

EXPLORING TRUST IN THE PROVIDER – PATIENT DYAD:
CAPTURING THE MOTHER’S VOICE IN HER OWN WORDS

by

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DEDICATION

“Children are one-third of our population but all of the future.”

- Select Panel for Promotion of Child Health, 1981

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ABSTRACT

In 2013, Montana was ranked 50th, or the lowest ranking state, for child health status according to the Annie E. Casey Foundation. The Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) was created when the Patient Protection and Affordable Care Act was signed into law. Several counties within Montana adopted the evidence-based Nurse-Family Partnership (NFP) home visiting program under the direction of MIECHV. The NFP program delivers care to at-risk pregnant mothers and their children. The purpose of this paper was to conduct a review of the literature to investigate communication approaches that the NFP nurse uses or could use during a home visit with the mother, that strengthens the ability of the nurse to capture and empower the mother's voice as customer. Three databases were utilized with a total of ten search terms. A total of five qualitative articles were found that directly examined the voice of the mother receiving home visiting services. Trust was the key term used to examine components of the dyad relationship. Trust within the provider-patient relationship is important as it is tied directly to program engagement and positive outcomes. After analysis of the articles, six themes surfaced that the mothers expressed and included personality, friendship, availability, empowerment, reducing vulnerability, and testing. Additional sub themes included emotional support, knowing, control, verbal praise, advocacy, and respect. Little research exists that directly examines and seeks to garner the experiences of at-risk mothers participating in home visiting programs. Complicating the literature search was the finding that trust is poorly defined in nursing literature and the health science literature as a whole. Further research and inquiry is needed to understand, according to the patient perspective, how trust is built, maintained, broken, and repaired. Understanding the concept of trust according to the patient perspective is imperative as home visiting programs are implemented within the state of Montana. Capturing the voice of the customer is not only a mandate but is imperative to improve the health status of our State.

CHAPTER ONE

INTRODUCTION TO THE PAPER

Introduction

In 2010, the Patient Protection and Affordable Care Act (ACA) was signed into law. One provision under the ACA was the creation of the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV). The purpose of the MIECHV funding in Montana was to help public health organizations implement an evidence-based home visiting program. The goal was to deliver and provide increased health and development results in at-risk children. There were a total of seven home visiting models that met MIECHV's criteria for being evidence based and thus approved for implementation into communities. The Missoula City-County Health Department (MCCHD) decision makers chose to adopt the Nurse-Family Partnership (NFP) model to execute delivery of care. The MIECHV program encourages engagement of the community and parents in a meaningful way including input into the decision-making process (Executive Office of Health and Human Services Department of Public Health, n.d., pp. 1, 5, 35, 57). This requirement ensures that the 'parent's voice' or 'voice of the customer' is captured and guarantees that parent-motivated suggestions are heard as care is provided to their children.

Furthermore, the MIECHV program under the Health Resources and Services Administration (HRSA) was awarded grant money for all fifty states and six jurisdiction in accordance with the ACA. Each state that submitted a grant application and needs

assessment was awarded grant money (Executive Office of Health and Human Services Department of Public Health, n.d.). Montana was awarded grant money, however implementation of the NFP model had unique challenges due to the rural nature of the State. Although decision makers at the Missoula City-County Health Department chose the NFP model, they did this through partnership with Yellowstone County. To meet specific NFP requirements several of the State counties became interrelated in implementing the program, thus working both dependently and independently of each other (K. Siegrist, personal communication, February 19, 2014).

Current literature supports the effectiveness of the NFP model but very few studies have evaluated the mothers' experiences or perceptions within this home visiting construct (Kurtz Landy, Jack, Wahoush, Sheehan, & MacMillan, 2012). One of the most valuable resources, as the NFP program is implemented, is to capture the parent's voice as customer, which is a component of developing a meaningful partnership approach. The National Quality Forum (NQF) (2013) has designated that family engagement and true partnership through shared decision making is a national health care priority. With the increasing demand to include parents as partners and foster a meaningful-partnership approach, further study is needed to understand how the parent's voice will be seamlessly integrated into the NFP program at the MCCHD.

Background

History of the NFP Model

The NFP model was developed by Dr. David Olds of the University of Colorado Denver and has been in place for over 35 years. The NFP model originated with Dr. Olds' work in an inner-city day care center in the 1970s. Subsequent to this early work, Dr. Olds used his background in pediatrics, psychiatry, and preventive medicine to develop the NFP model. During the beginning stages the model was tested in three different population locations including Elmira, New York in 1977; Memphis, Tennessee in 1988; and Denver, Colorado in 1994, via randomized controlled trials (RCT) (Nurse-Family Partnership, 2011d).

Results from the RCTs indicated three important outcomes from the home visiting intervention. First, pregnancy outcomes were improved (Olds, Henderson, Tatelbaum, & Chamberlin, 1986). Second, the health and development of children in the program were improved (Olds et al., 2004). Third, the program helped create a positive life course for parents (Olds et al., 2007). In 1996, these results encouraged a wider implementation of the NFP model. Communities that initially adopted and implemented the program were in Dayton, Ohio and counties throughout Wyoming. Other locations followed suit including Los Angeles, Fresno, and Oakland, California; Clearwater, Florida; St. Louis, Missouri; and Oklahoma City, Oklahoma. The U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention funded these program sites. To date the NFP exists in 43 states (Nurse-Family Partnership, 2011a).

The initiation of the NFP program began with Dr. Olds through his research and implementation of the program into local communities for research and replication purposes. In 2003, the Nurse-Family Partnership National Service Office was created as a national non-profit organization, to ensure quality replication of the program across the States. The National Service Office was initially started through the collaboration of Dr. Olds, private funders, and the University of Colorado Denver. The original founders recognized that Dr. Olds and the University should focus on research progression of the NFP model while the National Service Office would focus on business and disseminating the model into communities. Dr. Olds is not involved with the National Service Office but a formal agreement, or partnership, is in place between both parties (M. Stapleton, personal communication, December, 31, 2013). The National Service Office also serves to aid agencies that are implementing the program and to ensure support for related nursing education, practice, quality assurance, policy, marketing, and other connected services. Currently Dr. Olds continues with his team at the Prevention Research Center for Family and Child Health, to research long-term effects and ongoing improvement in the NFP model (Nurse-Family Partnership, 2011a).

Structure of the NFP Model

The NFP model is utilized among the population of first-time mothers and their unborn babies. The program is free to consumers, publically, privately and federally funded and enrolls vulnerable, low-income women who are pregnant. The goal is to support and foster healthy pregnancies, provide care to the child, and encourage economic self-sufficiency of the family unit. The program follows the mother prenatally

and the mother and child from birth to age two through 64 planned home visits. For the mother, establishing a trusting relationship is critical to the success of the program. Other family members, including fathers, are encouraged to be a part of the home visits as well (Nurse-Family Partnership, 2011c).

The program utilizes evidence-based research and outcomes that look at long-term improvement of the family unit in health, education, and economic self-sufficiency and ultimately, the community. The program focus is on vulnerable mothers entrapped in a cycle of poverty. The belief is that when the NFP program is implemented with fidelity it contributes to these outcomes at the individual and community level. The NFP model also provides structure and support to health departments, organizations, and nurses who are responsible for delivering the care at the intersection of the mother and baby. Education includes how to effectively implement the home visit to establish a trusting relationship that is needed for success (Nurse-Family Partnership, 2011a).

Fundamentals of the NFP Model

Mission. “Empower first-time mothers living in poverty to successfully change their lives and the lives of their children through evidence-based nurse home visiting” (Nurse-Family Partnership, 2011a, para 1).

Vision. “Children are healthy. Families thrive. Communities prosper. Cycles are broken” (Nurse-Family Partnership, 2011a, para 2).

Values.

“SCIENTIFIC INTEGRITY will lead our decisions. We seek excellence through a culture of LEARNING. Respectful, collaboration, caring RELATIONSHIPS are the foundation of every interaction. We promote and embrace INCLUSIVITY and DIVERSITY. We foster an environment of ACCOUNTABILITY to make extraordinary changes in the lives of the families we serve. We seek to SET THE STANDARD for evidence-based and home visitation programs” (Nurse-Family Partnership, 2011a, para 3).

Elements. The NFP model must execute 18 elements in order to have a high level of confidence so the known benefits will be appreciated. These include and are directly taken verbatim from the NFP (2011b, para 1) site and are as follows:

Element 1:

Client participates voluntarily in the Nurse-Family Partnership program.

Element 2:

Client is a first-time mother.

Element 3:

Client meets low-income criteria at intake.

Element 4:

Client is enrolled in the program early in her pregnancy and receives her first home visit by no later than the end of week 28 of pregnancy.

Element 5:

Client is visited one-to-one, one nurse home visitor to one first-time mother or family.

Element 6:

Client is visited in her home.

Element 7:

Client is visited throughout her pregnancy and the first two years of her child's life in accordance with the current Nurse-Family Partnership guidelines.

Element 8:

Nurse home visitors and nurse supervisors are registered professional nurses with a minimum of a baccalaureate degree in nursing.

Element 9:

Nurse home visitors and nurse supervisors complete core educational sessions required by the Nurse-Family Partnership National Service Office and deliver the intervention with fidelity to the Nurse-Family Partnership model.

Element 10:

Nurse home visitors, using professional knowledge, judgment, and skill, apply the Nurse-Family Partnership visit guidelines, individualizing them to the strengths and challenges of each family and apportioning time across defined program domains.

Element 11:

Nurse home visitors apply the theoretical framework that underpins the program, emphasizing self-efficacy, human ecology, and attachment theories, through current clinical methods.

Element 12:

A full-time nurse home visitor carries a caseload of no more than 25 active clients.

Element 13:

A full-time nurse supervisor provides supervision to no more than eight individual nurse home visitors.

Element 14:

Nurse supervisors provide nurse home visitors clinical supervision with reflection, demonstrate integration of the theories, and facilitate professional development essential to the nurse home

visitor role through specific supervisory activities including one-to-one clinical supervision, case conferences, team meetings, and field supervision.

Element 15:

Nurse home visitors and nurse supervisors collect data as specified by the Nurse-Family Partnership National Service Office and use Nurse-Family Partnership reports to guide their practice, assess and guide program implementation, inform clinical supervision, enhance program quality, and demonstrate program fidelity.

