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The relationship between first-time mothers and care providers in the early postnatal phase: an ethnographic study in a Swiss postnatal unit

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ABSTRACT

Objective: to consider the relationship between first-time mothers and care providers in an organisational context.
Design: an ethnographic approach was used to study the views and behaviours of providers and recipients of postnatal care. Fieldwork involved mainly conversations or qualitative interviews and observation.
Setting: a postnatal unit in a tertiary referral hospital in Switzerland.
Participants: 10 child-bearing women and the care providers assigned to them.
Analysis: analysis of the data was organised using the women's expectations of care and the maternity unit's mission statement. Thematic analysis centred around two main themes: the experience of 'being on a postnatal journey' and 'caring relationships'.
Findings: the findings presented fall within the framework of the second theme. A caring relationship was established through 'weaving the net'. This relationship was then maintained through 'keeping the thread'. The relationship was eventually ended through 'finishing off'.
Key conclusions: the quality of the caring relationship between a woman and a care provider influences satisfaction with received care. It determines the extent to which women feel in control of their situation at discharge. Organisational and professional factors influence this relationship, which in turn can influence a nurse's level of job satisfaction.
Implications for practice: changes in the provision of postnatal care may involve organisational as well as clinical interventions to ensure continuous and consistent care.

Introduction

Background

For the new mother, the hospital postnatal stay is short and constantly becoming shorter. However, this phase marks a crucial period in the transition to motherhood. The relationship between the new mother and her care provider during this time impacts on the satisfaction of both. The literature notes, with the ultimate in understatement, that 'postnatal care has been identified as a problem area for maternity services' (Shields et al., 1997, p. 91).

That this problem is not a recent development but long-standing is clear from research (Brown et al., 2005; Deave et al., 2008). The reasons for this problem status can be found in the paradoxical relationship between two aspects of care. First is the fundamental importance of satisfaction with the care provided if healthy physical and emotional outcomes are to be achieved for mother and infant. Second, and in stark contrast, is the fact that postnatal care is more likely than any other (in a UK setting) to engender complaints (Shields et al., 1997). Examples of the reasons for dissatisfaction with postnatal care may include its routinised nature (Marchant, 2006), which is reflected explicitly in the title of a National Institute for Health and Clinical Excellence clinical guideline (NICE, 2006). Such routinisation may be associated with staff perceptions of the postnatal period being insignificant (Schmied and Everitt, 1996). The provision of high-quality care is a major responsibility of health-care organisations. The assessment of quality involves the perspectives of women as well as clinicians to further develop practice and provision of care.

Postnatal care

Despite the aforementioned tendency towards shorter postnatal stay, the link with the mother's dissatisfaction is uncertain. However, the focus of research has increasingly been on the care provided for the woman and infant in the community after

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discharge. As a consequence, women's views on their hospital care have tended to be neglected by researchers (Shaw et al., 2006; Zadoroznyj, 2006).

With the changing focus of research towards post-discharge care, research into the new mother's satisfaction has involved more quantitative methods (Peterson et al., 2005). Using such approaches, aspects such as satisfaction and emotional changes have been measured and correlated to predictive factors (SIGN, 2002). While such approaches achieve a high level of precision, they may neglect the breadth and intensity of the new mother's experience.

In a qualitative study in England, Beake et al. (2005) sought to identify women's expectations of postnatal care and the extent to which those expectations were met. Unlike the largely quantitative studies mentioned above, these researchers used grounded theory. The three major and closely inter-related themes which these researchers identified were 'support', 'how women feel' and the (hospital) 'environment'. The study showed that women expected to be well supported through positive relationships with carers. What was highlighted, though, was the contradiction between women's expectations of postnatal care and the reality of their experiences. Although this study clearly illuminated fundamentally important issues, the researchers stated that 'the interviews were carried out eight to twelve months postnatally' (Beake et al., 2005, p. 82). It is therefore impossible to know whether the women's perceptions of their care were coloured by their subsequent experiences of motherhood. Similarly, Brown et al. (2005) in Australia relied on a questionnaire which was distributed five to six months after the birth. In anticipation of these problems, an ethnographic study was planned involving prospective data collection by observation and interview. Obviously, collecting data in the early postnatal period raises difficulties, but alternative times to access women's views have also proved problematical (Raisler, 2000).

