14. Do you think a gap exists between typical and ideal practices with regard to the management of infant development?
15. Do you think the nurses have the necessary knowledge, skills and competence to address infant development to its fullest?
16. Do you think there is consensus amongst nurses working in primary health care clinics on how infant development should be managed?
17. Do you think you have the necessary knowledge and experience to guide and support your colleagues on the management of infant development? Why?

18. Do you think that the knowledge base nurses acquire during their pre-service training is sufficient to assist with the management of normal and special infant developmental needs in their current practice?
19. Do you think the following topics are important for the management of infant developmental needs in the primary health care clinic:
20. Child developmental theories
21. Factors that influence growth and development
22. Ecological perspective
23. Family dynamics
24. Socio-cultural aspects
25. Best practice principles of assessment and intervention
26. Zoom lens approach to assessment
27. Social utility approach to assessment
28. Resource-based approach
29. Different service delivery models, e.g. family-focussed community based model and collective empowerment.
30. The latest “buzzword” is evidence-based practice. How do you keep yourself abreast of the latest information? Do you incorporate any of this information in your training?

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| <p><b>INTERVIEW GUIDE – FAMILIES INFANTS WITH DEVELOPMENTAL DELAY OR<br/>DISABILITY</b></p> |
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1. Do you think every baby has the right to develop to his or her fullest potential?  
Why?
2. How do you think parents can help their baby develops to his or her fullest potential?
3. Your knowledge with regard to growth and development do you think it is sufficient? This knowledge, will it enable you to identify any problem pertaining to growth and development at an early stage? Where did you obtain this knowledge?
4. The nurse at the clinic where you took your baby, did she at any time offer you any information on growth and development of babies? What was the format of this information? Do you think it was sufficient? Do you know when they assess a baby which areas of development must be included in the assessment?
5. At what age did you realize there was a problem with the baby's development?
6. Was the nurse at the clinic involved in any way with the identification of your baby's problem? Who identified the problem? How were you informed about this problem?
7. How did you feel when you heard about this problem? Did they offer any form of support? What type of support was offered? Do you feel this support that they offered was sufficient?
8. Are there times when you feel depressed or worried about your child's progress or future? When you experience these feelings to whom do you turn for support?
9. Have you received any information about the baby's developmental problem? What was the content of this information? Do you have any recommendations on how information can be offered?
10. Are you satisfied with the service that the nurse rendered at the clinic that you attended with your baby? Were there times when you felt frustrated with the service?
11. How would you describe your relationship with the nurse at the clinic?
12. Except for clinical competence what other characteristics do you think a nurse should have?
13. Please describe your last visit at the clinic briefly?
14. What were your feelings about this visit? Were there any shortcomings or barriers?
15. Did the nurse examine your baby during this visit? Please describe this examination of your baby? Did the nurse at any time explain why she was doing what?

16. Did the nurse at any time ask if you had any concerns or experienced any stressful situations? If you mentioned that you had concerns were you satisfied with how it was managed?
17. During the visit did the nurse just focus on the baby or did she ask any information about the family? Did ask if you had an informal support system? Did she encourage you to utilize this support system?
18. Did the nurse refer you to any other health care professionals e.g. speech therapist, physiotherapist?
19. Did the nurse tell you about any resources in the community that could be valuable to your baby's development?
20. Were you involved with the planning and decision making pertaining to your child's intervention/treatment? Do you think parents should be involved in this and to which degree should this involvement be?
21. Do you think the nurse saw you as a person that is competent to look after your baby?
22. Did the nurse ever visit you at home? Do you think a home visit could be valuable?
23. Do you think your contact with the nurse exposed you to knowledge, skills and resources?
24. Do you think the nurse has the necessary knowledge and skills to identify developmental delays and disabilities in the clinic?
25. Do you have any comments?

**ANNEXURE E**  
**TRANSCRIPT OF INTERVIEWS**

**Community nurse**

**Management**

**Personnel involved in the training of nurses**

**Other health care professionals**

**Family with infant with typical development**

**Family with infant with developmental delay or disability**



## INTERVIEW: COMMUNITY NURSES

Date: 25 October 2004

Duration of interview: 50 minutes

Venue: Park Street Clinic

Interviewer = R

Participant = P

- R Where and when did you complete your training?
- P I've completed my training uhm 1984 I as a staff nurse by then I've started training as an enrolled nurse ag (oh) I mean a sister from 1991 until now.
- R Where did you do your training?
- P I've done my training at Natalspruit hospital then I worked at Boksburg hospital.
- R Oh excellent did you complete any post-basic courses after your initial uhm pre-service training.
- P Yes, the post one was was eh midwifery one because after enrolled I mean being a professional nurse I did midwifery
- R Ok. Do you think that the knowledge base you acquired during your pre-service training is sufficient to assist you with the management of normal and special infant uhm developmental needs in your current practice?
- P Yes, I can say it, but it need a person to be more on this field, you know the longer you are the more corrective and more I mean knowledge you enquire.
- R Thank you. In your pre-service training, did you focus on any of the following aspects? I am going to mention it to you and you can say just yes or no. Child developmental theories.
- P Yes.
- R Ok. Factors that influence growth and development
- P Yes
- R Umm, ecological perspectives
- P Yes, yes
- R Family dynamics
- P Yes
- R Socio-cultural aspects
- P Yes
- R Eh, best practice principles of assessment and intervention
- P No, I haven't done that
- R Zoom lens approach to assessment

- P No
- R Social utility approach to assessment
- P No
- R And resource-based approach to assessment?
- P No
- R Different service delivery models example the family-focused community model and the collective empowerment models. Have you ever heard of that?
- P No
- R Not. Umm, would you like to to know more about the the aspects that you didn't learn about in your pre-service training?
- P Yes
- R Ok you think that would really be of great uhm value for you in your assessments
- P It would be yes
- R Of the patient. Ok, right. The latest buzzword is evidence-based practice. Do you keep yourself abreast of the latest information pertaining specifically to infant development?
- P Mmm. You, you know what, because I've I've been working with adults for long I think it will be very good if I can know more about the infant yes and.
- R Ok, but even for for eh to keep yourself up to date for the adults what do you do to to get new information?
- P The information we get it through the symposium that we we do to the, you know sometimes we do attend the courses where they teach us more about the new diseases and how to handle and to treat them and those are the things that eh equip a person.
- R Do you read any scientific journals or magazines?
- P Yes I do.
- R Ok. Umm are you you reading the magazine on a monthly basis or do does the clinic get the magazines. Which type of magazines do you read?
- P You know I'm getting the magazine every month especially the our DENOSA our Nursing Council magazine it's having most of you the know the the.
- R Contemporary issues.
- P Yes that is happening you get much there.
- R Do you try to incorporate the information that you've gained trough that article maybe into your daily practice?
- P Yes.
- R Ok and do you share the knowledge with your colleagues?
- P Yes I do I do that.

- R Tell me do you have a formal programme for continuous professional development here at the clinic.
- P Yes, we do every Wednesday. We do have in-service training where one can give us the the training.
- R Mmm mmm
- P Maybe just a condition and teach us more about it or teach us about how the treatment is supposed to be given to a certain uh problem so that's how we do it
- R Tell me in this programme, your individual needs are they ever assessed at any time or were they ever assessed at any time.
- P Yes they do assess they usually assess us maybe sometimes uh uh after eh month they do come for assessment
- R But what I mean here is did they ask you what are your needs pertaining to training. Each and every person has certain training needs. I would love to know more about infants. Have you got the chance to tell them I've got certain needs pertaining to training?
- P Yes, yes
- R Ok and do they take that needs into consideration when they plan the programme?
- P The, they do that. Some of us they do send them for training according their needs that they've asked
- R And tell me umm this programme, has it ever focused on infant development as far as you know?
- P Yes, when we are doing this health road chart it's where we are, I mean concentrating on the development of the child
- R Thank you. Ok what is your view on interdisciplinary training? By that, I mean you take for instance a physio an occupational therapist a social worker and a nurse they meet on a regular basis. They share their ideas on what they do in the work and how they do certain things of their work to enhance for instance the nurse's knowledge to to uhm function better in the clinic. Do you feel that the knowledge and skills of other health care professionals could assist with the management of the developmental needs of the infant?
- P They can. Yes it's we really need it.
- R In what way do you think can this interdisciplinary training be achieved? How can you go about to to get this because this is not normally done?
- P Not normally done. You know according to me it would be better if maybe lets say once a month if it was possible for the nurse and the social worker and you know to meet all those people to meet and discuss the problems of the

children because sometimes you find that this child doesn't grow well because of the low socio problem at home and so if you all we all meet and see where we can help know this child to grow well sometimes it is due to poverty then the grant can be supplied to that family so that this child can be able to get food and so on so that he can grow

R So you think it is possible via sort of in-service training but you incorporate the other disciplines as well

P That's right

R Ok super I am going to read a statement to you and then uhm you respond around this statement Infants and young children have a human right to develop to their full potential. To allow unmanaged disability and arrested development to occur in these children is a violation of their basic human rights. Do you agree with this statement?

P Yes

R Ok why do you agree with this statement?

P As as the statement say it it's also their human right the infant you know they are also have the right to get whatever are they suppose to get you know from us we adult yes

R It is the experience of rehabilitation professionals that is the occupational therapists and the physiotherapist that many developmental delays and disabilities are not identified. This is also uhm proved by research that all the the delays and disabilities are not identified so it is not identified despite the knowledge that early detection and intervention lead to better outcomes. What is your opinion on this? How do you feel about this that they say many developmental delays and disabilities are not identified?

P Yes they are not identified I I I I agree on this because you find after especially other children their problems are not identified early so that they can be able to be helped then at the long range then that you will find that this happened because of that which was not rectified at the beginning

R Ok so why do you think this, happen?

P I think the negligence of the parent you know to to bring their children for a problem so that it can be identified and eh sometimes I can also say we we health workers we we overlook some of the problems of the children because some parents they can't see but can be able to detect when we are I mean giving this children their immunization and so on that this child is lacking something and that can be bring up to the eh social workers

R Thank you they also add to this that mothers and caregivers as you said bring infants too late for evaluation of their development, which they say, is due to a

lack of knowledge about that development how do you feel about that statement? What do you think are the reasons that prevent them from bringing the the child to the clinic? Most of the times they have found via research that it is due to a lack of knowledge about child development they don't basic things like a child needs to sit at that age it needs to to stand up against or walk you know basic very basic things they do know but the finer details about child development they don't know about so they say that is the reason sometimes as well why people bring their children too late for evaluation how do you feel about that?

P Yes it is true that means that we we which are having the light we must give this uhm parent some insight what they must expect that means you must give them also in-service training as they are bringing their children what they must look af uh what they uh you know you know as eh in-service training to parent also the nurses the health worker the in-service training must also be done to them that they must know also what is expected from children when you are doing those circum measuring the head circumference why are you doing that at the end what are you trying to get and so on so that you can be able and to know what's the importance of doing that things we mustn't overlook those things

R Do you think the prevention and early detection of developmental delays are the responsibility of community nurses or should it be the responsibility of other health care professionals for instance physiotherapists or occupational therapists

P I think all the health workers it is their responsibility

R If you think in an environment like this clinic?

P Mmm

R You as community nurses do you think it is their responsibility to detect developmental delays and disabilities.

P Yes

R Ok and uhm why do you think it is their responsibility?

P I think if the child come you you must observe in totality so that you can be able to refer the child to to the the eh other health workers other uh social workers or where supposed to be referred to so we are also responsible

R In a lot of cases you as community nurses are the first point contact for for the health care

P That's right

R So that that they come here instead of going to the they never directly go to the physio or occupational therapist.

- P That's true
- R So we as nurses regard it as our responsibility according to the current scope of practice of registered nurses how would you define this responsibility of the management of normal and special developmental needs of infants the current scope of practice if you've got that in mind how would you define your responsibility with regards to uh the management of development?
- P According to my scope of practice I uh must refer that's one of that's a must do if there is a problem to this child I must refer to to other people to to to help and again I must be able to to diagnose to see this child needs this so that's also important according to
- R What else?
- P And eh I must also be able to give the right treatment and to see to it that the treatment that has been given is it helping the child so that if it's not we must review and the child should be treated correctly
- R Ok in your current scope of practice with regard to the developmental the management of developmental needs
- P And again as I've I've said the mother must also have the knowledge that means you must also explain to the mother so that the mother must also have the knowledge of what to to take care of the children
- R So there are several aspects that you are going to look at?
- P Mmm
- R It is uhm to promote health you are going to maintain health
- P Yeah
- R And if it is not possible to treat the client
- P Refer
- R And last but not the least is your
- P I've forgotten the last one
- R Patient advocacy
- P Yes, of course yes
- R It is very important if someone especially children cannot speak for themselves cannot make appointments for themselves so you need to be their voice to advocate for them
- P Yes
- R Oraait uhm in your daily care of infants do you assess each infant's development even if the reason for the visit is a minor ailment?
- P I think it should be done actually ok but sometimes you we overlook that but as it in fact it is there we must do everything ever so so that we can be able to detect even some of the things that the parent didn't bring that children for

- R If you don't assess the infant when do you think is the most opportune time to assess the infant's development?
- P I don't think there is a right opportune time. The right opportune time is that time when you get contact of that baby the time you usually you're in contact with that baby
- R Right uhm do you record that you have done a developmental assessment write it somewhere in a record a clinic record?
- P Yes it must written you write in the clinical record what ever eh findings that you have find and even if you refer you must also write it there that you did refer this child to a certain person because of this
- R If you find that everything is normal, are you going to write something about that?
- P Yes, that it must also be referred in the card that everything is normal
- R Thank you. According to literature, there is currently no gold standard to assess an infant's development. Which techniques do you employ to assist you in this task the things that you do as a nurse to assess the child's development?
- P Yes you know when a child is supposed to crawl that that age of crawling you can ask the mother if the child has started to crawl or you can also you know give a child something just to see if that child is responding and also you can let the child sit to see that the child is able to sit and if it is that time of walking you can just let the child to walk you know just to see that that child is having all those factors
- R So you are going to focus on parental concerns and going to and
- P Yes
- R And recall the milestones and you are going to via your history taking and physical assessment
- P Yes
- R Ok uhm which indicators of development do you assess.
- P Mmm
- R Components aspects the important domains of development are you going to look for when you assess a child.
- P Yes the the the the hearing and if he can see if that child can talk and you know the milestones and if the child you know can use the the limbs you know those we can check
- R That is basically your motor development
- P Mmm yes

- R What other domains are you going to focus on or are you not sure, because you mentioned earlier that you are basically working with with adults and not as much with children
- P Yes I am unsure the the that last one actually
- R Mmm do you think there is consensus among the nurses working in this clinic as to how developmental assessment should be done? Do the next sister and the next sister are you all going to do developmental assessment in the same way or do you got some guideline policy or or something or does everyone do his own thing how they were taught initially at university or college
- P Mmm actually here as eh eh I've just started working, here I don't know whether we are doing it in a pattern here but figurative the other one does it the way she was taught
- R Ok so each and everyone has got its own way
- P Its own way of doing it
- R Ok right uhm do you know whether there are any specific policies and guidelines available in this clinic with regards to developmental needs of infants.
- P Yes, there is a policy uh uh the guideline
- R Where do where do you get this policy and guideline from?
- P We got our own file where we keep the policies and guidelines
- R Is it a government policy or is it a guideline that you guys compiled for the the staff for the staff who work here?
- P It's the guideline that they've compiled before I've started working here
- R Ok so it is their own guide so it is not an external government policy.
- P It's not an external government policy
- R Ok right uhm if you do an assessment do you include the family in your assessment.
- P Yes, I do its important
- R Ok why do you why do you say it is important?
- P It is because I can get more from the family about the child cause as we've said the child cannot speak for herself so the family can give up more information you know about the child's health the child is doing so it's very important
- R Would you regard them as eh equal partner or just as a person to to get information from?
- P If they its an equal partner it is still good even if the person that I can get information from because some children find out that they are being brought up by a grandmother and so on so the person that I can get information from



- R Any family member
- P Any family member yes
- R Ok if you and there is no developmental delays or disabilities present what type of action would you take to promote the normal development the optimal development?
- P Mmm it depending according to which a delay of development it is
- R But there is no delay currently
- P Mmm
- R It is a normal functioning child you have done an assessment and you found that there is no delay or disabilities so according to you this child or this infant actually is developing according to the normal pattern
- P Ok
- R What are you going to do to make sure that normal development is still going to take place?
- P Ok as they are bringing their child you will see that they are bringing their child from maybe newborn 6 months as the child comes every time I must assess whether this child is still developing in the normal way of development I must always assess keep on assessing until the child reaches five years where you are going to give the last immunization I must observe if we are keeping our records correctly they must observe until adult time
- R So is that all you are going to do?
- R And also I think that we'll have also to to to teach the very same mother as she the the child is developing well to to to you know to to congratulate her to keep on doing whatever so that the child is growing is well and to I mean the diet that she is giving it is a good diet and the way she is bringing up the child is fine its how it can keep it up
- R Uhm now that same child if you suspected that there is a developmental delay or disability what are you going to do to address that issue
- P Mmm then now I must start teaching the mother finding out how is she bringing up this child and help to teach her maybe where I can see she is lacking and also if there is something that she need me to refer this mother because of the problem I must refer this mother to and if there's something that you may as the health worker I need to do you know to see to it that child develops well I must also do that to see that child is developing well
- R Ok tell me is there a formal referral system in place here at the clinic
- P Yes, there is a formal we do have a form where we say then refer the child

- R Ok to whom do you refer mostly to if it is a child to whom do you refer say for instance the child has a developmental delay to whom would you refer this child?
- P Actually we start to refer the child to the doctor then the doctor will refer the child further if maybe see that this need to be referred further
- R Is that sort of an unspoken rule that that it that the baby must be referred to the doctor or can you if you want to refer the baby directly to an occupational therapist?
- P You can also to refer the baby directly to a occupational eh but then its also you know good also to refer to the doctor to assess also and refer to the to the occupational but you can also go straight to the occupational that's how we are doing it
- R Ok so you it is up to you as a community nurse to where you would like to refer to
- P Yes
- R Do you think this referral system in the clinic currently is effective?
- P It is effective it is effective
- R So there is no problem
- P There's no problem at all
- R South Africa is a country with a diverse population do you think cultural competence is of great importance in the management of developmental needs of infants you as a community nurse do you need to be cultural competent before you can work with a diverse group of of people?
- P Mmm yes I can say you know sometimes you need to know the this this other culture it will at least guide you to understand why this child having this problem because you find other culture they are eating eh eh eh certain type of meat and then then their children are growing up on that type of diet and meanwhile this child it will be lacking the nutrients so that cultural thing is also needed to so that you can be able to find out
- R Ok tell me do you incorporate any cultural traditions values or customs in your interventions
- P Yes
- R How do you do that?
- P You know what I usually do this because you'll find that some culture do put eh something on the neck of the baby and that thing will stay maybe for a year and they don't take it and the the flies and this child will keep on having diarrhoea and so on because of this thing which is here so such a thing you ought to come in you know to to to teach the parent about it although its their

culture and you must find a way to to to try to tell them what is the right thing to be done about that

R So would you take a pair of scissors and cut that thing off?

P You must have the actually you must try to get the consent from them and explain it in a way that they will understand you know it is their culture they are used to that but you must try to to explain it you know the way that you are going to talk to a person will make her to give her consent of doing that although even if they can take it out and wash it and put it again but it must stay clean to to prevent those you know that way of talking to them it can give you consent.