Element 16:

A Nurse-Family Partnership Implementing Agency is located in and operated by an organization known in the community for being a successful provider of prevention services to low-income families.

Element 17:

A Nurse-Family Partnership Implementing Agency convenes a long-term community advisory board that meets at least quarterly to promote a community support system to the program and to promote program quality and sustainability.

Element 18:

Adequate support and structure shall be in place to support nurse home visitors and nurse supervisors to implement the program and to assure that data are accurately entered into the database in a timely manner.

Outcomes of the NFP Model

Highlights that have surfaced over 35 years of research include health, developmental, social, and financial advantages that span the age of the child into adulthood. Advantages include:

- A 24% reduction in tobacco use during pregnancy was found when compared to control groups as well as self-report studies (Miller,

2013). The incidence of low birth weight babies is higher in lower socioeconomic groups and among women who smoke and subsequently contributes to negative infant outcomes (Olds, Henderson, Tatelbaum, & Chamberlin, 1986).

- There was a decrease in hypertensive disorders during pregnancy as compared to the control group (Kitzman et al., 1997).
- An increase in the amount of time between subsequent pregnancies, or fewer closely-spaced pregnancies, and fewer subsequent pregnancies overall resulted (Kitzman et al., 1997; Olds et al., 2004; Olds et al., 2007; Olds et al., 2010).
- By age 12, nurse-visited children, self-reported fewer internalizing disorders, such as anxiety or depression, compared to control group children (Kitzman et al., 2010).
- Math and reading grade point averages increased for middle school aged children (Olds et al., 2007). Furthermore Peabody Individual Achievement Tests scores in reading and math were higher at age 12. Higher grade point averages and achievement test scores in reading and math were seen for grades one through six (Kitzman et al., 2010).
- Regarding the use of alcohol, cigarettes, and marijuana, nurse-visited children at age 12, were less likely to have used, used fewer, or used these substances for fewer days compared to control group children (Kitzman et al., 2010).
- There was a reduction in child abuse and neglect, as well as a reduction in childhood injuries (Kitzman et al., 1997; Olds, Henderson, Chamberlin, & Tatelbaum, 1986). This is significant as injury or unintentional injuries are the leading cause of death for children age one to 18 and the fifth leading case of death among infants (Heron, 2012).
- An increase in the father's presence and involvement through longer partnerships was appreciated within a family's household at six and nine-year follow-up compared to the control group (Olds et al., 2007).
- Women had fewer months of using food stamps and welfare programs such as Aid to Families with Dependent Children and Temporary

Assistance for Needy Families (TANF) (Olds et al., 2004; Olds et al., 2007; Olds et al., 2010).

- Estimated government cost savings per family served include a 54% reduction in Medicaid cost, 20% savings in child protective services and criminal justice costs, 14% reduction in TANF and food stamps, as well as an 8% savings in special education (Miller, 2012).
- For every government dollar spent a \$5.70 return was seen or a societal net benefit of \$34,148 for each NFP family according to an analysis by RAND corporation (Nurse-Family Partnership, 2013).
- On an individual level there was an 82% increase in employment of the unmarried mother compared to counterparts not enrolled in the NFP program (Nurse-Family Partnership, 2011d).

The Coalition for Evidence-Based Policy (2011) is an impartial and objective non-profit and non-partisan group that reviews evidence for both Congress and federal agencies. The Coalition studied eight home visiting models that are currently being used within communities across the country. Out of the eight models studied for their ability to produce improvements in the lives of at-risk children and their families, the NFP model scored the highest level of confidence. In fact it was the only model that was given a confidence score of strong. Integral to this rating is that the program is correctly implemented within the community. The NFP model is also recognized as the only childhood program that meets the Coalition's top tier of evidence ranking.

In considering the cost benefit of the program, it is also important to provide cost analysis of implementing the program. For a development start-up it costs approximately \$4,070 per first-year program site. To train a NFP home visiting nurse it costs \$3,950. Additional education materials and guidelines include \$502. To train the nurse supervisor it costs \$4,663. As stated above, the NFP model believes in continuing support of the

nurses implementing the model. This is reflected in the ongoing annual education during the second year that costs \$1,526 per nursing team. Additional costs such as quality improvement, technical assistance, web resources, and measurement tools to name a few can cost approximately \$17,000. The NFP model developers require all these costs listed above. In conclusion the NFP can cost \$2,914 to \$6,463 per family per year with an average cost of \$4,500 (National Registry of Evidence-based Programs and Practices, 2013).

Nurse Role

According to the Nurse-Family Partnership official website, the nurse must develop a long-term relationship with the patients enrolled in the NFP model. This enables the nurse to encourage patients to achieve goals and focus on the strengths of the patient. The role is likened to that of an advisor or life coach. The advice for the mother encompasses preventive health, prenatal care, diet, substance reduction, and emotional preparedness for the arrival of the new baby. An additional goal includes helping the family gain economic self-sufficiency through realization of the family's future, gaining education through finishing school, aiding in securing employment, and planning for future pregnancies. Related to the child, the nurse provides education on child development, milestones, and behaviors, and encourages appropriate parenting techniques including nonviolent discipline and use of praise (Nurse-Family Partnership, 2011c).

The program nurse must be a registered nurse and have a minimum of a baccalaureate degree in nursing. Additionally a nurse who has a history in either maternal

and child health, behavioral health, pediatrics, or public health is preferable. The hired nurse must go through NFP specific training. Support for this nurse also lasts through the course of a career within the NFP model. There is a national nursing practice team that is utilized to equip individual public health nurses in the program delivery. From the beginning, the nurse must be a member of a local Nurse-Family Partnership agency. Within this model there is a nurse home visitor and a nurse supervisor. The agency provides education, resources, and tools for nurses fulfilling either one of the mentioned roles (Nurse-Family Partnership, 2011c).

NFP Conceptual Model

Three theories are integrated within the nurse's education of the NFP model and in turn must be used during program implementation. These include the self-efficacy theory by Albert Bandura, human ecology theory by Urie Bronfenbrenner, and attachment theory by John Bowlby. The self-efficacy theory is embedded in the idea that people will engage in a desired behavior if they believe that the behavior will produce that desired outcome. Furthermore they must believe they can carry out that behavior and achieve the desired outcome. The NFP model utilizes this theory to aid parent(s) to set realistic goals thereby increasing their confidence to achieve the goals. Increasing self-efficacy may be developed through helping a parent cease a risky behavior, engage in a new behavior and then learning to manage associated difficult situations. In the human ecology theory it is believed that how a parent cares for his or her child is influenced by the current social context. This context is defined as relationships with family members, friends, neighborhoods, communities, and even the culture as a whole. The NFP nurse

helps the parents successfully navigate through these different environments.

Generational effects are a component of the attachment theory. The principle of the generational effect is that a child who is raised in a sensitive and responsive environment will grow to be a sensitive and responsive parent. The NFP model uses this understanding of nurturing to provide teaching and parenting suggestions through the use of a supportive relationship between the nurse and parent. (Nurse-Family Partnership, 2011c).

Each nurse serves a maximum of 25 families. Each agency executing the model must have at least eight nurse home visitors, serving a total of 200 families. Oversight of the nurse home visitors by a full-time nurse supervisor is required. For program startup, the community agency must be able to provide care to a minimum of 100 families (Nurse-Family Partnership, 2011c).

NFP Model Pertaining to Montana

Montana does not have a listed state profile on record with the NFP home website although information on communities using the NFP model in Montana are available. There are 32 states listed with downloadable Adobe portable document format (PDF) files to view. These files contain state demographics specifically related to the implemented NFP model including counties that utilize the model, funding information, positive outcomes listed in statistical forms, and state-client demographics. The MCCHD, as of 2013, just had their first enrolled baby birth within the NFP model, however department personnel are still enrolling clients within the program (L. Blunt, personal communication, February, 11, 2013). Other Montana Counties that are adopting the NFP

model include Hill, Yellowstone, and Lewis and Clark (Nurse-Family Partnership, 2011b).

Overview of Montana

According to the United States Census Bureau (2010) the total population of persons living in Montana are 989,415. The three largest races making up the total population are 89.4% White, 6.3% American Indian/Alaska Native, 2.9% Hispanic/Latino. The remaining 1.4% of the population are various races including African American, Asian, Native Hawaiian/Other Pacific Islander, and other non-stated races.

The median household income in 2010 was \$44,011. The overall unemployment rate in 2011 was 6.8%. However, children under age 18 in 2010, living in poverty as defined by 100% below the federal poverty level, was 21% (Montana Kids Count, 2012). That is one in five children live in poverty within the state of Montana. Despite our rich natural resources and cultural heritage, Montana's children need proven social support systems to break through the cycle of poverty in order to live healthy lives that will last for generations.

Child Demographics. In Montana, 22% of the population was less than age 18. Child population by age group for Montana includes: ages zero to four comprises 28%, ages 5 to 11 comprises 38%, ages 12 to 14 comprises 17%, ages 15 to 17 comprises 18%, totaling 100% of those less than 18 or 222,979 children. Four percent of Montanan children live in an immigrant family and of those families, 7% are immigrant families

where the parents are not citizens of the United States (Annie E. Casey Foundation, 2013).

Child Health Indicators. Living in Montana may increase risks for vulnerable children. The Annie E. Casey Foundation, a leading national organization focused on research of children and their families, produces annual data and subsequent reports on child and family indicators for the nation and for each state individually. One domain that is studied by the Annie E. Casey Foundation is health. Health indicators that are considered within the domain include low-birth weight babies, children without health insurance, child and teen deaths, and lastly teens who abuse alcohol or drugs. Each state is ranked, one (best) to 50 (worst). In 2013, Montana ranked 50th in health (Annie E. Casey Foundation, 2013).