Attempting to resolve these challenges, a novel approach was used by Yelland et al. (2007) in Australia: they surveyed and then interviewed care providers, rather than child-bearing women. This study identified the routinisation previously mentioned, combined with a lack of individualisation of care. These researchers highlighted the low priority accorded to postnatal care, which may explain its challenging nature, as outlined above. On the basis of these findings, the authors suggested that the quality of postnatal care would be enhanced by ensuring a 'continuum of care' and 'collaborative approaches' (Yelland et al., 2007, p. 295).

This brief review of the recent literature demonstrates the need for further study of women's expectations, perceptions and experiences. The research which has been undertaken so far has focused on either the woman or her caregiver (Beake et al., 2005; Yelland et al., 2007). In order to gain an accurate impression of the woman's experience, an examination of the relationship from the viewpoint of both participants would be necessary. Further, a qualitative approach would be required to encompass the breadth and intensity of the woman's experience, and a prospective study would be appropriate, as mentioned already.

In this article, the focus is on the caring relationship and how this influences women's and care providers' satisfaction with the care they receive and deliver, respectively. This paper draws on the findings of a wider study that explored the nature of postnatal care for first-time mothers (Frei, 2005). Reflecting this, the research question for this study was: 'What is the nature of the caring relationship experienced by first-time mothers and the care providers assigned to them?'

The study

The study setting was a 27-bed certified baby-friendly postnatal unit in a tertiary referral hospital in Switzerland with an average birth rate of 1200 per annum. Approximately every third child is born by caesarean section (Bundesamt für Statistik, 2008). In the maternity unit, the staffing is relatively generous, with about one nurse to four women. Provision of early postnatal care is largely institutionally based and the cultural expectations of women are framed in this context. Health insurance companies guarantee a five-day stay after a vaginal birth, including the day of birth. Therefore, the current post-hospital services provided by parental clinics[1] and community midwives are organised around the routine of a four- to five-day hospital stay (Blöchlinger, 2008). There is an unstated assumption that the needs of the mother will have largely been met by the time of discharge.

Postnatal care, based on UNICEF's recommended 'ten steps to successful breastfeeding' and locally defined quality standards, was provided by staff nurses with different qualifications, and pre-registration nursing and midwifery students. Looking across Western Europe, postnatal care is provided by various groups of professionals (Expert Group on Acute Maternity Services, 2002a, 2002b) and this also applies to the study setting. The staffing mirrors the current practice in postnatal units of hospitals of similar types in this cultural context, and the nurses, regardless of their primary qualifications, are obliged to provide woman and child care according to the care process. Antenatal, perinatal and community-based postnatal care is provided by midwives with the exception of 'parental' clinics, which employ a mixed staffing. These arrangements result in a fragmented maternity service.

Methods

A qualitative methodology was utilised, drawing on ethnographic principles to understand human behaviour, values, beliefs and meanings relevant to health (Spradley, 1980; Morse and Field, 1995; Atkinson and Hammersley, 1998). An ethnographic approach enabled closeness through participation in the daily lives of women, their partners and babies, nurses and other health-care professionals. This was important in this early postnatal phase to facilitate the gaining of an interpretative understanding of their social world (Hammersley and Atkinson, 1995). However, as Honer (2004) observed, it is not possible to reach the inner view of participants, but only to become acquainted with the world in question from the outside and from different perspectives. A focused approach was chosen since time was limited and the people under investigation were a fairly discrete group (Germain, 2001). The common characteristics of all ethnographic research are holism, contextuality and reflexivity (Morse and Field, 1995). Contextual information such as specific issues of maternity care within the professional, institutional and national health policy and standards of care in the study setting helped to interpret the data in a more holistic sense (Wolcott, 1999). Reflexivity as a continuous checking on achieving understanding (Wasserfall, 1997) was important, particularly since this study was conducted in the researcher's professional field.