R Ok tell me to what extent does management support you in your execution of your daily tasks. By management I mean your nurse in charge and then your higher up in the province you've got the AD's at the clinic and then with the city council you've got mister Booysen the head of the department. How do they support you as a community nurse in your daily functioning in the clinic? Do you think you get the necessary support from them?

P Yes I do because I mean by helping us to give the you know treatment I am talking about the the seniors of us now the treatment that we need to to to treat our eh client and the health environment that they are trying to to help us keep uhm all the stationery they the equipment we need because we cannot function without the equipment that we need.

R So you feel their support is sufficient.

P Their support is sufficient

R We were talking about the type of support you have mentioned resources now what other type of (end of tape) type of support you mentioned resources finances. Do they support you in any emotional way?

P Yes because sometimes we do have a a questionnaire that is for us now where maybe were not satisfied with something where we can put our grievances and they can attend to that that is helping also at our hand also for our clients too so that they that we we can be able to see we are I mean helping them if they do have any query or any crisis or anything to to to make us aware we do have a questionnaire for them where they can also write and put it in the box that our supervisor can be able to see if whether we are serving them

R Oh excellent uhm and you you are satisfied with the support.

P We are satisfied

R Ok in your execution of your daily tasks does the current infrastructure contribute to a job done well or deter you in your daily functioning?

- P Mmm here in our clinic now there is a little bit of eh infrastructure where they deter us in our daily working because as you can see we've got few toilets that's where the problem is and it is not easy for the female to go at the same toilet with male its giving us a little bit of a problem because yes at home it is easy but at the public situation like this it is not easy for people to do that so its where we got a little bit of a problem
- R So the facility as such is a problem
- P The facility yes it's not so good
- R Ok but otherwise
- P Otherwise
- R Equipment
- P Equipment is sufficient
- R You've got enough informational material that you can supply the patients with.
- P That's right we do
- R Ok uhm in your current scenario of service provision do you think there are any barriers uhm that could prevent community nurses from managing developmental needs of infants. Anything that could prevent you from doing your job properly when you want to assess a baby?
- P Here at Park Street at least the the the there is nothing because all the equipment that we need to assess the baby it's there and if we can only I think have enough you know patients for the day because sometimes we find that we are overloaded with with babies uh uh we sometimes you do find instead of doing a thorough examination because of the queue we sometimes we we don't
- R Because of the workload
- P We do the workload and the thorough examination is important for each child to get I don't know how we can manage maybe to say at least we must see 35 or 30 babies per day that we can be able to do the examination
- R Ok anything else besides workload
- P Mmm no also you know to to observe the as we have said when we have the child to also have the the toys that the children are using just to see the skills of this children how are they doing how are they growing up also that thing I think it is also important for the baby room just when you examine the child
- R What about the nurse?
- P The nurses also I think we need to to have in-service training so that we all
- R So you think the knowledge is not up to scratch currently
- P Not up to scratch currently
- R Ok just to recap the infrastructure ag I mean the facility

- P Facility
- R Toys and and equipment like the toys and stuff and then the knowledge
- P And the knowledge
- R And the workload
- P The workload
- R Tell me if you have a family in front of you and their child has a developmental delay or disability do you provide any form of support to this family.
- P You need that a lot
- R Ok what type of support do you provide?
- P Eh if the child is having a disability you can also eh you know direct them where they can get help depending what type of eh eh disability it is maybe this child can need a shoe eh orthopaedic shoes or maybe this child will need something that will help that child you can also be of help to that family to support them
- R Ok so we've got eh eh resources now what else are we going to to to do to support them you get several forms of support
- P Even emotionally you can also support them that you know to to have a child that like this it's not that maybe you've done bad or whatever but it's what God has given you and just accept the baby be able to to to help the baby well you can help the baby and and now I can see spiritual support also emotional support and as you can say those which we have mentioned
- R Uhm are you responsive to family priorities preferences and concerns
- P Yes
- R In which ways are you responsive to these priorities?
- P The family as the origin of the child the family are the one known world in this child's life you know that's why we ought to give the response and the support to them. As I've mentioned the spiritual part of that the emotional you must also be responsive to and the the what the treatment that they can use to bring this
- R Ok so you are going to listen to what they say and then you are going to prioritize what is really important to them and then from there on you are going to try and do something about it and incorporate that concerns in your treatment plan
- P It is right yes
- R Uhm in your current work scenario do you feel you have the time and flexibility to provide support to families.
- P Yes yes

- R Do you think this function is the responsibility of the community nurse or the function of the social worker you've identified a family dearly in need of support are you going to give it yourself or are you going to refer them to a social worker?
- P Uhm depending what it is I can refer them to the social worker but those ones which I can be able to help them with I can help them
- R Ok do you do any home visits?
- P Yes we do
- R Ok what is the reason for doing home visits?
- P Uhm it is with eh that you can see this social problem we ought to visit that home and see how they living there and how what is the situation how is the situation there so that you can know more about this child and their parent where they are living so that you can refer if there is a problem
- R Ok so are you actually really doing home visits here in the clinic here and now are you doing home visits for for assessing the the children's home environment is that one of your reasons for doing home visits?
- P It it depends on the condition of the child if I can see this child it's eh maybe eh eh low socio problem they are not visited at home
- R And you get the time to visit and have the time and the resources to visit that child?
- P Yes, we do have a car to visit such places
- R Ok so it's not only that you can do a home visit for eh TB's to eh to trace contacts and things like that so there's no reason that you can't visit this child
- P No, we are free to do it yes
- R Ok are you familiar with the type of resources available in the community for families with children with developmental delays and disabilities?
- P Eh, I am not that much familiar because now mostly it is being done at the occupational therapy so most of the time we just refer them mmm
- R What do you regard as community resources?
- P What do I regard as community resources?
- R Ja what do you use as a resource in your community?
- P Uhm the resource that we are in the community eh we do give them milk for those with that need the the
- R The feeding scheme
- P The feeding scheme for those who got the problem, which we can see that they can't, and uhm that's only that we we can do
- R Ok do you regard family friends eh the church those places do you regard that as resources?

- P You know I haven't come that far it's only the feeding scheme that we have and to refer them to the social worker
- R Ok so how would you go about to identify the necessary resources for a specific family what would you do if you think this child needs something besides the occupational or physiotherapy or besides professional help how would you go about to to identify resources in the community?
- P Actually the the other churches they do come forward to say if there is children without clothes they bring the clothes so that we can be able to identify those who doesn't have clothes I mean to give it's how they do it
- R Mmm but what are you going to do?
- P Me as a health worker I just get it from the parents that they are struggling and I refer them
- R Ok so you refer them.
- P Yes
- R Ok uhm after you have referred the patient to whatever resource in the community do you try to keep track of the family in any way.
- P You know most of the times to say the truth we don't try to keep track but if that family come to the clinic, again we do ask them
- R Ok so
- P Did they get the help and eh are they now fine with the assistance that they've got
- R Why don't you keep track of the families? Is there anything that prevent you from doing that or are you too busy or
- P Actually I think I think it's because we are too busy I can put it that way because the the the transport it's available for us to keep track
- R And via telephone if they've got a telephone number are you able to phone the family.
- P The problem it's a problem to phone outside
- R Ok that is another barrier
- P That's another barrier
- R Because it is preventing us from doing
- P To yes
- R Our job
- P Yes
- R Because we can't phone just pick up the phone and phone the family and find out about the child and how are they doing
- P Mmm we've got only stipulated numbers that we can phone and not the families and so on

- R Ok uhm the ability to develop and maintain strong positive relationships with families requires an adequate understanding of one's own personal styles and factors that influence personal behaviour do you ever reflect think about your own style and interactions with people think back and say today I've done this or said that what could I have done otherwise to prevent frustration introspection
- P Yes you you know as I've said before you know when you are talking to to the parent you must be sensitive not to hurt them so sometimes you sit down and ask yourself did I done by so saying eh was I mean hurting that particular parent so you do introspection to find out did you do well or
- R Tell me sister have you got anything that you would like to add any comment anything you think you would like to add with regards to the management of developmental needs of infants in the clinic.
- P No the way we have said as I was saying we are the advocate of this children so I would like if we health workers we can really have that in us so that we can stand for this children you know be able to be able to stand for them to their parents because some of the things they can't even tell their parents what they must do and also with us we must be able to do what is good standing for them doing the best the best way for them because they can't say you didn't do that for me you didn't that as adults we come and complain so for children we must on our 2 legs trying to do the best that we can because they can't say anything we are there for them fully
- R Ok thank you sister I really appreciate your time once again if I listen to the tape and I find there is anything I am not completely sure about can I get back to you and discuss it with you
- P Yes, you're welcome
- R Thank you sister
- P Thank you



## INTERVIEW: MANAGEMENT

Date of interview: 7 October 2004

Duration of interview: 36 minutes

R = Interviewer

C = Participant

- R Babies and young children have a right to develop to their full potential to therefore allow uncontrolled disability and disturbed development of these children is a violation of their basic human rights. What is your viewpoint and feeling of this statement? Do you agree with statement?
- C I think so yes, do I have to motivate or can I just say yes?
- R I shall be glad if you motivate.
- C I shall only think that someone must take responsibility for it, because a child cannot do it himself, he cannot tell you I cannot yet lift up my head by myself or as result of the baby's condition, I mean he himself cannot there's a problem so somebody must do it on his behalf and if the mother doesn't or the mother is anxious then she needs someone to confirm it and there the nurse can play a role.
- R Play a role with regard to, to to
- C Identification.
- R Of identification and you definitely feel strong about it that children should be allowed to develop to their full potential?
- C Yes.
- R Ok, eh what you think is the opinion of government regarding the development of children to their full potential?
- C But listen here, I do not quite know the human rights manual, but I do know there is a lot of emphasis on human rights and in particular on the rights of children, so I believe that government will support it.
- R To which extent do you think will they, how will they uhm in a precise manner create policy documents with manuals and such types of documents.
- C Ok, there is the charter in human rights and in children's rights there are also such things, I am not up to date, but I believe there will be. R... I don't know.
- R Uhm if you then think in terms of the management of development needs of babies, according to you, what can the authorities do to identify priorities, identify development of babies and priorities regarding your work here in the clinic? How do you feel what is important, according to you what is priority and

what must the authorities do, the government, the local authority, provincial government. What must they do to identify priorities and to put it in place?

- C So more to identify priorities and to put in place for national, provincial and everywhere?
- R Everywhere, yes.
- C Well I shall say in the first place there must be structures to give education to parents who on ground level, this thing must be phased from above. To say we set as policy there must be a development framework or instrument or a thing must be to be able to this thing to be able to identify and then one should perhaps also be able to cancel the thing that there can be training and that people can be equipped to be able to identify and to do that up to ground level.
- R So uhm training is important to you, right? Uhm tell me C... the uhm how will they reach consensus in other words so that they can all work together?
- C I don't know. It must surely be national policy.
- R National policy and how is national policy passed on to you?
- C Basically from our management to the provincial level.
- R And they, they discuss it with you in meetings or in what format do you then receive it?
- C We receive it as in-service training.
- R In-service training.
- C Yes.
- R How do you think uhm do the authorities manage these changes, the changes that must be brought about? In other words the moment when new policy is being implemented it brings about change?
- C Uhm...
- R How do they help to bring about these changes so that it can be implemented? What do they do to make that change easier for you?
- C Ok, it is done by, by by by first of all to give you training and then the must give the aids or yes that which you need to do it they should provide you with it. What do you call it, your equipment, your stock should be provided so that you can do it and the human resources, because if you do not have hands to do a thing then policy also does not mean anything.
- R Now to which degree are there being focused on the development of babies during service delivery at clinics?
- C Listen here I am being very honest with you, I have told you just now that in the past there had been time to set aside for milestone development and to be able to do it. To the extent that there are as result of the structure in health more services shifted down to clinics and we sit with an excess of patients and

we sit with too few hands and there is no more time to specifically aim at milestones. We pick it up in the handling of the babies during an immunization clinic to say listen here, but you feel this baby cannot, you know has no muscle tone, you see in the eyes something is not right, but it is picked up by the way, it is not made in particular by appointment or as it had been in the past.

R Do you only focus on the milestone development or do you focus on a wider spectrum than only milestones? Do you for example involve the parent? Do you ask the parent whether there are any concerns regarding the child?

C Yes we do ask whether there are any problems, if the mother says no, then you know there is something that you pick up that the mother does not have, you will fix her attention on it and say Ok, we will give you another month and then we will see how it goes next month or give to her, I mean it can be motor, social behavior whatever right and to say try this and this to put it right and if it does not improve we refer.

R Tell me to what degree are the prevention and identification of development handicaps and disabilities the responsibility of the nurse in the clinic?

C I think you have a responsibility regarding yes.

R Uhm...

C Look quite often mother will a mother's instincts as far as I'm concerned are always right. With regard to that you have a responsibility to be honest with the mother to say yes it is like that and you cannot manage it to refer to someone who can help the mother.

R You then think in other words it is the nurse's responsibility?

C Yes.

R You do not think that it should rather belong to someone like the occupational therapist or a physiotherapist?

C No, but that is why I say where you cannot help her, if it is not a nurse's issue when it comes to, to to motor development or something else, right to then say I cannot manage it, I refer you to wherever, to a pediatrician or speech therapist or an occupational therapist or whoever is in the team, yes.

R According to the current scope of practice the registered nurse has a responsibility regarding the identification of health needs and the development and implementation of a nursing care plan to provide in these needs, the prevention of disease and the promotion of health, the facilitation and achievement of optimum health for all, and the promotion of physical and mental health, and the provision of effective patient advocacy to enable patients to obtain the necessary health care. If you now think in terms of what I have just said about what the scope of practice is, how will you describe the

responsibility of the community nurse with regard to the management of normal and special development needs? This is all about the responsibility, management and identification. How will you see it when it is about the management, the management of normal and special development needs? You can say the identification of health needs, the development and implementation of a nursing care plan, the prevention of disease and the promotion of health.

- C It includes almost everything that is in the scope of practice. You must basically only apply your scope of practice practically.
- R Good so you will say it is that whole spectrum that must then be applied. Initially we spoke about immunization, if we refer back to the spectrum of practice, do you feel all those aspects are important?
- C That's right.
- R Everything must be included regarding the development and implementation of the nursing care plan to provide in the needs of the baby who possibly has a development handicap. How do you go about it, what do you do?
- C It has firstly as you, as you uhm have identified the abnormality, right eh eh can I take an example?
- R Yes use an example.
- C Look usually with small babies who come to us, it is more about social, ear, ear motor and sensory observation and development right. Ok it can even be an illness to say listen here, this is this, our first thing is to see whether we ourselves can help with it, if we cannot help with it, not help, it is an issue of referral, but basically it boils down to your problem identification and then must say listen here write up a plan of action, can I, know it is implemented and then do it and then basically evaluate to see whether it works or not and if it does not work then you must say Ok, refer to the next one who can help.
- R (Begins to speak but C... interrupts her).
- C Except as, please excuse very often you realize with the first time with the identification it is outside my field and the I feel it is a waste of time to say let us try this and this and then you should refer immediately to a place where they can be helped.
- R The prevention of disease and the promotion of health, how do you manage it in your daily execution of your task regarding development needs of babies?
- C Say again that first part of uhm the prevention.
- R The prevention of disease and the promotion of health.
- C That's right, it basically fits in with health education.
- R What type of education?

- C Nutrition, in particular with the small babies, that's basic, you have said the prevention and promotion of health?
- R With the view to development of babies.
- C With the view to development of babies?
- R In other words what do you do to promote the development of a baby so that he can reach his full potential. Except to now identify problems, this is a healthy baby and there are no real problems. Now how do you make sure that he can reach his full potential at the end of the day?
- C I think this is where health education, what else R... (almost laughing).
- R Let us hear how it works with your health education. If you say you give education, what type of health education will you give to that mother?
- C You will basically give her guidelines in the first place, on nutrition of the baby, to say listen here uhm nutrition plays a very important role, if the child does not get enough food he cannot develop adequately and maybe to her education on the different development stages and to say listen here at so many months should be able to do this and this. Can your baby already do this and this, that she basically confirms or uhm I do not know what else.
- R It is important uhm to focus on the development stages before they are at that point.
- C Is at that point.
- R Uhm then only regarding the effective advocacy, to enable the patient to obtain the necessary health care. What, what do you do in connection with that, how do you manage it?
- C To refer them is what it boils down to. Your question to say that if I am act as advocate for someone, it means that the person cannot speak for himself, so I do it on his behalf, right.
- R Yes it is on his behalf, but whatever the advocacy is, to enable a patient to obtain the necessary health assistance yes such as with referral, make sure that he will get to a place, make sure that he has arrived there and that type of thing, how do you manage that?
- C You know, we do it with a letter of referral, written and we phone, we make an appointment. The feedback that we received back from the hospital had been addressed in terms of the referrals it is not what it should be. That, that someone also there eh eh there's a gap that that that you basically if you have referred for a patient that he receives a letter at the other end to also you give feedback. To say, listen here it was a grounded concern and you know how, how it is managed at the hospital.
- R How can you bridge that problem, out of your own?

- C Man out of my own, all that we can do, we report these things at, at management on a level higher than us and they take it to the central meetings with the hospital because we do not have direct, I mean I, I cannot uhm I report, we now have these AD's who are with us, right, and they go to a meeting at, at ms A...at the hospital and she again is the liaison person with the issue to the hospital. So it goes up through the channels, right, and those chaps manage it at the hospitals with a meeting to say listen here, these are the needs of the nurses on ground level it is to say let us know.
- R Then you feel that those needs were, when you passed it on, it will be addressed in such a way. You now have addressed it, have you had feedback from, from the side of the hospital.
- C Listen here, I think it's a shame, it does not always happen, only here and there, but is rather is the exception.
- R Just to recap, in other words you feel it is absolutely the task of the registered nurse to within her scope of practice, to now identify, make nursing care plans available, to manage it and if she cannot manage it, then to refer and so eh absolutely emphasizes the prevention of, of disease, not only disease, but also development handicaps and the management of handicaps, disabilities and the promotion of health so that everyone can achieve the optimal health level, in other words develop their full potential and you will advocate on behalf of the patient if he cannot do it by himself. The scope of practice defines the responsibility of the nurse for you.
- C Yes and you know where the advocacy of the nurse comes in. If you think of our structure today, that this patient no longer has access to the hospital without referral from the clinic. Our responsibility is actually very great.
- R Is there standard procedure manual in the clinics that guide nurses in the rendering of their services?
- C Listen here, that's a broad question. Listen it is very broad regarding
- R The focus here is on development of babies specifically 0 to 2.
- C We still have the old milestones, that type of thing from what E... and L... We have a set of that.
- R In other words, nothing further had been added except those of years ago?
- C Not with regard to development, no we only have our basic books of baby care. What is the book's name, uhm 'Pasgebore Baba' and that type of thing, but we do not have specific manuals.
- R Do you think this is a deficit that there is not a specific manual?
- C Yes it is.

