2013

An Exploration of the Past, Present and Future of Nursing in Early Parenting Services in Australia

Elaine Bennett
University of Notre Dame Australia

Follow this and additional works at: https://researchonline.nd.edu.au/theses

Part of the Nursing Commons

COMMONWEALTH OF AUSTRALIA
Copyright Regulations 1969

WARNING
The material in this communication may be subject to copyright under the Act. Any further copying or communication of this material by you may be the subject of copyright protection under the Act.

Do not remove this notice.

Publication Details

This dissertation/thesis is brought to you by ResearchOnline@ND. It has been accepted for inclusion in Theses by an authorized administrator of ResearchOnline@ND. For more information, please contact researchonline@nd.edu.au.
An Exploration of the Past, Present and Future of Nursing in Early Parenting Services in Australia

A thesis submitted in fulfilment of the requirements for the degree of Doctor of Nursing

Elaine Bennett
MN, B.App.Sc.(Nsg)., RN.

School of Nursing and Midwifery
University of Notre Dame
2013
Contents

Chapter 1: Introduction and Background ............................................................... 1
  1.1 Introduction ........................................................................................................ 1
  1.2 Background to the Research Topic..................................................................... 1
    1.2.1 Early Parenting Services .............................................................................. 1
    1.2.2 Ngala in Perth, Western Australia ............................................................... 3
  1.3 Topic and Purpose .............................................................................................. 4
  1.4 Significance of Study ......................................................................................... 4
  1.5 Research Questions ............................................................................................ 6
    1.5.1 The Research Questions and Related Literature .......................................... 6
  1.6 Literature Providing a Broad Context to Nursing in EPS .................................. 7
    1.6.1 The Rise of the Infant Welfare Movement .................................................. 7
    1.6.2 Nursing Roles and the Development of Advanced Nursing Practice .......... 8
    1.6.3 Collaborative and Partnership Approaches ............................................... 11
    1.6.4 Interprofessional Education and Practice .................................................. 12
    1.6.5 Changes in Government Policies ............................................................... 13
  1.7 Literature Providing a Context to Nursing in EPS and the Gaps Identified ...... 14
    1.7.1 The Nursing Context within National Early Parenting Services ............... 15
    1.7.2 The Nursing Role within Interdisciplinary Teams .................................... 16
    1.7.3 Nursing Workforce Priorities within Early Parenting Services in Australia .......................................................... 21
  1.8 Chapter One Summary ..................................................................................... 23

Chapter 2: Methodology .......................................................................................... 25
  2.1 Introduction ...................................................................................................... 25
  2.2 Research Paradigm ........................................................................................... 25
    2.2.1 Integrating Research Paradigms ................................................................. 26
    2.2.2 Case Study ................................................................................................ 27
    2.2.3 A Mixed Methods Approach ..................................................................... 30
    2.2.4 Triangulation .............................................................................................. 30
    2.2.5 Rigour ........................................................................................................ 32
  2.3 Phase One ......................................................................................................... 34
    2.3.1 Introduction ................................................................................................. 34
    2.3.2 Sampling Phase One .................................................................................. 35
    2.3.3 Data Collection Methods Phase One .......................................................... 39
3.15.4 ACT—Queen Elizabeth II Family Centre, Canberra
www.cmsinc.org.au ................................................................. 174
3.15.6 Victoria—Tweddle, www.tweddle.org.au ........................................... 175
3.15.7 Victoria—Queen Elizabeth Centre, www.qec.org.au ......................... 175
3.15.8 Tasmania—Three Parenting Centres, www.dhhs.tas.gov.au............. 175
3.15.9 South Australia—Torrens House, www.cyh.com ................................ 176
3.16 Chapter Three Summary......................................................................... 176

Chapter 4: Findings ....................................................................................... 177
4.1 Introduction ............................................................................................... 177
4.2 Phase One: Ngala ..................................................................................... 178
  4.2.1 Introduction.......................................................................................... 178
  4.2.2 Demographics ..................................................................................... 178
  4.2.3 Findings of Phase One ......................................................................... 180
  4.2.4 Summary of Phase One ...................................................................... 239
4.3 Phase Two: National Teleconferences ...................................................... 240
  4.3.1 Introduction.......................................................................................... 240
  4.3.2 Demographics ..................................................................................... 242
  4.3.3 Findings of Phase Two ........................................................................ 243
  4.3.4 Summary of Phase Two ..................................................................... 248
4.4 Phase Three: National Findings ............................................................... 249
  4.4.1 Introduction.......................................................................................... 249
  4.4.2 Demographics ..................................................................................... 249
  4.4.3 Findings of Phase Three ..................................................................... 256
  4.4.4 Summary Phase Three ....................................................................... 304
4.5 Chapter Four Summary............................................................................ 304

Chapter 5: Discussion of Findings ................................................................. 306
5.1 Introduction ............................................................................................... 306
5.2 The Role of the Nurse in Early Parenting Services ................................... 307
  5.2.1 The Past: The Evolution of the Nursing Role over Time (1890–1989)... 307
  5.2.2 Current Role Defined: Profile of the Role of the Nurse in EPS (1990 to Current) .......................................................... 310
  5.2.3 The Unique Role of the Nurse When Working Closely with Other Disciplines in EPS ............................................................. 311
  5.2.4 The Framework for the Future of Nursing in EPS ............................... 311
5.3 Comparison of Findings with the Literature ............................................. 313
  5.3.1 The Nursing Role within EPS ............................................................... 313
  5.3.2 National Workforce .......................................................................... 313
  5.3.3 Comparison with Child Health Nursing Role and Issues within the Universal Child Health System ............................................. 315
  5.3.4 Broadening Scope of the Child Health Nurse Role .............................. 317
  5.3.5 Recruitment and Retention of Multi-generational Nurses ................... 321
  5.3.6 Articulating the Advanced Practice Role ............................................. 322
  5.3.7 The Role Within an Interdisciplinary Framework ................................. 324
5.4 The Workforce Development Strategy ..................................................... 326
  5.4.1 Increasing the Development and Availability of Innovative Options for Post-Qualification Education in the Early Parenting Sector........ 327
  5.4.2 Develop Retention Strategies for the Ageing Workforce in EPS ............ 331
  5.4.3 Develop Innovative National Professional Development Strategies .... 332
  5.4.4 Develop Sustainable Strategies for a Multi-Generational Workforce .... 334
Declaration of Authorship

This thesis is the candidate’s own work and contains no material that has been accepted for the award of any degree or diploma in any other institution.

To the best of the candidate’s knowledge, the thesis/dissertation contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

____________________________   ____________________
Elaine Bennett     April 2013
Acknowledgements

The inspiration for this study is my family and my belief in the importance of those first three years of life, as well as the longevity of my work through many contexts of working with families with young children. My first grandson Lachlan is three now and is rather special—he is as old as this study. Therefore, my relationship with this little man throughout the process of this research has nurtured my creative spirit with the amazing growth and development that occurs during this period of time. One day Lachlan when you read this I hope you will see how your influence in my life was so important during this time. Now with a second little man, Jayden, I am relishing again this special time of being a grandmother.

Nursing has been a large part of my life, given I will be entering into my sixth decade very soon. This profession has taught me so much, and my hope is that this study in a small way will contribute to the future directions of nursing in this very important work of early childhood and parenting.

There are many people that have supported me over the past three years with this study and I am very grateful for this. I wish to express my sincere thanks to the following people:

- The nurses and allied professionals at Ngala for giving of their time and knowledge so willingly;
- The nurses around Australia for also contributing their time and knowledge to this study;
- The site coordinators and support people at each EPS who assisted with the coordination of participants at each site;
- My colleagues at Ngala, who are a great group of people to work with, and particular thanks to Rae Walter and Ashley Reid for their support of this study;
- My supervisor, Professor Selma Alliex, who was always accessible, supportive and encouraging and kept me focused on the end goal;
- My co-supervisor, Dr Caroline Bulsara, also for her supportive guidance, and also to my PhD colleagues, for their support;
• Professor Max Bulsara, for his expertise as a biostatistician;
• Financial assistance from the Joyce Wickham Scholarship, RCNA; the WA Nurses Memorial Trust and an Australian Postgraduate Award.

The journey of this study has been a fabulous experience and one that I have really enjoyed. It will provide me with tools that will contribute to the next part of my career and further learning.
## List of Appendices

Appendix 1a: Ethics committee approval letters, Notre Dame University, Dean of School of Nursing & Widwifery, UNDA 18/11/10 ........................................ 380
Appendix 1b: Ethics committee approval letters, Notre Dame University, The Human Research Ethics Committee for Low Risk Ethics Clearance 11/1/11 ........................................................................................................ 381
Appendix 2: Ethics approval from eight national sites. Letter sent to organisations ...................................................................................................................... 382
Appendix 3: Case study protocol .............................................................................. 383
Appendix 4: Letter to organisation—site of study .................................................. 388
Appendix 5: Confidentiality form ............................................................................. 389
Appendix 6: Approval for access to archived records, Battye Library, Perth ......... 390
Appendix 7: History of Ngala in the Western Australian context ........................... 391
Appendix 8: Protocol for focus groups .................................................................... 393
Appendix 9: Information sheets for focus groups/interview and teleconference ... 395
Appendix 10: Consent form for focus groups/interviews and teleconference ...... 397
Appendix 11: Pre-reading for the webinar ............................................................... 398
Appendix 12: Protocol for webinar .......................................................................... 401
Appendix 13: Protocol for national teleconference .................................................. 403
Appendix 14: Participant pre-reading for teleconference ........................................ 404
Appendix 15: Teleconference PowerPoint presentation slides ............................... 406
Appendix 16: Teleconference group questionnaire ................................................ 412
Appendix 17: Teleconference questions ................................................................. 413
Appendix 18: Summary and comments from national teleconference—January 2011 ............................................................................................................ 414
Appendix 19: Phase three planning and process for data collection ...................... 416
Appendix 20: Expert survey validation tool ............................................................. 418
Appendix 21: Expert reviews of survey, summary .................................................. 424
Appendix 22: Marketing postcard for national survey ............................................ 428
Appendix 23: Protocol for planning and distribution of national survey ............... 429
Appendix 24: Information sheet for national survey .............................................. 430
Appendix 25: Attachment to survey—the study so far ............................................ 431
Appendix 26: National questionnaire ...................................................................... 434
List of Figures

Figure 1. Early Parenting Services in Australia ........................................................... 3
Figure 2. Intervention applied to C-Frame (Hauck et al., 2011, p. 55) ...................... 21
Figure 3. Phases of the case study strategy for ‘An exploration of the past, present and future of nursing in EPS in Australia’ ......................................................... 29
Figure 4. Visual representation of phase one .............................................................. 35
Figure 5. Example of a document and its corresponding notation by the researcher, 28/2/11 ............................................................................................... 41
Figure 6. Example of coding the transcripts ................................................................ 45
Figure 7. Example of searching for themes and reviewing themes ............................ 46
Figure 8. Reviewing themes ..................................................................................... 47
Figure 9. The theme of nursing role in EPS and a breakdown of one sub-theme .......................... 48
Figure 10. Visual representation of phase two ........................................................... 49
Figure 11. Visual representation of phase three ......................................................... 56
Figure 12. Example of coding the transcripts in Survey Monkey ............................... 61
Figure 13. The themes for ‘there are concerns nationally for the future of nursing in EPS’ ................................................................................................................. 62
Figure 14. Example of coding quantitative data using Survey Monkey ...................... 63
Figure 15. Example of correlation of variables—age and state of respondents .......... 63
Figure 16. Ngala 1978 Annual Report (Ngala, 1978) ............................................... 74
Figure 17. The case ................................................................................................. 83
Figure 18. Clock Face for Four-Hour Feeding (Bryder, 2003b, p. 42) ....................... 87
Figure 19. Plunket celebrates 100 years (Anonymous, 2007) .................................... 88
Figure 20. Admission statistics 1969–1970 (Queensland Department of Health, 1971, p. 31) ......................................................................................... 100
Figure 21. Child Health Nurse’s Assignment 1970 (Ducrow, 2011) ......................... 104
Figure 22. Annual report 1911 .............................................................................. 111
Figure 23. Annual report 1912 .............................................................................. 111
Figure 24. Annual report 1913 .............................................................................. 112
Figure 25. Annual report 1914 .............................................................................. 112
Figure 26. Newspaper article, West Australian 1926 ............................................ 116
Figure 27. Newspaper article West Australian 1935 (Hobbs, 1980) ....................... 117
Figure 28. Brochure of the Governor’s visit to Alexandra Home for Women and Babies and Mothercraft Training School (1) ................................................ 122
Figure 29. Brochure of the Governor’s visit to Alexandra Home for Women and Babies and Mothercraft Training School (2) ............................................. 122
Figure 30. Brochure of the Governor’s visit to Alexandra Home for Women and Babies and Mothercraft Training School (3) .................................................. 123
Figure 31. Brochure of the Governor’s visit to Alexandra Home for Women and Babies and Mothercraft Training School (4) ............................................. 123
Figure 32. Brochure of the Governor’s visit to Alexandra Home for Women and Babies and Mothercraft Training School (5) ............................................. 124
Figure 33. Brochure of the Governor’s visit to Alexandra Home for Women and Babies and Mothercraft Training School (6) ............................................. 124
Figure 34. Medical treatments advertised in 1951 .................................................... 128
Figure 35. Nursing notes 1959 (Ngala, 1959b) ........................................................ 129
Figure 78. Category 1—Early Parenting Nursing Practice ...................................... 196
Figure 79. Early Parenting Nursing Practice—Coordination and Planning .......... 204
Figure 80. Category 2—Application of Evidence .................................................. 208
Figure 81. Category 2—Application of evidence, with sub-categories .................. 208
Figure 82. Category 3—Linking with others .......................................................... 212
Figure 83. Linking with others, with sub-categories .............................................. 213
Figure 84. The nursing role within an interdisciplinary team ................................. 217
Figure 85. The uniqueness of the nursing role within an interdisciplinary team .... 218
Figure 86. Some differences in the perception of the Early Parenting Nursing ... 222
Role .................................................. 222
Figure 87. Nurses’ and allied professionals’ perceptions of working together ....... 226
Figure 88. The concept of the EPP .................................................................. 238
Figure 89. The skills and knowledge for an EPP ................................................... 238
Figure 90. Workforce planning ............................................................................. 246
Figure 91. Survey response rate by State .............................................................. 250
Figure 92. Response to ‘Please indicate your age category’ .................................. 251
Figure 93. Response to ‘Longevity of work within EPS’ ....................................... 252
Figures 94. Response to ‘Nurses indicating continuation of work within EPS’ ... 253
Figure 95. Nurses’ breakdown of qualifications ...................................................... 254
Figure 96. Response to ‘Working closely with other disciplines at your site’ ....... 255
Figure 97. Response to ‘indicate how you work with allied professionals’ .......... 256
Figure 98. Response to ‘It is essential that nurses working in EPS are experienced’ .... 257
Figure 99. Qualitative response categories for ‘nurses working in EPS are experienced’ .............................................................. 258
Figure 100. Response to ‘Nurses maintain a unique role when working within a collaborative partnership model with other disciplines’ ................. 260
Figure 101. Qualitative responses to ‘nurses maintain a unique role within EPS’ .. 261
Figure 102. Responses to ‘There are concerns nationally for the future of nursing in EPS’ ........................................................................................................ 266
Figure 103. Qualitative responses to ‘there are concerns nationally for the future of nursing’ ........................................................................................................ 266
Figure 104. Responses to ‘Increase the development and availability of innovative options for post-qualification education in the early parenting sector’ ........................................................................................................ 272
Figure 105. Qualitative responses to ‘increase the development and availability of innovative options for post-qualification education’ .............................................. 273
Figure 106. Responses to ‘the need for innovative national professional development opportunities’ ........................................................................................................ 275
Figure 107. Qualitative responses to ‘the need for national professional development opportunities’ ........................................................................................................ 276
Figure 108. Responses to ‘the need to identify further research areas relevant to the EPS workforce’ ........................................................................................................ 278
Figure 109. Qualitative responses to ‘the need to identify further research areas relevant to EPS workforce’ ........................................................................................................ 278
Figure 110. Responses to ‘in order to plan for the next 5–10 years there is a need for a workforce development strategy in EPS’ ........................................................................................................ 280
Figure 111. Qualitative responses to ‘the need to develop a workforce development strategy’ ........................................................................................................ 281
Figure 112. Responses to ‘the need to identify the skill mix for the various practice contexts of EPS’ ........................................................................ 283
Figure 113. Qualitative responses to ‘the need to identify the skill mix for various practice contexts of EPS’ ........................................................... 283
Figure 114. Responses to ‘the need to develop marketing and recruitment strategies for a future multi-generational workforce’ ............................. 286
Figure 115. Qualitative responses to ‘develop marketing and recruitment strategies for a multi-generational workforce’ ...................................................... 289
Figure 116. Responses to ‘consider sustainable strategies to support a future multi-generational workforce’ .......................................................... 291
Figure 117. Qualitative responses to ‘consider sustainable strategies to support a future multi-generational workforce’ ...................................................... 289
Figure 118. Responses to ‘the need to develop retention strategies for the ageing workforce’ ........................................................................ 291
Figure 119. Qualitative responses to ‘develop retention strategies for the ageing workforce’ ........................................................................ 291
Figure 120. Three highest-ranked priorities for the next 3–5 years ................. 293
Figure 121. Highest-ranked priorities for the next 5–10 years .......................... 295
Figure 122. Qualitative responses to ‘identification of any further strategies’ ...... 296
Figure 123. Workforce development strategy for EPS ............................................ 300
Figure 124. The early parenting professional .......................................................... 301
Figure 125. The addition of an Enrolled Nurse with EPS certificate....................... 302
Figure 126. A visual representation of the past, present and future of nursing in EPS.............................................................................................................. 308
Figure 127. Figures for universal scheduled child health checks in WA (WA Auditor General’s Department, 2010) ................................................................. 317
Figure 128. Collaborative practice process and outcomes (D’Amour & Oandasan, 2005, p. 15) ............................................................................. 348
Figure 129. Interprofessional capability framework (Nicol, 2013, p. 24) .............. 349
List of Photos