The study was designed to comprise an interview with the expectant woman two to three weeks before the anticipated birth, followed by observation of her care over two to three nursing and midwifery shifts while she was in hospital. The observational notes of the woman's care, her hospital records and documents from the postnatal unit stating standards of care provided guidance for the subsequent interview with the nurse assigned to her, and a final interview with the woman two to three weeks after discharge.

[1] Parental clinics are community health centres and provide a cost-free basic service for families with a child up to one year of age.

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Population and recruitment

Women who had registered to give birth at the study hospital and nurses who worked on the postnatal unit were the key informants (Hammersley and Atkinson, 1995). The recruitment process for both women and nurses took place over a six-month period. Whereas women were chosen from the hospital's birth registration list via purposive sampling, participating nurses were chosen as a result of being assigned to one of the women. The selection criteria for women were: expecting their first infant but not necessarily pregnant for the first time, intention to stay in hospital for up to five days and fluency in spoken German. Potential participating women were contacted by the departmental secretary approximately one month prior to the anticipated birth date. Interested women were provided with information and after a set period of time, they were asked by the researcher if they were willing to participate. Out of 15 women contacted, 10 agreed to participate and signed a consent form (See Table 1).

All staff members of the postnatal unit including nursing and midwifery students were provided with verbal and written information. Formal recruitment began at a team meeting and information was provided individually to each new team member. They were asked to state their agreement or refusal to participate either by signing the consent form or returning it unsigned, respectively. Of the 41 staff members, three diploma nurses did not consent. Eventually, 20 staff members (See Table 2) were included in the study: 14 diploma nurses and six nursing or midwifery students respectively. Their involvement was directly linked to their assignment to the participating women, and five nurses participated more than once.

Data collection and analysis

The initial interviews with the women were conducted according to a conversation guide (Rubin and Rubin, 1995) to identify their expectations of care in the early postnatal phase in hospital. The information was sought to determine the subsequent observation and provided first-hand data. Observations took place during early and late shifts on three successive days whenever the participating woman met with their assigned nurse. The researcher's engagement in care provision as phrased in Spradley's terms (1980) fell between passive and moderate participation. Field notes were handwritten on the spot and transcribed to computer files later. Those notes raised questions which informed the interview with the nurse towards or at the end of her shift. At discharge, arrangements were made to contact the woman for the final interview. All interviews with the participating women took place at their homes.

Using the interviews and the observational notes, questions were developed for this final interview. Permission was given by all participants to tape-record the interviews. Subsequently, they were transcribed verbatim. The women's nursing records were examined in terms of their well-being, their needs and care received. Throughout the fieldwork, a diary was kept for important information and reflexive notes. The interviews, the observational notes as well as all the written material were in German. The excerpts used for the report were translated into English. For quality reasons, the translation was double checked by two professional translators.

Data analysis consisted of an analytic movement from data to ideas (Coffey, 1999), starting with the initial interviews with the woman. Emerging themes provided guidance for the observation as well as for the later interviews with the study participants. Formal analysis commenced after completion of data collection. In the first step, the main issues arising from the data were mapped into themes. Two accounts were written, one covering the women's expectations and their experiences, and the other covering the nurses' views of women's needs and care provided during the early postnatal phase. The accounts were presented to the participants and they were asked for critical feedback. Taking their comments into consideration by further reading and experimenting with the data, which included writing vignettes for each woman and fiction-like accounts from different viewpoints, socio-cultural themes emerged (Spradley, 1980). 'Being on a postnatal journey' and 'caring relationships' were the two overarching themes identified, of which only the latter is presented in this article.

Ethical issues

The Local Research Ethics Committee approved the study and the Chief Nursing Executive gave permission for access to the study field. Throughout the study, constant monitoring to ensure participants' rights to privacy, confidentiality, autonomy and freedom from harm was a paramount concern (Spradley, 1980; SBK, 1998). Respect for women's dignity was particularly important since they were in a vulnerable position and in a public place where the boundaries of privacy were already limited. Women and nurses were therefore asked for consent before each observational period. An indication that observation was not welcome in a particular situation was unhesitatingly accepted. All data obtained were constructed in such a manner as to ensure that participants and locations remained unidentifiable.