Missoula City-County Health Department Needs Assessment

In 2012, the MCCHD conducted a Maternal, Infant, Early Childhood Needs Assessment that included a parent survey. The survey consisted of 35 questions administered to parents of children living in Missoula County who utilize and are recipients of public resources. Of note, question 32 stated, “Would you consider partnering with local agencies to help improve Montana’s health outcomes (pp. 75)?” A total of 77 respondents answered and of these 75.3% stated yes they would while 24.7% stated no. This finding demonstrates that parents do in fact want to be partners in their local agencies. However question 33 inquired further into the application of a parent’s involvement and asked, “Have you ever participated on a board to represent the ‘parent

voice' for any agency (pp. 76)?" Of the 79 who answered this question, only 12.7% of respondents answered yes while 87.3% answered no implying an incongruence of those parents who would like to participate and those who actually do. The following question, number 34, asked an open ended response question, "What would make it possible for you to participate or what would prevent you from participating (pp. 76)?" Of the 54 written responses 33 or 61% mentioned time or scheduling as a constraint within their written responses. There were three comments of particular concern including, "If someone actually listened," "Not sure that my voice would make a difference," and "The notion of just being there but not being heard, or probably, understood (pp. 76-77)." These findings reflect the need to develop meaningful relationships, where the voice is captured, during the implementation and execution of service programs.

The Needs Assessment was never independently analyzed for themes or results. Therefore an item analysis or comprehensive overview cannot be discussed at this time regarding questions 32 through 34. Although parents may desire for their voices to be heard and would like to play a significant role in the services they receive, many of the parents voiced concern over having enough time for this type of activity. Even more concerning, some parents partaking in the needs assessment believed their voice might be disregarded if they participate. NFP researchers repeatedly assert that positive maternal and child outcomes are interrelated with the development of a trusting and therapeutic relationship between the mother and nurse. In addition, special considerations apply to the population of NFP mothers. The mothers that are typically enrolled within the NFP programs are young, at risk, and of low socioeconomic status. In regards to the NFP

mother population, fostering this voice so she can express it openly and without fear while respecting her time limitations may be found through the development of this trusting relationship. Part of this therapeutic relationship is the nurse enabling the mother to become empowered and active (Kurtz Landy et al., 2012).

Statement of the Problem

In 2013, Montana's overall child health status was 50th, or the lowest ranked in the United States (U.S.) (Annie E. Casey Foundation, 2013). The above statistic necessitates the need for improved health outcomes for Montana children. The NFP home visiting program has evidence-based research supporting and validating health outcomes among participants including the child, parents, and community. The MCCHD has adopted the NFP home visiting program, and has started implementation within Missoula County. The nurses at the MCCHD are required to engage in rigorous training developed by the NFP program. However within this strict implementation process community involvement is imperative. Specifically the State must have a two-way communication with the public to "ensure public input into decision-making processes," and that the State is both aware and responsive to any public concerns (Executive Office of Health and Human Services Department of Public Health, n.d., pp. 57). Additionally regarding implementation of the home visiting programs, the State must "describe how the at-risk community(ies) will be engaged in the decision-making regarding the home visiting program" (pp. 5). In relation to the implementation of the NFP model, the mother's voice or voice of the customer must be captured, as this is a specific and required provision

under the MIECHV. Historically capturing the parent voice has resulted in parents volunteering as advisory board members or volunteering to be present during meetings. Considering the atypical age demographics of an NFP parent and multiple barriers she must overcome daily, NFP mothers may be engaged in a nontraditional way. As MCCHD nurses implement the NFP program special considerations need to be given to include both traditional and nontraditional approaches for capturing the parent perspective.

Statement of Purpose

The purpose of this paper is to conduct a review of the literature to investigate communication approaches that the NFP nurse uses or could use during the home visit with the mother, that strengthens the ability of the nurse to capture and empower the mother's voice as customer.

Inquiry Question

What communication approaches are used by health care providers to strengthen and empower the mother's voice?

Conceptual Framework

The conceptual framework that will support this paper and be utilized is the self-efficacy theory by Albert Bandura. Bandura is an active theorist and has contributed to the understanding of the well-accepted social learning theory. A sub theory of his social learning theory is the self-efficacy theory (Arkes & Garske, 1982, pp. 212). In fact, the

self-efficacy theory is one of three theories that supports the NFP model and is employed into clinical care and delivery by NFP nurses.

Self-efficacy is a person's belief, in this case the mother's, that she can accomplish a task or situation through her own motivation and ability (Arkes & Garske, 1982, pp. 209-212). Self-efficacy is important and can be developed and strengthened in the mother, during home visits with the NFP nurse. Possible communication approaches that the NFP nurse uses or could use during the home visit with the mother may strengthen the mother's self-efficacy. Self-efficacy will be the conceptual framework for this paper and later discussed in chapter two.

Significance of the Study to Nursing

During the investigation of this subject, much research and data exist in how the voice of the customer can be captured within community programs designed to enhance the well being of the target population. There is equally as much literature proving the effectiveness of the NFP model in mothers, children, and communities where the program exists. Interestingly only one article was found that discusses key attributes of the nurse applying the program. This is the sentinel article addressed above by Kurtz Landy et al. (2012). The significance is that the NFP model only employs nurses in the delivery of the model. The nurse is the vehicle that delivers the NFP model to the mother. In essence the nurse is serving as one component of the intervention.

Furthermore the nurse is expected to assess, diagnose, and then apply targeted interventions, or treat, the human response to either actual or potential health problems

(American Nurses Association (ANA), 2014). Understanding the human response of at-risk new mothers and the communication that empowers this group of women contributes to improved outcomes. Olds chose nurses as the instruments; this creates a very important responsibility for NFP nurses. In conclusion, this idea of relationships is also highly regarded by the NFP authors and is evidenced through their values statement. “Respectful, collaboration, caring RELATIONSHIPS are the foundation of every interaction” (Nurse-Family Partnership, 2011a, para 3).

Operational Definition of Terms

Life coach is a person who helps people make decisions, set and attain goals, or solve problems. May be synonymous with advisor (Merriam-Webster, 2013).

Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) is a home visiting program that assists in both collaboration and partnership at three levels; federal, state, and community. The use of evidence-based programs are utilized with the goal of improving both health and development outcomes in at-risk children. There are three statutory purposes of the program and six benchmark areas that grantees must demonstrate improvement among the participating families, according to legislation requirements. MIECHV is authorized under the Social Security Act, Title V, Section 511 (42 USC 711) and amended by Section 2951 of the Patient Protection and Affordable Care Act (Health Resources and Services Administration, 2013).

Nurse-Family Partnership (NFP) is a community health program that is evidence-based. It provides care through ongoing nurse home visits by a registered nurse to low-

income, vulnerable women who are pregnant with their first child (Nurse-Family Partnership, 2012).

Self-efficacy is an individual's belief in his or her own personal capabilities. Additionally it is the belief that a person has control over the events in his or her life and those subsequent actions will be effective (Stuart, 2005, pp. 211). Theoretically self-efficacy is a concept of personal expectations "of competence in a performance situation" (Arkes & Garske, 1982, pp. 210). This theory was first defined by theorist Albert Bandura.

Voice of the Customer (VOC) is a process by which a customer's requirements are captured. A set of detailed wants and needs are produced and then organized into a hierarchical structure. There are four characteristics included in the voice of the customer and include a customer's needs, a hierarchical structure, priorities, and customer perceptions of performance. According to the Quality Function Deployment, voice of the customer can be a key input for new product definition. Understanding and developing this voice is an extremely important piece of the process in developing a new program or product (Gaskin, Griffin, Hauser, Katz, & Klein, 2011).

Organization of the Remainder of the Paper

Chapter Two will follow with the process and results of the literature review. Chapter Three will focus on the findings from the articles found in the literature review. Discussion on both the articles meeting inclusion criteria as well as the articles retained

for background information will be addressed. Chapter Four will summarize with a discussion on summary, recommendations, limitations, and conclusions.

CHAPTER TWO

REVIEW OF LITERATURE

Introduction

There are many studies and articles that have been written regarding parents' experiences while enrolled in a health program as well as examining the parents' voice as it relates to involvement in a formal avenue like a committee or as a board member. However few studies have explored the experiences of mothers participating in home visiting programs or the NFP program, and even fewer studies have explored how to capture their voice as customer. One study in particular by Kurtz Landy et al. (2012), entitled "Mother's experiences in the Nurse-Family Partnership Program: A Qualitative Case Study," was aimed at exploring and describing "the experiences of mothers participation in the NFP program from the time of program entry before 29 weeks gestation until the infant's first birthday" (pp. 16). Kurtz Landy et al. found that while many studies have both examined and demonstrated effectiveness of NFP programs that "no published research was found that specifically examined the experiences of mothers participating in this nurse home visiting program" (pp. 16). Kurtz Landy et al. did examine mothers' experiences and perceptions of home visiting by nurses and discussed these findings in the overview and background section but their specific research is unique to those mothers enrolled in the NFP program.

Jack, DiCenso, and Lohfeld (2005) have described how socially disadvantaged mothers perceive in-home visits by public health nurses. They noted that these mothers

feel vulnerable, powerless, and must overcome fear while engaging in social processes. The development of connected relationships may be supported through intentional actions including building trust, seeking mutuality, and provider actions. DeMay (2003) had similar findings in that mothers emphasized this theme of the nurse's qualities as well as feeling respected and not being told what to do.

One may hypothesize that capturing the mother's voice may be more dynamic and not as straightforward as requesting a mother to participate as a committee member or to contribute in a comparable fashion. Alternatively it may be through the development of a strategically developed nurse-mother relationship that this voice is captured in a meaningful way.

The results of this qualitative case study approach by Kurtz Landy et al. (2012) produced three themes that focused on the experiences of the mothers with their NFP nurse. The themes are as follows (pp. 18):

1. Getting into the NFP program.
2. The NFP nurse is an expert, but also like a friend providing support.
3. Participating in the NFP program is making me a better parent.

Of particular importance to this paper is the second theme that "the NFP nurse is an expert, but also like a friend, providing support" (pp. 18). The second theme does not directly state that the mother's voice was captured through this process. However when reading the six sub-themes that surfaced under this primary theme, it is apparent that the qualities exhibited by the nurse allowed the mother to develop a positive relationship.

From this positive relationship the mother was able to allow her voice to be expressed within the dyad relationship thus fostering the mother's voice.

The six sub-themes discovered include (pp. 18-19):

- (1) the nurse's personality;
- (2) the NFP nurse is "like a friend" who supports you;
- (3) the NFP nurse is respectful and trusting;
- (4) the NFP nurse is empowering and an advocate;
- (5) the NFP nurse is an honest expert; and
- (6) the NFP nurse is easy to access when you need her help.