Photo 1. The commencement of the Webinar with the researcher, November 2011.................................................................53
Photos 2 and 3. SCGH PTS May 1971—Elaine (left) with Lesley and whole group .................................................................67
Photo 4. Amy Dusting 2008 at Fremantle Hospital.................................................................68
Photos 5 and 6. Elaine with Helen and an Aboriginal boy at PMH 1973 .........................69
Photos 7 and 8. Elaine with a medical student at SCGH, 1973 ........................................70
Photos 9 and 10. Elaine in special care nursery, KEMH, 1976........................................71
Photo 11. Elaine at Midwifery graduation, 1977 .................................................................71
Photo 12. Elaine at Midwifery graduation receiving Director of Nursing’s prize, 1977 .................................................................72
Photo 13. Elaine at KEMH with two babies for adoption, 1977 .................................72
Photos 14 and 15. Elaine with colleagues undertaking the Child Health Certificate at Ngala, 1978; Elaine with two babies for adoption, 1978 .... 73
Photo 16. Collection of badges from all training schools of nursing.................................73
Photo 17. Flying to Flinders Island with colleague DON Dianne Kent, 1991 ..........76
Photo 18. Graduation of Master of Nursing with supervisor, 1998 .........................77
Photo 19. Poster presentation at the First Congress of Women’s Mental Health in Berlin, 2000.................................................77
Photo 20. Time at Newman & Nullagine ........................................................................79
Photo 21. Time at Exmouth and Coral Bay .................................................................80
Photo 22. Curtin Award .................................................................................................81
Photo 25. The House of Mercy 1890 ........................................................................109
Photo 26. The Alexandra Home 1951 ........................................................................119
Photo 27. Matron Ulrich with Nurses in 1949 .................................................................119
Photo 28. Alexandra Home nurse and babies 1957 (Malloy, 2010) .........................127
Photo 29. Beryl Grant 1959–1980 (Lang, 1980, p. 60) .........................................................134
Photo 30. Matron Beryl Grant with artwork at front entrance of Ngala ...................138
Photo 31. Toddlers at Ngala in Dining Room (Ngala, 1961) ......................................139
Photo 32. Deputy Matron Dreger lecturing RNs in child health (Ngala, 1963) ...........140
Photo 33. Dr Dugdale, an Honorary Paediatrician (Ngala, 1963) .................................142
Photo 34. Beryl Grant 1980 .......................................................................................146
Photo 35. Rae Walter with the new Board of Management, 1989 .........................156
Photo 36. Photo Rae Walter, Elaine Bennett and Beryl Grant, 2011 .........................171
List of Tables

Table 1. The service parameters of the APN role, adapted from the Strong Model of Advanced Practice (Gardner et al., 2007, p. 388) .............................................. 10
Table 2. Summary of the integrated research paradigm ................................................. 26
Table 3. Participants in phase one ............................................................................. 179
Table 4. Current demographics of the nursing workforce at Ngala (as at Oct 2012) ........................................................................................................ 179
Table 5. Current demographics of the allied professional workforce at Ngala .......... 180
Table 6. National numbers of nurses in EPS (January 2011) ...................................... 242
Table 7. National teleconference participants ............................................................. 242
Table 8. Summary teleconference questions ............................................................... 243
Table 9. Response rate to the survey by State ............................................................ 250
Table 10. Age of respondents .................................................................................... 251
Table 11. Longevity of work within EPS .................................................................. 252
Table 12. Nurses indicating continuation of work within EPS .................................... 253
Table 13. Three issues on which a national perspective was sought ......................... 256
Table 14. Rate of positive response about the future of nursing in EPS .................... 271
Table 15. Responses to ‘rank the above mentioned strategy statements according to your perception of their priority for the next 3–5 years’ ....................... 293
Table 16. Responses to ‘rank the above mentioned strategy statements according to your perception of their priority for the next 5–10 years’ ................. 294
Table 17. Selected characteristics of nurses working in child health in Australia (2008) ........................................................................................................... 315
Table 18. Example of generational characteristics .................................................... 336
## List of Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAPCH</td>
<td>Australian Association of Parenting and Child Health</td>
</tr>
<tr>
<td>AHPRA</td>
<td>Australian Health Practitioner Regulation Agency</td>
</tr>
<tr>
<td>ARACY</td>
<td>Australian Research Alliance for Children and Youth</td>
</tr>
<tr>
<td>C&amp;FHN</td>
<td>Child and Family Health Nurses</td>
</tr>
<tr>
<td>CALD</td>
<td>culturally and linguistically diverse</td>
</tr>
<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td>CHAPS</td>
<td>Child Health and Parenting Service</td>
</tr>
<tr>
<td>CMS</td>
<td>Canberra Mothercraft Society</td>
</tr>
<tr>
<td>CWA</td>
<td>Child Welfare Association</td>
</tr>
<tr>
<td>DCS</td>
<td>Department for Community Services</td>
</tr>
<tr>
<td>EBA</td>
<td>Enterprise Bargaining Agreement</td>
</tr>
<tr>
<td>EOI</td>
<td>Expression of Interest</td>
</tr>
<tr>
<td>EPP</td>
<td>Early Parenting Professional</td>
</tr>
<tr>
<td>EPS</td>
<td>Early Parenting Services</td>
</tr>
<tr>
<td>FPTP</td>
<td>family partnership training program</td>
</tr>
<tr>
<td>HR</td>
<td>human resource</td>
</tr>
<tr>
<td>IDT</td>
<td>interdisciplinary team</td>
</tr>
<tr>
<td>IHA</td>
<td>Infant Health Association</td>
</tr>
<tr>
<td>IPE</td>
<td>interprofessional education</td>
</tr>
<tr>
<td>IPP</td>
<td>interprofessional practice</td>
</tr>
<tr>
<td>KEMH</td>
<td>King Edward Memorial Hospital</td>
</tr>
<tr>
<td>LGH</td>
<td>Launceston General Hospital</td>
</tr>
<tr>
<td>NSW</td>
<td>New South Wales</td>
</tr>
<tr>
<td>NZ</td>
<td>New Zealand</td>
</tr>
<tr>
<td>OBE</td>
<td>Order of the British Empire</td>
</tr>
<tr>
<td>PD</td>
<td>professional development</td>
</tr>
<tr>
<td>PTS</td>
<td>Preliminary Training School</td>
</tr>
<tr>
<td>PYPS</td>
<td>Pregnant and Young Parent Support</td>
</tr>
<tr>
<td>QEC</td>
<td>Queen Elizabeth Centre</td>
</tr>
<tr>
<td>QEII</td>
<td>Queen Elizabeth II</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Full Form</td>
</tr>
<tr>
<td>-------------</td>
<td>-----------</td>
</tr>
<tr>
<td>RO</td>
<td>Research Officer</td>
</tr>
<tr>
<td>SA</td>
<td>South Australia</td>
</tr>
<tr>
<td>SCGH</td>
<td>Sir Charles Gairdner Hospital</td>
</tr>
<tr>
<td>SHWCV</td>
<td>Society for Health of Women and Children of Victoria</td>
</tr>
<tr>
<td>SPSS</td>
<td>Statistical Package for the Social Sciences</td>
</tr>
<tr>
<td>TASA</td>
<td>the Australian Sociological Association</td>
</tr>
<tr>
<td>TSIT</td>
<td>Tasmanian Institute of Technology</td>
</tr>
<tr>
<td>UK</td>
<td>United Kingdom</td>
</tr>
<tr>
<td>UNDA</td>
<td>University of Notre Dame Australia</td>
</tr>
<tr>
<td>VBHCA</td>
<td>Victorian Baby Health Centres Association</td>
</tr>
<tr>
<td>WA</td>
<td>Western Australia</td>
</tr>
<tr>
<td>WAIT</td>
<td>WA Institute of Technology</td>
</tr>
<tr>
<td>WANA</td>
<td>WA Nurses Association</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
</tbody>
</table>
Abstract

Nursing has a long history of providing services to families and children over the past century and more within Early Parenting Services (EPS) in Australia. Much has been written on issues regarding the general nursing workforce and requirements for the future, but little is known about the role of nursing within the EPS area around Australia in the context of an interdisciplinary team.

The aim of this study was to describe how nursing has responded to the changing needs of EPS in Australia and to investigate nurses’ and allied professionals’ perceptions of the nursing role within an interdisciplinary team. This enabled further reflection on, and consideration of, the future nursing workforce priorities required for EPS nationally.

A case study strategy using a mixed methods approach provided an in-depth analysis of the organisation Ngala (a not-for-profit EPS in Perth, Western Australia), as part of a broader network of EPS organisations around Australia. The study involved a three-phase approach, commencing with the focus on Ngala and then moving to the broader context of national services. The first and second phases used qualitative methods. The first phase employed several sources of data collection, such as archived documents, focus groups, interviews and nurses journals. Thematic analysis using the framework of Braun and Clarke (2006) informed the second phase—the national teleconferences. The data from phases one and two informed the third phase, which utilised the instrument design model of Creswell, Fetters and Ivankova (2004) to inform the development of the survey instrument. This approach ensured a strong link between the qualitative methods used and the move to the development of the quantitative phase. A commitment to a quality result in the measuring instrument meant that a reliability and validity criterion was applied. The survey had a 37 per cent response rate via online and postal responses. These data were analysed through survey monkey software. The findings were then compared with relevant literature and theories.

The three phases have informed a framework for future direction in the form of a workforce development strategy. Role theory and interprofessional practice theory
have contributed to both an understanding of the findings and the recommendations for organisations, nursing practice, education and research. The study conclusions for nursing and early parenting work will assist in future workforce planning at Ngala and EPS around Australia.
Chapter 1: Introduction and Background

1.1 Introduction

Early Parenting Services (EPS) and nursing have a long and interesting history in Australia. The past is described as prior to the 1990s and the current is from the 1990s to the present day. In discussing the future, the focus is on the following 10 years. This chapter will give an outline of the format of the thesis, provide a background to the research topic and explain the need to conduct research in this area.

1.2 Background to the Research Topic

1.2.1 Early Parenting Services

EPS within Australia have a key role in providing services to support families with young children. They strive to continually keep abreast of new evidence, and evaluate their services to align with best practice in the field of early childhood and parenting (Hauck, Kelly, & Fenwick, 2007). There is substantial national and international evidence (Hertzman & Power, 2003; Keating & Hertzman, 1999; Maselko, Kubzansky, Lipsitt, & Buka, 2010; McCain & Mustard, 1999; Shonkoff & Phillips, 2000; Zubrick, Silburn, & Prior, 2005) that comprehensive prevention and early intervention services and programs for children and their families have long-term benefits for physical and mental health, educational achievement and emotional functioning.

Families present to EPS for a range of issues including adjustment to parenting and isolation in the parenting role; an infant’s dysregulated sleep and feeding behaviour; behaviour management strategies; nutrition issues; poor maternal postpartum mental health; and parenting assessments for child protection (Fisher & Rowe, 2003; Hauck, Hall, D’Arcy, & Allen, 2006).

For over a century, nursing has been the major discipline within the multidisciplinary setting of EPS in Australia. It is timely to focus on these services because a range of
factors are influencing national directions in family support and children’s services, such as families’ needs in presenting to services; the impact of government policy on services; the professional skill mix to meet the needs of today’s families; and predictions of future nursing shortages over the next two decades (Belardi, 2012).