Findings

Caring relationships

This section will present a summary of the three themes identified within the wider theme of the caring relationship. The themes identified were organised into three main areas: 'weaving the net', 'keeping the thread' and 'finishing off'. This way of organising the data provided a structure and helped to

Table 1
Demographic characteristic of participating women.

Pseudonym	Age	Marital status	Main social support	Highest level of education	Nationality	Type of birth
Alicia	31	Married	Husband	Degree	German	Spontaneous vaginal birth
Britta	29	Married	Husband	College	Swiss	Spontaneous vaginal birth
Carol	26	Married	Sister-in-law	College	Swiss	Caesarean birth
Diana	29	Married	Husband and mother	Degree	Italian/Swiss	Caesarean birth
Eleonora	27	Married	Husband	Degree	African/Swiss	Instrumental birth
Flavia	23	Married	Husband	College	Swiss	Spontaneous vaginal birth
Giovanna	28	Married	Husband	Degree	Swiss	Spontaneous vaginal birth
Hanna	29	Married	Husband	PhD	Swiss	Spontaneous vaginal birth
Kirstin	35	Married	Husband and mother	Degree	English/Swiss	Caesarean birth
Liana	21	Living with partner	Partner	College student	Greek/Swiss	Spontaneous vaginal birth

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Table 2
Demographic characteristics of participating staff members.

Pseudonym	Age	Professional qualification	Years of experience
Angela	25	Registered General Nurse	3
Anja	59	Registered Child Nurse	27
Barbara	50	Registered Child Nurse	28
Bettina	23	Registered General Nurse	1
Carla	32	Registered General Nurse	10
Esther	37	Registered Child Nurse	15
Fabienne	29	Registered Child Nurse	6
Helena	30	Registered General Nurse	7
Jennifer	48	Registered Child Nurse	25
Ladina	31	Registered General Nurse	10
Larissa	22	First year nursing student	
Laura	20	First year midwifery student	
Leah	22	Registered General Nurse	1
Maja	41	Registered Child Nurse	20
Marika	22	First year midwifery student	
Muriel	22	Fourth year nursing student	
Naomi	19	First year nursing student	
Noelle	36	Registered Child Nurse	14
Sanna	29	Registered Child Nurse	7
Simona	22	Third year nursing student	

create coherence among the themes. This section begins with a consideration of women's expectations and issues of establishing a relationship between the individual woman and the nurses, and goes on to explore how a relationship is maintained and then terminated in this postnatal phase of first-time mothers.

Weaving the net

All the women who participated in this study held expectations regarding self-care and infant care with a strong emphasis on breast feeding. Participating women expected professional expertise and experience, but also anticipated that they would need emotional support in the way that the nurse would be there for her, showing an understanding for her situation. The women anticipated that they would connect on the basis of a common empathy. Women's statements implied the uncertainty of the unknown as they embarked on that journey. One woman (all names are pseudonyms) stated:

> The main thing really is to trust the professionals and that they are there for you that I can fall back on them. (Carla; prenatal conversation)

Trust became pivotal because prenatally, women were uncertain of what to expect in terms of birth and its emotional outcomes. Emotional care, albeit preferably coming from partners or other close persons, was also considered a professional responsibility, as one woman said:

> You know because you're so sensitive and I hope, that the nurses, that there is an understanding for you. I'm sure it depends a lot on the nurse what you get. (Giovanna; prenatal conversation)

Statements such as this one revealed the belief that a positive outcome depended on the assigned nurse and how she established a relationship with the woman. During the initial meeting, the nurse carries out an assessment, which allows her to get to know the woman and her infant. Nurses experienced this first contact quite differently:

> Well, from the beginning we had a relaxed relationship maybe because of our age. I think she felt fairly comfortable and it was so unproblematic with her. (Student Nurse Simona)

> I'd say that very little has come from her side. I can't quite get a feel for her as a person and she might need some time. (Nurse Angela)

These statements show contrasting experiences of the nurses' first meetings with women. Nurses evaluated how they connected with women and reflected on the relationship. They also brought up their professional competence, and how this could impact on the quality of care:

> I realised this was the first time I had been assigned to a first-time mother in that early stage and I noticed that I felt unsure of myself with her care. You know things like, when do I make clear suggestions or where do I leave it open? (Nurse Carla)