As evidenced these six sub-themes speak to the similar findings of Jack et al. (2005) as well as DeMay (2003). The mothers in the Kurtz Landy et al. (2012) study directly point to the nurse's qualities that allow the mother to express her voice through the developed relationship.

Nurse as the Intervention

The Kurtz Landy et al. (2012) qualitative case study discovered one theme that the nurse is like an expert "friend providing support" (pp. 15) and consequently highlighted six further sub-themes that are more specific to this topic. The idea that the nurse is a friend is an interesting finding that allows for further research in how do nurses establish this friendship yet maintain nursing professionalisms while following the strict directives set forth by the NFP model. In essence, this theme points to the reality that nurses are the intervention. One limitation is that the author of this paper has not undergone any NFP training, which limits the ability for discussion on how this theme

and sub-themes are or are not already integrated into the rigorous NFP training.

Alternatively this may also be viewed as a strength, in that the review of literature will be uninfluenced by previous training and allow for the literature review to provide new insight. Furthermore the Kurtz Landy et al. article did not provide discussion within their paper of how these themes are currently integrated into NFP curriculum but rather implied that these are new themes and developments that have yet to be discussed or incorporated formally. The research found may not only contribute to how NFP nurses may utilize therapeutic techniques to accomplish the sub-theme goals but may be broadly applicable to nurses at every level and in every setting, to better benefit the therapeutic nurse-patient relationship.

Organization and Structure

The remainder of this chapter will first discuss the search methods and results that were utilized in the literature review for sub-theme three, that the nurse is trusting. Based on constraints and the ability to adequately review the topic of trust only one sub-theme was chosen for investigation. Results will be given of each article found, as well as background articles that were retained for further information but did not meet inclusion criteria. Detailed results of analysis and synthesis of the information found will be expanded upon in chapter three. Lastly will be a discussion on the conceptual framework, self-efficacy theory, and the application in regards to the review of literature.

Search Methods and Results

The following databases were utilized in the literature review: Cumulative Index of Nursing and Allied Health Literature (CINAHL), Web of Science, and PubMed. Limitations included articles published after January 01, 2000, and articles written only in the English language. The articles found must be based on the population of mothers or parents receiving home visiting services. The primary search term was *trust*. The secondary search terms were *develop* and *establish*. The following seven terms were interchanged in the search criteria: *home visit*, *public health nurse*, *nurse family partnership*, *patient perspective*, *health care provider*, *nurse*, and *physician*. The application of MeSH was trialed in the literature search however this was unable to be completed. According to the PubMed MeSH database *trust* was indexed as a MeSH term in 2003 with an assigned tree number but no entry terms or synonym terms exist. *Develop* and *establish* have not been indexed in the MeSH term database and do not exist.

After reviewing articles, two different approaches to capturing the mother's voice surfaced. First is through direct evaluation of public health nurses (PHNs) or other health care professionals delivering patient care. Second is through evaluation, collection, and exploration of the experiences of the mothers, as reported in their own voice (Rautio, 2013). Many studies have asked PHNs what strategies are used or what is considered important in developing a therapeutic relationship and capturing the mother's voice. Studies directly examining the mother's experiences and perspectives, through her voice, are few (Jack et al., 2005; Kardamanidis, Kemp, & Schmid, 2009; Kurtz Landy et al., 2012; Rautio, 2013). Although obtaining nurses or health care professionals perspectives

are irreplaceable in understanding the patient population served, for the purpose of this paper only articles focusing on the mother's or even parent's perspective were kept for review. Several articles were retained for review and background information on trust but did not meet inclusion criteria.

CINAHL

Searching the terms *trust* AND *develop* yielded 545 articles. It was apparent that the additional seven search terms were needed to narrow the topic of interest. *Trust* AND *develop* AND *home visit* yielded two irrelevant articles. Adding the third search term *public health nurse* yielded one applicable article (Jack et al., 2005). Adding the third search term *nurse family partnership* yielded zero articles. Both search terms *patient perspective* and *health care provider* yielded one irrelevant article each. Placing *nurse* as a search term yielded 133 articles resulting in two applicable articles (Jack et al., 2005; Norris, Howell, Wydeven, & Kunes-Connell, 2009). One of these articles was a duplicate from the search with *public health nurse*. The third term *physician* yielded 38 results with no applicable articles.

Searching terms *trust* AND *establish* yielded 177 results. Placing independently both the third search terms *public health nurse* and *nurse family partnership* yielded zero results. Placing *patient perspective* yielded two irrelevant articles. Search term *home visit* and *health care provider* yielded one irrelevant article. Search term *nurse* yielded 43 results with one applicable article (Norris et al., 2009). *Physician* as the third search term yielded 15 irrelevant results.

Table 1. CINAHL Studies Meeting Inclusion Criteria

Author	Year	Country	Design	Purpose	Sample	Results
Jack et al.	2005	Canada	Qualitative study using classic Grounded theory; interviews	Describe the process by which mothers of children at-risk engage with PHNs in a home visiting program.	N = 20 mothers	When home visiting services are provided mothers feel vulnerable, powerless. Mothers engage via basic social process to limit vulnerability; overcoming fear, building trust, seeking mutuality. PHN characteristics influence the speed of each phase and to create connected relationships.
Norris et al.	2009	USA	Qualitative study using Grounded theory; focus groups.	Describe nature of how nurses establish/maintain relationships with pregnant teenagers to achieve positive health/life outcomes.	N = 4 mothers who had completed an NFP program N = 6 nurses	Theory of Partnering was utilized to address patient engagement, mutual goals, and disengaging. Trust is the turning point in the relationship and action processes for maintaining boundaries. Study results provide model for building nurse-patient relationships.

Web of Science

Searching the terms *trust* AND *develop* yielded 8,069 articles. *Trust* AND *develop* AND *home visit* yielded two applicable articles (Jack et al., 2005; Rautio, 2013) out of 22. The article by Jack et al. was also found under the CINAHL search. Adding the third search term *public health nurse* yielded four applicable articles (Jack et al., 2005; Norris, 2009; Porr, Drummond, & Olson, 2012; Rautio, 2013) out of 30 total. Two of these articles were already found using CINAHL. The search term *nurse family*

partnership yielded 12 articles and one redundant applicable article found earlier (Poor et al., 2012). *Patient perspective* yielded 124 results with one semi-applicable article (Klostermann, Slap, Nebrig, Tivorsak, Britto, 2005) that will be retained for background information and insight. *Health care provider* yielded 171 non applicable articles. Placing *nurse* as the third search term yielded 367 articles resulting in three applicable articles (Norris et al, 2009; Poor et al., 2012; Rautio, 2013). All three articles had been previously discovered with search terms *home visit*, *nurse family partnership*, and *public health nurse*. Two further articles will be retained for background information (Dinc & Gastmans, 2013; Hupcey, Penrod, Morse, & Mitchman, 2001). The third term *physician* yielded 306 results with one result that was previously found and retained as a background article (Klostermann et al., 2005).

Searching terms *trust* AND *establish* yielded 4,182 results. The third search term *home visit* yielded ten irrelevant articles. *Public health nurse* yielded two articles meeting the inclusion criteria out of 18 total but were redundant findings from previous searches (Norris, 2009; Poor et al., 2012). *Nurse family partnership* yielded two total articles with one redundant article previously found (Poor et al., 2012). Placing *patient perspective* yielded 51 irrelevant articles. Search term *health care provider* yielded 84 irrelevant articles. Search term *nurse* yielded 175 results with two previously found applicable articles (Norris et al., 2009; Poor et al., 2012). Two articles were retained for background information (Dinc & Gastmans, 2012; Dinc & Gastmans, 2013). One article had been previously found through Web of Science and the second was a new research article that had not been previously found through the literature search. *Physician* as the third search

term yielded 156 irrelevant results. Several of the articles found not meeting inclusion criteria were conducted through capturing the patient's voice however the patient population was inappropriate according to the inclusion criteria; for example population focuses on the elderly or male patient.

Table 2. Web of Science Studies Meeting Inclusion Criteria

Author	Year	Country	Design	Purpose	Sample	Results
Jack et al.	2005	Canada	Qualitative study using classic Grounded theory; interviews.	Describe the process by which mothers of children at-risk engage with PHNs in a home visiting program.	N = 20 mothers	When home visiting services are provided mothers feel vulnerable, powerless. Mothers engage via basic social process to limit vulnerability; overcoming fear, building trust, seeking mutuality. PHN characteristics influence the speed of each phase and to create connected relationship.
Norris et al.	2009	USA	Qualitative study using Grounded theory; focus groups.	Describe nature of how nurses establish/maintain relationships with pregnant teenagers to achieve positive health/life outcomes.	N = 4 mothers who had completed an NFP program N = 6 nurses	Theory of Partnering was utilized to address patient engagement, mutual goals, and disengaging. Trust is the turning point in the relationship and action processes for maintaining boundaries. Study results provide model for building nurse-patient relationships.
Poor et al.	2012	Canada	Qualitative study using Grounded theory; interviews	How do PHNs develop therapeutic relationships with single, mothers living in low-income situations?	N = 21 mothers N = 15 PHNs	Development of a theoretical model, Targeting Essence: Pragmatic Variation of the Therapeutic Relationship; six stage relationship-building process. Third stage: Ascertain Motives is to trust or mistrust.

Table 2. Web of Science Studies Meeting Inclusion Criteria, continued

Author	Year	Country	Design	Purpose	Sample	Results
Rautio	2013	Finland	Qualitative study; interviews	Gather and investigate home health visiting experiences of parents as reported in their own words.	N = 9 parents	Two surfacing themes; building trust among parents and professionals. Second theme is empowering parents through support.