EPS within Australia have had a vital role in the community in supporting vulnerable parents with young children who need extra assistance in their parenting role. These services are not the universal child health services provided in each state, instead providing services such as intensive support, parent education and targeted services that focus from pregnancy through to the pre-school years. There is at least one Service in each State and each has, to some extent, its origins in the first part of the twentieth century. These services, listed below, are mostly situated in the capital cities of each state, as shown in Figure1:

1. Western Australia: Ngala
2. Queensland: The Ellen Barron Family Centre
3. New South Wales: Tresillian Family Care Centres
4. New South Wales: Karitane
5. ACT: Queen Elizabeth II Family Centre
6. Victoria: Tweddle Child & Family Health Service
7. Victoria: O’Connell Family Centre
8. Victoria: Queen Elizabeth Centre
9. Tasmania: Parenting Centres (3 day stay services) Hobart, Launceston and Burnie
10. South Australia: Torrens House.
1.2.2 Ngala in Perth, Western Australia

Ngala, a not-for-profit early parenting organisation, originated in 1890 as the ‘House of Mercy’ and was established as a ‘Refuge for fallen women’ in Perth (Lang, 1980). Over 120 years, the organisation has evolved and changed to meet the needs of society’s families with young children. This work has included a refuge for pregnant young women, out-of-home care for children, adoption services, parenting support and information and training for mothercraft and child health nurses. From 1916, the organisation changed its name to Alexandra Home for Women. Nurses had a key role in service provision during this time, and in 1959 the organisation was named Ngala Mothercraft and Training Centre. ‘Ngala’ is an Aboriginal word from the Bibbulmun dialect that means ‘mother and child’ or ‘we two’ (Lang, 1980, p. 57). The 1980s brought radical change to Ngala and into the 1990s there was a refocus towards an increased multidisciplinary approach with an expansion and diversification of services from the traditional nursing practice. The majority of disciplines practicing now at Ngala are nursing, midwifery, social work, psychology and early childhood. The predominant discipline continues to be nursing, with most

---

1 Prior to this time nurses were the major discipline, along with visiting medical officers. The first introduction of a social worker occurred in the 1980s.
of Ngala’s nurses in their emerging years leading up to retirement age. This is consistent with other EPS around Australia.

The challenge for Ngala in the future is how to best plan and meet workforce requirements, the expectations of nurses in this setting, demand from families with young children and the range of complex needs facing many families. Questions about the best skill mix and ratio of staff and how best to prepare for the future are often asked, particularly given the intergenerational issues for the nursing workforce. Issues such as different attitudes to work and the need for increased flexibility, shared governance approaches and ongoing learning opportunities need to be considered (Crowther & Kemp, 2009; Jamieson, 2009; Lower, 2008; Schwarz, 2008; Wilson, Squires, Widger, Cranley, & Tourangeau, 2008b). These issues are expected to affect recruitment and retention and organisational succession planning for the future.

To consider the above issues, it is necessary to understand how nurses perceive their role, and how their non-nurse colleagues perceive the nursing role within an interdisciplinary team.

1.3 Topic and Purpose

Nursing in EPS has evolved and developed over time. Nurses working in this specialist area in Australia are predominantly registered nurses with child health certificates or diplomas, or midwifery certificates or diplomas; mental health nurses; or mothercraft or enrolled nurses. They all work in various contexts within EPS in conjunction with other professional disciplines through centre-based services or community outreach programs. The purpose of the study was to explore the perceptions of nurses and allied professionals to determine how the past and present context of EPS influences its future.

1.4 Significance of Study

The need to provide evidence for how services are operating is a continuous challenge facing EPS throughout Australia. Funding bodies now require reports on outcomes for families and children’s services. While over the past decade services have been focusing on evaluation and research for their services, there has been
limited documented evidence of workforce planning for these areas. Duffield has been the most active in the area of nursing in Australia and internationally (Duffield, 2008; Duffield, Gardner, Chang, Fry, & Stasa, 2011; Duffield & O’Brien-Pallas, 2002; Gardner, Chang, & Duffield, 2007) and has looked broadly at the context of paediatrics, neonates and child health (Duffield, 2008). Health Workforce Australia (2012a, 2012b) have also been analysing the nursing workforce data, and have found there to be poor data in the area of community health nursing generally.

Over the next two decades, there will be an exodus of nurses reaching retirement, with little or no evidence currently available for EPS to guide future directions. It is thus timely to ask nurses how they perceive their current role as they work directly with other professionals within this specialist area, and what solutions they see could assist in future planning of workforce directions for EPS.

To establish a comprehensive understanding of this issue, it was necessary to explore the perceptions of nurses and their non-nurse colleagues in one State setting, before then using this specific State case to explore national service sites. In doing so, an overall framework for future directions in nursing is developed that considers an interdisciplinary context and focuses on the needs of families with young children today and for the future.

This study contributes to new knowledge in three areas. Firstly, it describes how nursing has evolved through the history of Ngala and early parenting organisations in Australia. Secondly, it describes the current nursing role within the context of an interdisciplinary team environment. Thirdly, it provides a framework for the future direction of nursing in EPS in Australia and identifies the priorities for the next three to 10 years.

Ngala, as the formative part of this research, informs phases two and three of the case study from a national perspective, which had the aim:

- To explore the past and present and explain the future of nursing in EPS in Australia.

Further questions were developed based on this aim, to guide an exploration of this subject matter.
1.5 Research Questions

The aim and purpose of the study gave rise to the following research questions:

1. How has nursing evolved within EPS at Ngalu?
2. How do nurses perceive their role within the context of an interdisciplinary team?
3. How do allied professionals perceive the nursing role within the context of an interdisciplinary team?
4. How has nursing evolved within EPS in Australia since the inception of services?
5. What is the present situation of nursing in the context of EPS nationally?
6. What are the future changes required in EPS as perceived by nurses nationally?

1.5.1 The Research Questions and Related Literature

1.5.1.1 Introduction

This literature review is presented in two parts. This chapter gives the broader context, including the history of the infant welfare movement and its influence on nursing in EPS within Australia (see Section 1.6). This includes the professional context; that is, nursing roles and the development of advanced nursing practice, collaborative and partnership approaches, interprofessional education (IPE) and interprofessional practice (IPP), and changes in government policies. Section 1.7 encompasses literature pertinent to the gaps identified for EPS, including as regards the nursing context within national EPS, the nursing role within interdisciplinary teams and nursing workforce priorities within EPS.

The context and the published literature related to EPS overlaps to a great extent. Therefore, it was decided to include the literature review along with the background in Chapter One, rather than to separate them by chapter. An extensive review of the literature was conducted overall, using library computerised search facilities and the researcher’s extensive experience in this area of work. Further, the researcher’s current networks in Australia were used to identify further key literature and studies being undertaken, to confirm the gaps in the literature. The search was continuous
throughout the study and enabled the following synthesis of contextual issues to contribute to the understanding of the past, present and future of nursing in EPS.

1.6 Literature Providing a Broad Context to Nursing in EPS

This section focuses on the professional issues affecting the context of nursing in EPS in Australia. However, first, an historical background is provided on the development of EPS (covered in greater detail in Chapter Three) and the infant welfare movement around Australia, and the influence of scientific motherhood.

1.6.1 The Rise of the Infant Welfare Movement

The infant welfare discourses of the first 70 years of the last century were strongly influenced by scientific child-rearing, whereby the nurse’s role was to train and teach the skills of ‘mothercraft’ to ‘ignorant and indifferent mothers’ (Callaghan, 1992, p. 9; Kitchens, 2005a). Infant mortality was often central to the debates of the 1800s and the first part of the 1900s (Featherstone, 2009; Kitchens, 2005a). The infant welfare movement focused on the health of infants and young children, but with a community emphasis. Internationally, similar trends can be observed from the beginning of the twentieth century in the United Kingdom (UK), Europe, New Zealand (NZ) and the United States (US) (Armstrong, 1939; Bryder, 2003a; Reid, 2001b). In most Australian states and NZ, medical officers were championing the cause of reducing infant mortality. Examples include Armstrong (1939) in New South Wales (NSW), Truby King in NZ (Bryder, 2003b) and Jull (1940) in Western Australia (WA) (Jull, 1940; Lang, 1980). In this context, nurses were responsible for health surveillance, providing support for breastfeeding and the education of mothers in relation to household management, hygiene and efficient child care (Brennan, 2007; Callaghan, 1992; Wilson, 2003).

The rise of this movement was also supported around Australia by many women’s volunteer organisations. In some cases, these organisations even employed nurses until governments eventually took control of infant welfare services. These volunteer organisations also assisted with the building, upkeep and running of the infant welfare facilities, including EPS in many states (Kane, 1980; Lang, 1980; Thorley, 2000).
1.6.2 Nursing Roles and the Development of Advanced Nursing Practice

Child and family health nursing is one of the oldest postgraduate certificates for registered nurses, having been available since the early part of the twentieth century. This course could only be undertaken after a nurse had undertaken general and midwifery certificates, with the nurse then known as a ‘triple certificate’ sister. The ‘infant welfare’ or child health course transitioned into the tertiary sector during the 1980s, and since this time the role has changed and broadened to align with social, political and economic perspectives, policy changes and societal and family needs (Brookes, Daly, Davidson, & Halcomb, 2007).

Role theory is a useful conceptual framework to describe role perceptions that are influenced by societal attitudes, government policies and trends in professional issues. The theory defines how individuals behave in social situations and how these behaviours are perceived by external observers (Brookes, et al., 2007). A large part of this study involves exploring and understanding the evolving nursing role within EPS in Australia from the perspective of the past, present and future. It was decided to explore ‘role theory’ to explain the trajectory in the role of nursing in EPS over time. Although this theory initially appeared more relevant to the earlier nursing role, contemporary views also explain societal changes important to the changing role of nursing in EPS. Biddle (1986, p. 68) states that ‘role theory concerns one of the most important characteristics of social behaviour—the fact that human beings behave in ways that are different and predictable depending on their respective social identities and the situation’ (p. 68).

A number of perspectives on role theory began appearing from the 1930s, and these have been developed since that time. Biddle (1986) addresses this diversity of role concepts by examining the five different theoretical perspectives of functionalism, symbolic interactionism, structuralism, organisational psychology and cognitive social psychology. These theories are organised around the notion that individuals occupy a variety of social roles or positions, each of which specifies certain normative behaviours and attitudes (Biddle, 1986). Biddle argues that norms, beliefs and preferences are tied up in expectations of roles (Biddle, 1986), and that individuals hold expectations for each other. As these expectations become known, individuals will conform either because the person holding the expectation is in a
position of power and can apply sanctions, or because the individual simply internalises the normative expectations.

Some theorists have discussed problems with role theory and the concept of expectations, with some suggesting that role theory holds that social integration is to be valued and that personal satisfaction is intricately tied to one’s acceptance and fit within the existing social structure (Biddle, 1986; Jackson, 1998). Although role theory does emphasise conformity and social integration, theorists do recognise that conflicting pressures can occur that create ‘role conflict’, such as role ambiguity, role overload, role incompatibility or inadequate skills to perform the role (Biddle, 1986; Jackson, 1998).

Jackson (1998) states that the role theory perspective of human agency minimises the creative nature of humans as they adapt on a daily basis to their environments; how people improvise to reach their goals or life choices, given the constraints of their particular situation against a backdrop of social, economic and familial forces, is not sufficiently explored (Jackson, 1998, p. 53). Role theory would say that the support of organisations is crucial while nurses are being challenged with their role expectations during a transition phase, for them to generate a sense of meaning and purpose that contributes to their own psychological wellbeing. Nurses must then modify their attitudes and expectations through anticipatory socialisation and adapt through training and professional support in their new defined role (Burnett, 1999).

As nursing evolved following the introduction of nursing into the tertiary sector, considerable ongoing changes were created for hospital-trained nurses. Models of nursing were developed and implemented in response to changes in policy, clinical management and budgetary constraints (Wagner, 2001). Many of these proposed significant changes to the historical role of nurses working in community settings, including a substantial move towards specialisation (McKenna, Keeney, & Bradley, 2003). Nurses in child and family health services broadened their roles in response to changes in society, the changing nature of family needs and issues, or because no other disciplines were able to do or assist with the work necessary to meet demands (Barnes, Courtney, Pratt, & Walsh, 2003; Borrow, Munns, & Henderson, 2011; Harmer, 2010). While many embraced this change, others found this to create role conflict and overload (Brookes, et al., 2007; Marron & Maginnis, 2009).
Advanced practice roles have developed over time, creating conflict and tension within nursing from some perspectives (Duffield, et al., 2011; Gardner, et al., 2007; Laperrière, 2008; Woods, 1998). Gardner et al. (2007) developed an operational framework to identify, establish and evaluate advanced nursing positions. The authors adapted (Gardner, et al., 2007) and validated (Chang, Gardner, Duffield, & Ramis, 2010; Chang, Gardner, Duffield, & Ramis, 2011) the Strong Model of Advanced Practice by Ackerman, Norsen, Martin, Wiedrich and Kitzman (1996) to provide workforce and health planners with a tool by which to differentiate the profile and service potential of the advanced practice nurse. Table 1 outlines the domains of the framework, with descriptions of each domain.

**Table 1. The service parameters of the APN role, adapted from the Strong Model of Advanced Practice (Gardner, et al., 2007, p. 388)**

<table>
<thead>
<tr>
<th>Domain</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct comprehensive care</td>
<td>The APN role will have a clinical component in a field of health service. This direct care translates to a proficiency in patient care that will enable the clinician to inform care coordination, care delivery and guidance and direction to others relative to a specific patient population.</td>
</tr>
<tr>
<td>Support of systems</td>
<td>The APN operates within a system of health service. The APN role will be a response to the need for innovative models to address unmet patient care and/or health service needs. The role will be involved in facilitating the optimal progression of patients through a health care or health service system.</td>
</tr>
<tr>
<td>Education</td>
<td>Education is part of APN roles and includes a wide range of activities that relate to dissemination of current scientific knowledge. The APN clinician provides education to patients and communities to promote wellness, to patients enabling them to cope with illness and self care, and to trans-disciplinary clinicians and students.</td>
</tr>
<tr>
<td>Research</td>
<td>The APN role supports the generation of knowledge and integration of research findings into clinical practice. The emphasis in this domain is about creating and supporting a culture that questions current practice and seeks creative and innovative solutions to clinical questions. It is about sustaining a best practice environment for patient and community care.</td>
</tr>
<tr>
<td>Professional leadership</td>
<td>The APN clinician will demonstrate a commitment to sharing and dissemination of expert knowledge both within and external to the institutional setting. This dissemination relates to involvement with professional activities as well as activities that promote public involvement and public awareness of specific health-related issues.</td>
</tr>
</tbody>
</table>

The role of the community child health nurse has been documented internationally (Barnes, et al., 2003; Borrow, et al., 2011; Briggs, 2006, 2007; Cowley, 1995; Eronen, Pincombe, & Calabretto, 2010; Fägerskiöld, Wahlberg, & Ek, 2000; Forbes, While, Ullman, & Murgatroyd, 2007; Grant & Luxford, 2008; Kruske, Barclay, & Schmied, 2006; McPherson, McIntosh, & Mann, 1980; Munns, Downie, Wynaden, & Hubble, 2004; Ochiltree, 1991; Reid, 2001b; Schmied et al., 2012; Shepherd, 2011). Historically, the work of nurses has been divided into the public health role including parent education and the health and wellbeing of children. More recently, this role has broadened to include health promotion and consideration of the psychosocial dimension of families (Briggs, 2006, 2007). In response to growing evidence that childhood experiences are closely linked to later adult functioning,
nurses have had to incorporate this knowledge into their practice (Edgecombe & Ploeger, 2006; Kruske, et al., 2006; Marmot, 2005). Studies also indicate that the nurse–family relationship is central to practice and cultural competence (Briggs, 2007; Drennan & Joseph, 2005; Grant & Luxford, 2011; Kemp, 2005; Riggs et al., 2012). There are descriptions of nurse competencies for the advanced role in child and family health nursing in WA, NSW and South Australia (SA). Briggs (2011) responds to the Productivity Commission’s (2011) draft report and highlights the need for national consistency for educational preparation and support for new graduates. Kruske and Grant (2012) also recommend that national consistency of education of child and family health nurses needs close consideration.