- R Should there be guidelines do you think nurses in the clinic would be able to use and utilize it?
- C We will be able to use and utilize it but hands should also be provided to do the thing such as existing, that there is right. It's a pity but it's a part of the work that is neglected, I am being very honest with you.
- R So your focus then is rather curative instead of preventative and promotive. Is that what you are trying to tell me and the workload has been added?
- C Yes, because the services that we get are rather curative, it is chronic diseases, it is TB, epilepsy and it is psychiatric that now also, various services that are shifted off, that the children there has actually lost, in particular your, your normal baby clinics.
- R How do you ensure the quality of service delivery? You as manager, what do you do to ensure that the nurses under your control and supervision deliver a quality service?
- C Do you know, but to make sure that they get the necessary training and even if is only in-service training in the clinic. To say and when a mistake is made to put it right and there where there is a need for training, where there are training opportunities, to send those people for training.
- R You have mentioned resources, manpower and of course it is essential for the delivery of effective and successful service to babies. What is the role of management regarding manpower and resources? It is not only manpower but also all resources in the clinic. How does management take care, what is their role to provide regarding resources and is manpower then included?
- C Do you mean management at our level or at a higher level?
- R At your level.
- C At my level is to say well we have a shortage of personnel and that under that, you know to bring it under my manager's attention and to say our workload per nurse is too high for example to say listen here, here a new service is being delivered but there are no people to do the work because every time the load is increased and the higher the load becomes, the lower the quality of service, that's a fact.
- R And other resources, equipment?
- C That's right.
- R To be able to provide in the clinic in... in the needs of the community.
- C Is that with regard only to the babies and development of children?
- R The development of babies and children, yes.
- C Do you know the equipment that we have, uhm... basically we only have measure tapes, the measure rug regarding growth in length, you know

physical development, that's what we have, but but as we have had in the past, toys and things to to to what do you call it?

- R Can further development such as motor, sensory.
- C Yes those things we do not have, so equipment is a shortage.
- R What would you as a manager do about it?
- C You know if we have guidelines according to which we can work and do a thing to the end, to then motivate that we also have the necessary eh equipment, to also do that, but you know how it goes. Within a moment we get to do something and then you must motivate and you wait a long time for the equipment to do. To get it, that is not an issue that you you cannot implement your service before you have all the equipment so you must also have these things in place and then you can deliver a service.
- R And then further you have also said training, you have mentioned training quite a few times. It is therefore essential for successful delivery of the service. How do you as management ensure that nurses remain up to date regarding the development of babies so that they can deliver an effective service?
- C Uh R... there it is a question of one must basically see that the existing protocol and and uhm guidelines that you have, that it actually applied, but because there is a shortage of it exists, it is not done. So it really is I am very honest that is being neglected.
- R The training in particular?
- C With regard to to to development of babies, yes regarding this thing.
- R So you focus more on other facets of service delivery than on the development of babies?
- C Yes.
- R Do you think if we must now take it back to to to the scope of practice and you've said it is a definitive responsibility of of the nurse. How will you address that thing?
- C Basically it boils down to the fact that we do not show responsibility towards these children. If it is a service that is within the scope of practice that is neglected then you must do it. Our eyes are not completely closed to it right but there is not, it is done by the way, so there is room for improvement.
- R There is a further facet that I have also realized, is the uhm referrals and things, cooperation with other instances for example your hospital, is that therefore essential for the delivery of effective service to babies. Which role of management concerns the cooperation? How do you promote this cooperation?
- C Do you know on my, on "wêna's" level?



- R Yes.
- C Laughs.
- R Do you feel that you can make a real contribution to to strengthen bonds? Do you see it as as the role of higher level management or or how would you, how do you feel about it, what is your your perception thereof?
- C Do you know that that that at the moment you know, I do not even know who is the physiotherapist at the hospital, I do not know who is the occupational therapist I do not know the speech therapist. I refer people to them but for me they are people whom I do not know who they are. So what what I can only say to you right I know, just say that question again.
- R It is about the cooperation with other instances, in other words how do you promote cooperation between your clinic and the occupational department at the hospital? Is it only through a referral and this is where my responsibility stops or do you feel you have a broader responsibility towards your patient to promote this cooperation so that the client uhm can utilize that service with ease?
- C Do you know I refer I have never even personally spoken to those people, because we refer them to the hospital and that's that.
- R Do you think it is a deficiency that one could do something about?
- C Yes, perhaps it will be better if one, right it could perhaps yes it is a deficiency. It could be better I think it is more if one has a person of whom you know listen here she she has a figure right, it could be an improvement and maybe there can be better cooperation if a person knows it is that sister or this one. If there exists a relationship at the moment there is no relationship.
- R How can you as a manager of your clinic.
- C Perhaps one can.
- R Improve that relationship?
- C By physical contact, by getting together and to say listen here, I am this and that, or to invite her to the clinic and to say maybe come and give us an in-service training session or come and introduce your service at the clinic.
- R While we are now talking about cooperation, do you think it can be a more effective service if that type of personnel are with you under one roof at the clinic, in other words the occupational therapist, the physiotherapist, the speech therapist are all physically available at your clinic on a daily basis?
- C Do you know I do not think it is practically feasible it...it can...can be an improvement, but I don't think it is practicable that we have a speech therapist at each clinic, or if she can be for a part of the day for an hour per day. It will also depend on the need that exists for such a service. Is it really necessary or

maybe to say she can come to the clinic once a week, or once a month whatever the need may be, but one will there yes you certainly do not mean a fulltime person. That there, that there is a time, say once a month, once, yes make it once a month, that she has a session at, at a clinic to see where there are children, you know can help a lot.

- R Yes, but if you have a look at the literature, they are referred to as the so-called one-stop-shopping experience that that means that the mother has a comprehensive service delivery in terms of of their background, their financial set-up, in other words their total logistical set-up. They come to you. The child comes, to bring the child for either immunization and you identify a problem and you refer the child, because you cannot manage it. The mother must now make an appointment or you make an appointment on behalf of the mother, in other words she must again ask her employer for another day off to come to hospital. Another day from her her day task where she is working. Again it is expenses for her and it so happens that they cannot manage her on that day and another appointment must be made and you do not get a referral back from the hospital in other words.
- C That's right.
- R So eh with the result that you can have one on a session basis as you have described, perhaps it can prevent late referrals taking place, in other words early management it is of in other words not possible, this is where the problems become worse in the sense of the child's development.
- C Yes, and you know even even if not at the clinics because each community with us has basically a community center, right. We are a clinic, but Jouberton is a community health center. They manage us, we refer for example our people with eye anomalies to Jouberton because there they have an eye clinic and the eye clinic functions from there, right, as you for example at your community outside, at your community health centers say, maybe has an occupational therapist, because I do not think a clinic such as ours you will do for an occupational therapist, because one should think of her time as well that that maybe she does not have enough work at one clinic to say I go there once a month and maybe make it later that she is not motivated to come and that the service will also fall through.
- R Yes you as manager must think in terms of the broader picture it is not about about maybe only about the
- C Yes.
- R Clinic where you don't work, so it is right that you say, in other words she must be applied effectively.

- C Yes.
- R And not placed at a small satellite clinic, I mean it will not really be practicable.
- C Yes, I mean besides we will score, but she will possibly feel at one stage...  
listen here its its not for me. Know I go there, I am on the road for an hour, it is half-an-hour's drive from there, you know, down to the clinic and back to see one person. I could have seen so many people if I had been stationed in one place. So, then one can apply your service at your community center and say ok, she goes there and you refer the people there, whoever may be the therapist.
- R Just now you referred to barriers regarding the delivery of service in the current service delivery. Can you identify the barriers that prevent the nurses to give more attention to development needs of babies in more detail.
- C Yes, eh you know I think the biggest one is the number of babies and the number of nurses that are there.
- R The ratio in other words?
- C Yes.
- R For arguments sake 1:100.
- C Yes is is about input, you know there are so many services. If one thinks in terms of what the service at the clinic had been 10 years ago and for what services are being made provision today. We got more people, but time remains a factor, time and hands ratio in in relation to your patient it it is a big thing and then for this project of yours basically also is is the guidelines according to which this thing we must assess the babies, a measuring instrument, there is a shortage of a measuring instrument. You can help us a lot with it and when we have the measuring instrument, then also the necessary equipment that is not there at the moment.
- R In other words if there is an instrument.
- C And then at our clinic specifically, please excuse, and our clinic specifically also is eh eh I mean the place had been enlarged two years ago and again he is too small.
- R Space, physical space?
- C So, physical space is also a problem.
- R To go back to the measuring instrument to guidelines, should something like that be available, must there also be training?
- C That's right.
- R And currently, do you see the knowledge of the nurse, in general, who looks after the development of babies, also as a lack?
- C Yes I think definitely.

- R And, you also mentioned that you do not give enough uhm attention, in other words you focus on the development of babies, because you put so much emphasis on the curative part and that you current in-service training is more focused on that as for example on the development of of of babies?
- C That's right I I agree.
- R Now how do you think can barriers be overcome, what can, according to you be done?
- C Well it is it is first to create the physical space where the thing can be done, to provide the human resources, provide the training and the equipment.
- R Do you think it is really practicable that it can happen?
- C I don't know, I must first, one must perhaps look more critically look at. at how you are going to deliver your service, right, one could maybe in your day's program can you perhaps again look critically at how do you do it and when do you do it and how much time you spend on it, can you perhaps make space to I mean then the time and space is there, then it is only the training that must be done and then one must be motivated for the new job (laughingly) R... you make me tired.
- R Is there anything regarding the management of development needs of babies, your viewpoint as manager, anything that could be to my advantage, related to information. Do you think we have basically as, your responsibility as manager, basically touched on all the facets that you as manager must keep in mind?
- C No, I cannot think of anything else.
- R I am going to transcribe the interview and when transcribing I realize that there are still some gaps, may I arrange another interview with you just to extend that follow-up information. It is not going to be a problem?
- C Well, it won't be a problem.
- R Then I only want to say thank you very much for your time and patience. I really appreciate it very much.
- C Laughs.

## INTERVIEW: PEOPLE INVOLVED IN TRAINING OF NURSES

Date: 1 December 2004

Duration of interview: 25 minutes

Venue: Park Street Clinic

Interviewer = R

Participant = G

- R Can you tell me why do you have in-service training programmes?
- G It's for it is to improve the quality of care we give to the clients and it's to update the staff ne and then it's to it's also to let them be empowered.
- R Ok how often do you have in-service training sessions?
- G We have them fortnightly but it is best sometimes if you've got something you can see the need every week every week.
- R Every week. How long do you spend one hour, two hours?
- G One hour sometimes it depends on the session some sessions are too long maybe up to two hours.
- R Up to two hours.
- G It commences in the afternoon after.
- R After two?
- G To four ja.
- R Ok uhm do you think this is sufficient time to al to help the staff develop skills that they can use in our rapidly changing health environment?
- G I don't think it is efficient. I even complained that we are now now late pushing more the the client issue than the in-service because one or two feel that we are wasting time so I feel it is not sufficient time.
- R Ok uhm tell me do you have any policies or guidelines for your in-service training?
- G So far I've been trying to write the the policies ne but I couldn't due to the guidelines issue according to their level.
- R According to whose level?
- G Each professional level assistant nurse for the assistant nurses, professional nurses, counselors, clerks because some in-services we don't include clerks done according to their categories.
- R So you just wrote a policy eh a local policy for the clinics specifically?
- G Internal policy.
- R Internal policy ok. Tell me what topics do you focus on during your in-service sessions?

- G Commonly we focus on what we do in our clinics but now lately I can say we are more focusing on STI's (Sexually transmitted infections) and HIV.
- R Mmm why is that so?
- G Is because of the span of the need of HIV and most of our late training as we go out for late trainings we are being trained for STI and HIV in different forms.
- R I see. How do you decide on the content of your programme? How do you decide on the content?
- G Contents?
- R Ja (yes) the the eh topics the topics that you are going to discuss.
- G I I'd say according to what what is presenting more and at the same time what is needed like now the past four four five months we have the new personnel I have been concentrating on more that I know that they don't know so they have to be exposed e.g. family planning because they never went to family planning sessions eh baby growth, cold chains I've been trying to concentrate on those more for the new personnel to.
- R Ok. Are there any prescriptions from the province that you have to adhere to eh or do you just focus on on your current and perceived needs?
- G We said we we do on our current perceived needs not from the province.
- R Ok.
- G Because the province have got their own training on sub-district of service.
- R Ok.
- G It's internal
- R So you just focus on your own thing internal. Tell me do you take the needs of the staff into consideration when you compile your programme?
- G Yes I do e.g. whereby the our assistant nurses because I told them they are now to start to do health health programmes teaching the clients and because they have this clients they say they don't know how to present what are they to present. I did consider those needs even also for the professionals I do consider their needs they feel they need more of this they don't know this I go according to this.
- R Ok tell me how do you assess the needs of the staff? Do you just ask them do they eh complete a little questionnaire on on or
- G Is more orally than.
- R More orally.
- G Than questionnaires
- R Tell me what is your opinion of the professional, the registered nurses' perception of their limitations of their limitations on on their competence, skills

and knowledge. Do they eh do you think they're really honest about their limitations?

G I think they are not really they are not honest.

R They are not honest?

G Eh I think they are not honest because you'll find that some of those insist they are, they do but they just do because because it is imposed that they must do. I want to make an example. With this issue of down referral of other conditions such as epilepsy, psych because right now it is being discussed that they may also bring the anti-retro viral drugs to us they feel that some things are not for their level it is too much for them but they just do.

R Ok uhm the format of your in-service training uhm what type of of how do you present your in-service training?

G Commonly I use the active-participation system and also the written information and give out handouts with the highlight notes for them to read further after the session and then after we have given in-service everybody whose indisposed or who doesn't know can make arrangements to be retrained we do more orally we don't have overhead projector.

R Ok so you focus basic on lectures and handouts?

G Handouts yes.

R Written materials, eh do you have active group discussions?

G Too much.

R Too much?

G We have too much because I for instance as eh in-service director programme director I prefer active participation.

R Why is that so?

G So that everybody should be exposed to this and that and find out who doesn't know what.

R Ok uhm do you ever make use of other health care professionals to present training here at the clinic?

G Yes I do because we once invited sister W... to come and give us something about OREM their new research have research concerning HIV's they did come sister W... and also the other guys from the department of education they did come to give us something I don't recall it and then I do do use outside and such as even the social worker.

R Mmm mmm. Ok do you think that the provision of the information will translate directly into effective outcomes in their daily tasks of the nurses by attending your in-service training? Do you think that they they make the knowledge their

own, internalize this knowledge so that they can actively perform or to to to upgrade their performance?

G I think they do utilize it, they do utilize this.

R Ok how are you going to ensure the efficacy of your in-service training efforts? How are you going to make sure that they are really after the in-service that they are going to make use or utilize that knowledge that you've imparted?

G I make sure by making follow-up that sometimes when they consult I do sit where I follow what they some are saying.

R You observe you observe.

G I observe and except observing I do check their documentation if they apply what I was giving at in-service and then I also do interview the client.

R Ok.

G Eh with example with the issue of STI's where they talk talk about what they must do about their partners I do also interview clients like even counselors the way they counsel and to find out if the clients know. I do interview the client, make an interview to find out if ever did they left out whatever they once were taught in in-service.

R Ok good that's excellent. Uhm when you evaluate the eh skills that they are supposed to to uhm gain with the in-service training have you got a specific list of criteria for mastering that you use in this evaluation or do you make use of your your in-service training guidelines?

G I just do it according to in-service I don't have a specific tool to be used.

R Ok would you like to have such a tool?

G I would I would.

R Ok.

G Although they like saying to me I mustn't make them as if it is a test.

R Laugh. Do you have the necessary resources to ensure that information can be translated into effective practices when you do give the the uhm in-service?

G On STI's

R On STI's are there certain handouts that you can give to the clients?

G Yes there are such handouts. I commonly give them handouts and if I don't have handouts and if I have got notes from somewhere I do make copies and give the copy.

R Ok so there are sufficient resources for you to to utilize. Tell me have you ever addressed infant development as a topic during any of your in-service training sessions?

G No but since I am from the syndromic approach course of HIV children I feel I want to do it with them because I was taught about the growth chart on that



course I attended. I was explaining that I am going to give them all that syndromic information I got I was planning for that but I was on leave.

R Tell me has any of the staff ever identified eh infant development as an area where there is a lack of knowledge on their side?

G Ja there are staff staff members, there are especially the new appointed and even the old appointed because I've see last that most of those would do only primary health care and they've never been exposed to children. They've got a need for this infantile infantile development and growth.

R Tell me how, when do you assess their needs or how often do you assess their needs for instance once a year or quarterly or monthly or is it an ongoing process?

G It is an ongoing process because even today I was assessing some of those sisters feeling that how she must go about during the immunization session she was busy with.

R So it is an ongoing session and if you notice something you try and incorporate that in the programme. So you have the the uhm the power to to change the programme according to specific needs?

G Ja but I also do talk to them that I feel this week we are going to push this topic lets push this one.

R Ok so that's good uhm do you view infant development as an important aspect of your daily tasks here in the clinic?

G I view it since I am been from that new course I view it that as important hence part of guidelines of the syndromic approach to disease managements.

R Ok so uhm why do you think previously before you went on this course why uhm hasn't it been addressed with in-service training?

G It's been taken it's been taken as its usual it's like it's a usual thing.

R So you take it for granted that.

G Ja (yes) you take it for granted ag (oh) they know about the infantile growth they can't go on this problem but I I feel now they should be re-serviced about this in in-service.

R I see uhm do you think there's a gap between the typical what's going on, on a daily basis and the ideal practices with regard to the management of infant development?

G Ja (yes) there is a gap although this new IMCI course.

R Uhm.

G Is working towards closing the gap.

R But the IMCI is mostly focusing on on on infant illnesses not the.

- G They do, they do concentrate concentrate on infant illnesses, ne (yes), but somewhere along the way us interview the mother it somewhere emphasizes about weight gain of the child the milestones the things.
- R Ok so uhm do you think the staff has the necessary knowledge, skills and competence to address infant development to its fullest?
- G I don't think they've got full competence except those who were exposed to this IMCI or those been longer exposed to baby clinics.
- R Ok in this clinic do you think there is consensus on how infant development should be managed? Do all the sisters work accordingly do the same or does each one do his own thing?
- G No each one do his her own thing.
- R Ok do you think there should be consensus?
- G I feel there should be consensus.
- R Ok so uhm now I am going to ask you do you think you have the necessary knowledge and experience to guide and support your colleagues on the management of infant development?
- G I do have according to what I got from that course maar (but) I feel I still need more.
- R Ok so where are you going to get that more that you you just identified?
- G That more I am gonna open my eyes there's a course exposing us to infantile development and growth I'll have to ask to go for it or they should communicate to us like their training facilitator of the sub-district. I might also highlight to her that I feel we need more of this infantile growth.
- R Ok so anything else you would like to add pertaining to training in-service training with regards to infant development?
- G Ja (yes) it's just that I feel we need more more to be to be guided to be done on more service and more exposure to infantile development and growth and if I may say also another thing I would like to suggest to my colleagues is that one of having same formats should stop having my own system to assess the child health or system irrespective of IMCI because the IMCI is also pushing us to see that what child is that according to the level of her age what milestone is her weight going down or up but I feel we should have a format even if you can maybe even go to that old system where we used to chart our our cards that the child is still the milestones all so far the abnormalities and abnormalities and so forth.
- R Tell me another thing. I am just thinking about it, anticipatory guidance uhm and and eh teachable moments, do the staff make use of that when a mother comes in to them and talk to them and and they pick up there's there's a gap in

this mother's knowledge. Do you think they they make use of anticipatory guidance?

G They make.

R Do they have the knowledge and skills once again to to impart that necessary information to the mother?

G They do make it some of them although some of them they don't do it because what I've realized what I've noticed some personnel they that feel they feel that they should work and get through work and get through and not give quality care because according to quality care when you are with a child you must give something a to z wholeness whole heart you should treat that patient in totality so I feel they need to be guided to give anticipatory action they must do something about it to give to the mother the information about infantile development.

R Ja (yes) because you know uhm as we've discussed previously that eh it is said in the literature that eh infant development delays are identified too late and that they feel that the mothers don't have sufficient knowledge on growth and developmental principles on the child so eh it seems as if the nurses in the clinic don't eh give the necessary education to the mothers.