The level of confidence influences how and to what extent two people can relate to each other. Sharing personal information such as experience with breast feeding helped women to relate to the nurse. Women would ask personal questions, e.g. if the nurse had children, but they would also watch her closely, evaluating her performance and assessing her trustworthiness:

> I thought she was a very competent nurse and she really took a lot of time just to explain things to me over and over again. (Diana)

A contrasting experience is presented in the following statement:

> Well, it was the uncertainty of the student nurse, she didn't know what to do next and this happened a couple of times. (Alicia)

Both nurses and women wanted to establish a good relationship as these examples show. Competence influences how women and nurses experience their first encounters, and a further important aspect for women is to what extent they feel they can trust the nurses.

Keeping the thread

All women in the study hoped for the best available care during childbirth and postnatally. The women as well as the nurses sought consistent and continuous care provision. The nurse was concerned about knowing the woman in order to

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provide the best possible care but, moreover, appreciated a continuous assignment:

> You can really keep at it and you know what goes on in-between. As I said, it makes caring rewarding because it rounds it off. (Nurse Jennifer)

> She really had a complete picture, of being a human, being a mother, being a woman something like that, just so things come full circle. (Flavia)

In this situation, relational continuity and the nurse's individualised care was recognised and fully appreciated by the woman. In another situation where care was provided by three nurses, the woman still perceived the care as being continuous. In our final interview, she referred to each of the three nurses who had been caring for her in relation to specific subjects. With a continuous assignment, the nurses found a point of reference through which they could assess the woman's well-being. As a result, attendance to the woman's emotional needs featured more prominently and job satisfaction was expressed as the nurses evaluated a positive care outcome on the grounds of the woman's response.

Contrary to the above statements, there was also discontinuity of carers. During a conversation between a woman and a nurse on the subject of continuous assignment that took place during an observation, both women expressed their concerns on the topic. In the final interview, the woman disapproved of how the care was organised:

> Every day a new face and they have to get used to you, and I was very tearful. But the way they came round at the beginning of a new shift and went through everything and if I asked one nurse something, it would always be passed on to the next shift. It was very good in that sense but I didn't understand how they couldn't organise that better because it can be very unsettling. (Kristin)

Provision of high-quality care, as the unit's guidelines state, is the target of postnatal care. However, during the observation on the unit, discussions amongst staff nurses showed that staff shortage, staff instability, young and inexperienced nurses, and educational responsibilities led to constraints, inconsistent assignment of nurses and limited individualised care. Additionally, work stress caused by high bed occupancy and rapid turnover of women compromised the quality of care provision:

> I told her that we're very busy and therefore I could only focus on breast feeding. Since this is so important to her because of her being allergic to so many medicines, it's important that she gets support with that at least. (Nurse Fabienne)

> I realised I can't offer the things that I want to because I'm still not quite up to it. (Nurse Leah)

The time available for women's care as well as perceptions of professional competence influenced the nurses' perceived levels of stress and hence job satisfaction. If little time was spent with women, the care given was regarded by nurses as unsatisfactory. However, when they had women's needs in perspective, nurses reported better satisfaction with the care outcome.

Contradiction in teaching care tasks because of a lack of competence or non-adherence to the unit's policy caused stress for women and frustration for nurses:

> I sensed uncertainty coming from her and I find situations like that tricky. You know as she said, someone just showed me to do it like this and now someone else is telling me something different, what I am meant to do now? (Nurse Sanna)

Since this woman lacked a frame of reference, this conflicting advice contributed to her increased stress and dissatisfaction with her care. With many care tasks, women relied on the knowledge and skills of the nurses to enable them to take care of themselves and their infants. Women appraised care provision on the basis of their met or unmet needs and according to the level of confidence they gained during hospitalisation. However, women in this study tended to be reluctant to reveal dissatisfaction with care:

> If this is all coming across as really critical of the nurse, that's not what I meant either. (Alicia)

Maintaining a caring relationship is influenced by several factors. It takes diverse forms depending on professional competence and conduct as well as on structural and organisational conditions. It appears that job satisfaction, as well as women's satisfaction with care, is considerably influenced by the quality of such relationships.