1.6.3 Collaborative and Partnership Approaches

Collaboration is a means of producing something together from the interactions of people or organisations, their knowledge and resources. These interactions are facilitated by relationships that are established and maintained by the people and organisations participating in the collaboration. Relationships give collaboration strength and the ability to function effectively. The quality of these relationships is determined by three factors: ‘trust, reciprocity and mutuality’ (Keast & Mandell, 2010, p. 1).

The key to having an effective partnership model is the surrendering of professional control and reliance on the expertise and ability of the client in understanding, learning and managing their situation. Working in this way does not deny the expertise of the professional; it merely identifies the complementary expertise of the parent (Dunst & Dempsey, 2007; Shields, Pratt, & Hunter, 2006). Effective collaboration with other services and disciplines requires knowledge of the roles and responsibilities of colleagues and recognition of one’s own boundaries. This was seen as important for nurses in universal services to increase their engagement with vulnerable families (Schmied et al., 2010). Many child health services have implemented ‘family partnership training’ with nurses to enable practitioners to work more collaboratively with clients and other professionals (Nemeth, 2008; Rossiter, Fowler, Hopwood, Lee, & Dunston, 2011). Nurses have generally described this experience as ‘a large-scale cultural change, taking them out of their comfort zones
1.6.4 Interprofessional Education and Practice

Collaboration and working in partnership are crucial elements to successful relationships within IPE and IPP. More universities are now focusing on IPE in their undergraduate programs. Engum and Jeffries (2012, p. 147) consider core elements needed to ensure effective practice, giving their shared competencies for IPE curricula as communication, professionalism, system-based practice, knowledge and problem-solving. The authors stressed that team members must understand their goal, and they reinforced that strong leadership is crucial in managing the various team disciplines, roles and experience levels that comprise collaborative work. The role modelling of partnership and reflective practice approaches is necessary for an interdisciplinary team to work together to achieve the desired goals (Bennett, Hauck, Bindahneem, et al., 2012).

For IPE to be successful when transferring the application of skills into a service organisation, commitment across all settings is required. Champions in the workplace need to be identified to enrich the student placement experience (Missen, Jacob, Barnett, Walker, & Cross, 2012). An exploratory study was undertaken in WA to ascertain the scope and range of IPE activities taking place in WA institutions (mostly universities) (Nicol, 2013). Nicol found that professional perspectives were such that they supported IPE, but many were not prepared to actively engage with it. Some of the perceptions presented were fear of role substitution and insufficient evidence to persuade professionals to adopt IPP. There appeared to be a knowledge deficit of other disciplines and an attitude of ‘professional territorialism’. The lack of training for clinicians delivering teaching content was also a matter of concern. The resistance to teaching IPE from teaching staff included the above reasons, as well as perceptions of ‘change fatigue’, the belief that IPE was a ‘flavour of the month’ and would not last, and insufficient time for IPE because of the focus on discipline-specific content. The report recommended that local universities establish common cross-disciplinary competency and capability standards and assessment criteria that could become an Australian example (Nicol, 2013, p. 21).
Internationally, support for IPE is gaining momentum, such as in ‘learning together for working together’ (Barnsteiner, Disch, Hall, Mayer, & Moore, 2007; Barr & Ross, 2006; Clarke, 2006; D’Amour & Oandasan, 2005; Dunston et al., 2009; Hammick, Freeth, Koppel, & Barr, 2007; Matthews et al., 2011; World Health Organisation, 2010b). A study by Matthews et al. (2011) in Australia found that a range of interconnected changes is required to successfully mainstream IPE for health professionals, incorporating policy, cultural, institutional, funding and practical dimensions. Cooper, Braye and Geyer (2004) propose ‘complexity theory’ as a framework that can provide the scaffolding on which to build IPE and provide clear guidance for its future development, and assist with guiding practice, intervention goals and explanations for outcomes.

1.6.5 Changes in Government Policies

There are many policy drivers driving health care reform and the focus of IPE. First among these is the Australian health workforce shortage. To meet current demand and future challenges, it is becoming increasingly necessary for governments and health care providers to look differently at the provision of health care in Australia. Secondly, there are issues with health demographics and inequalities. These include the demands of an ageing population, necessitating a focus on chronic disease, and the disparities evident for disadvantaged sectors of the Australian population; namely, for Aboriginal and Torres Strait Islander peoples and people with disabilities and mental health conditions. Thirdly, with advancing technology, there are demands for new models of health care and workforce practices. As the fourth driver, consumers now play a critical role in the delivery of services and are increasingly informed. Finally, the focus on quality and client safety has created systems that can be quite cumbersome and administratively burdensome. Together, these issues create a complicated service delivery context, the navigation of which requires effective interdisciplinary teams (Nisbet, Lee, Kumar, Thistlethwaite, & Dunstan, 2011).

Schmied et al. (2011) reviewed policy and frameworks for maternity and child health services around Australia. They found that current policies were in line with international research and policy directions, emphasising prevention and early intervention, continuity of care, collaboration and integrated services. All states are consistently advising health professionals to work in partnership with women and
families, to collaborate with other disciplines and use team approaches to care planning, and to collaborate across the government and non-government sectors (Roche et al., 2005; Schmied, et al., 2011). However, to shift from traditional expert-based system approaches and to work collaboratively requires substantial socio-cultural and organisational change (Dunston, Lee, Boud, Brodie, & Chiarella, 2009).

Integrated approaches to health care delivery are now advocated by governments internationally (Nisbet, et al., 2011). In Australia, strategies have been developed and implemented for a more integrated response to the needs of children and families (Schmied et al., 2008). Localised integrated service models are being developed in most states with the support of both State and Commonwealth Governments to enable better outcomes for families in accessing health, welfare and education services. At a system level, key strategies have included the implementation of liaison positions, multidisciplinary teams, co-location of services and care coordination or case management. Lessons from collaborative practice in the field emphasise a need for health professionals to understand and respect each other’s skills and be willing to negotiate spaces for professional engagement (Moore & Skinner, 2010).

These broader professional contextual issues have affected EPS around Australia. The following sections presents the literature that is more directly related to EPS.

1.7 Literature Providing a Context to Nursing in EPS and the Gaps Identified

This section divides the literature into three major groupings, described under the following headings:

1. The nursing context within national EPS;
2. The nursing role within interdisciplinary teams;
3. Nursing workforce priorities within EPS in Australia.
1.7.1 The Nursing Context within National Early Parenting Services

Nurses working within EPS in this study are described as follows:

1. Child health nurses are registered nurses with either a child health nursing certificate or postgraduate certificate/diploma of child and family health nursing. Many child health nurses also have a postgraduate certificate or diploma in midwifery.

2. Midwives are registered midwives with other qualifications such as general nursing and either a midwifery certificate or a postgraduate diploma in midwifery.

3. Mothercraft nurses/enrolled nurses are registered with the Nurses and Midwives Board.

4. Mental Health Nurses are registered nurses with other qualifications such as general nursing and either a mental health certificate or postgraduate diploma in mental health nursing or a postgraduate diploma or Master’s degree in infant mental health.

Nurses have been undertaking nursing research in EPS over recent years. Outcomes include the development of a model of care, a Delphi study, and the development of an interdisciplinary research agenda to identify research priorities (Bennett, Hauck, Bindahneem, et al., 2012; Hauck, et al., 2011; Hauck, et al., 2007) and practice-related issues (Briggs, 2007; Chavasse, 2010; Fowler, Rossiter, et al., 2012; Fowler, Rossiter, DeGuio, & Briggs, 2009; Hauck, et al., 2011).

Nurses have been the predominant discipline within EPS for many years, and in many states this remains the case. However, no comprehensive overview of nursing exists for EPS in Australia. Some states have developed competencies for child health nursing (Australian Confederation of Paediatric and Child Health Nurses, 2006; Community Nurses Special Interest Group, 2001; The Child and Family Health Nurses Association (NSW) Inc., 2009a), and various authors have described aspects of nursing history broadly (Mein Smith, 1997) or more specific to their State (Ashton, 2009; Brennan, 2007; Cilento, 1967; Crockett, 2000; Edman, 2010; Kane, 1980; McFarlane, 1968; O’Connor, 1989b; Selby, 1992; Thorley, 2000). Yet there still appears to be a gap in the literature in consolidating this information, or in
specifically focusing on EPS. Moreover, there has been no documentation of the nursing role and context of change at Ngala.

Family-centred practice underpins the work within EPS. Over the past two decades, service delivery to families has been shifting from a professionally centred expert approach, to a family-centred model with increasing emphasis on interventions based on family strengths and supports, rather than solely on their needs and deficits. The other elements of this practice contain characteristics that focus specifically on the premise that the family, parent or carer are the primary influences on the child’s development and are critical to the success of early intervention for the child. Family-centred practice places the family as the expert and as central to understanding the wants and needs of their children (Dodd, Saggers, & Wildy, 2009; Dunst & Dempsey, 2007; Keen, 2007; Scott, 2005; Wade, Meldon, & Matthews, 2007).

An increase of allied professionals working in EPS over recent years has meant that nurses are being exposed to and influenced by other ways of working. This process of change has created some overlap in roles and work across discipline boundaries (Orchard, Curran, & Kabene, 2005a; Priddis & Wells, 2010b; Scholes & Vaughan, 2002). Duffield et al. (2011) raised the issue of role blurring, which can be a problem of ‘role confusion’ more in the context of industrial relations. The various awards and pay scales for different professionals can create some unrest when practitioners from different disciplines work alongside each other and are perceived as doing similar roles. Brown, Crawford and Darongkamas (2000) found some evidence of role blurring in their study with mental health community professionals. This was found to be welcomed by a few respondents, while others sought to preserve their own professional identity within the multidisciplinary environment. Brown et al. noted that lack of managerial direction and the encouragement of generic working seemed to make some respondents all the more insistent on separate professional identities. This reinforces the need for broader policy and support at all levels to ensure interdisciplinary approaches.

1.7.2 The Nursing Role within Interdisciplinary Teams

The numbers of other allied professionals involved in EPS around Australia vary considerably depending on the service. Some services are staffed by diverse
disciplines, while in other contexts and jurisdictions there may be very small numbers of other allied professionals working in the service. The major non-nursing disciplines are: medicine, psychology, early childhood education, social work and other social or applied science disciplines. As the number of other disciplines in EPS is steadily increasing, it is important to understand the role of the nurse within an interdisciplinary team—this is a gap in the literature.

**Interdisciplinary team practice** is described as a partnership between a team of health professionals and a client in a participatory, collaborative and coordinated approach to shared decision making around health issues (Orchard, et al., 2005a, p. 1).

**Interdisciplinary teams** take different forms in EPS depending on the context of work—whether universal, targeted or intensive. In terms of Ngala’s services, these contexts are defined as:

- *Universal Services*—services aimed at the general population, such as the Ngala Helpline, parenting and professional education and early years’ resources. (Note: different description than universal child health service system in which the targets are to reach 100 per cent of specific targeted age groups of children through child health centres).
- *Targeted Services*—geographically or culturally targeted, such as Ngala’s Parenting and Play Time at metropolitan locations and Ngala’s Indigenous parenting and children’s service.
- *Specialised/intensive Services*—where an intensive response for parents with young children is required by an interdisciplinary staff team. This includes Ngala’s day stay and overnight stay and the parenting advice and support service at Bandyup Women’s Prison (Ngala, 2012b).

It is not clear at Ngala or other national services how nurses work with other professional disciplines. Anecdotally, it appears that nurses undertake the major role with families, and use referral mechanisms to allied professionals to share the workload in more intensive work through overnight and day stay services. Within other programs in the community context, there appears to be an increased sharing
and collaboration across roles and disciplines. Briggs (1997, p. 91) describes four models of teamwork:

1. Uni-disciplinary: one professional discipline attempts to serve all the needs of the family and child;
2. Multidisciplinary: several professional disciplines work in parallel to meet the needs of the child and family, with limited interaction and exchange of information and expertise;
3. Interdisciplinary: several disciplines coordinate their services to the child and family but with limited crossing of disciplinary boundaries;
4. Trans-disciplinary: several disciplines provide an integrated service to the child and family, with one professional staff member acting as a conduit of services for the team.

Glenny and Roaf (2008) examine a series of case studies of multiprofessional work to understand what works and why. In the successful case studies, the practitioners were able to reflect on the organisational contexts in which they worked. This was achieved through a carefully managed series of feedback loops, which ensued that good quality information was shared at all levels. With an effective communication system in place, practitioners could resolve difficulties and evolve new ways of working together to improve their joint practice. Glenny and Roaf draw on complexity theory to provide the analytic tools for exploring and developing the communication systems that underpin effective multiprofessional practice. They argue that the effectiveness of working with families with young children is vitally dependent on the quality of the families’ relationship with practitioners—communication is the key.

The focus of this study is on elucidating the role of nurses and how they work with other allied professionals in EPS contexts. The perception of these nurses of the future of EPS will also be explored.

Duffield (2008) raises an important issue for future consideration of nurses working within child health, neonatology and paediatrics, and asks whether or not the principles and skills needed are different for nurses, doctors and allied health
professionals. The author puts forward the challenge of whether there are better ways of preparing this specialised workforce given Australia’s population and distribution.

1.7.2.1 Family partnerships

Collaboration is the essence of effective teamwork. EPS use one of two frameworks for collaborative practice throughout their services. These are the ‘Family Partnership’ model by Davis (Davis, Day, & Bidmead, 2002) and the C-Frame framework (Victorian Parenting Centre, 2005). Both frameworks move the practitioner from the need to ‘fix things’ to a partnership approach when working with a family. The family partnership training works with practitioners to enable them to work with the parent to explore the difficulties they face, to clarify the situation and to develop the most helpful and effective strategies for optimising the psychosocial development of their children (Lamont, 2008). C-Frame also incorporates the family partnership model. Recent studies have been evaluating the effectiveness of the family partnership model in EPS and recommend that organisations ensure sustainable systems to support the process of implementation over the longer term (Fowler, Lee, Dunstan, Chiarella, & Rossiter, 2012; Fowler, Rossiter, et al., 2012; Lamont, 2008; Nemeth, 2008).

For their way of working with families, Ngala in WA uses a strengths-based solution-focused framework called ‘C-Frame’ (Connect, Collaborate and Change). C-Frame provides a process and tools for practitioners to connect with families and colleagues and work collaboratively towards positive change (Ngala, 2012b). The framework was developed by a consortium of EPS—Tweddle Child and Family Health Service (Victoria), Tresillian Family Centre (NSW) and Queen Elizabeth II Family Centre (ACT)—in conjunction with the Parenting Research Centre in Melbourne (Ngala, 2012b).