Table 3. Web of Science Studies Not- Meeting Inclusion Criteria but Retained for Background Information

Author	Year	Country	Design	Purpose	Sample	Results
Dinc et al.	2012	Publication of articles include: United Kingdom, USA, Canada.	Argument-based literature review	To provide understanding of the conceptual understanding of trust/trustworthiness in nursing.	N = 17 articles	Trust/trustworthiness is inadequately researched and explored in nursing ethic literature.
Dinc et al.	2013	Publication of articles include: USA, Sweden, Australia, Canada, China, United Kingdom, Ireland, Taiwan, Finland, Iran, Norway, South Africa, and Iceland.	Integrative literature review	Report results of literature review on empirical studies on trust in the nurse-patient relationship.	N = 34 articles (publish dates 1980-2011) (22 articles = qualitative. 12 articles = quantitative)	Trust is a relational phenomenon and process. Trust can be broken but also re-established. Competencies and attributes of the nurse are important in developing trust.
Hupcey et al.	2001	Authors from USA and Canada. No breakdown of articles or publish location such as the country of origin.	Integrative literature review, concept analysis.	Clarification and development of the scientific concept and definition of trust.	N = 107 articles	Interdisciplinary concept of trust was found to be immature therefore questions were asked of the data. Led to development of an expanded interdisciplinary conceptual definition of trust that transcends disciplines.

Table 3. Web of Science Studies Not- Meeting Inclusion Criteria but Retained for Background Information, continued.

Author	Year	Country	Design	Purpose	Sample	Results
Klostermann et al.	2005	USA	Qualitative study; focus groups.	Examine adolescents in how they perceive patient-physician trust. Identify physician behaviors that relate to these trust perceptions.	N = 54 adolescents (aged 11-19)	Adolescents hold certain beliefs related to trust in their physician. They hold similar elements that adults do such as fidelity, confidentiality, competency, honesty. However there were noted differences in these domains.

PubMed

Searching terms *trust* AND *develop* yielded 3,376 articles. Placing the third term *home visit* yielded six non-applicable articles. *Public health nurse* yielded a total of 30 articles with one applicable article (Jack et al., 2005). *Nurse family partnership* yielded five articles and no articles meeting inclusion criteria. *Patient perspective* yielded 44 articles with no applicable articles. One article (Ridd, Shaw, Lewis, & Salisbury, 2009) within that search was excellent on obtaining the patient voice in primary care settings. However this literature review resulting in 11 articles found contained reviews in which the patient population was unknown; this does not meet the criteria of obtaining the voice of child-bearing aged women or parents. Placing *health care provider* as the third search term yielded 367 articles with no applicable articles. Placing *nurse* as the third search term yielded 366 articles. Two articles (Jack et al., 2005; Norris, 2009) were found that were previously retained from previous searches in CINAHL and Web of Science. One article (Lori, Yi, & Martyn, 2011) was retained for background information. The article

was relevant in capturing the mother's voice from the appropriate population however the article was addressing women's experiences in a primary care clinic setting. Placing the third term *physician* yielded 162 articles with no articles meeting inclusion criteria. One background article that was retained from a previous search was found (Lori et al., 2011).

Searching terms *trust* AND *establish* yielded 2,166 articles. Placing the third term *home visit* yielded four irrelevant articles, *public health nurse* yielded nine irrelevant articles, *nurse family partnership* yielded one irrelevant article, *patient perspective* yielded 18 irrelevant articles, and *health care provider* yielded 145 irrelevant articles. Search term *nurse* yielded 125 articles. One article (Norris et al., 2009) was applicable but was a redundant finding from CINAHL and Web of Science and one article (Dinc & Gastmans, 2012) retained for background information but was also redundant from previous searches. *Physician* yielded 77 irrelevant articles.

Table 4. PubMed Studies Meeting Inclusion Criteria

Author	Year	Country	Design	Purpose	Sample	Results
Jack et al.	2005	Canada	Qualitative study using classic Grounded theory; interviews.	Describe the process by which mothers of children at-risk engage with PHNs in a home visiting program.	N = 20 mothers	When home visiting services are provided mothers feel vulnerable, powerless. Mothers engage via basic social process to limit vulnerability; overcoming fear, building trust, seeking mutuality. PHN characteristics influence the speed of each phase and to create connected relationship.
Norris et al.	2009	USA	Qualitative study using Grounded theory; focus groups.	Describe nature of how nurses establish/maintain relationships with pregnant teenagers to achieve positive health/life outcomes.	N = 4 mothers who had completed an NFP program N = 6 nurses	Theory of Partnering was utilized to address patient engagement, mutual goals, and disengaging. Trust is the turning point in the relationship and action processes for maintaining boundaries. Study results provide model for building nurse-patient relationships.

Table 5. PubMed Studies Not- Meeting Inclusion Criteria but Retained for Background Information.

Author	Year	Country	Design	Purpose	Sample	Results
Dinc et al.	2012	Publication of articles include: United Kingdom, USA, Canada.	Argument-based literature review	To provide understanding of the conceptual understanding of trust/ trustworthiness in nursing.	N = 17 articles	Trust/ trustworthiness is inadequately researched and explored in nursing ethic literature.
Lori et al.	2011	USA	Qualitative Study	What do African American pregnant women identify as important provider characteristics when receiving prenatal care in an outpatient setting?	N = 22 women (ages 19 – 28 years of age)	Desire of the women to be known and remembered by their providers. This leads to development of a trusting relationship.

Discussion of the Conceptual Framework

One characteristic of the social learning theory is that of self-constructs. Two self-system constructs that illuminate the role of motivation in the social learning theory are that of self-reinforcement and self-efficacy. Self-efficacy will be the focus and expanded on with consideration of how it will apply to the following literature search and incorporated into this paper. An understanding of this theory is that motivation of a person's behavior arises from three self-regulatory processes: observation, judgment, and response. These processes are not explained under self-reinforcement but rather under self-efficacy. Self-efficacy is a person's expectations and consists of two classes: outcome expectations and efficacy expectations. Definition of outcome expectation is "a person's probability estimate that a certain behavior will lead to certain outcomes (or reinforcements)." While efficacy expectation is "a person's estimate that he or she can

perform the behavior required for the outcomes.” Simply the first definition is the knowledge of what to do, while the second definition is a judgment of whether or not it can be done (Arkes & Garske, 1982, pp. 209-211). Considering the NFP model both outcome expectation and efficacy expectation are employed by the PHN within the dyad relationship with the mother. First the PHN provides knowledge of what the mother ought to do in relation to pregnancy health and positive outcomes and then regarding the health and development of her baby. Second, and more importantly to this paper, the PHN strengthens the mother’s self-judgment or belief that she can perform the expected behaviors required for positive maternal and child outcomes. Again, this strengthening process is through the use of the therapeutic relationship and fostering of voice.

Furthermore on the development of efficacy expectation, a person’s efficacy expectations are important in that it is one’s beliefs regarding “mastery, competence and ability” in any given situation. Therefore a person’s belief of self-efficacy will determine the motivation in performing the task at hand. Self-efficacy belief is based on four sources of information including performance accomplishments, vicarious experiences, verbal persuasion, and emotional arousal. Performance accomplishments are defined and affect a person’s expectations of self-efficacy through personal successes and failures retained in memory. Vicarious experiences are symbolic coding of previously modeled activities that affect expectations. Verbal persuasion is typically an influence on efficacy through the use of prompting, coaxing, and praising by others. Lastly emotional arousal is the ability to decrease fear and anxiety, traditionally in a threatening situation, that will be influential in determining expectation related to self-efficacy. People in fact are able to

reinforce themselves leading to motivation of their own behavior and choices that are established through self-efficacy (Arkes & Garske, 1982, pp. 209-212).

From a working definition based in nursing education, it is believed that if a patient has a high level of self-efficacy then this will positively affect the “thoughts, motivation, mood, and physical health” of the patient. “Preventive interventions related to health education can equip people to take control of their lives and start a process of self-regulated change guided by a sense of resiliency and personal efficacy” (Stuart, 2005, pp. 211). This is an understanding of the theory in light of the nurse-patient dynamic.

In conclusion, Bandura’s theory understands that learning principles explain and predict behavior and change. Bandura himself stated, “Both people and their environments are reciprocal determinants of each other.” Furthermore both the interactions of the individual and with others are aspects of personality functioning and should be taken into account within the social context in which behavior is acquired and maintained. The above postulation highlights that behavior change can take place through modeling or that “social learning theory is based on the premise that human behavior is largely acquired and that the principles of learning are sufficient to account for the development and maintenance of that behavior” (Hall & Lindzey, 1978, pp. 617-618).

In consideration with the NFP model and consistent with self-efficacy theory, change needs to be brought about by therapeutic techniques by means of any form. This allows the development of self-efficacy so that the expectation of the mother, in this case, by her own personal efforts, is able to master a situation and bring about the desired outcome. The problem arises when the mother has a belief that she is unable to cope

successfully within a situation. Central to self-efficacy is the ability to decrease negative emotional arousal and the sense of imminent threat through techniques that remove the mother's disbelief in her personal efficacy. Observing this model, the NFP nurse, is a utilization of vicarious experience. Most effective however is the ability of the mother to successfully perform accomplishments in actual situations. This is strengthened through repeated successes and building strong efficacy within the mother. Important is the mother's ability to attribute her success to her own effort, not the efforts or interventions of an outside agency like the NFP model. Techniques should also focus on the attributes of the mother's own efforts but also the introduction of outside methods. It is important for the outside model, the NFP nurse, to allow the mother to progressively become independent in her own efforts thus decreasing the effects of learned helplessness or lack of self-efficacy. Behavioral change and processes that enhance this will increase the mother's self-efficacy. Critical is that the mother believes she is able to perform the tasks at hand and that her self-efficacy has been strengthened by the program end (Hall & Lindzey, 1978, pp. 624-625).

In conclusion the mother needs to realize that she is able to regulate her own behavior, control it, as well as her environment to a certain degree; in essence that she is not controlled by her environment but can influence the outcome of her future (Hall & Lindzey, 1978, pp. 624-625). One may suggest that if the mother does not feel safe to express her voice, or that the voice of the mother is not actively garnered in the dyad relationship within the NFP model, how then will the PHN be able to develop and

strengthen the even more complicated mastery and development of self-efficacy within the mother?

CHAPTER THREE

RESULTS AND ANALYSIS OF DATA

Introduction

A total of five qualitative articles were found directly examining the voice of the mother and met the pre-established search criteria. Three search engines were utilized with a total of ten search terms. Five articles were retained as background and supplemental articles that had some applicability to the topic of interest.