G Uhm its is not all of us who are giving education you find two out of three because what I've realized there are some other people they just concentrate on what the baby is there for and forget to check the other things which go hand in hand with development.

R Ja (yes) and it also came to my knowledge that with with my other interviews that that the mothers uhm they don't realize that the imparting of knowledge information is part and parcel of the nurse's job.

G Uhm.

R So that's why they they don't see it as a lack because they've they've never been exposed or I can't can't generalize but but most of them haven't been exposed to getting or.

G Information.

R Information from the nurses.

G Mmm.

R So you see that is a lack so that should also then be addressed in your training programme

G Mmm

R Thank you very much.

G Any time.

R And eh once again if I feel there's anything else I need I will phone you.

- G Please phone me and I hope this time (points to ears)
- R I am sure I'll be able to hear. Thank you very much.

## INTERVIEW: OTHER HEALTH CARE PROFESSIONALS

Date: 20 October 2004

Venue: Consultation rooms of therapist

Duration: 30 minutes

Interviewer = R

Participant = P

- R Many stakeholders in different environments are involved in the evaluation or assessment of babies' development. The degree to which they focus on this development is inconsequential and it is the experience of therapists such as you, concerned with rehabilitation, that the diagnosis of handicaps and disabilities is made too late for effective intervention. What is your opinion and experience thereof?
- P I think in the first place is that uhm that my feeling is that early intervention and early identification is an entirely new playing field and that we, there is so much new information thereof, so many things available, but most people uhm will say never mind, but you know what it is, the child is normal uhm a bit late in developing, wait until your child is three years old and this is actually a pity, because one can do all the therapy before he is three years old and that is too late as they turn three years and older. So, I think my feeling is that the information on what one can do in such an intervention is too limited. I do not think people always know what each type of therapist does and that one can work with children who are four weeks old, eight weeks old. Everybody always waits until children start talking before you can really do something uhm there is simply not enough information on everything concerning communication development.
- R Have you had various such cases here in your own practice that you felt if only I could have had this child earlier, I could have done so much more for him?
- P Yes, I think it is a regular a reasonably regular phenomenon it appears reasonably regular.
- R That's it. What is, according to you, the responsibility of a nurse who works in a primary healthcare clinic regarding assessment of the development of babies? It is stated very widely, but if you can think how you would like to see her role with regard to the development, the assessment, the identification?
- P I think it will be good if the nurse has a proper uhm almost a checklist, for the different developmental milestones. At this stage I feel as if the milestones are too wide. They look for example at uhm what a baby must be able to do at

three months and six months and eight months and 12, while weekly milestones occur within the first six months. The other thing is that most of the time one only looks at the motor development and chat about whether your child babbles and maybe you ask about the child's hearing, but there are no proper uhm questionnaires or checklists in use that looks at all these things such as parent-child bonding, parent-child interaction uhm communication development. Those things are left completely behind. There are also things that the parents do not always remember, because nobody ever asks them, but everyone asks when does your child begin to sit, when does your child start to walk and never ever are you about communication development.

R Do you think the nurse has the necessary knowledge and skills to identify early developmental handicaps and disabilities in babies uhm and if not, what do you think is the solution to put it right?

P I think in the first place people has too little information on which development milestones are important at which stage, and as I have said, I think the information that a person has is incomplete. I think that they are in a very good position to identify such children very early and that they have regular contact with the parents as result of inoculation uhm they rapidly build a relationship with mothers with young babies. So, the task with regard to this position is actually to pick up these children early.

R So, how do you think we can correct uhm this knowledge, information that is incomplete? What do you think we can do about it?

P I think one must look at what uhm nurses use to evaluate uhm in the first place there must be a proper instrument, there must be a good questionnaire or checklist for uhm more ages, I can say it must be complete. Even if it is a short questionnaire that parents complete, I know time is limited and one cannot expect that the nurse must have a whole diagnostic session on it, because well placed basic questions can give you enough information to say which referral is necessary and I also think that uhm training sessions to say exactly what each therapist type do to make the correct referral is very, very important because I feel that the information in that regard is not always sufficient; people do not ask what different disciplines do.

R In following up on your question or your answer regarding the measuring instrument: currently there is not a 'gold standard' as the saying goes, for assessment of babies uhm you referred just now to a checklist. Do you think this is the most effective way for the nurse in the clinic to assess the various areas of development?

- P My personal opinion is that a checklist will be a good thing because, in the first place the time aspect in a clinic is a big problem uhm because the nurse does not have in-depth knowledge of what the therapist is looking for regarding planning of the intervention. It is also necessary that one have basic information for referral, so I think a well-compiled checklist can address the problem of time. It is also something that can be given to parents in the form of an information brochure. Mothers can quietly think about it and it makes it more effective for me because to fire a lot of questions to parents and to get a rapid answer without giving the mother time to think about it, sometimes you are given wrong information, while if you can give it to the parents in the form of an information brochure and they can quietly read through it at their own time and maybe watch their baby for a while and then decide there are things that my baby is not doing quite right; discuss it with the nurse and then they can decide together to refer the child so that it is not just a question of diagnosis and treatment and not a participative decision making process.
- R How do you think they will it in the event where the parent does not have the necessary uhm development and education to, for example to read, to then take such an information pamphlet home to make her own?
- P I do not think it is so difficult to present behaviour that children should have uhm in picture form and uhm motor behaviour is of course easy and a mother, a person, can easily see whether a baby can adopt all these different positions, play in those positions uhm I think that the things with which children play and things such as parent-child interaction and bonding are things that one can represent to a certain extent by means of pictures, but it is also where the nurse's background information must be good enough to draw a fast conclusion to what the parent-child interaction and bonding is when they themselves are in the consulting rooms for inoculation. Even so it is a stressful situation, a good interaction occurs between a baby and a parent in such a uhm situation and it should give one good clues, again not to make a diagnosis and to treat, but only to decide a referral is necessary.
- R Uhm you have now also answered the next question.
- P Laughs.
- R It was about the opinion for giving practical guidelines for the nurse, so you have also answered that. Thank you very much. Eh intervention for shortfalls in development usually takes place outside the clinic and maybe liaison, interaction between the nurse and the therapist is inadequate. How important is this liaison, interaction for you in the continuing care of the high-risk baby?

- P I think it is of cardinal importance but I think it does not happen even for us who know that it must happen, it does not happen as well as it should uhm I think not always to the advantage of the patient. I think there should be much closer and much better cooperation between therapist doing the intervention and the nurse who uhm who does the tracing thereof. And I also think the more a person knows of each other's field, the more we can properly inform the parents uhm repeat information to parents because they hear one thing from one person and a next thing, but sometimes the information is half amiss and wrong, and one sometimes wonder what the parents had been told by other disciplines. I think if there is regular contact, shared training sessions uhm and shared uhm information inputs with one another, one may possibly have a good reference framework to again and again repeat information to parents uhm and to make cooperation and decision-making so much more effective.
- R Do you think it is really workable, because when you are in a busy practice and then also to focus on these shared information sessions, or do you think one should spare time for it?
- P I think practically it is very difficult because we all think about how much time you must spend and everyone has extra administrative work for which you cannot always ask a fee, so it makes it difficult, but I think we all have a responsibility towards the patient with whom we work and the responsibility makes that we actually make time for this type of information session, coming together to share information. The other important thing that I feel is a plus point for us, is that we all are exposed to CPD points, we can be acknowledged for it and we can organize small group activities and for one or other reason we simply do not do it because we can all find advantage in such a gathering, sharing information uhm by an organized uhm small group activity for the sake of CPD so, actually we all get something from it and uhm patients and our own professional uhm skills can definitely benefit from it.
- R Concerning the therapists in the provincial hospitals and in the clinics uh from my previous interviews it came out very strongly you know, that they do not even know who the therapist in the hospital is to whom they refer. The result is they get, they send a letter with the mother, make an appointment and then this person literally disappears from the horizon so they don't get feedback. So, it is not only in the private practice but also in the uhm provincial setup it also is a real problem. There they again say that it is the result of the patient load, work pressure, a staff shortage and all those types of things, but I think uhm at the end of the day when your concerns are patient care and



development, then we must really think about it. As result of a scarcity in trained therapists particularly in rural areas, the nurse is often the first contact with health care. In the literature it is referred to as role release and role extension with the therapist who then acts in a consultative capacity. What is your opinion concerning this? Do you think it can really contribute towards helping a little with these problems that have been identified with regard to interaction, early identification and early referral?

P I think it is something important if a person sits in the country and there is not enough knowledge and enough people, trained persons to do therapy and so on. So it is very important, I mean every bit of knowledge can help this patient so uhm it can be done successfully and everywhere in research it is told to a person that we must follow this trans-disciplinary approach and I think for our country it is our only option uhm the problem only is all our little professional selfishness I think (laughs) and we do not want to share because maybe we feel a bit threatened uhm but it is also because we do not have contact with one another, because we do not know each other's skills and we will never change it before we do not begin to share information and uhm to put this whole situation to the test and one can only test it and you can only iron out the problems if you have done it once. It does not help to sit with these negative thoughts every time and then to hope that something else is going to work because the ideal health model, as we all want it to work, is not a workable option. We cannot do it so uhm one must be prepared to limit oneself to those things perhaps circumscribed by your role. One must also know your limitations, it is also important and a person must learn to seek help, a person must learn to communicate with other disciplines without this professional jealousy, professional uhm (laughs) now I have stated it a bit strongly, but it is right, maybe one should not say it but that is really how I feel. One puts up walls and barriers that are not to the advantage of our patients or certainly not to the advantage of our own uhm own professional skills and uhm yes, and for us and for our country's health care it definitely is the best thing to do.

R Do you have any additional comments that you think will make a contribution?

P Can I tell you what I think of your clinic set-up? (laughs)

R You are most welcome.

P I am very grateful for uhm clinic personnel who are open to conversation, who are prepared to listen to what a person says and who uhm is prepared to give of their time to parents. Because some parents complain that they were strung like sausages good morning missus let us quickly do the immunization and

then you are out whilst it is actually very important for patients that someone spends 5 to 10 minutes with them, to chat a little with them and I think therein lies the key for the correct referral and the uhm showing the right way to patients for intervention and uhm and from my experience I really find that where one works together with people who are open as long as one is prepared to share information that one gets appreciation and good results from intervention, but where one also not always do your share to uhm make contact with other disciplines and in particular to make contact with the nurse, there are many things that fall through, so for me this is a passionate issue, that I must be able to work with something like that.

R Yes, no it is also very important for me that there must be cooperation and uhm if I think back to when I have done my M, I received this hiding by saying that you as a nurse is the problem why children arrive late at uhm early or at intervention or early diagnosis and action. You know, but I think there is two sides to an issue and can only tell you.

P It is very harsh to say something like that, because as a therapist I know that we do not make enough time and also not uhm take enough care to use you as nurse, to chat we don't even do that, actually expect and I think there even is an attitude in therapists that the nurse must contact in stead of the therapist seeking the nurse's knowledge for a change, the nurse contact, so yes, it again brings us back to the, our own (laughs) professional jealousy and things. This is for me, it is a very harsh thing to say, there definitely are two sides to an issue and I think, I think that therapists make life difficult for the nurse. We have not really talked to each other, the disciplines have never worked together, so it is an absolutely barren field that lies here and somewhere someone must start to scratch, begin to plough and plant and do something, so yes I think it is a bit harsh to say it is only the nurse's fault, it is not.

R But thank you very much for your time, I appreciate it. If I go now, assimilate it and realize that I still left out a few things, may I contact you telephonically just to get further information?

P You are most welcome.

R Thank you very much.

|                                                           |
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| <b>INTERVIEW: PARENT - CHILD WITH TYPICAL DEVELOPMENT</b> |
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Interview date: 11 December 2004

Interview duration: 45 minutes

Venue: Interviewer's office

I = Interviewer

P = Participant

- I Tell me do you think every baby has the right to develop to his or her full potential?
- P Yes I think so because it's important for the baby to develop to its full potential and I think it gives him or her a chance
- R Uhm
- P So that maybe during because of the time it's much easier for the parents to see the development of a child
- I Uhm
- P So that they can recognize if there's anything wrong
- R Ok good. So uhm how do you think you as a parent can help your baby eh to reach this full potential? What can you do?
- P I think it's wise for every parent to read more meaningful material get some information anywhere
- I Uhm
- P from someone
- I Uhm
- P And make sure that he takes the child to the clinic for check-ups
- I Uhm
- P And identify if there's any problem
- I Uhm
- P Pertaining to the development of the child
- I Ok that's wonderful. Tell me uhm your knowledge about growth and development do you think it is sufficient?
- P I think it is sufficient for now because normally we take our kids to primary health care
- I Uhm
- P We normally take them for injections immunizations and it is then there that they can detect if there is any wrong with the child
- I Ok but, but with the knowledge that you have do you think you will be able to detect on your own that there is something wrong with your baby?

- P Some, some of the things you can detect on your own but others you can't.
- I Ok so you will need help and more knowledge to do so. Do you think it would be nice for the nurse at the clinic to to inform you more about your baby's growth and development?
- P I think it's wise because sometimes there are people even in rural areas where they can't get more information maybe they travel to clinics once a month or twice so if that person has got the knowledge then sometimes if she doesn't get the time she can see or identify some of the problems on her own and then maybe take some initiative to see what she can do about the problem.
- I Ok good. Uhm How do you think they could help to to elaborate on your knowledge?
- P I think by having workshops by work shopping the mothers' uhm making information available like having some kind of pamphlets
- I Uhm
- P Mostly for development of the child
- I Uhm
- P Then that people can get more information
- I Ok excellent uhm tell me the nurse at the clinic you attended with your baby has she ever given you any information on growth and development of the child?
- P She never said a thing so that I kept asking her about some of the questions like my child is having yellow eyes
- I Uhm
- P At birth and then I took her for some tests took her for some tests and then they said I should come back
- I Uhm
- P And when I went back they said she was fine so when I took him to the clinic I told them about that the
- I The eyes, ja (yes)
- P The eyes and he told me it was nothing he'll see during growth whether it was something serious
- I Ok but she never gave pamphlets on growth and development she never offered any information on eh you bring the baby for 6 weeks, 10 weeks, 14 weeks so for instance in the next month you can expect the following to happen with your baby's development and growth
- P Eh uh (no) the only thing
- I That type of information?

- P The only thing that she gave me was a pamphlet were they they talked about  
uhm immunization because I took him for immunization so it was stated the  
after effects what I should expect after the
- I The immunization
- P The immunization how I should treat the after effects
- I Ok so she never offered you any additional information on growth and  
development. Ok so right The service at the clinic were you satisfied with that  
service or were there times that you felt frustrated with regards to I expected  
more, I expected more information things like that?
- P The service was ok, anyway the nurse was fine
- I Uhm
- P He, he made us, she made us feel at ease you know
- I Ok that is great
- P And and the child also she she she she tried to make him calm because  
normally when you take the child for injection it start to cry and everything
- I Mmm mmm
- P So she was nice anyway
- I Ok that's good so so you felt at ease with, so uhm uhm Besides the clinical  
competence of the nurse what other characteristics would you expect from a  
nurse? How would you like her to treat you and your baby?
- P Mmm I think every nurse should should give you a chance to ask questions
- I Mmm
- P To say how you feel what you experience
- I Mmm
- P Then your actual needs your fears
- I Mmm
- P For the future about the child maybe you can tell her what you think could  
happen when sometimes your child is sick and then you fear about the  
sickness
- I Mmm
- P And give you some more information or maybe pamphlets what to date or  
even if there are no pamphlets at least tell her where to get the information
- I Ok the environment of the clinic as such is that important to you that it should  
be neat, warm and friendly and comfortable those type of things or doesn't
- P No no it should be like that because
- I Mmm
- P Normally the the small kids they have this thing some of them can even it's like  
they can feel they are going for injections or whatever

- I Mmm
- P So that fear so I think if the environment is good then maybe that thing will just come out
- I They will be more relaxed
- P Relaxed
- I Ok so you want the nurse to be friendly towards you eh she must respect you as a person and eh your opinions
- P Yes
- I That type of thing
- P Ja (yes)
- I Friendliness, ok good. So you would say you had a nice relaxed uhm relationship with the nurse when you went for the baby's vaccination? Ok, right with your last visit to the clinic can you tell me from the minute you walked into the door till you left what happened in that time? Just briefly
- P Mmm we went there and then normally you make an appointment
- I Mmm
- P So there was somebody in the consulting rooms we had to wait for some few minutes
- I Mmm
- P And then she called us in
- I Mmm
- P We sat there she just talked to us while she was busy preparing the dosage for the kid and then
- I What did you talk about? Can you remember?
- P Eh she asked us about the baby's weight
- I Mmm
- P Because the other time we were there she told us the baby was eating too much
- I Mmm
- P It was so I told her we no longer give him too much food so ok she prepared the dose and then asked me to take off the clothes and she talked to the to the kid
- I Mmm
- P While she was preparing that thing you know
- I Mmm
- P The baby kept smiling, and it was giggling
- I Mmm
- P And she she brought cotton wool and I don't know

- I The wipes, ok ja (yes)
- P So she gave the baby the injection
- I Ok
- P And then
- I Eh
- P She rubbed the Vicks
- I Eh, ok tell me did she weigh the baby?
- P Yes she took the baby's weight
- I Ok did she measure the baby's height?
- P Uhm yes somewhere on the
- I On the couch
- P Yes on the couch
- I Ok can you remember whether she measured the head circumference?
- P Yes, there was a measuring tape where she measured the circumference and then the length yes
- I Ok so that was done. Did she explain in any way to you why she was doing that and what did it mean with regards to your baby?
- P The only thing she said was that at least the baby is growing. The height she no longer was the same the length
- I Ok she mentioned some things but she didn't explain why. Would you like that she explains to you so that you can understand better why she was measuring and weighing and things like that?
- P Ja (yes) I think it is important because I know with the the weight they normally weigh the child to see if there is any weight loss or weight gain during that period
- I Mmm
- P To see if the baby is over weight or not because if the baby is over weight then eh she might have the heart problem
- I Ok
- P So eh she told me is measuring the length to see if there is any change
- I Mmm
- P And and she also ok she tried to see if the baby can is able to balance
- I Mmm
- P On the floor and to see if there's any development
- I So she she did some examinations with regard to the development
- P Mmm

- I To see whether the baby is lying on on the stomach if he lifts his head up nicely and if there is any head lag when she pulls him up from lying on his back
- P And then there was he make the toy
- I So she dangled
- P She rattled it to see if there's are any ear conditions
- I Ok so you were satisfied with with the examination
- P Yes
- I Ok right eh so it's just basically that you would like her to explain more
- P Explain more
- I Why she was doing anything specifically say for instance the head circumference and did she explain to you on the on the eh baby's chart the height and weight chart
- P Ok this chart she showed me uhm the way that the that the baby's weight and then she told me if this line is going beyond this one it means the baby is over weight
- I Ok she took the chart and she explained to you
- P Yes
- I Ok that's nice
- P And I should now monitor the baby's weight
- I Ok
- P Not to give him too much milk or food so that at least the weight would go down because maybe he was having a problem of phlegm
- I Mmm
- P He would normally get flu every now and then
- I Mmm
- P The nose would be blocked
- I Mmm
- P So she told me to monitor the weight
- I Ok right excellent. So you were satisfied in total with what you experienced at the clinic?
- P Yes
- I There was nothing in your point of view that hampered the services?
- P No
- I Ok excellent, uhm right tell me did the nurse ask you whether you had any concerns personally concerns for your family any worries things like that?
- P No she never asked me any thing like that all she wanted to know was whether there was suitable care with my boyfriend