Being effective in providing support to families requires constructive and helpful partnerships from the outset, to ensure child safety and wellbeing throughout the stages of child and parenting development. In all kinds of parenting support, from the briefest contacts to extended interventions, professionals and parents come together in a unique relationship. Very different from informal social relationships, this relationship has a specific focus (the child), purpose (helping the parent achieve desired changes) and structure (parameters are placed around the nature and
frequency of contact) (Bennett & Walter, 2010; Pagan, Walter, & Webster, 2004; St John & Flowers, 2009). Parent strengths and life experiences are utilised in the process to motivate the parent/s or significant caregiver towards the positive changes they seek. An underlying principle is that it is the parent/s themselves that need to initiate and maintain behaviour change. Therefore, the relationship between the professional and parent is critical to the process (Hauck, et al., 2011; Victorian Parenting Centre, 2005).

The framework consists of four main phases, which are not necessarily all used or used in any particular order with the exception that phase one is the first step in the process:

- Phase 1: Creating a collaborative relationship;
- Phase 2: Developing a commitment to change;
- Phase 3: Contextual analysis;
- Phase 4: Negotiating change and intervention (Ngala, 2012b).

An example of using C-Frame in a longer consultation (day stay) with parents is cited in Hauck et al. (2011).
An important task embedded in C-Frame is the requirement that practitioners engage in regular, scheduled and ongoing reflective practice (Victorian Parenting Centre, 2005). This way of work is also emphasised for when working with colleagues in the organisation (Ngala, 2012b).

While these approaches to care provide a framework for the process of work for practitioners and families, there is no apparent literature available that discusses the nursing role within the interdisciplinary team context in EPS, or how practitioners navigate their roles together with families with young children.

1.7.3 Nursing Workforce Priorities within Early Parenting Services in Australia

As previously stated, Australia’s health and community sector workforce is facing significant challenges. Such challenges are well documented and include an ageing population, increased demand for health services, increasing expectations for service delivery, a changing burden of disease and broader labour market issues. In addition, health expenditure as a percentage of gross domestic product is rising, and is projected to increase significantly in the coming decades. It is critical that these
challenges are addressed together to ensure the sustainable delivery of health services that support the health and wellbeing of Australia’s population (Health Workforce Australia, 2012b).

EPS has a significant ageing workforce. Gabrielle and Jackson (2008) identified some unmet support needs for older nurses in the health workforce that could discourage them from remaining in nursing. Two major themes were identified. The first was ‘feeling uncared for’, which contained three sub-themes: unsupportive work relationships, ‘we should be helping each other’; workplace bullying and stress; and burnout. The second main theme was ‘adapting to ageing’. These findings highlight a need for further research into the support needs of older nurses to find ways to maintain their knowledge and skills in the workplace.

In thinking about the future, Duffield (2008, p. 7) raised questions that can be asked of the early parenting context. Some of these questions relate to the appropriate professional discipline best able to meet the needs of families/children with vulnerabilities today. Further, with the increasing and future demands of families, it is necessary to identify the discrete roles to which nursing contributes, and identify those roles that could be appropriately shared or undertaken by other disciplines.

Duffield (2008, p. 7) also raised the issue that, in this era of intense professional specialisation, we should be ‘work[ing] with’ parents and children and ‘with each other’ as professionals, to focus on the needs of our clients, rather than on those of the professional.

With this background in mind for this study, the driver was to understand how nurses working in EPS perceive and understand their role, and how they work with other members of their team in partnership with the parent, family and child to achieve health and wellbeing outcomes.

This study is significant at a local level for the early parenting work at Ngala, but also has potential implications for national parenting centres around Australia. Given the shortage of child health nurses nationally and the lack of research into this specialist area of nursing, it is a timely study. It will also provide direction for future workforce requirements, and the findings will have the potential to be used to
develop, implement and evaluate a range of future strategies for the staffing and training of an interdisciplinary workforce.

1.8 Chapter One Summary

This thesis presents a research project exploring the past and present and explaining the future of nursing in EPS in Australia. Research on these specialist services has been increasing over the past two decades, yet remains scant. No research has been conducted on the nursing role in the context of an interdisciplinary team.

The research project comprised three phases, followed the trajectory from the investigation of a sole EPS site in WA to the national setting of eight other sites. This approach provided rich data through mixed methods and the inclusion of the researcher’s own experience in the history of nursing and connection with Ngala. At the time of commencement of this study, uncertainty was being expressed by nurses about the necessary requirements of the workforce, and there was some nervousness about the potential future crisis looming for nursing. The organisation Health Workforce Australia was also gathering momentum and starting to analyse data to make future projections about the need for health workforces.

The following chapters and the research study format have been approached in the following way:

Chapter Two: The methodology chapter gives an overview of the research paradigm and strategy. The details of each phase of the study are addressed, including the sample, data collection and analysis. The researcher’s reflection on her personal nursing experience and connection with Ngala is situated at the end of this chapter.

Chapter Three: ‘The case’ sets the context as EPS with relevant international and national literature and the historical experience and overview of each state. The history of nursing at Ngala is explored in-depth.

Chapter Four: The analysis of the data and findings are presented in this chapter, with the three phases of the study presented in respective sections.

Chapter Five: The discussion of the findings is presented with a summary of the new knowledge in relation to the relevant literature and theoretical considerations.
Chapter Six: The conclusions and recommendations consider the significance of the findings, their limitations and the implications for clinical practice, education, research and organisations.

The importance of the early years of life is well documented, but despite this there remains a shortage of good quality evidence to guide organisations on the nursing role when working closely with other disciplines in EPS. Likewise, no framework exists for future directions in workforce development for EPS. This study bridges this gap and provides recommendations for the future.

In this chapter, the general background of the topic leading to the research questions was introduced. This included a discussion of the overall context of EPS and Ngala, and the significance of this study to Australian EPS. The following chapter will present the research paradigm and the case study strategy, while Chapter Three provides a detailed description of the case of interest—that is, nursing in EPS in Australia.
Chapter 2: Methodology

2.1 Introduction

This study explores how nursing practice within EPS evolved and how nurses and allied professionals perceive the nursing role within an interdisciplinary team environment. Based on this, a way forward for the future is proposed. However, to understand the study to the best effect, it is important to explain the researcher’s choice of methodological approach for this study. To this end, the paradigm is here elucidated, and the study design is detailed.

The research questions detailed in Section 1.5 necessitate a case study approach, for which a three-phase approach using mixed method strategies was deemed appropriate. This chapter details the rationale for choosing this design, including the design reliability and validity strategies. The phased approach determined the methods employed to conduct the study. In Sections 2.3–2.5, each phase is discussed systematically, including a description of the sample, data collection procedure and analysis methods employed. Section 2.6 provides an explanation of the ethical considerations for this study, and the researcher’s reflection on her own experience of nursing and connection with Ngala is detailed in Section 2.7. The chapter concludes with a brief summary in Section 2.8.

2.2 Research Paradigm

An exploration of the paradigm used for this study is now discussed. The definition used by Weaver and Olson (2006, p. 460) holds that ‘paradigms are patterns of beliefs and practices that regulate inquiry within a discipline by providing lenses, frames and processes through which investigation. … and interpreting significant substantive issues to the discipline … [are] accomplished’ (p. 460). It was decided that to comprehensively study the case of EPS in relation to its past, present and future, different paradigms would have to be used in conjunction. This is explained below.
2.2.1 Integrating Research Paradigms

The use of qualitative and quantitative approaches was required to provide a richer context for nursing in EPS to develop a future-orientated framework. An exploration of the history of nursing required an integrated paradigm involving both interpretive and post-positivist perspectives. The interpretive paradigm supports the view that there are many truths and realities, and the focus is holistic on the person and the environment, which is consistent with the nursing discipline (Weaver & Olson, 2006). As detailed in Sections 2.3 and 2.4, the first two phases employed qualitative approaches. The first phase involved a sample of nurses and allied professionals within one EPS; while in phase two, involvement was extended nationally to include a sample of nurses within EPS from around Australia. These qualitative phases informed the third phase, which was quantitative in focus and used a post-positivist paradigm. The philosophical underpinning of a post-positivist paradigm is the emphasis on well-defined concepts and variables, controlled conditions, precise instrumentation and empirical testing (Creswell & Plano Clark, 2007; Guba & Lincoln, 1994). Table 2 summarises the integrated research paradigm and provides examples in bold of how these views were incorporated into the study.

Table 2. Summary of the integrated research paradigm

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Interpretive View</th>
<th>Post-positivistic View</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose</td>
<td>The researcher will analyse documents and interview stakeholders recognising the value and depth of the individual content</td>
<td>The researcher will objectively collect data with an instrument Questionnaire</td>
</tr>
<tr>
<td><strong>Historical and Archived Documents</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interviews, Written Journals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beliefs</td>
<td>Many truths and realities</td>
<td>One truth exists and must be objective</td>
</tr>
<tr>
<td></td>
<td>Different people have different perceptions, needs and experiences</td>
<td></td>
</tr>
<tr>
<td><strong>Focus Groups</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Research Methods</td>
<td>Qualitative</td>
<td>Quantitative</td>
</tr>
<tr>
<td>What Study Data are Based Upon</td>
<td>Descriptive, explanatory and contextual words of document analysis and interview data</td>
<td>Measurable outcomes from questionnaire data</td>
</tr>
<tr>
<td>Study Sample</td>
<td>Representatives able to provide expertise from different points of view</td>
<td>Clear inclusion and exclusion criteria</td>
</tr>
</tbody>
</table>
The bringing together of the interpretivist and post-positivist paradigms facilitated the researcher gaining in-depth understanding of the nursing context for all early parenting national organisations, recognising that history informs both the current context and future directions. The combination of both approaches gave the researcher the ability to statistically analyse the scientific data from the total number of nurses working within EPS nationally.

The discussion that follows will further elaborate and describe the influences of the paradigm and methodological approaches as they were implemented in this study.

2.2.2 Case Study

Ngala was selected as the basis of a case study describing the nursing context within an interdisciplinary team. This case study in turn informed an extension of the study to the national context of nursing within EPS in Australia.

The case study methodology was chosen because it can provide in-depth understanding when a situation is not well understood (Punch, 2005; Yin, 2009). Yin (2009, p. 4) states that the case study methodology allows researchers to ‘retain the holistic and meaningful characteristics of real-life events’ (p. 4) such as organisational and management processes, small group behaviour and community change. In this study, the organisational study of Ngala informed a greater understanding of national EPS within the Australian context. The design of triangulation to the case study strategy and the use of multiple sources of data added rigour, richness and quality to this research.

A case study approach can be used as a qualitative methodology or as part of a mixed method approach (Jackson & Borbasi, 2008) that considers the breadth and depth of a particular phenomenon. It can be focused on a person, group or organisation (Mabry, 2009; Yin, 2009, p. 4). Yin (2009, p. 2) explains that when using a case study strategy, an essential approach is to use multiple sources of evidence, with ‘data needing to converge in a triangulating fashion’ (p. 2). Case studies can utilise a single or multiple case design. The current study is best described as a single case study, as the ‘objective is to capture the circumstances and conditions of an everyday or commonplace situation’ (Yin, 2009, p. 48). The criteria used by Yin (2009, p. 47) for a single case study is met because the design is suitable if the case:
• is representative or typical; or
• represents an extreme or unique case;
• is one that provides an opportunity to investigate something previously unavailable for research; or
• can be considered a significant case to test aspects of a particular theory.

In exploring the concept of nursing within EPS, using a case study strategy facilitated observations and insights into what the future holds for nursing in this unique Australian context. Within the concept of a single case design, this study is described as having multiple units of analysis embedded within a single case (Yin, 2009). This case study has three phases (or three units). The first phase, which focuses on Ngala, is in-depth, to give a greater understanding of the context. This phase provides the foundation for the next two phases, which view the issue nationally to inform the broader context. Only the mixed method approach was considered appropriate to study the case of EPS due to the past, present and future context focus and because of the comparison between one service and services nationally. How the case study exploration was implemented through the three phases, and how the picture of nursing within EPS evolved over these phases is explained below.

In the first phase of the case study, an in-depth view of the organisation of Ngala was developed, including the history of nursing over its 121 years, and nurses’ and allied professionals perceptions of their current roles. Ngala is studied through multiple sources of data such as focus groups, interviews, documents, journals and archives to provide the context for nursing work within an interdisciplinary team framework. The data analysis is undertaken through a description of the case and the themes in the case (Cresswell, 2007).

Phase two investigated nurses’ perceptions nationally of EPS by reviewing historical and current contexts in each State and by running a teleconference at each EPS site. Following the completion of phases one and two, the picture of nursing in interdisciplinary teams in EPS was clearer, such that it could inform the design of a survey instrument, developed and used nationally in phase three (see Figure 3).
Figure 3. Phases of the case study strategy for ‘An exploration of the past, present and future of nursing in EPS in Australia’

When thinking about mixed methods design, it is also necessary to consider the rationale for mixing qualitative and quantitative methods and how they relate to each other in the collection and analysis of data. For the qualitative phases of this study (phases one and two), the Braun and Clarke (2006) framework was applied for data collection and analysis (for details of this framework, see Section 2.3.4). For moving from the qualitative to the quantitative phase of data collection and analysis, Creswell et al. (2004) presented an instrument design model that integrates the two phases by using the data themes from the qualitative phases to identify the themes for the development of the quantitative research instrument (Creswell, et al., 2004; Schifferdecker & Reed, 2009). The following section further explains the mixed methods design.
2.2.3 A Mixed Methods Approach

Mixed methods research is ‘a research design’ (Creswell & Plano Clark, 2007, p. 5) that allows a researcher to ‘address more complicated research questions and collect a richer and stronger array of evidence that can be accomplished by any single method alone’ (Yin, 2009, p. 63). Both qualitative and quantitative approaches have their strengths and weaknesses (Punch, 2005), as well as different foci in terms of what it is hoped will be achieved (Creswell & Plano Clark, 2007, p. 23). Using both can increase the dimension of the study. In this case study, it was felt that using both approaches would assist to answer the questions of the study.

Phases one and two used qualitative methods to investigate the perceptions of nurses and allied professionals. This ‘bottom up’ form of inquiry studied the participants in more detail and informed the design of the quantitative method used in phase three. This latter phase asked specific questions of nurses with the aim of developing recommendations and directions for the future interdisciplinary EPS workforce (Creswell & Plano Clark, 2007, p. 22). In addition, a national context was established for considering the issue of nursing in EPS.

As demonstrated in Table 2, qualitative and quantitative methods have philosophical differences regarding the structure and confirmation of knowledge. Foss and Ellefsen (2002) believe that both types of knowledge should be seen as equally valid because nursing research requires designs that mirror the multidimensionality and complexity of practical nursing knowledge. This can enable a richer and more comprehensive picture of the issue under investigation (Foss & Ellefsen, 2002; Jones & Bugge, 2006). In combining two different types of method, ‘triangulation’ should be used. Foss and Ellefsen (2002) explain that triangulation can be viewed as a distinct epistemological position in which different methods of equal importance offer insights across a knowledge continuum. This study uses triangulation to explore nursing in EPS and to develop a framework for nursing into the future.

2.2.4 Triangulation

Triangulation involves the application and combination of several research methodologies in one study (Schneider, Elliot, LoBiondo-Woord, & Haber, 2003; Taylor, Kermode, & Roberts, 2007). The objective in mixed method studies is to use
different data collection methods or different perspectives for the collection and interpretation of data to gain a more accurate representation of reality, thereby enhancing the rigour of the research (Foss & Ellefsen, 2002; Williamson, 2005).