Finishing off

As women move towards discharge, the termination of the caring relationship becomes an issue. At this point, women in this study became aware of the approaching loss of a relationship and structural support, as well as dealing with uncertainty about living with an infant. Building a bridge between the two worlds seemed pivotal, as it helped the women to strengthen their confidence in their coping abilities.

Depending on the rapport that a nurse had developed with a woman, she would form an impression of the woman's capabilities, which would lead her to ask about the woman's home life:

> I think she's going to be fine at home from what I've seen of her. But it's definitely good to explain that she can always call the lactation consultant or the parental clinic. (Nurse Helena)

Asking about home life involved finding out what support women would be receiving from their social network or by referring them to professionals in the community setting. Women in this study had some general knowledge about available support in the community, but additional issues materialised in the discharge talk:

> I had my questions ready, what I wanted to know and I got that information so I was happy. And I had to know what to do if you've a problem, that's the most important thing. (Kirstin)

> One thing that made me feel confident was knowing I could always call them, just having a phone number. (Liana)

It emerged that the parental clinic was the most important source of support for women in this study. A few women also telephoned the postnatal unit because of the 'around the clock' availability, but also because they had not yet made contact with the parental clinic. Contacting a community midwife was an option in two cases, but at the time of the final interview, none of the participating women had accessed the midwifery service:

> Somehow breast feeding's gone well and so I didn't want to have somebody else in my home. You know, my partner helps and apart from that I haven't really needed any help. (Britta)

Women's partners were the most valued support persons within their social network. It was important to women to spend time together with their partners and to share the duties and the experience of the first days at home. The transfer from hospital to home was experienced as a crucial step in the transition to being a family. However, there were also relatives and friends involved in supporting the women and caring for them and their infants at home.

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Establishing a connection to the time after discharge was an inherent part of the day-to-day care that nurses provided on the ward and this can be seen as preparation for ending the caring relationship. Nurses ensured that women could draw on a support network. Although discharge can cause uncertainty and anxiety, the women in this study were able to maintain their confidence and establish a support network which helped them to take control of the situation and cope with their responsibilities at home.

Discussion

This was a small exploratory study of one specific maternity unit. The data were generated from a small and homogenous, but fairly typical group of women and nurses in a defined cultural context. However, the findings offer some insight into the complex issue of the caring relationship between women and nurses on the journey through the postnatal unit, and women's and nurses' satisfaction with the care they received and provided, respectively. However, whilst they might resonate with descriptions from other studies, they cannot be generalised to other maternity settings.

In this study, the establishment of a caring relationship and continuous care provision have been identified as being important from the point of view of both women and nurses. The metaphors used illuminate the complex process of a caring relationship (Carpenter, 2008). During their time on this postnatal unit, both women and nurses tuned in to each other to ensure the best possible care for mother and infant.

Participating women expressed their expectations of their time on the postnatal unit and beyond. Whilst the practicalities of infant care were quite prominent in their statements, there were subtle indications that interpersonal aspects were also important to the women. This was because they felt that such support was comforting, enabling them to take on the role of mother and to grow into a family successfully. These findings echo Hasseler's (2002) study, which found that women particularly valued practical care and guidance, receiving answers to their questions and help with problem-solving. The need for emotional care was not made explicit and women in her study did not give much thought to the time after birth. During pregnancy, women concentrate on the self and the body, and on birth as the long-awaited event (Smith, 1999). The time after birth remains difficult to imagine and is characterised by uncertainty.

Available care depends on the nurses' assessments of women's needs and on the structural conditions of the unit, but also on what women expect from the professionals. The competences and reliability of the professionals, together with the belief that the staff are there for the women are prerequisites for forming a relationship (Johns, 1996). Morse (1991) indicates that trust is built progressively, is fragile and is necessary for the generation and maintenance of caring. Pierson (1998) reasons that trust develops slowly within an atmosphere of mutual respect. Participating nurses were aware of the importance of interconnectedness with women from the beginning to facilitate the full potential of care in each individual situation. With the fragmented care approach in this setting, nurses cannot draw on previously acquired knowledge about the woman since they only get to know them at admission to the postnatal unit. Assessing each woman's needs is therefore of paramount interest to nurses. However, these first encounters are sensitive shortly after the highly emotional experience of giving birth, and nurses act within structural boundaries and their competencies. In that respect, birth experiences and how nurses were able to appreciate women's coping influenced their relationship.