- I Mmm mmm
- P Were we having things together?
- I Mmm mmm
- P Were we doing things together?
- I So she tried to concentrate on your family right but you felt that she could have asked a little bit more regarding your concerns your worries fears things like that
- P I think it is important
- I Ok right uhm pertaining to to the visit did she only focus when she was examining the baby did she only focus on the baby or did she tried to incorporate you, the family, the extended family? Did she ask questions pertaining to the family how, what, where? She asked about your boyfriend that's nice, but did she ask about any other family members?
- P No the thing what she asked me if there was any one in the family with with TB or any other disease
- I Mmm
- P So in my case there was no one with that it's only my grandmother who is having high blood pressure
- I Ok she asked medical history about the family right uhm did she ask you at any stage if you have an informal support system to help you look after the baby?
- P No she didn't
- I Do you think that is important to know for a nurse to handle or manage you and your child pertaining to his or her development?
- P I think it is important because some of us have no knowledge at all
- I Uhm
- P So it is important for a nurse to coordinate to at least give some information try and find out if there is any kind of support that you are getting as a mother on home or rent or whatever and try and see what she can do to help
- I Because that support is important
- P It is important
- I Because if you are all on your own and there is no one to assist you that's that's difficult for a mother
- P Yes it is very difficult because normally you find out that some of the mothers are still young they don't even have a clue they don't know anything
- I Mmm
- P So at least if there is some one out there maybe a mother aunt or whoever it is easier

- I Mmm
- P It's easier to grow a child in that way than when you are just on your own and you don't get any support
- I Ja because when you are on your own problems might occur and you don't know how to handle it
- P How to handle it
- I Or how to cope with that
- P Especially with this young kids sometimes you just will be sleeping at night and then the child getting the fever and you don't even know how to handle the fever what are you supposed to do or maybe something can just happen and you don't know how to handle that at least if you have someone you can go to or maybe ask for advice
- I Ok excellent. Ja (yes) so and you do have people like that in your
- P Yes
- I That's great, that's great and it is important to make use of them because then they at least feel involved ja (yes). Tell me did the nurse at any stage tell you about sources in the community that you can make use of with regard to your child's development growth and things like that? How she assist you in
- P She never mentioned anything
- I Do you think you would like to know more about the resources that is available for instance to just make eh eh like your library tell you have you ever been to the library uhm there's lots of books that you can know maybe read about how a child is growing up there is things like uhm what we call kindermusik you know with music how to stimulate a baby's growth and development mothers and miracles so there are several things like that eh Do you think uhm you would like to know about things like that and then at least if you know there are things like that available you can make an informed choice whether I would like to take my child or not
- P Yes I think it is important to get information like I said sometimes it is not easy to go to the clinic or to nurse now and then every now and then but at least if you know there's information out there available you can just go and read or maybe buy a certain book because you know that the book is going to help it's gonna (going to) guide you on how to help the child grow and develop
- I Ok did you did you breastfeed your baby at any stage?
- P Yes
- I Did she refer you to any support group like eh eh a breast feeding support group where other mothers who are breast feeding come together and you you support each other and you get some one from outside to come and and give

you talks and more information, share your anxieties and fears and worries and things like that

P No she never mentioned anything like that

I Ok once again you would have liked to know about groups like that

P To know more

I Because a new mother as you've mentioned earlier, you know you don't know everything and that support

P And even if you are like a new mother sometimes maybe you had a child 10 years ago some of the things are out of your mind and you would like to know more maybe there are some new things you might like to know

I Mmm

P So at least if you come together as groups if you share your ideas your angers your fears what you've experienced during the process

I Do you think that such a support group would work in in your eh situation in your where you live in your community do you think young mothers would be interested in a support group like that?

P I think it might work it might work if if you as mothers are willing to do it

I Mmm mmm

P And you can you can you know discuss the the importance of such a support group

I Mmm mmm

P Maybe try to sit down and discuss your problems your fears what you experienced

I Mmm mmm

P Even if someone is not interested I think that person would feel maybe this would help why especially because maybe sometimes I've experienced this and this but I didn't know how to handle this so if somebody experienced the same problem that I had and managed to overcome hat problem then it might be easier if that person explains to me how she overcome the problem where she went you know who helped her

I Mmm mmm

P Or whatever it is what she did

I Ok no thank you that's interesting. Were you in any way involved in planning the interaction or was it the just the nurse as the so called expert and you sat on the other side of the table as the mother with the baby and she sort of told you what to do and she never allowed any discussion. How, how was that interaction, if I can use the word power, the power between you as a mother and the nurse. Was the power just with the nurse or was it a shared power

were you at any stage allowed to be part and parcel of the decisions and the intervention as such?

P It it was some kind of discussion I asked her questions and she told me you should expect this and that during the development of your child

I Mmm mmm

P And I asked her questions that I felt that I needed clarity on

I Mmm mmm

P And then she explained everything to me

I Ok but you never once felt that that she was the one who felt that she had the knowledge and you should listen to her and you should uhm do what she tells you and things like that?

P No

I Ok well that's great. Uhm do you think she regarded you as a person who is competent and able to look well after your baby?

P I think she regarded me as a competent person because uhm normally the child goes for this immunization after some weeks I think if if there was anything she thought was wrong with the baby she would have explained to me maybe I am not doing this correctly maybe you should do it like this so she was pleased

I Oh that's excellent

P With how I was taking care of my baby

I Ja (yes) that's great. Tell me do you think your contact with the nurse gave you entrance to more knowledge, more competence and skills and resources

P In a way I might say so, because it is not each and every nurse who would make you feel at ease when you are with her, but I thought the one that I was interacting with was really helping

I Ok, but regarding to information she could give more information

P I think she could give more information

I Ok and and and ways ways of empowering you with competencies, you think she could do a little bit more?

P A little bit more

I Ok and with regard to resources she never referred to resources in any way

P No

I So besides the fact that she made you feel at ease and it was a warm encouraging relationship she could do more with information competency building and and resources

P Yes

- I Ok right. Do you think it would be nice for a nurse to come and visit you at home with your baby? How do you feel about home visits?
- P I think they are important at least in in in making home visits the nurse is able to see how you interact with your baby how you relate to your baby
- I Mmm mmm
- P Maybe in that way she is able to monitor the progress because every time you go to the clinic you bring along your babies card and if there is anything she thinks you should improve on maybe relating to how you take care of your baby
- I Mmm
- P At least she knows uhm she has an idea how you relate your child
- I Ok and she can see the environment and
- P Where you live how you, the impact that it has on your child, where you have to improve, maybe you know the the the effects of the environment where you live in how it have can effect your child's development and growth
- I Ok do you think it is possible for nurses in the current eh scenario of rendering services for health care to do home visits? Not just the private clinics I'm talking about the government clinics and things like that. Do you think their work load allow them to do uhm home visits? Or is it a nice to have?
- P I don't think it allow them to do it they have too much to handle
- I Mmm mmm
- P And then the hours that they are working it's it's like they are working long hours so I don't think it's going to be easy for them to have home visits
- I Ok so one must be realistic about things like that it's a nice to have and it would be excellent for them to visit you at home
- P But the hours that they are working won't allow them to do that
- I Ok do you think in your mind that nurse or nurses working in a primary health care clinic have got the necessary knowledge and skills with regards specifically to the management of the development developmental needs of your baby?
- P No I don't think they really have the necessary knowledge and skills unless otherwise if they are neglecting some of the things because some of them really don't don't treat don't treat eh eh these mothers they don't handle them well and some times even after you give birth they they they they really won't how should I say. Sometimes you'll have a child and then they say you know when you gave birth they didn't remove all the phlegm from from the child then at least there are some skills lacking from the nurses
- I Mmm mmm

- P They should really get enough training on on on the child's development
- I Ok right can I ask you why did you choose to visit a private clinic and not your local clinic in in your township?
- P Uhm local clinics eh they there queues are normally long
- I Mmm mmm
- P And then if the queues are long somewhere along the way these nurses get tired and they don't really give the kids a thorough
- I Attention
- P Yes they don't give the kids thorough attention that's why I said I'll go to a private clinic because I know with the private clinic you have an appointment you know that at that period the nurse will be ready and she would really give your child all the attention and she'll go through it thoroughly
- I So there are a difference or differences eh regarding you between a private clinic and a government clinic?
- P Yes
- I Your first child did you take him to the government clinic?
- P Yes
- I So you have first hand experience of of of the services rendered there at the clinic ja so you can compare nicely now the private clinic with regards to the local government clinic
- P Yes
- I If you think back at the time when you attended the government clinic eh what barriers besides you mentioned long queues now what other barriers are there with regards to rendering a proper quality service to the client
- P Uhm we also had a problem of lack of resources
- I Mmm mmm
- P Sometimes you take a child there and then they find out a child is having a certain illness
- I Mmm
- P And if they check they don't have proper medicine for that type of illness so you just have to go home with that child and then it's it's really sad if it won't have money to take the child to a private doctor so you just have to stay home with that child having some kind of an illness
- I Mmm
- P Until such a stage that you can take him back to the clinic and then she can get eh proper medicine and sometimes there is a lack of staff
- I Mmm
- P Eh a shortage of staff in that maybe there will only be 2 nurses there

- I Mmm mmm
- P And there are a lot of people there waiting for those 2 nurses to take care of them so it's really not it's not good
- I Ok if you think back eh with the first baby when they examined your baby compared to the nurse you took your youngest baby to how do that weigh up with the visit at the private clinic?
- P You know what normally the nurses at the the government hospitals and clinics sometime they look at you they see if you got knowledge
- I Mmm
- P So they're able to undermine if they see this one doesn't know a thing I can just do this and tell them to take the baby home but if they realize that at least you've got some knowledge know how you should be treated you know what to expect from them it is then that they are able to give a child a thorough checking
- I Mmm mmm
- P So eh really it is not that easy why especially for those people who don't eh access to information you know it is not that good
- I Mmm mmm
- P But with people with knowledge who knows what they should expect
- I Mmm
- P At least they are trying to give what that person expect
- I Mmm Ok have you got any other comments you would like to add? That you feel could be important to me with regard to clinics the services the nurses anything regarding that?
- P I think they should improve their situations at clinics why especially government clinics you know the the the treatment that are giving people there some some nurses really are not giving people proper treatment so if they could improve on the the kind of treatment
- I Is that now the personal treatment relationship wise or
- P No relationship relationship
- I Or competencies or skills and knowledge how would you explain that?
- P Uhm some of them really lack uhm ex the skills the experience and I think when it comes to eh giving birth they didn't give uhm this student nurses the chance to when when coming to giving birth because really sometimes these people don't have the necessary skills they are still on training and I think that that the process of giving birth it's it's very dangerous there might be some complications so it's wise if it is handled by somebody who really knows what she is supposed to do

I Uhm that's a valid point, any thing else?

P No

I Then I would just like to say thank you for your time I really appreciate it



|                                                                |
|----------------------------------------------------------------|
| <b>INTERVIEW: PARENT - CHILD WITH DEVELOPMENTAL DISABILITY</b> |
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Interview date: 20 December 2004

Interview duration: 60 minutes

Interviewer = R

Participant = P

R In general do you think each baby has the right to develop to his full potential?

P Yes, yes definitely.

R Why do you think so?

P Uhm, I think everybody is capable to more and uhm in the end it counts against the child if he not uhm when he is an adult he is not going to to how can I in English have the skills and those things in other words he cannot live the life that he could have lived if his potential is not developed.

R Yes.

P And in the end it depends on the parents and and all the people that he encounters or to when he himself cannot decide whether he will do it, to do it for him.

R Yes.

P To take that decision on his behalf, yes.

R No well. How do you think can parents assist that their baby whether a normally developed baby or a baby with a handicap help to achieve this particular individual baby's potential?

P Uhm, I rather believe in things like uhm, uhm this Mothers and Miracles and music and so forth and I think at the end to spend time with children and to see uhm who looks after your child when you work and ah, there are people who for instance do not believe in routine examinations done by pediatricians and so uhm while I think it is important.

R No well.

P I think it is very important.

R Your knowledge regarding growth and development, do you think it is sufficient?

P Yes, no ah, I think so. I, uhm rather read a lot and I myself 'swot' education and even 'swot' psychology, so I have at least

R A good background with regard to that.

P Yes, yes.

R That your tertiary training supplied you with. So do you think you you will, the knowledge will assist you to identify problems?

- P Yes, well it has uhm it has helped me, me in my case, although uhm the moment when you are personally involved then
- R You are not objective.
- P It is but partly, I think it is partly a denial type of thing and uhm one, maybe it is because it is my fourth child, one becomes know, not so uptight with the first best little thing, you begin to think no what, everything comes with time and so on and uhm but yes, if it had not been that I uhm eventually insisted that I want to make sure whether there is a problem with my child, then I don't know by this time we should surely have found out, but uhm I, I have reasonably early thought there is something.
- R Something is not right for you.
- P Yes, yes.
- R Tell me do you think the average mother in the community, has the, has the right knowledge and background to be able to help eh with with early identification?
- P Uh eh no, no.
- R Do you think it is responsibility of the nurse in the clinic, one of her responsibilities to sharpen up this mother's eh knowledge with regard to the growth and development of babies?
- P Yes, yes very definitely.
- R Good uhm the clinic that you visit, has the nurse ever given you any know background knowledge or information regarding growth and development?
- P They have, they have yes.
- R The format of the content of this information was it very basic information, was it only in broad outline?
- P Yes very basic.
- R Very basic, so you think there could be a bit more in depth.
- P Yes, yes.
- R Information given?
- P Yes, yes.
- R Which, which domains, which areas of a baby, development have they touched?
- P To a great extent partly uhm motor development and so forth, but uhm but really also in broad outline things like sit and uhm taking things from the one hand to the other, there was never really looked in very fine detail.
- R So the other areas for example speech and language and, and mental development.
- P Yes.

- R All those types of things were touched nowhere.
- P Did not get much attention.
- R Good uhm at what age have you realized with with little baby that there or when have you started to feel there is, something is not right?
- P He began to sit at uhm six months, began to sit.
- R Uhm.
- P But uhm I (interrupt interview, children require attention).
- R You were busy telling.
- P Yes eh at six months he began to sit, but he wanted, he did not want to stay in a sitting position. He only sat for a few seconds and the he shoots himself backwards.
- R Mmm.
- P And when I, we have been away when he became six months on, on leave and my other children had chicken-pox, so I waited before I took him for his six month's immunization and then it was at seven. Actually it was for his six-month follow-up and not immunizations. Took him for his follow-up examination at the pediatrician and I said to him that it bothers me, because it is not that he falls topples over due to, to flaccidity. It is almost as if it is an act of will.
- R Mmm.
- P And uhm now that I have now done. So I have here uhm but it was the first uhm open. Wait, wait it is as if I want to speak in English.
- R Use English.
- P The first obvious.
- R Sign.
- P Awfully obvious sign that something is not right. When he, I mean by eight months still not wanted to, I cannot just put him down and leave him. He could sit, but I could not him at all, I could not put him down and just turn around, because the next moment he simply shoots backwards, no matter how much he his head hurts.
- R Mmm mmm.
- P In ten minutes he does it again and uhm now yes then unfortunately, I don't know whether I must tell the rest of the old sad story.
- R You can by all means.
- P Because you know, it had then, at eight months I then began taking him for occupational therapy and then unfortunately for three months took him to an occupational therapist, who never told me uhm listen here you must go to a

more specialized specialist I almost want to say not only an ordinary pediatrician.

R Yes, yes.

P And she has uhm really seems to me acted unprofessionally in the sense that she uhm only saw him once in three weeks and uhm just continued for three months. There had been no progress, but she has, she just carried on and on and uhm I have so after two and a half months then I said to her should I not maybe just take this child to a neurologist or someone. Must I not do something else.

R Further.

P Then she said well maybe I think about it .Uhm she then told me the name of a specialist in Pretoria, but in the same breath told me that he is very fully booked so I will ten to one wait at least three months before I can get in there and uhm he can be very obstreperous and and half blunt, but I must not pay attention to it and in the end a uhm friend of mine who wanted to know how this thing bothers my child not that something must be at fault, because I mean he now was almost eleven months at that stage and he could still not sit and uhm otherwise he seems cognitively it appears as though it is all right, but this obvious thing you see now golly it just is not right. And she then told me of another occupational therapist who does not have an uhm official practice, but who is a wonderful, wonderful occupational therapist and human being. We have literally begged the woman to please just look at our little one.

R Mmm.

P And when she the morning, it was a Wednesday morning, eight o'clock came here and nine o'clock she phoned me and told me that she is going to arrange an appointment for me that eh eh a in Potch, but then it was prof S... who was the locum in place of E... S...and eh actually he is an oncology pediatrician. But then she knew him and she arranged that he talk to the neurology pediatrician in in Bloemfontein and that same day we took him for a brain scan. So for this woman it was absolutely obvious that something must be at fault. That a person cannot just plod along. Well sure at the end he was diagnosed.

R Tell me uhm so he was more or less firstly diagnosed at eleven months?

P Firstly diagnosed.

R Tell me this nurse at the clinic have they to some degree suspected something with earlier investigations?

P Uh eh, no.

R Has there been anything visible with previous investigations according to you?

P Do you know what uhm except.

- R That he could not sit there must have been.
- P Other things you know the sit was the first uhm very obvious thing.
- R Mmm.
- P When A... now worked the first time with him, A... F... the wife of doctor S... F... when she now the first time uhm worked with him she fixed my attention on things that I have just oh I unfortunately I think it was a coincidence of circumstances. I have four children and I was a teacher and I was awfully busy and uhm then she now fixed my attention on other smaller things like for example that he uhm not behind him or do not turn to the side to take things.
- R Mmm.
- P He plays just in front of him, he takes things in front of him he does not turn to the side and then it became clear that control of his trunk and things completely uhm yes is off standard. It was definitely not what it should have been and there are other things like muscle tone that she also for me uhm.
- R Pointed out. Showed that I, it is something that I not enough uhm have known about and I have not uhm realized.
- R Do you think the nurses if they have the necessary knowledge and background and skills could it perhaps earlier have been picked it up for you?
- P Yes.
- R Because look at birth an examination is done, plus minus at six weeks then again at three months.
- P Three months and at six months.
- R And by only handling a child you must realize that he reacts or his reaction is not right.
- P Yes.
- R And that pick-up you know the head remains behind and all those types of things.
- P Yes, I rather feel, I really feel where someone must uhm.
- R Somewhere picked up something.
- P Somewhere damn.
- R Because you really came a very long way.
- P Look the very obvious things have here at six months where you now expected a child must begin to sit now it begins to show uhm but it feels to me someone who has more knowledge and when I eventually got him to H... D... the uhm speech therapist then she showed me everything, the inside of his little cheeks, his tongue, his lips everything's muscle tone is low. It's not it is

absolutely it is rather uhm reasonable I do not want to say now deadly serious, a layperson will look at him and not.

R And think nothing is at fault.

P Yes and think nothing is at fault with him, but uhm people who are trained are like she like A... with F... B... with doctor F... B... I have I have all the time taken him here to doctor V... brought him here uhm when I then took him for the first time uhm since he was diagnosed uhm to doctor B... because we struggled so with his reflux that I now also found out is ten to one as result of the muscle tone.

R Mmm.

P Uhm when I took him to doctor B... and I say uhm you know he has a very low muscle tone his first words were sure so I see and that is before he touched him examined anything to do with him just this child on my lap.

R Just his attitude.

P Yes just with it for him and I cannot understand that no-one else uhm maybe they saw it, but did not tell me.

R Many have a wait and see attitude you know.

P Yes.

R While we are involved with early childhood intervention only a question of we look and we rather refer.

P Yes, yes, yes.