Total number of relevant articles found was a surprising find. Initially the search was refined to articles that were applicable to only nursing; however after consideration other health professional allies were included in the search. Widening the search criteria to include health care providers and physicians did not result in a larger sample size of articles meeting search criteria. In fact the five articles that were found focused primarily on nurses in the home-visit setting. Trust was the specific means of expression utilized for the literature review. Although the sample size of articles is small, relevant themes and concepts can be gleaned and will be discussed below.

While the sample size was disappointing, it speaks to the relevancy and even necessity of the search. In December 2013, nurses again were overwhelmingly rated the top profession for honest and ethical standards (Gallup, 2014). The ANA (2012) validated this and cited a Gallup finding that nurses are truly “the most trusted profession” (pp. 1). Established is the reality that nurses are trusted among their patients and the population as a whole. Less established is the understanding of how we garner

that trust at the individual and intimate level of the nurse-patient interaction. Second is the noteworthy understanding that continued research is required in how we capture this voice as a whole but also in relation to specific at risk or unique populations like low income first time mothers. The five articles will be analyzed below with themes and findings followed by a discussion of the conclusions and recommendations in chapter four.

Trust

Through the literature search several articles were found that directly spoke to the definition and overview of trust. These three articles were retained for background information and are worthy of review prior to discussing the results of the literature review. Discussing the findings from these articles may aid the reader in understanding the concept of themes discussed below. Several working definitions from the literature will also be given regarding trust. Consideration is needed to remember that the discussion below on trust is the summarization of three integrative literature review articles. The articles were not strictly based on the patient's voice or voice of the customer as they included health professionals as part of the sample population. Furthermore the articles include various patient population ages and different settings.

Background and Definitions

The word trust is used in both lay and everyday conversation as well as in the health and scientific fields. Various allied health professions utilize the term trust including nursing, medicine, psychology and sociology disciplines. No widely accepted

term has been adopted that can be utilized in an interdisciplinary understanding (Dinc & Gastmans, 2012; Hupcey et al, 2001). Furthermore the definition of trust can be immature, vague, ambiguous, and not well established within different health care domain's definition. Known is that trust is used to describe the health care provider and patient relationship. It is widely understood that it is important to have trust in order to serve the patient and improve health outcomes (Dinc & Gastmans, 2013; Hupcey et al., 2001).

Nursing. Findings from a nursing approach included that trust is built over time and represents an increase in vulnerability due to the component of reliance. Trust is utilized extensively in research and conversation but the definition of trust for nursing is historically taken from other disciplines. Loss of trust results in a disruption of the relationship and contributes to a subjective or biological disturbance experienced by the patient. Interestingly measurements of trust are truly absent or limited in the nursing literature (Hupcey et al., 2001).

A greater understanding of trust related to nursing according to findings by both Hupcey et al. (2001) and Dinc and Gastmans (2013; 2012), is that trust is an expectation or having confidence in someone. Trust involves relationship. Yet although nursing has applied this concept and term, the profession has done so “without a clear conceptual development” (Hupcey et al., 2001, pp. 285). Trust as a word, is found throughout nursing literature without a clear working definition. In an age where evidence-based practice is the expectation, we are applying this concept and it has “been bound to the nurse-patient relationship” but without a real definition or ability to measure quality

(Hupcey et al., 2001, pp. 285). Dinc and Gastmans (2012) also support the idea that trust or trustworthiness is poorly explained in nursing ethics literature.

Dinc & Gastmans (2013) found several quantitative studies during their integrative literature review, which used scales to assess the provider-patient relationship and trust. The scales found included: Trust in Provider Scale, Cultural Mistrust Inventory, the Michigan Academic Consortium Patient Satisfaction tool, Group-Based Medical Mistrust Scale, Black Racial Identity Attitude Scale, Trust Subscale of the Patient's Opinion of Nursing Care, Caring Behaviors Assessment tool, and Caring Assessment Questionnaire. Not all these scales are based on nurse-patient relationships, some scales measure the patient's perspective while other scales measure the provider's opinion, and some scales only address trust as a subset within the scale. The NFP program utilizes a tool called "How are we doing" that directly allows for the mother to give feedback during the course of the program (K. Siegrist, personal communication, February 19, 2014). The "How are we doing" tool is unavailable for viewing unless the material is purchased and is applicable only to the NFP model.

The understanding of trust is important to the nursing profession. In a review of 34 articles, Dinc & Gastmans (2013) found only one article that addressed preconditions or "necessary conditions" for the formation of trust in the nurse-patient relationship (pp. 505). If a working definition of trust is established this will aid the professional obligation, nurse-patient relationship, aid educators, and facilitate future research (Dinc & Gastmans, 2012).

Medicine. In medicine, stress is placed on a patient trusting the physician and health outcomes tied to the level and ability of trust. Also described in the medical literature is the ability of society or the population to trust the health care system as a whole. Specific attributes of physician-patient trust development were found and include the patient's welfare or best interest is given priority as well as "thoroughly evaluating problems, understanding a patient's individual experience, expressing care, providing appropriate and effective treatment, communicating clearly, building a partnership and being honest and respectful to the patient" (pp. 285). One instrument was found in the medical literature regarding measuring trust. Distrust was also found as a relevant term relating to trust (Hupcey et al., 2001).

Psychology. Psychology had its own unique findings on trust and is defined as an interpersonal term. Trust is seen as an essential component in societies and human development. Trust is considered a learned behavior and not an inherent personality trait. To trust implies inherent risk taking. Similar to nursing, trust is established over time and through repeated interactions. Like medicine, distrust was an equally relevant term. Psychology, more than nursing or medicine, has designed scales and ways to measure trust and distrust (Hupcey et al., 2001).

Sociology. Sociology had the least defined understanding of trust according to the literature. Trust in sociology is examined on the individual, system, institutional, and societal plane as a whole. Trust is broken down to cognitive, emotional, and behavioral components. Just as nursing and psychology address components of trust being built over time, so does sociology. Interestingly sociology implies that there are personality traits

that influence trust. Like psychology, sociology acknowledges the inherent risk that is assumed with trust, but unique to sociology is that an individual can calculate trust-associated risk. No measurements have been developed in the discipline of sociology to measure trust according to Hupcey et al.'s findings (2001).

Interrelated Terms

Terms that are most closely related to trust vary by discipline. Dinc and Gastmans (2012) found the term most linked to trust in nursing literature was faith, belief, goodwill, confidence, and hope. Hupcey et al. (2001) linked nursing's definition of trust to respect. Medicine utilizes truth. Psychology synonym for trust includes faith with no likened term in sociology.

Specific to nursing are two different forms that further define trust, interpersonal and impersonal. Simply interpersonal trust is the provider-patient relationship. Impersonal trust is established through identification with an organization. To complicate the understanding of trust is the ethical component of trust referenced in nursing literature, which concerns values and norms when attempting to verify the rightness of ones actions regarding trust. Describing and measuring the ethical component of trust is also not agreed upon in nursing literature. However the concept of goodwill, do no harm, and moral commitment are represented in the literature (Dinc & Gastmans, 2013; Dinc & Gastmans, 2012).

All three articles support the idea that trust is a process with steps. Agreed is a need and willingness by the patient to seek help from another, yet past patient experience can be influential and a power balance can exist between provider and patient. Then a

level of risk is considered with trusting, referring to vulnerability and dependency assumed by the patient. The decision to trust and assume risk is a choice. During the process of building trust, which requires time, is the understanding that an expected outcome will be achieved and a certain behavior is anticipated of the caregiver.

Boundaries exist with trust and a person may render their trust in one area but not another area of their life. A testing of trust may also be observed. Testing can be subconscious or conscious. There is a measuring of the outcomes of the trust relationship and if needs were met. Complicating the process is an understanding that building trust is fragile and intimate. Not agreed upon, but an important consideration, is the understanding of how much the moral virtue and character of the trustee contributes to the relationship.

Furthermore is the question of how much does the bond of friendship, sharing of feelings, competence of nursing knowledge and skills, and other components factor into trust development (Dinc & Gastmans, 2013; Dinc & Gastmans, 2012; Hupcey et al., 2001).

Major Themes in Establishment of Trust

Through analysis and examination of the five applicable articles, major themes found of mothers participating in home-visiting programs and expressed as important factors in receiving care and building trust include: the nurses or health care provider's personality, friendship, availability, empowerment, reducing vulnerability, and testing. Sub-themes include emotional support, knowing, control, verbal appraisal, advocacy, and respect.

Personality

The nurse's personality was highlighted as an important element in developing a therapeutic relationship and engagement during the home visit (Kurtz Landy et al., 2012; Porr et al., 2012; Rautio 2013). Many of these components named by mothers are multifaceted and overlap with other relevant factors in the patient-nurse relationship that supports voice. Personality traits described by the mother include use of humor, friendliness, honesty, non-judgmental, reliable, and easy going (Kurtz Landy et al., 2012). Additionally a cheerful or lively nature, happy, friendly, laughing, smiling, relaxed posture, soft voice, joyful, eye contact, and overall down-to-earth appearance were positive traits expressed (Porr et al., 2012). Genuineness is yet another personality trait identified (Jack et al., 2005; Rautio, 2013). Warmth, reliability, humor, respect, smiling, encouraging, empathy and caring were further terms identified by Jack et al. (2005). Alternatively if the nurse at any point insulted the mother during a home visit, the nurse's personality may be one aspect that could keep the mother participating despite this offense (Kurtz Landy et al., 2012). A single component of relational trust building identified as a component of the nurse's personality was the ability of honest and open communication, both in a personal and professional manner (Rautio, 2013).

Friendship

Friendship or being like a friend implies several different components including professional and non-professional aspects. The ability of the nurse to make him or herself at home and look comfortable is a characteristic one mother perceived as supporting a friend like relationship (Kurtz Landy et al., 2012). Even the length of time that a nurse

was willing to spend during a home visit was an important component (Rautio, 2013) yet spending too much time of an already taxed young mother could have the opposite effect (Kurtz Landy et al., 2012). The mothers even explained that the nurse was like a mother or the idealization of what a supportive friend or family should be (Kurtz Landy et al., 2012; Porr et al., 2012). Another friendship feature explained by the mothers was that they became attached to their PHN (Norris et al., 2009). Unique yet critical to building friendship is the ability of only one nurse providing care, thus maintaining continuity (Kurtz Landy et al., 2012). Length of time with a health care provider was also validated as important by Jack et al. (2005) for building trust.