Of the many factors facilitating a trusting relationship, nurses' competence and available time emerged as the most important issues. Relating on a personal level seemed important to nurses, but it also became obvious that the nurses' confidence levels were inevitably linked to a trusting relationship. This demonstrates the influence of professional competence on the partnership and hence its effect on the caring outcome. Care receivers measure quality care on outcome criteria such as 'feeling comfort, happy, informed and satisfied' (Attree, 2001b, p. 67). Evaluation of quality care by recipients places importance on the interactional and interpersonal aspect. Such care 'was provided humanistically, through the presence of a caring relationship by staff who demonstrated involvement, commitment and concern' (Attree, 2001a, p. 456). Most women were satisfied with the care they received. However, and echoing the findings of Sitzia and Wood (1997), few patients reflected critically on the care they received. They would not complain, preferring to indicate areas of potential improvement, as also reported in the study by Ellberg et al. (2008).

While maintaining a caring relationship is influenced by professional competence and conduct, structural and organisational conditions are also crucial determinants. Continuous care provision was of interest to nurses. Knowing the woman, knowing the tasks and working towards an agreed aim were elements contributing to satisfaction with given care and hence job satisfaction. Lu et al. (2005) identified the following sources of job satisfaction in their literature review: abilities and skills, working conditions and relationships with patients. There were situations observed during this study where women received conflicting advice, which was confusing for women and frustrating for nurses. Since the participating women lacked a frame of reference, they were unable to judge which advice to take on board. Hillan (1992) reports that conflicting advice is one factor contributing to an increase in stress. Although conflicting advice is reported to present a dilemma for women, it does not explain breast-feeding self-efficacy nor affect women's ability to be actively involved in decision-making (Hauck et al., 2007). Care is considered consistent when professionals demonstrate good communication and adhere to a shared policy (Green et al., 2000). As Green et al. (2000) state, the most important aspects for women are that they can trust their health-care providers and receive consistent care and a woman-centred care approach, although continuity of provider is not that important. In contrast, Yelland et al. (2007) advocate continuity of caregivers after birth, since this would help to ensure the support of women after discharge, especially those at risk. Relational continuity as 'an ongoing therapeutic relationship' (Haggerty et al., 2007, p. 1212) was favoured by the participating women and nurses and was perceived as important for nurses' satisfaction with delivered care.

Establishing a connection to the time after the woman's stay on the unit was inherent in the day-to-day caring process; this can well be seen as preparation for the termination of the caring relationship, which happens concurrently with the woman's preparation for returning home with her new infant. Although there were no obvious strategies for terminating the relationship with a woman, the caring actions were clearly directed towards the future. For women at this stage, feelings of loss and anxiety about being alone with their infant make them aware of their new responsibilities (Oakley, 1980). Assuming control and negotiating professional support in the community became prominent issues for the women in this study. This can help women to end the relationship; an important act in the care process (Walsh, 1999). Most important, however, was the family support, mainly provided by the women's partners, but also by mothers, sisters and female friends. It appeared that women in this study

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were able to maintain their confidence and to establish a support network that helped them to cope with their responsibilities at home.

Conclusion

This ethnographic study addressed a gap in the literature by using a prospective approach to the experience of both the new mother and her care provider. The caring relationship has been shown to be largely influenced, if not determined, by professional and organisational factors. Key findings of this study will be useful and important in effecting change in the provision of postnatal care, mainly in maintaining continuous and consistent care provision to women and their families.

In contrast to the perceived insignificance of postnatal care, mentioned in the Introduction, this study has demonstrated the crucial importance of postnatal care to the woman. The role of and the relationship with the formal carers is the subject of expectations and aspirations on the part of the woman. The woman invests considerable optimism in this relationship. This should be recognised by staff if a woman-centred service is to be provided. The benefits to staff of such an arrangement would require evaluation.

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