R And manage when necessary, because the earlier you intervene the better are the outcomes.

P But that is what I now see with uhm S... if I now and I I everything must be applicable. What what C... has done for my child is actually, actually I should report her, because it is actually unbelievable that an occupational therapist did what she has done.

R Uhm.

P And this is a woman who is world-renowned, it is a woman with a very good reputation that deprived my child of three month's therapy, three months that my child could have progressed. Then I don't even speak of all the other people who have worked with him and saw uhm must must at least have seen the signs.

R Picked it up yes.

P She has now worked very intensively with him. My child could not sit, my child could not turn to the side, my child could not even pick up things alongside him. He did not when he fell, he did not try to stop himself with his hands.

R Uhm.

- P If he fell forwards, he did not try to stop with his hands. She has tried to teach my child to crawl. She had him on his hands and knees and tried to teach him to crawl while he could not even sit.
- R Uhm.
- P And uhm so yes we feel we have been uhm left in the lurch.
- R Mmm mmm.
- P Through and I have all my children, all four of my children for routine examinations, not to GPs, I took them to pediatricians. They have not been injected at the Klerksdorp clinic with their immunizations I have them uhm yes I have him here to B... and I do not want them, they were very nice, they have not rushed and gabbled.
- R Uhm.
- P They were very nice they have not rushed and gabbled and nobody, nobody realized it, not even someone like C... who who.
- R Neuro development.
- P Well only once very three weeks, but then for uhm half-an-hour to an hour worked very intensively with him. She told me that his muscle tone is low, but she has done things with my child that he should not have done for time to come. She deprived him of uhm well no good but in three months what I now take what he has accomplished in three months since A... has worked with him. A... saw him for an hour and immediately did something about it and uhm oh he progressed so much it's unbelievable. Uhm I could erect monuments for her, A... and H... D... I would have done it. These really are the most wonderful two women and you know they, they work together. They they absolutely talk weekly to each other concerning S... specifically eh and the one says what she sees and what she needs and the progress.
- R Wonderful approach.
- P Absolutely wonderful.
- R Sure it is.
- P I only have the greatest praise for them, but we uhm we really feel we were left in the lurch in general not only by the nurses by.
- R By various members of the health team.
- P Yes people who should.
- R It is a reasonable common occurrence.
- P Oh no it feels for me.
- R You are not the first and the only and that why I say that is about what the focus of my study is.
- P Yes.

- R To see if we can sort out the problem, because uhm it seems as if it is anyhow not a priority in the South African health system.
- P Not a priority.
- R You know development of babies, they rather focus on on diseases and HIV.
- P Yes.
- R That at the end of the game can anyhow be carried forward to your child's development.
- P Yes.
- R They see development as as a healthy baby uhm clinic you know separate whereas I feel every handling where where you or contact that that you have development of a baby must be part of that visit.
- P Yes.
- R You must be impressed by absolute ah only a few little questions that you to the parents, because I feel that a mother's instinct is highly valuable.
- P Yes, yes.
- R You know, because a mother is not going to say listen here I think there is a problem with my child and then she is now just neurotic.
- P Yes.
- R She experiences that child on a daily basis.
- P Eh, eh.
- R And and that information that she has is very valuable.
- P Valuable yes.
- R And you must react to it this is simply my point of view you know.
- P It is very bad for me as to how I for example uhm struggled that someone must actually do something about his about about the problem that we had with his reflux.
- R Yes.
- P I only want to know how it has impeded his development, because he permanently has heartburn. I mean any any adult with heartburn.
- R He certainly has limited his movements.
- P Yes he did not want to be manipulated on his stomach and and nobody around here was willing to for him eh oh Losec, because things like this uhm Ulsanic uhm has not done the trick and it often makes his milk, or his feed thicker in his stomach. But the moment that you press on his stomach it still comes out and it is still sour and uhm at the end it cost us to phone the uhm pediatrician in Bloemfontein so that he can phone somebody here and say but prescribe this and that for this child and since since he started using Losec
- R He is a different child



- P Oh man, I wish I could for you... A will be able to testify how that child, A... and H... how he within a short period of time that his uhm uhm specifically his progress to get him to crawl.
- R Uhm
- P How it went forward only since he can can be manipulated on his stomach
- R Oh it's wonderful
- P Sure so
- R Tell me R... how have you initially felt when you realized but there is now this real problem with him and the he was diagnosed eh how did you feel about that news?
- P You know very, very upset and uhm angry. Angry with the people who never noticed it and uhm who worked with him and did not uhm fixed our attention on it. Uhm ah I don't know everything I don't want to sound as if I let everything go back to C... but to an extent we, we had very angry. Look doctor V... perhaps at a stage I should have gone back to him out of my own perhaps I should have done it. Ah and it does not help to blame yourself in the end and I have decided I will not do it I have done what certainly would have been expected from a standard person. I to Ok my child to a pediatrician and said to him it worries me that he has said to an occupational therapist and that I to Ok and not to any 'palooka' this is a woman with a very good reputation. Uhm so very, very upset and we were angry so we felt as if we. Uhm.
- R Had been wronged
- P Had been wronged, yes
- R Your child in particular.
- P Yes, yes.
- R Tell me has any form of support been given to you after you had been given this news
- P Except by A... mmm and no
- R It's damn not nice
- P (Laughs) No look it was oh no it was very bad uhm our family doctor felt extremely bad that he had not realized it.
- R Mmm.
- P Ah I know everybody have much well good let me say damn so he said he felt very bad that he had not picked it up although he had been a very healthy baby and uhm I had never with him specifically gone and sat there with him and said to him 'ma' please know let he now really examined him and but I arrived there with him in my arms with other children and he did not notice. He

felt very bad about it. Someone like C... had until today not even said golly sorry or...

R Mmm

P Uhm not anything

R What type of support do you think will be of value to you?

P You know information at that stage I cannot tell you uhm that it was what I thought the most traumatic story of everything was uhm the fact that so many people had something to do with him who said no man it cannot be major ah it cannot be something major ah no he's just slow or so. Uhm so it was a tremendous shock and since we had discovered what the problem is. Beginning with a radiologist who sat behind a table and peered at us over his glasses and told us no uhm his brain had or is busy to shrink there are some of his brain cells so as to say the sun shines in the day and the moon in the evening or night. Uhm hence it was you get this terrible shock and nobody can tell you well he had not explained uhm what atrophy is uhm he could not have given an idea what it could have caused it. He could not have given us an idea as since when I Ok not that I say it is his job, but beginning with him nobody could have given you information. Nobody knows you hear this terrible word uhm of this terrible thing that happened to your child and you do not have an idea of what it is all about. Is it going to continue, is it going to happen again, what has caused it, what does it mean? What oh no information was uhm A... was has has uhm has rather done for us at the end ah tried to explain what uhm the thing of atrophy now means. What it now and and she arranged for us for a pediatric neurologist to us ah a neurological pediatrician to uhm see us within two weeks in Bloemfontein and uhm arranged that we can phone him so that he can give us more information though not that he much over the phone but at least can give an idea what these things what these things that we have heard means and so on uhm/

R So it was a terrible shortcoming for you?

P Yes

R That there had never any information been given to you. Was there any form of emotional support?

P Ah well A...(laughs) A... and and just the family that's just yes yes.

R Good so tell me are there times that you still feel depressed or worried over you child's future?

P Do you know uhm ah at times then I am so I feel I feel so half sorry for him I feel this potential that he has had that half from him away. Wait let me first explain the whole story. It now seems at the end what it could have caused it is

that uhm doctor P... says according to my file with him is that I had uhm flu at weeks pregnancy. Now I am allergic to paracetamol so I could not drink Panado or so uhm for fever and.

R Uhm.

P So no and the neurologist says it is almost 100% sure that it that it what had caused it because he says I mean at that stage it is particularly the brain that develops and uhm apparently the temperature in the uterus is 2 degrees higher than the rest of your body so that when the mother's uhm temperature rises say to 40 39, 40 degrees it is very bad (children cry terribly) it is very bad news for for the those brain cells that and it but is only something uhm it is something that has happened what it is not something that has been there since the beginning ah ah uhm with development problem so it is just externally that it that it has been an influence yes. So sometimes but, I uhm I have really made up my mind not to sit on a heap and feel sorry for myself and for him. Uhm I have decided I will rather try to do for him.

R As much as you can.

P As much as I can possibly do yes.

R This is wonderful, tell me if you feel down, to whom do you turn for support?

P A... (laughs embarrassingly).

R It is wonderful to have someone like that.

P I do not know whether you know her.

R I do not know her, I think I should go and meet this woman.

P Oh it's the most wonderful, wonderful person.

R I know H... very well.

P Oh yes, and she's also

R I have never heard heard about the woman.

P And I will not actually uhm uhm leave out H... What now, what now for A... it is an unbelievable special person that you know uhm she is no longer working officially. But she also has an M in occupational therapy and she was a tutor in occupational therapy at Kivsies and she also has done that NDP the eh eh neuro development that course.

R Uhm

P And uhm yes unbelievable (terrible thunder and rain that suddenly started to fall). Now what eh eh makes it so special is that she now comes here on a Monday and a Wednesday morning and than we now had for him from the roof a hammock and balls and everything. She absolutely adapts to him if he does not feel well the day, even if she sits, sometimes she sits here from half-past seven to nine o'clock (son calls).

- R There he is it's so fantastic that she comes here to your house.
- P Yes and she really is an unbelievably special person. She loves him very, very much and she is very supportive so uhm.
- R It's wonderful.
- P and uhm doesn't ask a cent for the therapy that she gives him she does
- R She does it as an act of love
- P She does it absolutely as an act of love.
- R Ah it's fantastic. Tell me what type of strategies have you employed for yourself to be able to manage this situation?
- P Uhm well I stopped working, that I certainly feel bad about (very heavy thunder, disrupts interview to call in other children who are outside).
- R You say you have stopped working, yes.
- P Oh, I stopped working and this is the one thing that I feel bad about uhm, ah I was simply too busy to after him eh things like children's music and where I took all my other children, I was I simply did not have time and uhm then I felt bad about it, because it was extra stimulation that he could have received that he didn't have and that could perhaps have helped that he that his problem earlier uhm that his problem earlier by other people uhm
- R Was picked up.
- P Was picked up yes and since I now stopped working I see to it that he gets to music and Mothers and Miracles. Initially H... has seen him once every two weeks and then I asked A... to convince her to see him each week. Because she really does very, very good work and uhm she and A... complimented one another well uhm because she saw the importance of motor development for speech development that if he doesn't have control over his trunk if his tone and so on is not right his speech can and so on and then uhm I see to it that I in the mornings all his therapy and things classes (children interrupt again) do everything in the morning so that it does not unsettle the lives of the rest of the children, because the neurologist said to us that we must be very careful thereof, uhm because you give all your attention to him this lets the rest of your family derail completely.
- R Yes.
- P In due course leaves a completely dysfunctional
- R So you found a golden midway
- P Yes.
- R So when the children return from school then everything is finished (not quite clear, because baby's crying dominates voices)
- P Yes.

- R This is wonderful tell me uhm you spoke just now of of the information that is terrible shortcoming, what would you suggest regarding this information to improve this shortcoming in information?
- P Yes, well this is certainly now out of this type of thing is after all now the sort of information that a standard person needs so I do not believe. Do you know I would really things like a clinic and investigations or visits I think recommend say for instance at a monthly basis
- R Uhm
- P So that a person can enlarge the opportunities that it can be picked up and then automatic (end of tape last few words not recorded).
- R The service that the nurse at the clinic offered you were you satisfied with the service or has there anyhow been times that you felt frustrated that, that you have not found that that you were looking for with regard to their management.
- P Do you know I was really satisfied with them, they were very, very nice and relaxed and could chat and ask questions and so on, but the times that I was there, uhm because I can now, I can now not remember the specific times for immunization.
- R Six weeks, ten weeks, fourteen weeks.
- P Fourteen weeks.
- R And the again at nine months. At six months you go for a general examination.
- P Yes so by the time that I him at nine months. The early things I know here at fourteen weeks they have said that his neck must begin to be firm he begin to have better control but maybe (Baby sounds interrupt, cannot hear clearly)
- R So it had already been clear.
- P Yes, yes.
- R If they had referred you at that time to someone early intervention could have been applied
- P And at nine months it was that I have said to them never mind he is with an occupational therapist. She says
- R So and so.
- P All right yes
- R Tell me how will you describe the relationship with the nurse?
- P Uhm no very good uhm no yes on a and and so that I could ask questions and its not that I intimidated or
- R Or felt uncomfortable
- P Yes quite comfortable.
- R Apart from clinical competency what other qualities must a nurse working at a clinic have? What is important to you?

- P She must definitely have interpersonal skills and I think a nurse must be careful to be rigid when it comes to babies, because it also is so that not everyone begins to sit at exactly six months or so it does not help that they upset everyone for each little event. I would rather say, say to a person, say come back in a month's time that we can again see is it right, but interpersonal skills definitely. And they must also eh eh counseling uhm counseling uhm
- R Yes.
- P I should also think have skills to support one when you uhm find out something like that.
- R Do you think concern, consideration for you and your opinion
- P Yes, yes.
- R And your wishes that they should always treat you with respect
- P O very definitely yes, yes I
- R Do you want a warm, friendly environment?
- P Yes, yes definitely. No not a cold clinical, uhm sit in a row and uhm scold a little one who cries if he is injected that type of thing uhm not at all, not at all uhm patronizing.
- R Mmm
- P So if you for example give baby a bottle and she thinks breastfeeding
- R ? (Cannot hear what is being said).
- P Yes, that type of thing, because I have now accidentally, mercifully for him breastfed till nine month, but uhm I know I know that there is people that for example will say to pregnant women uhm they must breastfeed, because your child will be more intelligent if you breastfeed him. That type of thing I absolutely abhor. After four children of which I two, well one a year and nine months and two only breastfed for six weeks I can now with reasonable certainty. Well it can perhaps the nearness perhaps makes a difference if the bottle baby is put down there every time with a bottle, but it's surely you cannot as a rule say this child is going to be stupid and that type of thing I cannot go with it.
- R Your last visit to the clinic, can you briefly describe what happened during your visit?
- P When I was there last with him, it was for his MMR (measles, mumps and rubella)
- R Mmm
- P And uhm what then, then, then I now told her told the sister told at the very end with what he had been diagnosed and so on. She was very sympathetic and she uhm has then uhm well had a similar experience with her own child and

she has for me she could partly comfort me and eh eh and positively inspire and so she was very sympathetic and and has also uhm felt guilty that she herself has not earlier considered it seriously.

R With your previous visits what all have they done. Have they only focused on the immunization for example? What have they done when they examined him physically for example?

P They have well uhm for example in front of a mirror and held toys for him and so forth, but uhm if he did not respond to those things as how they perhaps expected him to respond the uhm accept that it is perhaps the strange situation and so on that makes him not to react as is expected.

R Good have they weighed him?

P Yes, yes, yes.

R And all those basic things had been done so uhm.

P Yes, yes.

R Has the nurses to some degree explained to you why she is doing what she is doing?

P Eh uh (indicates no)

R Do you think this is a shortcoming?

P Yes

R Are you eager to know why they do certain things with your child?

P I am eager to know yes. As far as immunization goes they have very, very well explained to me how the things have changed and uhm and so on and gave me pamphlets and information, but uhm I mean they always had at the pediatrician and at the clinic measured his the circumference of his head. When I now at a stage here at ten and a half months said to Christa I really feel we must get to another doctor or does she not think one must now do something I have also said to her what does she think it can be then she said well all that she can think it could perhaps be that he is busy developing a hydrocephalus uhm and then I did not know his head has always been

R Bigger.

P Bigger than they feel it should be is it about, is there something abnormal. Everybody always measure his head but nobody say

R Why they do it

P Why they measure it or say or tell me listen here no it's right or but then uhm a person sits and looks at his head, then you see now his forehead bulges a little here and then you also think just now it is maybe this, this and then now you don't have an idea.

R Then you have received information without it being really explained to you.

- P Yes, yes.
- R And this let loose a maze of emotions.
- P Yes, yes.
- R And what had been necessary oh my
- P And uhm I mean when we when she now for me now when I get home now I measure his head now I have a size, but now I don't have an idea
- R Why they measure the heads and wherefore is it measured?
- P Yes does that size means something too big certainly damn now not too small, because what is it now exactly.
- R Tell me has the nurse during your visits at any time enquired whether you experience concerns or stressful situations?
- P Eh uh no
- R And do you also see it as a shortcoming, because you want to see it is a place where I can go to share
- P Yes, yes
- R I feel open enough and be comfortable to be able to share, but she doesn't give you space to be able to do it.
- P Not space yes.
- R Yes well uhm during your visit has the nurse focused only on the baby or has she gathered any information with regard to your family your relatives, even the extended family as we are now talking?
- P No only that the
- R Only the baby.
- P Sure the first time you know the basic information how many children you have and how many pregnancies I have had and what type of births, but not a thing further, not again.
- R Has she in some way enquired whether you have informal support networks?
- P No, eh uh.
- R Because it is, it's important because I mean if you sit in this situation and you have this great need to, to, to that someone can keep an eye on him, must keep. Where do you go, what do you do?
- P Yes
- R Those type of things.
- P Yes, yes
- R So it is important that a person must look at the available resources that are available.
- P That is there.
- R What is available and encourages you to extend these resources



- P Extend
- R And to make use of them
- P And I think people are rather inclined to accept that because it is one's fourth child
- R You know
- P You go, but especially with a fourth child you are busier you have less time uhm and you have physically too little time to where with your first child you could have sat for hours and look at him how he plays you simply no more that you put the toys in front of him and you go on with whatever the hundred and ten things.
- R Yes.
- P That you must do
- R Yes and each baby is a unique being
- P Yes, yes, yes
- R Tell me has the nurse in any way referred you to because you spoke of mothers and miracles and child music, has she in any way referred you to something like that
- P No
- R To stimulate your child's development?
- P To stimulate no, no and I think it is very necessary, because when I well something like this mothers and miracles is unbelievable it really is and child music too.
- R Tell me were you in any way actively involved in the physical planning and decision-making regarding your child's continuous uhm intervention?
- P When A... uhm came into the picture, since she came into the picture uhm we became more involved since we realized what is wrong with him and since she came into the picture uhm we became much more involved. Yes uhm while he has been with C... was uhm we ourselves felt she should be the one who knows
- R The expert
- P Yes the expert so you accept absolutely uhm
- R That what is being said
- P That what she does that what she does and that what she says uhm
- R So there was never with you, you never sat with her around a table and the options for you were put on the table and all the proposals and has she
- P No.
- R Asked for inputs by other therapists, never?
- P No.

- R It is important for you
- P Very important, very important yes, yes.
- R Yes good
- P A... really goes out of her way to uhm she brought me a thing they speak that of a wall that is like eh eh ah he's now packed it looks like small bricks it's literally the wall like
- R Building blocks.
- P Building blocks that she has now explained to me. Before you can get to these bricks and first master these things be and uhm you must be able to master everything to get there that's why we work on this and work on that and that is why she cannot uhm teach him to crawl, because he must also this and that
- R He must first be taken back to find those building blocks before he
- P Before he yes, yes
- R It is important yes. Tell me uhm do you feel that the nurse in the clinic see you as a person who is competent to look after you baby?
- P Yes.
- R You never got that thought that feels, ah but shame
- P (laughs) No I think at this stage maybe but it now the maturity of age and or the wisdom of age and (laughs) and after four children that I will sort of not allow it anymore, because that is not how I have experienced in the past particularly with my eldest child uhm uhm but at this time I am not easily intimidated. Earlier on I very definitely accepted it like that, but
- R Do you think the nurse at the clinic does not yet have the, the, the realization of eh the power of a parent-nurse relationship still remains with me as a nurse. I am the expert and she must do as I say or is it a participative where where power and decision-making must be shared?
- P No I think there is unfortunately still uhm nurses who to a great extent fall back on their book knowledge and simply just say what the book says and so it must be and uhm
- R And not see the broader picture.
- P Not see no yes, yes
- R Tell me do you think the contact that you have had with the nurse has it given you entry to knowledge, skills and resources regarding your child's setup to can manage better?
- P Uhm eh no, no not from the nurse's side. I really have the, the one thing on which I received the most information from them, has been immunization further, further there had been not really
- R Sufficient information.