Nurses also displayed friendship qualities that were unique to their professional status. The nurse was described as not only an expert, but as an honest expert. The nurse gave advice, answered questions, provided expert opinion that the mother trusted, found comforting, and could rely on. Mothers felt that nurses had the ability to normalize the information given yet were able to assess the learning needs of the mother thus providing education the mothers could understand. Not only were the communication qualities of the nurse expressed as important but also the physical assessments skills. Mothers specifically identified this when nurses interacted with their infants (Kurtz Landy et al., 2012). Also noted was the nurse's ability to provide knowledge regarding parenting, even sharing one's own experiences as a parent (Jack et al., 2005; Rautio, 2013). Interestingly although the nurse was identified as being an expert professional, the nurse maintained the ability for the mother to believe that the exchange of information was simply from person to person. This enabled the mother to ask her nurse questions that she did not feel

comfortable asking other health care professionals (Kurtz Landy et al., 2012). Also supported by Norris et al. (2009) was that the mother felt that she could discuss with her nurse different aspects of her life or problems that she may not necessarily disclose to others.

Through the friendship, the mothers never expressed a loss in understanding the therapeutic relationship and the nurse's professional role. In fact 'friend' seemed to be the lay term utilized by the mothers for therapeutic relationship (Kurtz Landy et al., 2012; Porr et al., 2012; Rautio, 2013). Yet the strong emphasis that the nurse placed on a non-hierarchical, person-to-person relationship was pivotal for the mother in developing this strong, trusting relationship (Jack et al., 2005; Kurtz Landy et al., 2012).

Emotional Support. A component of friendship is the ability to provide emotional support when young mothers lack emotional support from their family or friends. The history of many of the mothers included loss of family or friends due to pregnancy, social isolation, or living in difficult situations like foster care. When the PHN entered the life of a mother it was often during a time when emotional support was lacking and the PHN became a trusted friend offering support (Kurtz Landy et al., 2012). Alternatively Rautio (2013) found that emotional sharing by the health care provider was important in the ability to become close.

Knowing. Furthermore is the nurse's ability to represent herself as a friend and not as if the home visit was 'like a job' as one mother asserted. The ability to talk about life, both the mother's as well as share one's own life and personal experiences is a demonstration of friendship. Sharing of stories and knowing the mother's stories built

trust. Mothers expressed that this developed friendship is an added, unexpected bonus to participating in a home visiting program (Jack et al., 2005; Kurtz Landy et al., 2012). Mothers repeatedly expressed feelings of being treated inconsiderately due to their young age, but often once a relationship is built with time and the ability to know each other developed, those feelings dissipated. Another component of knowing is that some mothers emphasized the importance on being asked how they were handling the home services and any related program stress. If mothers were not directly asked how they were coping, they may not inform the health care worker of any related complaints or concerns. Simply listening and the feeling of being understood were described as knowing (Rautio, 2013).

Porr et al. (2012) identified an additional component of knowing that was expressed as important by the mother and included the PHN knowing her child and “how much effort was put forth ‘getting to know’” the child (pp. 389). When the PHN approached the infant or child as a patient or as a component of the job, the mother received this poorly. Even the amount of effort and time the nurse chose to invest in the child was important. Mothers stressed that when the nurse acknowledged, made eye contact, addressed, called by name, and played with the child this built rapport and strengthened the relationship. Mothers even discussed how their infant or child was “smart” and “chose” the PHN they liked (pp. 389). Jack et al. (2005) briefly addressed that mothers noted when PHNs did not invest in knowing in their child and feelings of relational disconnect was a result.

Availability

The ability and ease of contacting the PHN was significant. Mothers felt they could contact their nurse for basic questions regarding health or to help with personal issues like relationship questions. Not only did mothers voice the importance of home visits when public transportation became difficult with an infant or when resources were lacking to travel; but the use of connection through telephone and timely call backs helped reduce stress felt by mothers and strengthen trust in regards to availability (Kurtz Landy et al., 2012). Also described was the nurse's willingness to travel to new locations or home visit sites if the patient had moved. This was seen as availability on the part of the nurse to accommodate the mother despite her transition in living situations or conditions (Norris et al., 2009).

Empowerment

Simply by being reciprocally trusted by the PHN was empowering to mothers. Explanations were not given specifically by what the nurse did to trust the mothers but regardless this was noted as empowering to the mother and strengthened her trust in the nurse (Kurtz Landy et al., 2012). Other acts of empowerment were seen through conversational support that was given in the home setting, aiding a mother in advancing her health and economic status, or supporting a decision made by the mother or family unit (Rautio, 2013).

Control. A component of empowerment was the mother's ability to control particular aspects of the home visit. Unique to the NFP model is the mother's ability to

control activities and learning agendas (Kurtz Landy et al., 2012; Norris, 2009). The ability to schedule appointments was also important, as was the ability to re-schedule appointments and the flexibility expressed by the nurse in this process. Aiding the mother in her ability to increase control in her and her child's health and life outcomes enforced empowerment by the mother (Kurtz Landy et al., 2012). This is a direct example of building self-efficacy. Jack et al. (2005) and Rautio (2013) also stated that allowing the mother to have control through use of allowing her to guide the structure and goals of the home visit supported empowerment as did allowing for opportunities of input.

Verbal Praise. Verbally praising young mothers was viewed as critical, especially with consideration of the patient's social context, background, and young age during pregnancy. Simply encouraging, informing of a job well done, and lack of verbal judgment towards the mother's decisions were all positive reinforcement that strengthened the dyad relationship (Jack et al., 2005; Kurtz Landy et al., 2012; Norris et al., 2009; Porr et al., 2012). Rautio (2013) also confirmed this finding that it is important for parents to hear verbal praise, particularly regarding parenting skills. Simply a small word or act can be very empowering. However when PHNs verbally praised mothers, the mothers were able to identify empty flattery or incongruence in verbal praise that was not sincere (Porr et al., 2012) highlighting the importance of appropriate and genuine praise. Verbally praising mothers was associated with strengthening of a mother's self-efficacy. Porr et al. (2012) expressed this as making the mothers "feel self-conscious in a positive way" (pp. 392). Verbal praise truly is significant and pivotal when considering the past experiences of the mothers that often are entrenched in histories of physical or emotional

abuse, social deprivation, feelings of not being loved nor “not amounting to anything” (pp. 392).

Advocacy. Through nurse advocacy, mothers felt empowered. Advocacy was demonstrated with the nurse giving guidance to the mothers in how best to interact with other agencies (Kurtz Landy et al., 2012) to praising the mother in front of her partner or other household members (Jack et al., 2005). Advocacy was also given through aiding the mother in maintaining her right to self-determination when working with the health care system. For example, a nurse supporting a mother in having a natural childbirth regardless of a doctor’s recommendations to persuade otherwise (Norris et al., 2009).

Respect. Expressed was the idea that the nurse treated each member as well as the family as an individual unit and not simply a recipient of a home visiting program. For example the “will of the family itself was respected” through honoring the wishes and values of the mother or parents. The act of the nurse encouraging and supporting other family members to engage in the home visit was a sign of respect for the family. This allowed others, not simply mothers, to feel that the nurse was building trust with the whole family. Themes of openness also overlapped with building respect of the family unit (Rautio, 2013, pp. 930).

Reducing Vulnerability

Many parents receiving services wondered and questioned the intentions of home visiting programs and health care workers entering the home. Parents may not fully understand the meaning of a program, even despite the voluntary nature of participation.

Feelings of shame and society's stigma can accompany participation in a home program, and may be a sensitive matter for recipients. Having a stranger into the home can provoke negative emotions by parents like powerlessness. Attending to these fears and feelings of vulnerability can enhance relational trust (Jack et al., 2005; Porr et al., 2012; Rautio, 2013).

A component of reducing vulnerability was acknowledging what mothers have learned through past experiences and identifying fears. For example is the understanding that social services have the authority to intervene in a life. State actions may have been observed by the mothers through either childhood experiences or seeing state interventions in others' lives. Considering the potential power of programs according to the mother's experiences is critical in understanding her perceived vulnerability. Furthermore is the inherent stigma and judgment that often is felt by mothers; therefore the strong sense of self-protection builds as a result (Jack et al., 2005; Porr et al., 2012). When a PHN enters the home, purposeful actions need to be considered to reduce vulnerability. One way to do this expressed by mothers was to guard against "seemingly innocent behaviors" that can increase feelings of vulnerability (Porr et al., 2012, pp. 393). These seemingly innocent behaviors can be gazing around the home and commenting on pictures. "Snoopy" and "arrogant" were terms utilized by mothers, as they already felt vulnerable and "under the microscope" (Porr et al., 2012, pp. 393) with the PHN present in the home. One father described his home visitor as, "she is our family worker" displaying the ability of reducing vulnerability and becoming a personal supporter of the family and not as a member of an organization (Rautio, 2013, pp. 930).

Mothers will also attempt to limit vulnerability through their own actions, as well as evaluate the risks associated with increasing self or family vulnerability. Components although not fully explained or understood include the mother's ability to overcome fear and her actions of seeking to build trust despite vulnerability. Mothers also displayed acts of trying to hide nothing yet maintain an element of protecting self. One act of shifting the power balance was for the mother to have a family member or friend present during a home visit until trust within the relationship could be established. As the mother's sense of vulnerability decreased, openness increased, than sharing of more personal and delicate issues took place. Mothers also revealed that a reciprocal exchange of information aided in vulnerability reduction. Mothers referred to this as "opening-up" and talking "from the heart" (Jack et al, 2005, pp. 186).