In this study, methodological, data and analysis triangulation were employed. Each of these aspects of triangulation is discussed individually below, with study examples provided to assist in illustrating the concepts.

2.2.4.1 Methodological triangulation

Methodological triangulation, according to Taylor et al. (2007), involves using two or more research methods in one study at the level of data collection or design. Methodological triangulation can be sub-divided into within and across-method triangulation (Halcomb & Andrew, 2005; Schneider, et al., 2003). Here, across-method triangulation was used, which involves combining research strategies, usually qualitative and quantitative methods. Such an approach is common in nursing studies (Foss & Ellefsen, 2002; Halcomb & Andrew, 2005; Jones & Bugge, 2006). In this study, for example, data from stakeholder interviews were utilised to incorporate into the development of the survey instrument. Complementary findings in a study make a more valid contribution to theory and knowledge development, enhance diversity and enrich the understanding surrounding the study’s aim and questions (Halcomb & Andrew, 2005; Schneider, et al., 2003).

2.2.4.2 Data triangulation

Data triangulation can be described as the use of multiple sources of data to obtain differing views about a situation in a single study (Halcomb & Andrew, 2005). For example, in this study, data were collected from various interviews, focus groups, written nurses’ journals and archived documents. Multiple sources of data assist to validate the findings by providing different views of the situation under investigation (Taylor, et al., 2007). There are three categories of data triangulation: time, space and person (Halcomb & Andrew, 2005). In this study, the researcher used only two categories; that is, space and person.

Space triangulation involves the collection of data from multiple sites (Halcomb & Andrew, 2005). In this study, for example, data were collected from nine national
sites in phase two. Analysis from all sites contributed to phase three, strengthening and increasing the validity of the study (Halcomb & Andrew, 2005).

Person triangulation requires that data be collected from more than one category of person (Roberts & Taylor, 2002). For example, in this study, participants included nurses and allied professionals in phase one. This provided greater insight into a variety of issues surrounding the role of the nurse within the context of an interdisciplinary team.

### 2.2.4.3 Analysis triangulation

Analysis triangulation is described by Halcomb and Andrew (2005) as the use of two or more analysis approaches to validate a data set for the purposes of validation of the findings. For example, in this study, the survey instrument encompassed both quantitative survey measures and qualitative questions to validate the quantitative results from the survey items (Creswell & Plano Clark, 2007).

Before moving on to detail each discrete phase of the study, it is important that the strategies used to maintain the rigour of this mixed methodology case study are explained. Details of these strategies will also be elaborated while describing the phases.

### 2.2.5 Rigour

Yin (2009, p. 69) suggested that the researcher must: have the ability to ask good questions and to interpret the responses, be a good listener, be adaptive and flexible so as to react to various situations, have a firm grasp of the issues studied and be unbiased by preconceived notions. Yin recommends researchers to access one’s capabilities as regards these attributes at the beginning of the study; researcher experience and knowledge is necessary to affect good outcomes for the study.

According to Creswell and Plano Clark (2007), the focus of rigour is on describing and demonstrating accuracy in the research process, which would involve referencing of material and explaining the techniques used. Yin (2009, p. 80) outlines the importance of developing a research protocol that guides the process of the study. The protocol sets out questions to be asked at each phase and prepares the researcher in thinking in more detail about each unit of the case study. This guide was used as a
framework for the researcher. Yin (2009, p. 40) explains four reliability and validity tests that are commonly used to establish the quality of empirical social research. Examples specific to this study are given under each of the four tests:

- **Construct validity** ensures establishing correct operational measures. Through the data collection phrase, this study used multiple sources of evidence to provide cross-verification; established a chain of evidence; ensured there was review by peers and appropriate mentors; ensured strong interview skills pre-interview and that relevant human resource (HR) professionals were present at the beginning of the focus groups; and trialled instrument design prior to implementation.

- **Internal validity** seeks to establish a causal relationship, whereby certain conditions lead to other conditions. This involves ensuring there is a logical link between the questions, data collection and the inferences or conclusions made in the analysis. Through the process of data analysis, the strategies used in this study were journaling and memoing; regular meetings with supervisors and consideration of alternative explanations; comparison of findings with literature and theory; member checking and validation of analysis by experts or past leaders; and multiple sources of evidence for cross-verification.

- **External validity** defines the context to which a study’s findings can be generalised. In this study, the three phases of the research process gave depth and a rich description of the case so that the findings may be generalised.

- **Reliability** demonstrates the operations of the study, such as the data collection procedures. This study used the strategies indicated in Yin’s framework, which included an overall research protocol to guide the research design and various other protocols for tasks that needed to be achieved, such as the national teleconferences. In addition, this study used other strategies of choosing appropriate data sources to answer the research questions, using a process of managing data, and being diligent with a detailed description of the methodology (Darke, Shanks, & Broadbent, 1998; Yin, 2009).

In detailing the three phases below in Sections 2.3–2.5, the rigour measures specific to each phase are further outlined. Briefly, phase one collected data from historical and current documents, focus groups, individual interviews with nurses and allied
professional staff and documented nursing journals. The researcher’s reflective journal was also used throughout the study.

Phase two studied and summarised a collection of key documents and websites from each service in Australia and undertook a teleconference with each national site. Ethics approval had to be obtained from each site and protocols guided the consistency of activities.

For the first two phases, Braun and Clarke’s (2006) framework was used for data analysis. This approach ensured systematic rigour to both data collection and analysis through reducing the data, displaying the data and drawing and verifying conclusions.

Phase three, as indicated previously, applied the instrument design model of Creswell et al. (2004) to develop the questionnaire tool. This approach ensured a strong link between the qualitative methods used and the development of the quantitative phase. A commitment to a quality result in the development of the measuring instrument meant that a reliability and validity criterion was applied.

A brief note on the structure choice of this chapter is necessary here. For readability, structuring the description of the sampling, data collection and data analysis methods according to the relevant phase rather than process step was deemed necessary to avoid unnecessary repetition and confusion. The three phases of the study will now be explained in more detail.

2.3 Phase One

2.3.1 Introduction

This section contains detailed information on the sampling, data collection methods and data analysis for phase one. Figure 4 offers a visual representation of this phase. The key feature of this phase was that it focused one site in WA—Ngala. In-depth historical data were collected and analysed; focus groups and interviews were held with nurses and allied professional staff; and nurses provided their reflections in written journals. These data were analysed using thematic analysis.
2.3.2 Sampling Phase One

Phase one was focused on Ngala, which is a community of 52 nurses and 26 allied professionals. The exclusion criterion for the nursing sample was direct-entry midwives. The rationale was that direct-entry midwives had no prior nursing qualifications and a limited body of knowledge on parenting and child development from 0–5 years. There were no direct-entry midwives working at Ngala.

The following sections describe the process of sampling the various elements of phase one; that is, the documents and archives (see Section 2.3.2.1), the focus groups and interviews, the written journals of the nurses and the researcher’s reflective journal (see Section 2.3.2.2).

A case study protocol detailed the process of preparing for and conducting data collection (see Appendix 3). This was an overall guide for the implementation of this phase of the study and was developed prior to the beginning of the research. As shown in Appendix 3, each part of this phase is outlined in the protocol.

2.3.2.1 Documents and archives

Consent was gained from Ngala to access their archived documents internally and from Battye library in Perth (see Appendix 4). Access to the documents at the library allowed scoping of what was available, and for a decision to be made on what was
important. A number of types of documents were accessed, including letters, photos, oral histories, minutes of meetings, administrative documents, news clippings, evaluations and books published (Yin, 2009). Punch (2005, p. 102) highlighted that ‘documents and texts studied in isolation from their social context are deprived of their real meaning’ (p. 102). Consideration was given to how the researcher would approach the documents in deciding the importance of the data available (Punch, 2005; Yin, 2009).

The entire Ngala collection was selected and sorted, with documents chosen based on their relevance for the period 1890 to 2011. All documents were unpublished, except for Lang (1980). Ms Beryl Grant was Matron between 1959 and 1980, and information has been published on her work and life (Grant, 2009; Lang, 1980; Oliver, 1978; Tanner, 2002).

The researcher was mindful of the key principles as suggested by Jupp (1996, in Punch, 2005, p. 185) when accessing the archived documents. These principles take the form of questions related to:

- evaluating documentary data—[a document’s] authenticity (whether it is original and genuine), its credibility (whether it is accurate), its representativeness (whether it is representative of the totality of documents of its class) and its meaning (what it is intended to say).

For the purpose of this research, the choice of material was therefore related to how nurses explained their role and how they worked with other disciplines during their work. From the Ngala collection, and following a lengthy sifting process, documents were chosen that related to the nursing role and activities; nurses’ descriptions of their work; the training of mothercraft and child health nurses; and how nurses worked with other disciplines, and when this occurred.

Historical documents had to be treated with due care because of their age, which involved using gloves, no pens, a certain manner of positioning documents and the use of a camera in a separate area. During this time a reference was also studied of the history of nursing in WA, to give context to nursing at Ngala (Hobbs, 1980).

Once all the required documents had been collected, they were divided into the major categories of Ngala’s time as an organisation, which were:
The House of Mercy 1890–1916. A home for young single pregnant women was started by a small group of committed women because young women did not have places to go during their confinement and delivery. An Infants Home was also started in 1904 as an adjunct to the House of Mercy. During this period, the House of Mercy provided advocacy for a maternity hospital. Infant morbidity and mortality was high.

Alexandra Home for Women 1916–1959. This change of name coincided with the opening of the King Edward Memorial Hospital (KEMH) (Maternity). The infant welfare movement was gathering momentum and the opening of the first Child Health Centre occurred in 1922. Two World Wars and the Depression occurred during this period.

Ngala Mothercraft and Training Centre 1959–1980. This period of 21 years was marked by the matronage of Ms Beryl Grant.

The transition decade of the 1980s. This was a turbulent time for Ngala, as nursing training was transferred from hospital-based to the tertiary sector and the training of mothercraft nurses ceased. Resources for services at Ngala were at low levels and there were many ‘reviews’. The committee of management was taken over by a Board and a new era began, with funding received from Government on a yearly contract basis.

Ngala Family Resource Centre and Ngala 1989–2011. This 23-year period saw Chief Executive Officer (CEO) Rae Walter in charge. The change for nursing during this period was significant.

2.3.2.2 Focus groups, interviews and written nurses journals

Focus groups use group discussion to generate a rich understanding of the participants’ beliefs and experiences (Morgan, 1998). Further, they are designed to obtain perceptions on a defined area of interest in a permissive, non-threatening environment (Harvey-Jordan & Long, 2002). Frequently, focus groups provide a sharing and comparing style of conversation (Morgan, 1998).

The key characteristics of focus groups include participants chosen for their knowledge and experience of the topic; prearranged questions and loose structure to the group; and discussion planned to encourage spontaneous dynamic interaction
between participants to generate exploration of themes and ideas (Hollis, Openshaw, & Goble, 2002). Focus groups have a number of strengths, including the provision of an opportunity to obtain different individual perspectives in a relatively short time. They also give participants the opportunity to interact, reflect and react to others’ opinions immediately (Harvey-Jordan & Long, 2002).

Semi-structured interviews allow the researcher to develop a number of guiding questions (see Protocol for Focus Groups at Appendix 8), with the scope to include exploratory probing questions to facilitate the collection of rich and comparable data (Nieswiadomy, 2008). This style of interviewing suited this case study approach, which required some flexibility and the option of exploring deeper questions if required to understand the context.

A meeting with nursing and allied professionals and the researcher was held to discuss the study prior to commencement. The role of the researcher was outlined, and the role of the coordination group for recruitment was discussed in view of the ethical considerations outlined in the ethics section. The researcher’s strategic role and power relations within the organisation were discussed at this time, and it was emphasised that participating in focus groups was entirely voluntary, with the choice of whether to participate having no bearing on employment status at Ngala.

A small coordination team comprising the researcher, manager and the research officer was initiated to provide administrative support for the researcher and coordination of recruitment for the focus groups. Confidentiality forms were signed by this group (see Appendix 5), and they did not participate in any data collection. Criteria for the recruitment protocol were made available for this group. The protocol described the mix of nursing staff and allied professionals, numbers per group, sharing of information and gaining consent. The protocol ensured there was consistency of information (see Appendix 3), and that appropriate resources and technology were available for the group work.

Phase one was the only phase that included allied professionals because, as indicated previously, there are limited numbers of allied professionals working nationally in EPS. It was not feasible to include their perspectives in later phases.
Advertising for the focus groups was problematic initially due to unrealistic notice meaning that many nurses would not be able to get the information in time to participate, due to the part-time nature of the workforce. As a consequence, the groups were re-scheduled due to low numbers and scheduled over a longer period, from May to June 2011. This arrangement also allowed different times to capture different nursing shifts. Individual sessions were also offered with the researcher if staff were unable to attend the focus groups. These were offered on site or off site, in a space that was acceptable to the participants.

During this focus group period, all nurses were given journals to write (with prompt sheets) by the coordinating group, providing a further source of data. Journaling is a form of reflective practice and has been well documented as a valid form of analysis of practice situations (Freshwater & Johns, 2005).

### 2.3.3 Data Collection Methods Phase One

Phase one collected data from the following sources: journaling by the researcher, documents, focus groups and interviews with nurses and allied professional staff at Ngala, and nurses’ written journals.

#### 2.3.3.1 Journaling by the researcher

Reflexivity relates to the degree to which the researcher has influence (regardless of intentionality) over the research findings (Jootun, McGhee, & Marland, 2009). The process of reflexivity involves continuous reflection by the researcher, examining his or her own values, beliefs and presence, and those of the participants that may affect the interpretation of the responses, and thus the data (Jootun, et al., 2009). This process of reflecting on one’s self and seeking to understand one’s influence on the interpretation of findings and over each stage of the research study adds rigour to qualitative research processes (Jootun, et al., 2009). It assumes that the researcher will engage in a process of continuous self-appraisal and critique and consider how their own experience has influenced their interpretations and the research process (Dowling, 2006; Jootun, et al., 2009). The process of reflexivity is usually achieved through researcher transparency; that is, knowing who the researcher is and keeping a reflective journal throughout the research study.
A journal commenced from the beginning of the study enabled the researcher to record her thoughts, ideas, clarifications, observations and reflections, to assist with the process and development of the study. A summary of the researcher’s nursing experience and connection with Ngala (see Section 2.7) also adds to the context of this study. Reflections with supervisors and senior colleagues after each focus group were a valuable way of identifying alternative question forms and the influence of the researcher’s language during the focus group. Memo notes were also valuable to capture the researcher’s impressions of the focus group participants’ non-verbal cues and relationship with the content being discussed. The following is an example of a notation in the researcher’s journal following the last focus group:

May 2011. That was such an interesting series of groups and interviews. It is worth noting that the allied professionals here at Ngala really value the work of nurses. In some areas there is obviously more engagement of interdisciplinary work than others, and where it is stronger there has been immense learning opportunities created for both nurses and APs. I must look into the concept of role blurring or overlap in roles across disciplines. The other thing that has struck me is the professional identity of nurses and how strong it is. I have been immersed in services predominantly for many years and I can see the journey that both nurses and APs have experienced given they have been working together for a long time. The concept of nurses ‘gate keeping’ this work is interesting.