- P The first time they had given me some pamphlet I think it was only one folio with very, very basic uhm indications of
- R Of development
- P Of development, yet
- R And not even all the areas
- P Yes, sure, no.
- R Basically motor orientated
- P Yes, yes
- R Uhm do you think the nurse possesses the necessary knowledge and skills to be able to identify developmental handicaps and disabilities or to be able to realize but here is a problem let us rather refer to a knowledgeable person like an occupational therapist or a speech therapist
- P Uhm I am not sure. I almost do not think so and I have in the meanwhile since we have now found out about his thing become aware of the fact that there is terrible jealousy amongst the different uhm professions. That uhm occupational therapists look down on speech therapists that this group look down on those that they feel threatened by one another that they do not like that uhm
- R Cross reference
- P That there is cross reference and
- R And this is so absolutely important for your child
- P It is the most stupid thing for me it is the most stupid thing for me
- R And one actually wants a one-stop shopping experience.
- P Yes.
- R Because you just want to walk in and you will basically can eh currently in America they have. H... they have perhaps told you of the arena assessment where the occupational therapist, the speech therapist, the pediatrician the
- P Yes
- R Everybody, who is involved with your child, sits in a team setup
- P Yes
- R And and work with the child and they see what is going on and the you as parent is involved
- P Yes, yes
- R The whole situation, discuss his progress. The focus is on the strengths of the child and not only on the disabilities.
- P Not disabilities
- R For example focus together on it and the family is terrible involved

- P I would absolutely will give my all to have that and that to me is very, very sad I cannot understand do you know C... has for example basically I have now found out about uhm independent sources that C... apparently cannot stand H... uhm and that is apparently an absolute issue of she feels threatened by H... and she feels that H... interfere in her field. That H... interferes in the field of H... and that is, I now see how the things uhm overlap
- R It is interwoven and I mean if I do not have a little of your knowledge I cannot do identification to refer to you and you know
- P Yes and the thing is.
- R (baby cries loudly). But I must be able to see there is a problem
- P Yes
- R So that I can refer to that person
- P And it is for me and at the moment it is absolutely wonderful for me that Hanlie and A... can work together in such a manner
- R Can work together.
- P Work together. What is very interesting to me is I mean they are two two different people so each one has her own personality and each one has her way of of doing and sometimes they will  
(Interrupt interview to give baby the servant)
- P What I wanted to say they complement each other, because S... would for example at a stage not in a side-sit he will definitely definitely not. The moment when they get him into a side-sit he yells blue murder and forces himself out of it and uhm it is also important for H... that he in a side-sit because he must it means his control of his torso is food which means his speech can progress so it is also important for her that he can be in a side-sit or comfortable is in a side-sit that he can stretch out his hand and so forth (talk to dog) and uhm when H... got the idea to him in a big basin to a big basin with sand play sand with play sand and him then first with one leg folded in and then later quietly the other one while he sits and plays he then stretches automatically
- R Then his attention has been diverted.
- P Yes so their personalities complement one another.
- R It's wonderful
- P And they work together, their personalities complement one another and it is clear for me that they work towards the same goal and that is to develop him. So and, and if, if a person can get it because A... now knows the neurologist personally uhm per and then also has worked with him for a long time she liaises anyhow with through the internet and she often speaks to him by

telephone but it would have been wonderful for me if if the doctor here and a nurse together sat with the two of them and talk and plan for uhm for the

R His future

P His future yes.

R How to manage it further ahead you know.

P Yes

R No this is extremely important. Tell me has the nurse ever visited you at home?

P No eh uh

R Not even when you have told them of of your your child's diagnosis?

P No, no

R Do you think it is a shortcoming?

P Yes

R Do you think it is necessary that the nurse pays home visits even if is only to hear how it is with you and S...?

P Do you know I think so. Something like that is wonderful I think that uhm even not only with children who have problems. I think a system where after one had a baby say those first three months after one had a baby. I think something like that will be wonderful and I think the moment they become involved with a child in that way then problems will, will

R More easier is identified.

P Definitely, definitely

R Do you have any other comments? Anything that you are willing to share with me that you think could be of value to my insight in, in a parent-nurse child with problems

P Uhm ah it seems to me at the very end only really as if when someone's heart is really in something that it is not only a job uhm it makes a big difference because since people absolutely work with S... and it is for them an issue of their hearts uhm my child develops and he progresses and he is just budding and for me it feels as if other people earlier on had such a passion his problem would have been picked up earlier and all that can with him and even though not all those brain cells can be replaced or you can't do anything that can make them grow he does not have such major damage to his brain that he uhm is lost that he is lost

R He is still going to can function.

P He has so MUCH potential, yes and uhm and this is and it feels to me uhm that potential there there all the time it feels to me there are eleven months in which we could have worked on it what we not what one has now not

done much about. If I now take since he had been for his first brain scan in May uhm they already can uhm the week before last when was it now when he has been for his second brain scan uhm they could uhm already see a difference on the brain scan that his white white matter had already increased

R Fantastic.

P And the small space between his skull and brain is already smaller uhm and this is a question of, you can really say six months and and I am not, apparently there are people that believe that you can now at two years make a forecast of where he would eventually end, but that I also do not want, because it is not for me

R It is day-to-day for you

P Well yes and

R You will build on that.

P Yes and immediately it is a limit to you if somebody tells you, but that is how far he will go in life then then they limit him

R Who are they anyway

P Even if they limit only my my eh eh uhm my thinking it already is a limit it is already a limit uhm and oh yes I want to go back to the story yes in in the very end a passion and love for what you do in the very end it makes a big difference

R Do you think the training of the nurse can also make a difference and or or additional courses that must specifically be introduced in particular for the nurse

P Oh yes

R Who works in the community?

P In the community

R That the focus is not only on immunization, but that should be directed at a wider area.

P Yes I definitely think so and I would rather say uhm that they must have a type of specialization that if a nurse wants to practice something like that if she wants to go into practice for a baby clinic or a clinic where she works uhm specifically with babies then they must specialize must they do extra courses in which they eh eh are sharpened up concerning development and all all the skills that a child must have and that they are then better equipped and are disposed towards more knowledge that they can share with the parent. I definitely think so. Yes I think uhm you know like a theatre sister specializes at the end and specializes like a maternity sister a sister must like that, because it

is not only about injections. That immunization is actually, it certainly is not a side-issue, but it is not the the uhm main

R Yes it is part of of protecting a child

P Yes, yes.

R That can handicap his development, but I mean.

P But it does not help a child never gets polio and he never gets diphtheria, but he is lost, he becomes four or five years old before he is diagnosed uhm the neurologist told us there are many children with similar type problem as my child who are only diagnosed at two or three years, because uhm the whole time it is wait and see, wait and see and and then a terribly tedious way that is followed before this child can eventually be properly diagnosed and by that time very precious time has been lost, because I mean a child's brain is at this stage you can uhm do much much more with him than what you can achieve when he is six or seven years old.

R No thank you very much (end of tape- appreciation expressed regarding participation and time).

## ANNEXURE F

### FIELD NOTES

#### Management

(Researcher included one example)

##### FIELD NOTES INTERVIEW 2

Participant: Head: Department of Health, City Council of Klerksdorp

Management Function: Head of Department

6 October 2004

Had an initial meeting with the participant to establish contact and to get consent from the council to conduct my research at Park Street clinic.

To establish contact with the clinic staff he arranged a meeting with the clinic nurses for me. Unfortunately this meeting did not take place due to an urgent union meeting.

Our meeting took place in his office (his office used to be at Park Street clinic, but due to problems with floor space he had to move to a building situated in another part of the city centre). I explained the purpose and possible benefits of the study to the participant and after reaffirming that participation is voluntary, I asked him to sign the informed consent. I also asked if he had any problems with the fact that the interview will be taped. The participant had no problems or questions and consent was signed.

I felt more in control of this interview although I had a problem with my notebook that kept going into “hibernation”. The environment was more conducive to a quality interview – quiet and no disturbances. The participant was relaxed and eager to participate, over eager I might add – he wanted to focus on his own agenda and concerns. Eye contact was maintained and the participant frequently used hand gestures to emphasize his replies. However, English is not the participant’s first language and that could have stifled more comprehensive replies. Several times during the interview the participant used Afrikaans words to assist him to bring across his meaning.

After listening to the recorded version of the interview and verifying with my notes, I identified the following as important aspects:



- Agreed with statement that development of children is important, however he would rather focus on other aspects of care e.g. immunisation, due to work pleasure
- Know that there are policies but unsure about content “can’t quote them”
- Feel that it is easy for authorities to articulate policies, but not so easy for them to execute it due to time constraint when it comes to training off staff with regard to that policy. Feel that they do try to build consensus by making information available through the ranks. However, the maintenance of the policies is a problem – due to workload no one is currently checking to see if it is maintained
- See prevention and early detection as a responsibility of the community nurse as she has first contact with the mother and she can refer if there’s a problem
- Not sure how to define the scope of practice of the community nurse but he is “comfortable that the majority of them work within their scope of practice” Do detect a note of uncertainty about what the scope of practice really mean and how to apply it to the real work context - it should be all of them and not just the majority
- Very concerned about the stress, due to workload and type of work, that nurses are exposed to
- Resources – Moratorium on filling of posts since 1995 and province is currently filling the vacant posts not the city council. Province, however, contribute to the budget but has a policy “no nice to haves so it’s only the bare essentials that they are providing”
- Training - Grateful towards province as training of staff is funded by province
- Interagency collaboration - According to him there is good interagency collaboration, especially with hospitals and NGO’s. On management level there is also a good relationship
- Barriers – funds, workload, floor space (facility), shortage of personnel, absence of other health care professionals were identified
- In-service training – think it needs more attention
- Quality of care – do look at stats, get feedback from area and facility managers as well as from parents. Good hands-on relationship important. However, ratio of complaints very high – 80 %
- Development of infants not getting the necessary attention due to an aim that is more curative

My impression:

- Development of infants doesn’t get the necessary attention. Not high on his priority list due to own priorities and work pleasure – immunisation and HIV/AIDS
- There aim is more curative than preventative and promotive

- Responsibility for rendering of services is not clear cut - council versus province and that could have a negative impact on services

Shortcomings of interview

- I tried to follow up on clues but am still unsure as to what will be guiding commentary
- Did not follow up sufficiently on clues to elicit further information
- Did not address what management is currently doing to support staff or to enhance their knowledge and skills

Follow-up interview will be arranged at a later stage.

**ANNEXURE G**  
**WORKING DOCUMENT: ANALYSIS OF DATA**  
**&**  
**FEEDBACK FROM INDEPENDENT ANALYSIS OF DATA**

Initial draft

**TABLE 3.1 SCHEMATIC EXPLANATION OF CATEGORIES AND SUB-CATEGORIES**

| <b>MANAGEMENT</b>                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|---------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Category                                                                              | Sub-category                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| 1 Framework for managers to support developmental care of infants by community nurses | <p>1.1 Clinical Governance</p> <ul style="list-style-type: none"> <li>• Clinical supervision</li> <li>• Training</li> <li>• Spot checks and on-the-spot training</li> </ul> <p>1.2 Support System</p> <ul style="list-style-type: none"> <li>• Investment in staff</li> <li>• Empathy</li> <li>• Information and helping behaviour</li> <li>• Feedback and communication</li> <li>• Recognition and trust</li> <li>• Time</li> <li>• Referral for professional support</li> </ul> <p>1.3 Interagency Collaboration</p> <ul style="list-style-type: none"> <li>• Meetings</li> <li>• Referral systems</li> <li>• Knowledge about other health care professionals</li> </ul> <p>1.4 Training and Development</p> <ul style="list-style-type: none"> <li>• Orientation</li> <li>• Existing knowledge and skills of community nurses</li> <li>• Intellectual stimulation</li> <li>• In-service training</li> <li>• Formal training</li> <li>• Interdisciplinary training</li> <li>• Funds for training</li> </ul> <p>1.5 Resources</p> <ul style="list-style-type: none"> <li>• Budget/finances</li> <li>• Equipment</li> <li>• Personnel</li> </ul> |

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|                                                                                       | <p>1.6 Administrative tasks</p> <ul style="list-style-type: none"> <li>• Reports</li> <li>• Statistics</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| 2 Developmental care of infants by community nurses                                   | <p>2.1 Human rights to develop to full potential</p> <ul style="list-style-type: none"> <li>• Can't speak for themselves</li> <li>• Parent/community nurse responsibility</li> <li>• Burden on community</li> </ul> <p>2.2 Focus on development of infants in clinic</p> <ul style="list-style-type: none"> <li>• Manager's perception of degree of focus</li> <li>• Domains of development</li> </ul> <p>2.3 Professional accountability with regard to scope of practice</p> <ul style="list-style-type: none"> <li>• Manager's perception of scope of practice</li> </ul> |
| 3 Barriers to developmental care of infants by community nurses                       | <p>3.1 Lack of resources</p> <ul style="list-style-type: none"> <li>• Funds</li> <li>• Personnel</li> <li>• Equipment</li> </ul> <p>3.2 Knowledge and skills of community nurses</p> <p>3.3 Workload</p> <p>3.4 Referral system</p> <p>3.5 Physical environment – space</p> <p>3.6 Lack of guidelines</p>                                                                                                                                                                                                                                                                    |
| 4 Government support with regard to developmental care of infants by community nurses | <p>4.1 Policies and guidelines</p> <p>4.2 Identification of priorities</p> <p>4.3 Consensus building</p> <p>4.4 Management of change</p>                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>PERSONNEL CONCERNED WITH CPD</b>                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| 1 Training programmes                                                                 | <p>1.1 Reasons for training programmes/sessions</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |

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|                                                                                       | <p>1.2 Format of training</p> <p>1.3 Content of programmes/sessions</p> <p>1.4 Time-limit for programmes/sessions</p> <p>1.5 Shortcomings</p> <p>1.6 Resources for programmes/sessions</p> <p>1.7 Focus on infant development</p> <p>1.8 Interdisciplinary training</p> <p>1.9 Knowledge of trainer</p> <p>1.10 Evaluation of efficacy of programmes/sessions</p>                 |
| 2 Needs analysis                                                                      | <p>2.1 Assessment of community nurses' needs</p> <p>2.2 Format of assessment</p> <p>2.3 How often are needs assessed</p>                                                                                                                                                                                                                                                          |
| 3 Knowledge, skills and competencies of the community nurse                           | <p>3.1 Sufficient knowledge</p> <p>3.2 Perception of community nurse with regard to shortcomings in knowledge and skills</p> <p>3.3 Evidence-based practice</p>                                                                                                                                                                                                                   |
| 4 Provincial support with regard to developmental care of infants by community nurses | <p>4.1 Existing policies, guidelines</p> <p>4.2 Identification of priorities</p> <p>4.3 Focus on infant development</p>                                                                                                                                                                                                                                                           |
| 5 Management of infant developmental needs by community nurses                        | <p>5.1 Infant development included in community nurses daily tasks</p> <p>5.2 Consensus on management of infant developmental needs by community nurses</p> <p>5.3 Guidelines on management of infant developmental needs</p> <p>5.4 Gap between reality and the ideal with regard to infant developmental needs</p> <p>5.5 Anticipatory guidance offered by community nurses</p> |

| OTHER HEALTH CARE PROFESSIONALS                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1 Late identification of developmental delays and disabilities by community nurses                   | <p>1.1 Perceived reasons for late identification</p> <ul style="list-style-type: none"> <li>• Insufficient knowledge and skills about infant developmental surveillance</li> <li>• Work load</li> <li>• Wait and see attitude</li> <li>• Parents bring children late for assessment due to insufficient knowledge on infant development</li> <li>• Impact of HIV</li> </ul> <p>1.2 Regular phenomenon in practice</p> <p>1.3 Value of guidelines for community nurses</p> <p>1.4 Most effective way of assessment for community nurses</p> <ul style="list-style-type: none"> <li>• Checklist</li> <li>• Physical assessment according to evaluation form</li> </ul> |
| 2 Perception of the community nurse's knowledge and responsibility with regard to infant development | <p>2.1 Insufficient knowledge</p> <p>2.2 Adaptation to changing roles in health care</p> <p>2.3 Focus on infant developmental delays during pre-service training</p> <p>2.4 Important responsibility</p> <ul style="list-style-type: none"> <li>• First point of contact for health care</li> <li>• Relationship with parents</li> <li>• Anticipatory guidance</li> </ul>                                                                                                                                                                                                                                                                                            |
| 3 Interaction between community nurses and other health care professionals                           | <p>3.1 Insufficient interaction</p> <p>3.2 Professional jealousy</p> <p>3.3 Sharing of knowledge/CPD sessions</p> <p>3.4 Importance of communication/feedback</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |

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|                                                     | <ul style="list-style-type: none"> <li>• Ensure continuity of therapy</li> <li>• Comprehension and knowledge about the role and function of other health care professionals</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 4 Interdisciplinary training                        | 4.1 Attitude towards interdisciplinary training                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>COMMUNITY NURSES</b>                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| 1 Developmental care of infants by community nurses | <p>1.1 Professional accountability of community nurses</p> <ul style="list-style-type: none"> <li>• Scope of practice</li> <li>• Responsibility of community nurses</li> </ul> <p>1.2 Human rights to develop to full potential</p> <p>1.3 Focus on prevention and early identification of developmental delays and disabilities</p> <ul style="list-style-type: none"> <li>• Ideal setting for identification of developmental delays and disabilities</li> <li>• Late identification of developmental delays and disabilities</li> <li>• Identification of developmental needs of infants technique, domains/indicators, consensus among community nurses</li> <li>• Inclusion of family</li> <li>• Anticipatory guidance to optimize infant development</li> </ul> <p>1.4 Policies and guidelines</p> <p>1.5 Cultural competence</p> <p>1.6 Documentation</p> <p>1.7 Support to parents</p> <p>1.8 Resources in the community</p> |



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|                                                                                                                       | <p>1.9 Referral system</p> <p>1.10 Home visits</p> <p>1.11 Reflection on personal interaction style</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <p>2 Impact of existing infrastructure and possible barriers to developmental care of infants by community nurses</p> | <p>2.1 Infrastructure</p> <ul style="list-style-type: none"> <li>• Resources</li> <li>• Environment</li> <li>• Telecommunication</li> </ul> <p>2.2 Barriers</p> <ul style="list-style-type: none"> <li>• Knowledge of nurses</li> <li>• Rendering of comprehensive service</li> <li>• Support by and communication with management</li> <li>• Telecommunication</li> <li>• Specific guidelines</li> <li>• Work load</li> <li>• Poor work performance of colleagues</li> <li>• Resources</li> <li>• Funds</li> <li>• Access to information e.g. pamphlets for clients/patients</li> </ul> |
| <p>3 Management framework to support developmental care of infants by community nurses</p>                            | <p>3.1 Lack of understanding of needs</p> <p>3.2 Resources</p> <p>3.3 Training opportunities</p> <p>3.4 Lack of feedback</p> <p>3.5 Negative attitude</p> <p>3.6 Insufficient contact</p>                                                                                                                                                                                                                                                                                                                                                                                                |
| <p>4 Training and professional development of community nurses to support developmental care of infants</p>           | <p>4.1 Pre-service training</p> <p>4.2 Orientation of new personnel</p> <p>4.3 Existing knowledge about developmental care</p> <p>4.4 In-service training</p>                                                                                                                                                                                                                                                                                                                                                                                                                            |