Testing

Although testing is not an action or characteristic the PHN can exemplify, but rather an action that the mother engages in to establish if trust can be built. Testing is an ability of the mother to assess risk. Specific behaviors and attitudes are associated with testing. According to Porr et al. (2012) mothers would appraise a PHN's facial display, gesture, or a meaning of a word. According to this estimation the mother would then behave in a certain way and choose to either trust or continue to mistrust the PHN. Testing is a way for the mother to evaluate the intentions of the nurse. To further test, a mother may ask "benign questions" and then wait for both the verbal and nonverbal response of the nurse to decide if the nurse could be trusted with further more intimate questions (pp. 389). Jack et al. (2005) describe similar actions of testing. Mothers

Background Articles on Voice

The last two background articles that were retained, as they specifically captured the voice of the customer, will be briefly presented below. Lori, Yi, and Martyn (2011) specifically stated that their purpose was to give voice to African American women and their experiences receiving perinatal care. The 22 participants ranged in age from 18 to 35 years. The women expressed some similar findings as discussed above, specifically aspects on communication, continuity of care, being treated with respect and receiving compassionate care. The women shared the desire to be both known and remembered by their providers and that they would be understood within the context of their lives.

Competence of their provider was expressed as an individual who listened and acknowledged concerns and questions, asked psychosocial questions, and communicated in simple words that patients could understand. Seeing the same provider was important in relationship building and specifically stated as helping “to establish a trusting relationship” (pp. 74). Respecting a woman equated to making certain that her questions were answered and that the provider valued all questions asked by the mother.

Components of compassionate care included not being judged and being made comfortable during the office visit. Non-verbal communication facilitating this was smiling and maintaining good eye contact. Asking how the mother was doing today was a constant theme. These women conveyed that they were sensitive to being judged or treated unfairly yet they longed for a close and trusting relationship with their providers in the primary care setting.

The second article that was semi-relevant as it captured the voice of adolescents in relation to what particular physician behaviors earn or lose trust. The population of adolescents is relevant as many NFP mothers are young. Interestingly the authors claimed that they were unable to find an article prior to their study that specifically defined trust from the adolescent's perspective on provider behaviors that built trust. Fifty-four adolescents aged 11 to 19, with both chronic and without chronic illnesses were questioned. Adolescents were found to value different aspects of the provider-patient relationship than adults. More specifically younger adolescents had different views than older adolescents. One surfaced theme of importance to adolescents was fidelity. Words used by the adolescents to describe fidelity included "caring, respect and advocacy" (pp. 682). One theme on provider actions that would break trust is taking advantage of the adolescent's vulnerability or breaking confidentiality. Competency and honesty of the provider also built trust. Consistent with other findings outlined above was the importance of friend-like characteristics of the provider including asking and sharing of personal information, and making the adolescent feel comfortable. Trust in the relationship was highlighted as important; in fact the topic of trust was not the original intent of the study but surfaced as the main theme among the adolescents. Adolescents too, have to move beyond feelings of judgment and vulnerability but clearly sought trust in their provider and within the relationship in a primary care setting.

The two supplemental articles were included as they spoke to the aspect of trust that may be applicable to health care providers serving low socioeconomic first time mothers. The first article related to a minority population receiving perinatal care. The

second population focused on adolescents and their unique perceptions of trust. Although the populations in the two articles did not focus on receiving home health care, some of the findings corroborate with the five articles discussed that did meet inclusion criteria.

CHAPTER FOUR

SUMMARY, RECOMMENDATIONS AND CONCLUSION

Summary

Under the ACA, was the creation and provision of the MIECHV program. Funding through MIECHV has allowed for state adoption of an evidence-based home visiting program with the target population serving mothers, infants, and children. The importance for the state of Montana of effective implementation of a home visiting program cannot be better stated than by the Annie E. Casey Foundation (2013) who found that in 2013 Montana ranked 50th, or worst, in child health indicators.

Several counties in Montana selected the NFP model, Missoula County included. The NFP model is an excellent home visiting program that boasts years of research validating effective maternal, infant and child health, social, and financial outcomes. However a MIECHV requirement is the assurance that the voice of the customer or parent's voice is garnered in the process of providing home health services. The purpose of this paper was to conduct a review of literature to investigate communication approaches that health care providers use or could use during a home visit that would strengthen the ability of the provider to capture and empower the voice of the mother. The significance to successfully garner voice through establishment of a strong and trusting relationship has been tied to program success.

A total of three search engines were used to find articles that applied to capturing the mother's voice in her own words. According to the findings from the sentinel article

by Kurtz Landy et al. (2012), trust was the key term utilized in finding applicable articles. Various search terms included *trust, develop, establish, home visit, public health nurse, nurse family partnership, patient perspective, health care provider, nurse, and physician*. Articles found had to meet the inclusion criteria of mothers receiving in-home services. A total of five articles met inclusion criteria. After examining the articles major themes surfaced that were expressed by the mothers in their ability to develop a strong, trusting relationship in which they had both the power and fortitude to express their voice. After analysis, six themes surfaced including personality, friendship, availability, empowerment, reducing vulnerability and testing.

Recommendations

Home Health Services for Mothers

New research and access to articles are needed that directly examine how to capture the voice of the mother receiving home health services. Understanding the full meaning and multifaceted components of the nurse-patient relationship is needed. First time young mothers who are recipients of either the NFP program or other community home health care programs typically represent low socioeconomic, at risk populations. Specific relationship attributes are unique to these mothers and require research directed at this specific population.

The NFP National Service Office was contacted to ascertain if any research or articles were available for viewing that captured the voice of the mother in her own words that were not already identified. Although the office was helpful in directing and

informing of research articles that confirm health, social and financial benefits of mothers participating in the NFP program; no articles were given or cited concerning mothers' views of the program or nurse-patient relationship. However direction was provided to review quotes from NFP clients that are recorded on the official NFP website (Benton & Yost, personal communication, March 10, 2014).

The conceptual model of self-efficacy helped guide the paper while understanding the literature relating to the population of interest. The application of self-efficacy is especially important while considering the demographics of NFP mothers. The mothers under study were identified in having to overcome feelings of vulnerability in order to meaningfully engage in the home visiting process. If the mother was able to overcome vulnerability and an effective working relationship was established and maintained, positive outcomes were realized. However looking through the lens of self-efficacy it is imperative that the mother recognizes that she facilitated, overcame, and realized her own potential. If the mother can attribute her struggles, growth and subsequent positive outcomes to her own strengths and abilities, then true self-efficacy will have been realized and the mother will be equipped to succeed in future endeavors. Discovering and uncovering more findings and data related to garnering the voice of the mother will also strengthen the ability of the nurse to develop a setting and relationship to support self-efficacy in the patient.

Nursing

The nursing profession needs to continue to identify and define the understanding and development of trust during nurse-patient interactions. Trust is unique to the

population being served and includes differences regarding age, culture, faith, and setting to name a few components. A person with a chronic illness will establish trust differently than an elderly person receiving care within the home or a pediatric patient in the acute care setting or a fragile psychiatric patient in a long term care facility (Dinc & Gastmans, 2013).

Furthermore a unified umbrella term for trust is needed, in addition to trust as it relates to a particular population or setting. The nursing profession has a continued obligation to utilize evidence-based practice in the understanding of cultivating patient trust. This will require the development of tools or models in order to assess and evaluate trust within a nurse-patient relationship. Developing a unified working term of trust and subsequent standards to measure it according to population and practice will aid educators in teaching future generations of nurses. Understanding trust will help the nursing profession maintain the public's perception and belief that nursing is and can continue to be a trusted profession in delivering health care. The understanding of trust as an interdisciplinary health term also requires further evaluation.

Rebuilding Trust

Although a review of literature was not conducted in ways to rebuild lost or broken trust, this may be an area that requires further research and evaluation. Knowing the process of rebuilding trust will require two inquires. First it will require an understanding from a nursing or health care discipline's perspective. Secondly research specific to how a patient views reestablishment of trust will be needed. Understanding the patient's perspective in what breaks trust and rebuilds trust will be a potential research

challenge. A study limitation in three of the research articles meeting inclusion criteria were that the authors were unable to interview mothers who chose not to participate in a home health-visiting program or who exited the program prematurely (Jack et al., 2005; Kurtz Landy et al., 2012; Rautio, 2013). Not only may these women have different perceptions of how to capture voice and build a trusting relationship but also may have unique views to enhance the understanding of bridging broken or lost trust.

Study Limitations

Foremost was the small sample size of articles that were found during the literature review evaluating the voice of the mother in her own words. The surfaced themes discussed in Chapter Three must be considered in regards to the small sample size. Applying the results of the findings should be done carefully and cautiously as the applicability may be limited due to sample size. In addition the sample sizes within each research article were small.

Second, the search term *trust* was indexed as a MeSH term but no linked synonyms existed. Search terms *develop* and *establish* were not indexed nor existed within the MeSH database. Due to the inability to search under the MeSH tool, additional synonyms should be searched regarding trust. For example the associated nursing terms for trust found by Dinc and Gastmans (2013; 2012) and Hupcey et al. (2001) could be used. The terms highlighted by the above authors included faith, belief, goodwill, confidence, hope, and respect. During the literature review these terms had not yet been identified as synonyms in nursing literature until after the search was complete. Re-

performing a literature search with these terms may add additional relevant articles on the topic of interest.

To truly understand how voice is garnered within the NFP model, it would be valuable to be trained as an NFP nurse and then utilize the information found and weigh the applicability of the findings against NFP training material and knowledge. However home health programs focusing on mother and child outcomes exist apart from the NFP program. Therefore data is needed for those nurses to successfully perform their respective jobs and support endeavors to build strong, trusting relationships with their patients.

Conclusion

The ability of the mother to trust her nurse is directly correlated with program engagement and positive outcomes. However the development of trust cannot be isolated to one or two qualities nor behaviors exemplified by the nurse but rather a synthesis of many different components (Kurtz Landy et al., 2012). The history of the patient and feelings of vulnerability also compound the dyad relationship. It is insufficient to assume that the good intentions or strong character of a nurse are enough to be certain that trust will be developed or maintained. Further, the possibility for trust to be broken may happen even with the most skilled nurse and in the perceived perfect relationship. When trust is broken, distrust can emerge, and a way to re-bridge the gap needs to be understood (Dinc & Gastmans, 2012). More quantitative data is also needed to learn how to assess trust, gain “objective evidence,” and develop “generalizable results” (Dinc &

Gastmans, 2013, pp. 509). Through this process the voice of the mother must be considered and respected. Understanding trust and capturing voice will strengthen families being served, build self-efficacy among individuals, and create a healthier State of Montana.

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