2.3.3.2 Documentation of archived and current Ngala records.

The archived records were contained within Battye Library in Perth, and consent for access was released to the researcher by the CEO of Ngala (see Appendix 6). Finnegan (1996, in (Punch, 2005, p. 185) offered a set of useful questions, which were used to guide the researcher in assessing the archived document (see Appendix 3).

As each document was obtained, notations were made about its identifying factors, such as how the document was produced in its original social context, the intended audience and purpose for which the document was written (Punch, 2005, pp. 226-227). An example of the researcher’s notations is given in Figure 5.
28/2/11 This seems an amazing reflection (almost a debrief) by the Matron 9/3/49. She seems very weary and this was a result of the refurbishment of the Alexandra Home facilities at the time of the launch of the new mothercraft training course. This was a quarterly report to the volunteer committee responsible for the mothercraft home.

Figure 5. Example of a document and its corresponding notation by the researcher, 28/2/11
A table was developed at Appendix 7 that gives a timeline summary comparing the history of Ngala against other events in WA history and nursing history.

Access to current documents was made available through the Ngala document management system. The researcher (an employee of Ngala) communicated with the CEO to obtain her opinion on which had been the most helpful documents during her 23 years as CEO. Additionally, multiple searches of ‘sharepoint’ on the Ngala intranet were conducted. Notations were made using the same process as above.

The document and archival retrieval was completed before undertaking the focus groups. A summary was written and themes extrapolated from each of the key periods to increase understanding of how nurses explained their role through nursing notes, minutes of meetings, photos, media images, organisational documents and reports. NVivo9 software training (QSR International, 2010) was undertaken by the researcher around this time, increasing her knowledge on managing and storing data.

2.3.3.3 Conducting focus groups

The protocol at Appendix 3 also guided the focus group process. The focus groups were held off-site at a local library in a very pleasant space. The format for the group was developed and pilot tested with senior colleagues at Ngala, and then refined. The role of the researcher in the group was one of facilitation (Punch, 2005). Prior to the group or interview, participants had read the information sheet (see Appendix 8) and signed and returned consent forms (see Appendix 9). At the beginning of the group, the researcher gave an overview of the study and explained that Ethics approval had been received from the University and reinforced the process of informed consent and confidentiality within the group. A Ngala HR management staff member was present at the introduction of all groups, to ensure transparency and an absence of coercion, as per the ethics committee requirements.

The participants had the opportunity to interact, reflect and react to others’ opinions immediately through the semi-structured questions (see Appendix 3). For example, during the focus group, it was found that one participant would raise a new idea, and then another two participants commented on that idea, when previously they may not have thought of that perspective. This dynamic participation was a strong attribute of

---

2 Sharepoint is the Ngala intranet.
the focus groups. The focus groups all flowed well and the feedback was that both the nurses and allied professionals found the subject very stimulating. Hence, very rich data were collected via an I-Pad recording. Four focus groups were undertaken; three with nurses and one with allied professionals, with the total number of participants being 19.

The transcriptions were manually coded and a thematic analysis was undertaken. The themes were entered into Nvivo9 software to manage the data, and a further reduction into sub-categories (nodes) was made, giving a more in-depth breakdown of the data.

The focus group with allied professionals used the same process as described in Appendix 3. The questions were tailored slightly to the different discipline mix; for example, ‘How would you describe the key components of the nurses’ role’?

2.3.3.4 Individual interviews

These were offered to any staff member unable to attend the focus groups. In this phase of the study, 12 semi-structured interviews were held with nurses, allied professionals and two past leaders. All occurred at a convenient time, in a private space internally or external to Ngala as negotiated with the participant. Participants provided written consent before commencing each interview. To reassure and develop trust, participants were assured of strict confidentiality as ethically required.

The researcher conveyed a professional, engaging style during the interviews through the use of active listening techniques (Kvale, 1996). Active listening has been described as the key to gathering rich data, as the researcher encourages the participant to talk and ascribe meaning. Non-verbal gestures were used to communicate interest, and pauses allowed for reflective responses and the maintenance of a focus on participants’ answers (Kvale, 1996).

Each interview was recorded with an I-Pad positioned unobtrusively. The researcher drew on previous experience and literature pertaining to interviewing to facilitate safe and productive interactions. The semi-structured questions, similar to the focus group questions, gathered rich data from each participant.
2.3.3.5 Nurses written journals

The journals were received from eight nurses who could not be involved in focus groups or had thought of other information after the focus group or interview. A prompt sheet was attached with each of the small notebooks and the questions were similar to those included in the focus group. The journals were returned to the researcher following the focus groups.

2.3.4 Data Analysis Phase One

For this study, the data analysis was approached in two ways. ‘Data analysis consists of examining, categorising, tabulating, or otherwise recombining the evidence to address the initial propositions of a study’ (Yin, 2009, p. 185). Tellis (1997) also suggests that the researcher rely on experience and the literature to present the evidence in various ways, using various interpretations.

The analysis of Ngala’s historical and current organisational documents was undertaken in two parts. First, the key historical milestones were identified and relevant events or noticeable themes becoming evident were described. Consultation was then made with a nurse historian to validate the process and findings. Two of the key historical milestones were also discussed with past leaders to verify the findings.

Thematic analysis was undertaken to answer certain questions such as what was unique to the current role within the context of an interdisciplinary team and what had changed for nurses over time. For example, the nursing role for the period 1940–1980s (as ascertained from historical documents and transcriptions of oral histories) and the current role of the nurse in EPS (using focus groups, written journals and document) were compared.

Braun and Clarke (2006) provided a six-phase framework for qualitative data analysis. These phases are now described, with examples from this study.

2.3.4.1 Phase 1. Familiarising self with the data

Transcribing some of the interviews was beneficial, as it allowed for a depth and breadth of familiarisation with the data. Braun and Clarke (2006) recommend this as an important part of undertaking descriptive research. Those transcripts that were typed by a transcriber were checked against the original audio recordings for
accuracy and this also assisted with familiarisation. Reading and re-reading the data assisted in immersion. Notetaking by the researcher also assisted with familiarising oneself with the data.

2.3.4.2 Phase 2. Generating initial codes

This phase involved reading the transcript and manually writing down the initial codes from the raw data. For example, with the focus groups, the semi-structured questions were a framework for the coding (see Figure 6). At the beginning stages of coding, the researcher’s supervisor undertook independent coding of three focus groups, for comparison with the coding by the researcher. Comparison was followed by discussion to verify the process.

Figure 6. Example of coding the transcripts

2.3.4.3 Phase 3. Searching for themes

Coding and collating the data set produced a long list of identified codes. These were then organised into theme piles and Nvivo9 assisted to manage the data. Braun and Clarke (2006) state that this phase ‘refocuses the analysis at the broader level of themes, rather than codes, involves sorting the different codes into potential themes,'
and collating all the relevant coded data extracts within the identified themes’ (Braun & Clarke, 2006, p. 89). The relationship between the codes and themes were also considered, leading to the development of main themes or sub-themes (see Figure 7). All extracts of the data were also entered into each theme, with this phase giving a greater sense of the significance of individual themes.

![Nodes](image)

**Figure 7. Example of searching for themes and reviewing themes**

### 2.3.4.4 Phase 4. Reviewing the themes

This phase involved the refinement of the themes. It became evident that some potential themes were not really themes if there were not enough data to support them, or the data were too diverse. Other themes might collapse into each other or need to be broken down into separate themes (Braun & Clarke, 2006). This process was assisted by the supervisor, whereby she reviewed a section of the analysis to review the process to-date. There were two levels of reviewing and refining in this phase. The first involved reviewing at the level of the coded extracts and checking whether these extracts appeared to form a coherent pattern. The second level required reworking the above to ensure best fit or create a new theme or discard as necessary.
An example is given in Figure 8, where ‘building connection and relationship’ was seen as an important theme in its own right, and subsequently moved from under ‘assessment’.

Figure 8. Reviewing themes

2.3.4.5 Phase 5. Defining and naming themes

This phase involved defining and refining the themes. In addition to description, diagrams assisted to demonstrate each theme (see Figure 9). The key themes of the nursing role were identified, with each theme having its own diagram to explain the breakdown into sub-themes. It was necessary to consider the themes themselves and each theme in relation to others (Braun & Clarke, 2006). The triangular figure in Figure 9 shows the overall themes for the nursing role in EPS, while the circular figure represents the sub-theme ‘application of evidence.’
Figure 9. The theme of nursing role in EPS and a breakdown of one sub-theme

2.3.4.6 Phase 6. Producing the report

This phase, which involves the final analysis and write-up of the findings, began upon finalising the fully worked-out themes. The write-up explains the story of the data and includes data extracts to demonstrate the prevalence of the theme (Braun & Clarke, 2006). The product of this sixth analysis phase of phase one of the study was used to inform phases two and three.

2.3.5 Summary Phase One

This section outlined the sampling, data collection and analysis methods for phase one, which comprised an investigation of documentation relevant to Ngala, and the conducting of focus groups and interviews with Ngala nurses and allied professionals. This section also detailed the researcher’s use of reflective journaling to capture ideas, impressions and explanations throughout the data collection process. Finally, Braun and Clarke’s six-phase framework of thematic analysis was described in relation to its use for this phase of the study. This phase one case study informed phase two, detailed in the following section.
### 2.4 Phase Two

#### 2.4.1 Introduction

This section seeks to explain phase two from the perspective of sampling, collecting the data with the methods employed and data analysis (see Figure 10).

#### 2.4.2 Sampling Phase Two

This phase involved the following steps:

1. Gaining support for the study and approval to access 10 national EPS through the Australian Association of Parenting and Child Health (AAPCH);
2. Contacting each organisation nationally;
3. Researching the EPS contexts in each state;
4. Organising and commencing a Webinar;
5. Organising teleconferences.

Each step will now be detailed in turn.

---

**Figure 10. Visual representation of phase two**

<table>
<thead>
<tr>
<th>SAMPLING &amp; DATA COLLECTION</th>
<th>ANALYSIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identification and explanation of National EPS key documents</td>
<td>Thematic Analysis</td>
</tr>
<tr>
<td>Eight Services (SA, TAS, VIC, NSW, QLD) Analysis of historical documents Current situation</td>
<td></td>
</tr>
<tr>
<td>National Teleconferences with nine services (includes Ngala)</td>
<td></td>
</tr>
</tbody>
</table>
2.4.2.1 Gaining support for the study nationally

In November 2010, the concept of the study was presented at the annual meeting of the AAPCH, and there was unanimous in principle support for the study. Individual letters were sent to the CEOs of the target organisations, and two states required further applications to state ethics committees. All states except one consented to be involved with the study. The CEOs of each organisation also delegated a person to be the site coordinator for the research.

The rationale for the state service declining to be involved was that their service only employed two enrolled nurses and was predominantly staffed by direct-entry midwives. They also employed Bachelor of Midwifery graduates that did not hold a qualification in nursing and some that held postgraduate qualifications in maternal and child health. Overall, it was felt by the Director that the focus of the service was midwifery rather than nursing, which could have adversely affected the study (Personal Communication, 2011).

In January 2011, letters were sent to each of the nine participating organisations (see Appendix 2), and this list was finalised by September in time for the planned webinar. Among the participating services were two government departments from different states, which required lengthy processes for approval through their Higher Research Ethics Committees. One particular State wanted all separate documents with their templates and letterheads and a great deal of in-depth information on the study, which was quite time consuming to provide. The process of seeking approvals took approximately nine months.

2.4.2.2 Contacting each organisation

Key personnel in each organisation were contacted by email and/or phone for access to relevant documents that explained the context, history and evolution of nursing in EPS for their state. On average, three main documents were obtained for most states. State organisations were very forthcoming and generous in their time, coordinating various activities throughout the research data collection phase.
2.4.2.3 Researching key documents on each site/state

Documents were obtained, including by searching various libraries, by applying the same sampling protocol (see Appendix 3) and criteria for relevant documents as detailed for phase one (see Section 2.3.2.1).

Each state organisation was able to provide reference to documents or refer the researcher to where possible information could be found. Some states had a range of information on their history, while others had minimal information. Site intranets and websites were also a valuable source of information. Examples of documents obtained from each organisation are included throughout Chapter Three.

2.4.2.4 The Webinar

A webinar is a medium for communication (Verma & Singh, 2010) whereby computer and telephone links are set up between sites. It was reasonably simple (but time consuming) to organise, and the context and format of the process was tested prior to the actual webinar with senior personnel at the various services. Engagement of nurses via the webinar was reliant on these same key personnel at each site. A pre-reading pack and site protocol was developed for each coordinator so that consistent processes could be used nationally (see Appendices 11 and 12).

Appendix 11 highlights the process of investigating and organising a national webinar. Invitations were sent to the national sites to engage up to five nurses for each group site. Information about the study was distributed to nurses. Nurses self-selected and consent forms were signed prior to the webinar and sent to the researcher. A pre-reading package (see Appendix 12) was sent to participants a week prior to the scheduled webinar, containing information on the purpose and process of the webinar. It was pointed out that polling was to be conducted during the webinar to establish the numbers, gender, age and type of nursing staff present; that is, management, education and research or clinical practice. If nurses at any site needed a longer timeframe for discussion, this was to be given to allow for group consensus regarding responses to the questions. A recording would be made of the webinar and transcripts of the blog material made available. These would be analysed and the data managed in NVivo9.
A facilitator was engaged to chair the webinar process, which was designed to take one and a half hours. A presentation was developed of the study’s findings to-date as well as nine questions that could be used through the polling process. Polling questions were designed to elicit a yes or no response. Time would be allowed for participants to complete questions (usually 5 minutes), after which the poll would be immediately collated and the results displayed on screen. Discussion would continue.

The national webinar was planned down to the finest detail. A practice webinar occurred two weeks prior to 23 September (the date of the webinar), involving one or two representatives at each site to clarify any difficulties or questions. The Australian Research Alliance for Children and Youth (ARACY) site was used as the location from which the webinar was conducted; booked in Fremantle with the site representative and facilitator. Individual support was also given to sites by Ngala and the researcher if they asked for assistance in the lead up to the webinar date.

The webinar connected with all nine sites (see Photo 1) around Australia. However, 20 minutes into the session, the connection started to break down and the webinar was abandoned. The fault was traced to the equipment at the main site, rather than the webinar process itself. This was very disappointing for all concerned.

The key learnings following an investigation with the site and the webinar company technicians are as follows:

- Plan for the risks;
- Have a site technician available for the webinar. As it turned out, this may not have helped the situation, as the reputable site selected had undertaken many webinars in the past and the event was explained as ‘one of those random things that can happen’;
- Investigate alternative webinar companies and consider options.