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|                                                                 | <p>4.5 Provincial training programme</p> <p>4.6 Interdisciplinary training</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>FAMILIES: INFANTS WITH TYPICAL DEVELOPMENT</b>               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| 1 Perception of infant developmental care by community nurses   | <p>1.1 Identification of infant developmental needs</p> <ul style="list-style-type: none"> <li>• Information obtained from parents and inclusion of family</li> <li>• Assessment of infant development</li> <li>• Identification of delay/disability</li> </ul> <p>1.2 Provision of information on infant development by community nurse</p> <p>1.3 Provision of information on resources in the community</p> <p>1.4 Recognition of cultural traditions</p> <p>1.5 Satisfaction with services</p>                                                                                                                                     |
| <b>FAMILIES: INFANTS WITH DEVELOPMENTAL DELAYS/DISABILITIES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| 1 Perception of infant developmental care by community nurses   | <p>1.1 Identification of infant developmental needs</p> <ul style="list-style-type: none"> <li>• Information obtained from parents and inclusion of family</li> <li>• Assessment of infant development</li> <li>• Identification of delay/disability</li> </ul> <p>1.2 Provision of information on infant development by community nurse</p> <p>1.3 Support for families by community nurses</p> <p>1.4 Provision of information on resources in the community</p> <p>1.5 Recognition of cultural traditions</p> <p>1.6 Interaction of community nurses with other health care professionals</p> <p>1.7 Satisfaction with services</p> |

**Second draft:**

Table 3.1 Categories, sub-categories and themes

| Categories                                              | Sub-categories                                                                                                                                                             | Themes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|---------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Support by management for developmental care of infants | <ul style="list-style-type: none"> <li>Clinical governance</li> <li>Mentoring of staff</li> <li>Resources and infrastructure</li> <li>Interagency collaboration</li> </ul> | <ul style="list-style-type: none"> <li>Orientation of staff</li> <li>Up-dated policies and guidelines</li> <li>Recordkeeping</li> <li>Clinical supervision</li> <li>Training and development</li> <li>Patient complaints</li> <li>Acknowledgement of input and achievements</li> <li>Investment in staff</li> <li>Communication and feedback</li> <li>Role expectations</li> <li>Finances/funds</li> <li>Adequate staffing</li> <li>Adequate equipment</li> <li>Appropriate facilities</li> <li>Liaison and meetings</li> </ul> |
| Developmental care of infants by community nurses       | <ul style="list-style-type: none"> <li>Rights of the infant to develop to full potential</li> <li>Focus on developmental needs</li> </ul>                                  | <ul style="list-style-type: none"> <li>Infants can't speak for themselves</li> <li>Aim of life to develop into independent adult</li> <li>Burden on community</li> <li>Parents' responsibility</li> <li>Government priorities</li> <li>Perception of management</li> <li>Perception of other health care professionals</li> <li>Perception of nurses</li> <li>Elements of assessments</li> </ul>                                                                                                                                |

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|-------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                       | <ul style="list-style-type: none"> <li>Professional accountability</li> <li>Training and development</li> <li>Family care</li> <li>Parents' view and expectations of community nurses</li> </ul> | <ul style="list-style-type: none"> <li>Enhancing development</li> <li>Barriers that nurses experience</li> <li>Perception of scope of practice of the nurse</li> <li>Knowledge, skills and competencies</li> <li>Evidence-based practice</li> <li>Ethical standards</li> <li>Preservation of human dignity</li> <li>Pre-service training</li> <li>In-service training</li> <li>Formal training programme</li> <li>Continuous professional development</li> <li>Relationship with parents</li> <li>Addressing concerns of parents</li> <li>Information on resources</li> <li>Social and formal support</li> <li>Recognition of cultural traditions and practices</li> <li>Reflection on personal interaction style</li> <li>Accessibility</li> <li>Approachability/interpersonal skills</li> <li>Knowledge and competence</li> <li>Information and advice</li> </ul> |
| Management of the infant with delays and disabilities | <ul style="list-style-type: none"> <li>Identification of delays and disabilities</li> </ul>                                                                                                      | <ul style="list-style-type: none"> <li>Changes in health care</li> <li>Anticipatory guidance</li> <li>Intervention</li> <li>Follow-up services</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |

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|  | <ul style="list-style-type: none"> <li>• Views on late identification of developmental delays and disabilities</li> <li>• Collaboration and co-operation with other health care professionals</li> </ul> | <ul style="list-style-type: none"> <li>• Insufficient knowledge and skills of community nurse</li> <li>• Insufficient knowledge about typical infant development</li> <li>• Workload</li> <li>• Wait and see attitude</li> <li>• Impact of HIV and poverty</li> <li>• Logistics</li> <li>• Traditional healer</li> <li>• Referral and feedback</li> <li>• Interaction/communication with other health care professionals</li> <li>• Ensuring continuity of therapy</li> <li>• Interdisciplinary training and skills development</li> </ul> |
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**Final draft**

Table 3.1 Themes, categories and subcategories

| Themes                                                  | Categories                                                                                                                                                                                            | Subcategories                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|---------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Support by management for developmental care of infants | <ul style="list-style-type: none"> <li>• Health care governance</li> <li>• Organizational culture and climate</li> <li>• Resources and infrastructure</li> <li>• Interagency collaboration</li> </ul> | <ul style="list-style-type: none"> <li>▪ Policies and guidelines</li> <li>▪ Induction of staff (orientation)</li> <li>▪ Role expectations</li> <li>▪ Documentation</li> <li>▪ Professional performance management (supervision)</li> <li>▪ Training</li> <li>▪ Client feedback</li> <li>▪ Acknowledgement of input and achievements</li> <li>▪ Investment in staff</li> <li>▪ Communication and feedback</li> <li>▪ Finances/funds</li> <li>▪ Adequate staffing</li> <li>▪ Adequate equipment</li> <li>▪ Appropriate facility</li> <li>▪ Liaison and meetings</li> </ul> |
| Developmental care of infants by community nurses       | <ul style="list-style-type: none"> <li>• Rights of the infant to develop to full potential</li> <li>• Focus on infant developmental needs</li> </ul>                                                  | <ul style="list-style-type: none"> <li>▪ Infants can't speak for themselves</li> <li>▪ Aim of life to develop into independent adult</li> <li>▪ Burden on community</li> <li>▪ Parents' responsibility</li> <li>▪ Government priorities</li> <li>▪ Perception of management</li> <li>▪ Perception of community nurses</li> <li>▪ Perception of people involved in</li> </ul>                                                                                                                                                                                             |

|  |                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|--|-----------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  | <ul style="list-style-type: none"> <li>• Professional accountability</li> <li>• Personal professional development</li> <li>• Family care</li> </ul> | <p>training of nurses</p> <ul style="list-style-type: none"> <li>▪ Perception of other health care professionals</li> <li>▪ Perception of parents</li> <li>▪ Assessment of infant for developmental delays and disabilities</li> <li>▪ Promoting development</li> <li>▪ Barriers that nurses experience in infant developmental care</li> <li>▪ Surveillance and home visiting</li> <li>▪ Perception of scope of practice of the nurse</li> <li>▪ Competence</li> <li>▪ Evidence-based practice</li> <li>▪ Ethical standards</li> <li>▪ Preservation of human dignity</li> <li>▪ Pre-service knowledge base</li> <li>▪ Identification and acknowledgement of training needs</li> <li>▪ In-service training</li> <li>▪ Continuous professional development</li> <li>▪ Formal training programme</li> <li>▪ Focus on infant development</li> <li>▪ Relationship with parents</li> <li>▪ Addressing concerns of parents</li> <li>▪ Information on resources</li> <li>▪ Recognition of cultural traditions and practices</li> <li>▪ Reflection on personal interaction style</li> </ul> |
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|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                  | <ul style="list-style-type: none"> <li>• Parents' view and expectations of community nurses</li> </ul>                                                                                                                                                                                                                                                                                                | <ul style="list-style-type: none"> <li>▪ Perception of service delivery</li> <li>▪ Accessibility</li> <li>▪ Approachability/interpersonal skills</li> <li>▪ Competence</li> <li>▪ Information and advice</li> <li>▪ Explanation of procedures</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| Management of infants with developmental delays and disabilities | <ul style="list-style-type: none"> <li>• Identification of infant developmental delays and disabilities</li> <li>• Management of infant developmental delays and disabilities</li> <li>• Support to parents of infants with developmental delays and disabilities</li> <li>• Views on late identification of infant developmental delays and disabilities</li> <li>• Collaboration and co-</li> </ul> | <ul style="list-style-type: none"> <li>▪ Identification</li> <li>▪ Intervention</li> <li>▪ Anticipatory guidance</li> <li>▪ Follow-up services</li> <li>▪ Effects of developmental delays and disabilities on parents</li> <li>▪ Social support</li> <li>▪ Lack of focus on infant development by community nurse</li> <li>▪ Changes in health care</li> <li>▪ Workload</li> <li>▪ Impact of HIV and poverty</li> <li>▪ Logistics</li> <li>▪ Traditional healer</li> <li>▪ Insufficient knowledge about typical infant development</li> <li>▪ Negligence/denial by parents</li> <li>▪ Lengthy process of identification</li> <li>▪ Wait and see attitude</li> <li>▪ Referral and feedback</li> </ul> |



|  |                                                |                                                                                                                                                                                                                       |
|--|------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  | operation with other health care professionals | <ul style="list-style-type: none"><li>▪ Interaction/communication with other health care professionals</li><li>▪ Ensuring continuity of therapy</li><li>▪ Interdisciplinary training and skills development</li></ul> |
|--|------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

FWA Nr. 0000 2567  
IRB Nr. 0000 2235



Soutpansberg Road  
MRC-Building  
Room 2 - 19

Private Bag x 385  
Pretoria  
0001

|              |                                                                               |
|--------------|-------------------------------------------------------------------------------|
| Number       | : 278/2003                                                                    |
| Title        | : The management of developmental needs of infants by community health nurses |
| Investigator | : Prof N C van Wyk; Department of Nursing Science; University of Pretoria.    |
| Sponsor      | : None                                                                        |

This Protocol and Informed Consent have been considered by the Faculty of Health Sciences Research Ethics Committee, University of Pretoria on 19/11/2003 and found to be acceptable.

|                        |                                                                                      |
|------------------------|--------------------------------------------------------------------------------------|
| *Prof P Carstens       | BLC LLB LLD (Pret) Faculty of Law                                                    |
| Prof S.V. Grey         | (female) BSc (Hons); MSc; DSc; Deputy Dean                                           |
| *Prof V.O.L. Karusseit | MBChB; MFGP (SA); M.Med (Chir); FCS (SA); Surgeon                                    |
| Dr M E Kenoshi         | MB,ChB; DTM & H (Wits); C.E.O. of the Pretoria Academic Hospital                     |
| Prof M Kruger          | (female) MB.ChB.(Pret); Mmed.Paed.(Pret); PhD. (Leuven)                              |
| Dr N K Likibi          | MB.BCh.; Med.Adviser (Gauteng Dept of Health)                                        |
| *Miss B Mullins        | (female) BscHons; Teachers Diploma;                                                  |
| Snr Sr J. Phaloli      | (female) BCur (ELAI) Senior Nursing-Sister                                           |
| *Prof H.W. Pretorius   | MBChB; M.Med (Psych) MD: Psychiatrist                                                |
| Prof P. Rheeder        | MBChB; M.Med (Int); LKI (SA); MSc (CLIN.EPI); Specialist Physician                   |
| Reverent P Richards    | B.Th. (UNISA), M.Sc. (Applied Biology) (Knights), M.Sc (Med) (Wits), TechRMS, DipRMS |
| Dr L. Schoeman         | (female) Bpharm, BA Hons (Psy), PhD                                                  |
| Dr C F Slabber         | BSc (Med) MB BCh, FCP (SA) Acting Head; Dept Medical Oncology                        |
| *Prof J.R. Snyman      | MBChB, M.Pharm.Med: MD: Pharmacologist                                               |
| *Dr R Sommers          | (female) MBChB; M.Med (Int); MPhar.Med;                                              |
| *Prof TJP Swart        | BChD, MSc (Odont), MChD (Oral Path) Senior Specialist; Oral Pathology                |
| *Dr S.J.C. v/d Walt    | (female) D. Cur, MEd, Department of Nursing                                          |

**PROF J R SNYMAN** MBChB, M.Pharm.Med: MD: Pharmacologist  
CHAIRPERSON of the Faculty of Health Sciences Research Ethics Committee - University of Pretoria

\* = Members attended the meeting on 19/11/2003.

### APPLICATION TO CONDUCT A STUDY

Faculty of Health Sciences Research Ethics Committee  
University of Pretoria  
Pretoria Academic Hospital  
Tel: (012) 339 8612  
Fax: (012) 339 8587  
E Mail: [manda@med.up.ac.za](mailto:manda@med.up.ac.za) - Main Committee  
E Mail: [gbehan@med.up.ac.za](mailto:gbehan@med.up.ac.za) - Student Committee

Soutpansberg Road - MRC-Building - Level 2 - Room 19  
Private Bag x 385 - Pretoria - 0001

#### GENERAL INFORMATION AND AGREEMENT BY APPLICANT

**APPLICANT:** Investigator - Ronéll Leech

**DEPARTMENT OF NURSING SCIENCE, UNIVERSITY OF PRETORIA:**

**Telephone Number:** (012) 354 2125 **Fax Number:** (012) 354 1490

**E-Mail address:** [nursing@medic.up.ac.za](mailto:nursing@medic.up.ac.za)

**Postal address:** PO BOX 667 Pretoria 0001

#### FULL TITLE OF STUDY:

The management of developmental needs of infants by community health nurses

#### OUTLINE DETAILS OF PREVIOUS STUDIES CONDUCTED IF ANY:

None

#### ARE ANY SPECIAL PRECAUTIONARY MEASURES TO BE TAKEN AND BY WHOM?

Over and above the agreement by the applicant, the applicant will ensure the following:

- Confidentiality of information
- Anonymity of participants
- No damage/harm to any property/staff of Klerksdorp Municipality

#### INDICATE EXPECTED DATE OF STUDY / EVALUATION REPORT:

| DAY | MONTH    | YEAR |
|-----|----------|------|
|     | December | 2004 |

#### INDICATE NUMBER OF CLIENTS INVOLVED:

| SOURCE     | ESTIMATION |
|------------|------------|
| RECORDS    | ? 50       |
| STAFF      | ? 5        |
| PARENTS    | ? 5 - 10   |
| MANAGEMENT | ? 4 - 5    |

#### THE NAME OF THE HEAD OF THE DEPARTMENT:

Professor NC van Wyk

#### WILL SUFFICIENT STUDY MATERIAL BE AVAILABLE?

Yes

INVESTIGATIONS (N/A)

#### AGREEMENT BY APPLICANT

The applicant agrees as follows:

- To conduct the study recorded in and under the conditions set out in this application form
- To conduct this study at no additional expense to the Klerksdorp Municipality whatsoever
- To exonerate the Klerksdorp Municipality from all liability of damages, legal, financial or otherwise
- To inform the Municipal Manager: Klerksdorp Municipality and other relevant authorities should it be deemed necessary to deviate from protocol or stop this study
- To make available without delay all the results of this study to the Municipal Manager: Klerksdorp Municipality
- I understand that the Municipal Manager: Klerksdorp Municipality having allowed this study to be conducted places himself or the Klerksdorp Municipality under no obligation whatsoever

#### THE APPLICANT MUST SIGN HERE:

| APPLICANT- INVESTIGATOR |            |         | DATE |         |      |
|-------------------------|------------|---------|------|---------|------|
| Signature               | Initial(s) | Surname | Day  | Month   | Year |
| <i>Leech</i>            | R          | LEECH   | 20   | OCTOBER | 2003 |

#### INITIAL CONSENT BY DEPARTMENTAL HEAD

I, Professor NC van Wyk, Head of Department of Nursing Science grant permission to submit an application to conduct a study to the Chairperson(s) of the relevant Ethics, Research and Therapeutic Committees of this Hospital.

The researcher conducting the study will be: Ronéll Leech

#### THE HEAD OF THE DEPARTMENT MUST SIGN HERE:

| HEAD OF DEPARTMENT |            |         | DATE |         |      |
|--------------------|------------|---------|------|---------|------|
| Signature          | Initial(s) | Surname | Day  | Month   | Year |
| <i>NC van Wyk</i>  | NC         | VAN WYK | 20   | OCTOBER | 2003 |

#### THE APPLICANT MUST SIGN HERE:

| RESEARCHER   |            |         | DATE |         |      |
|--------------|------------|---------|------|---------|------|
| Signature    | Initial(s) | Surname | Day  | Month   | Year |
| <i>Leech</i> | R          | LEECH   | 20   | OCTOBER | 2003 |

THE APPLICANT THAT APPLY FOR THIS STUDY MUST SEE TO IT THAT THE MUNICIPAL MANAGER OF THE KLERKSDORP CITY COUNCIL WHERE THE STUDY WILL BE DONE – SIGN HERE BEFORE THE ETHICAL COMMITTEE RECEIVE THIS APPLICATION FORM

#### APPROVAL BY: MUNICIPAL MANAGER

I, TZ Mokhatla, Municipal Manager of Klerksdorp Municipality, hereby agree that this study be conducted in the Klerksdorp Community Health Centre, Park Street, Klerksdorp. The researcher conducting the study will be: Ronéll Leech

| MUNICIPAL MANAGER  |          |          | DATE |         |      |
|--------------------|----------|----------|------|---------|------|
| Signature          | Initials | Surname  | Day  | Month   | Year |
| <i>TZ Mokhatla</i> | TZ       | MOKHATLA | 15   | OCTOBER | 2003 |



**REQUEST TO HAVE COUNCIL AS  
PRIORITY INFORMATION CENTRE  
IN OBTAINING Ph DEGREE IN  
MANAGEMENT OF DEVELOPMENTAL  
NEEDS OF INFANTS BY COMMUNITY  
HEALTH NURSES**

PURPOSE OF REPORT

To inform Council that the Department of Health PHC has been elected to participate in a research project of a student obtaining her Ph degree in the management of developmental needs of infants by community health nurses.

BACKGROUND

Sr R Leech was in Councils service from 1984 to 1996 as Assistant Chief Community Health Nurse, more specifically training of PHC personnel and Management of Park Street Clinic.

She is busy doing her PhD in the management of developmental needs of infants by Community Health Nurses with the following in mind and will make use of clinic personnel politician and members of the community for information.

- To describe what the responsibility / function of the community health nurse is within her scope of practice, with regard to the management of developmental needs of infants at a primary health care level
  - To determine the developmental and support needs of infants and their families
  - To identify the issues / aspects of developmental care that a nurse can address within her scope of practice
  - To determine what are the training needs of the community health nurse in the management of developmental needs
  - To determine what support / infra structure is needed to enable the nurse in the practice to fulfil her responsibility.

GENERAL

- There will be no financial impact or time loss for Council or its employees
- Council will be indemnified against any losses and / or claims from Sr Leech
- Council will be prominently mentioned in the compiled document; which will be available for scrutinization.

## RECOMMENDATION

That cognisance be taken of the PhD to be done by Sr R Leech on the management and developmental needs of infants by community health nurses and that information will be gathered from Council's clinics.