Overall the researcher knew a webinar could be an exciting and innovative research tool for the future, having had the experience of facilitating a national webinar prior to this event. The planning needs to be comprehensive and precise, but it is a quick tool to gather data from a large number of participants, especially from national sites.
2.4.2.5 The teleconferences

Following the abandonment of the webinar, it was decided to plan and undertake a teleconference with each site. These commenced in October and were finalised in January 2012. A similar process to that intended for the webinar was used for each teleconference. The protocol was revised to be more specific to the teleconference format. Most sites were more than helpful in trying to reorganise another five nurses around their shifts—not an easy task. Many of the same nurses involved in the webinar chose to again be involved with the teleconference, which was encouraging.

The protocol for preparing and coordinating the teleconference (see Appendix 13) was sent to each site coordinator. Issues that presented around the planning of the
teleconferences were that two sites were delayed due to leave arrangements and the other due to nursing strikes in their state.

### 2.4.3 Data Collection Phase Two

Phase two was informed by phase one and the historical investigation of the context of national early parenting organisations before undertaking a teleconference with nurses nationally at each site.

A teleconference was identified as the best data collection strategy as a consequence of the failure of the webinar, and was organised at each site with computer and telephone links set up with a maximum of five nurses present. Engagement of nurses into the teleconference was reliant on the local coordinating personnel. Thirty-eight nurses participated.

Prior to the teleconference, the participants read the information sheet and completed the individual consent forms (see Appendices 9, 10 and 14) as well as a group form with demographic details (see Appendix 16). The researcher chaired the teleconference process for one, to one and a half hours. The content of the teleconference (see Appendix 15) included an overview of the study, the findings from phase one, the current situation of nursing, and the future of nursing within EPS. The participants viewed the presentation via a computer as they listened to the researcher on speaker phone. Discussing the summary of the Ngala context with nurses from other services was intended to identify how nurses perceived their current situation, whether they validated the findings from phase one, and whether they had any concerns for the future or potential solutions for nursing within EPS.

The participants had the opportunity to interact, reflect and react to others’ opinions through the questions. During the session, there were nine questions asked (see Appendix 17) and answers were given as a group rather than by individuals—the answers reflecting the group consensus on the questions. There was some time allocation for open-ended discussion for certain questions if required. The process of the teleconference was much more difficult than a focus group, as the researcher could not see and use the body language of the group. Nevertheless, the groups flowed very well for most of the sessions. A recording was made of the group discussion of each teleconference via an I-Pad. Both the demographics of the group
and the nine responses to the questions were scanned and emailed back to the researcher by the site coordinator following the teleconference.

The researcher reflected on the experience at the end, and felt that the teleconferences gave a greater amount of rich data from each site, more so than would have perhaps been possible via the webinar. As it turned out, the use of teleconferences was a worthwhile strategy. The transcriptions of the teleconferences were finally summarised to identify the key points arising from the discussions.

2.4.4 Data Analysis Phase Two

2.4.4.1 Key documents

Key documents from nine EPS around Australia were sourced and investigated through the knowledge of key documents by key personnel from the various services. Following an email sent to site coordinators, they responded with what they knew of the available historical source material, and a library search was also conducted. Once these documents were collected, it was a matter of sifting through and selecting relevant material to summarise each state context. The results are described in Chapter Three, including a historical summary and the current situation for each state’s services.

2.4.4.2 The Teleconference

The teleconferences were transcribed and a manual thematic analysis was undertaken from the transcripts. A summary was developed from the data and informed the development of the survey (see Appendix 18). For example, two questions stood out as requiring more clarity. These were in relation to having an experienced nursing workforce and the concept of the proposed Early Parenting Professional (EPP). The suggestions given by nurses at the end of the teleconference were similar to those suggestions coming out of phase one. This result assisted in the development of the questionnaire, which is explained in Section 2.5.2.1.

2.4.5 Summary Phase Two

This section has explained the sampling, data collection methods, and analysis of data in phase two. This phase focused on the national setting of EPS, and was informed by the one site case study conducted in phase one. Documents detailing the
historical data and the current situation of national sites was collected and analysed; a webinar was planned, but had to be abandoned 20 minutes into the event due to technical problems. Subsequently, a teleconference was held with up to five nurses at each of the nine sites. Demographics and a series of nine questions were answered at each teleconference with a resulting summary of the overall results to inform the development of phase three.

### 2.5 Phase Three

#### 2.5.1 Introduction

This section will explain phase three, including the sampling, development and testing of the survey instrument and preparation for the survey. The data collection methods that were employed are discussed, as is the process of data analysis. Figure 11 is a visual representation of phase three.

#### 2.5.2 Sampling Phase Three

The sample for the national survey was a total cohort of 430 nurses in nine EPS. Communication with each site was established the year before the survey, enabling the researcher to obtain consistent numbers of nurses at each site to gauge a national estimate. During this period, it was decided not to officially include the southern

<table>
<thead>
<tr>
<th><strong>SAMPLING &amp; DATA COLLECTION</strong></th>
<th><strong>SURVEY</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Development of tool;</td>
<td>Questionnaire tested for Validity &amp; Reliability.</td>
</tr>
<tr>
<td>Questionnaire distributed to Nine Services.</td>
<td></td>
</tr>
</tbody>
</table>

| **ANALYSIS** | **Data analysis and overall findings and interpretation of results. Development of national framework.** |

**Figure 11. Visual representation of phase three**
Tasmanian Parenting Centre, as this service only employed nurses. The same survey tool was sent to this site, but with a separate identifying link. During communication with sites over time, relationships were established with those who had not previously known the researcher. This was important to gain commitment to the coordination of the survey at those sites. The phase-three planning process was discussed with the supervisor, as per Appendix 17. As the networks developed further, the researcher elicited interest in piloting the questionnaire for reliability testing. The next step was developing the questionnaire.

### 2.5.2.1 Development of the Survey Instrument

Creswell et al. (2004) presents an instrument design method of collecting and analysing data (Schifferdecker & Reed, 2009). There are two parts described. The initial qualitative data collection and analysis phase informs the design and testing of the quantitative design instrument, which is ‘grounded in the views of the participants’ (Creswell, et al., 2004, p. 11). Miles and Huberman (1994) describe this type of mixed methodology as ‘linking’ between the two methods. It was important for this study to conduct an in-depth qualitative analysis of nursing within EPS, to then inform the questions needed to be answered by a larger national cohort, to be studied using a survey strategy.

On completion of phases one and two, all data up to that point (from documents and focus groups of nurses and allied professionals) were brought together. The building of the picture from phase one and two through analysis of the data revealed key themes, which were then incorporated into the questionnaire for the third phase of the study.

The questionnaire contained three major components:

1. A number of closed-ended questions to collect information on nursing demographics (location, age, length of years in EPS and intent in years to stay at EPS, qualifications and proximity of work with other disciplines);
2. Questions related to current nursing practice in EPS;
3. Questions on future directions for the next 3–5 years and 5–10 years.
2.5.2.2 Assessing tool for Validity

Validity is the most fundamental consideration in instrument development and refers to the degree to which the instrument measures what it claims to measure (DeVaus, 2002). Content validity refers to the ability of the instrument’s items to represent the content of the given construct (DeVaus, 2002; Schneider, et al., 2003). To address the issue of content validity, the researcher approached 10 experts in the field. Eight experts agreed to review the questionnaire’s content. A tool reviewed by Monterosso, Kristjanson and Dadd (2006) was slightly adapted for this context to give a structure in which the reviewer could assess the survey tool for clarity, content validity and internal consistency. The following was sent to each reviewer:

- The aims, questions and significance of the study;
- A summary of the study so far;
- The draft questionnaire;
- Instructions and tool for assessment (see Appendix 18).

Comments on items in the survey and their relevance were clarified and modified according to the comments from the reviewers (see summary at Appendix 19). Minor modifications to the layout and wording were made prior to undertaking the test-retest reliability check.

2.5.2.3 Assessing tool for Reliability

As well as the issue of validity, it was essential to consider the reliability of the questionnaire. Reliability refers to the ability of a measuring tool to provide the same result on repeated occasions (DeVaus, 2002; Schneider, et al., 2003). Test-retest reliability is determined based on whether consistent answers are returned from multiple occasions of use. DeVaus (2002) suggests that a trial of the instrument be undertaken on a smaller but similar practice sample to that being used in the study. For this purpose, 15 experienced nurses were approached via email to be involved, 13 of whom agreed. A letter with instructions, background to the study and the questionnaire were sent to these nurses. A test-retest was conducted to check reliability of the survey with a two week timeframe in between questionnaires being sent out. The scores from both questionnaires were evaluated for consistency and reliability. A comparison of test scores was expressed by a Pearson correlation
coefficient, r. For most questions there was good reliability (ie. between 0.5 to 0.9). There was some variability in the scores of each question with questions 10, 13, 15 and 18 being over 0.8. Following discussion with the supervisor it was decided to ask all questions in the survey and confirm the data with open ended questions.

2.5.2.4 Preparation for the survey

A postcard that advised nurses of the survey release was sent to each nurse at all sites three weeks prior to the survey going out (see Appendix 20). The sample size was 430 nurses from nine sites, and they were given a month to respond to the survey. The email with the survey was sent to all site coordinators to distribute to nurses (see Appendix 21) with the attachment to the email (see Appendix 22, ‘the study so far…’) and questionnaire for the study (see Appendix 23). Appendix 24 gives the protocol for data collection for the site coordinators. Hard copies of the survey were available for some sites at which nurses did not wish to undertake the online survey. A total of 50 hard copies were sent out to these nurses.

2.5.3 Data Collection Phase Three

Phase three was a national survey that considered the future directions for the EPS workforce nationally. Once the focus of the questions was decided from the themes from phases one and two, a decision was made on whether to design the survey with a combination of question types, for example using open or closed questions, and/or whether a Likert scale was required for certain questions. There were three parts to the questionnaire, as explained in Section 2.5.2.1.

A validity assessment of the questionnaire was undertaken with eight senior personnel from various sites and/or senior colleagues, including researchers from universities. A summary of the findings led to revision of the questionnaire. The pilot test for reliability was then undertaken with 13 nurses from various services (see Section 2.5.2.3). The outcomes of the pilot study were positive. The tool was thus proven reliable as well as valid.

A month’s timeframe was given to nurses for the online survey to ensure an appropriate return rate. Marketing for the survey and the protocol for the site coordinator were sent out to sites prior to sending out the survey.
The survey was sent via email to all sites in May 2012 via the site coordinators for distribution to all nurses. Reminders were sent out during the month that the survey was open. The time line was extended a further two weeks due to the slowness of some sites in responding to the request. Hard copies were made available to some sites on request and those returned were entered into Survey Monkey. There was a 37 per cent response rate over the six-week response period.

2.5.4 Data Analysis Phase Three

The data from respondents were entered into Survey Monkey. Some analysis was able to be done with the Survey Monkey software. The overall results and the data were downloaded from Survey Monkey.

Most questions had a comment section and the written responses provided rich data. This qualitative data were analysed using the framework by Braun and Clarke (2006). The six phases of this framework (see explanation in Section 2.3.4) were applied to the data. Firstly, familiarisation of the data occurred by reading through the transcripts. Survey Monkey can provide a range of downloadable reports. Secondly, the initial codes can be generated using Survey Monkey. Figure 12 gives an example of how this is presented—the statement is indicated with the appropriate code in brackets.
In the third phase of analysis, themes were sought once all the data had been coded and collated across the data set. These were then manually organised into theme piles. The relationship between the codes and themes were also considered and this led to the development of main themes or sub-themes. All extracts of the data were also entered into each theme and this phase gave a greater sense of the significance of individual themes.

The fourth phase of the framework required reviewing the themes. During this step, it became evident that some potential themes were not really themes, as there were not enough data to support them or the data were too diverse. Other themes might collapse into each other or need to be broken down into separate themes (Braun & Clarke, 2006). There were two levels of reviewing and refining in this phase. The first involved reviewing the coded extracts and checking whether these extracts
appeared to form a coherent pattern. The second required reworking the above to ensure best fit or create new themes or discard if necessary.

The fifth phase involved defining and refining the themes. In addition to description, diagrams assisted to demonstrate each theme. The key themes of the nursing role were identified, with each theme having its own diagram to explain the breakdown of the sub-themes. It was necessary to consider the themes themselves and each theme in relation to others (Braun & Clarke, 2006). Figure 13 shows the overall themes for ‘there are concerns nationally for the future of nursing in EPS’.

![Diagram showing themes for the future of nursing in EPS]

**Figure 13. The themes for ‘there are concerns nationally for the future of nursing in EPS’**

The final phase involved the final analysis and write-up of the findings, which explained the story of the data and included data extracts to demonstrate the prevalence of the theme (Braun & Clarke, 2006).

For the quantitative information, the initial analysis of the results was undertaken in Survey Monkey. For example, 157 nurses responded about their intentions of further years of work within EPS. These were coded into age groups from the nurse’s initial response of how many years, making it easy to calculate the figures manually (see Figure 14).
The excel data were cleaned and entered into Statistical Package for the Social Sciences (SPSS). Support was obtained from a biostatistician who assisted with statistical techniques so that descriptive statistics could be applied to analyse the data. Correlation and regression techniques enabled the researcher to study the relationships with the data. Particular variables, such as age and location of the service (that is, state) were considered important in affecting the feedback obtained. These were all investigated, but no significant findings were revealed from the data. For example, in Figure 15, the correlation between age and state of respondents shows the greatest cohort of nurses are between 50 and 64 in most states.

Figure 15. Example of correlation of variables—age and state of respondents
A summary report was written, including the responses to all the questions from the quantitative and qualitative data. Further analysis was then required to generate findings, provided in Chapter Four. A framework with recommendations for the future was also developed, and is presented in Chapter Five.

2.5.5 Summary Phase Three

This section explained the methodology employed in phase three, including sampling, the development of the survey instrument, testing it for validity and reliability, and preparation for conducting the survey. The data collection methods were discussed, as was the process of data analysis.

2.6 Ethical Considerations

The guiding principles that underpin the implementation of ethical research are integrity, respect for persons, beneficence and justice (National Health & Medical Research Council, 2007). The ethical issues with the potential to arise from this research study were divided into those that affect participants (including Ngala’s internal and external stakeholders) and those related to the research process and methodology. Each will now be discussed in turn.

2.6.1 Researcher Bias

A strategy for dealing with potential researcher bias was required. Yin (2009) proposed several strategies to deal with this potential problem including being open to contrary findings. Denscombe (2002) described the aspects that a researcher needs to be aware of in terms of maintaining objectivity. These included being aware of the researcher’s background and experience, the need to consider the impact of personal assumptions and meanings, and considering alternate explanations. The strategies the researcher used for this study to ameliorate the potential for bias included:

- Conducting and recording a practice focus group before attempting to undertake the first one with participants;
- Offering focus group participants the opportunity to review the transcripts of their group;
- Utilising external experts in particular areas of focus during the research; and
• The supervisors and mentors were asked to review and provide feedback, and challenge with alternate viewpoints throughout the study.

2.6.2 The Participants

To deal appropriately with the issue of consent for the cohort of participants, a letter was sent inviting participation in a focus group, interview or teleconference. This letter contained a description of the purpose of the study, explained that if the participant chose to take part in the study they would be free to withdraw at any stage without penalty, gave the contact details for both the principal researcher and the supervisor from the university, and contained a description of the process that would be involved in the collection and storage of the data. The processes used to maintain confidentiality were also detailed. This involved all data, in the form of audiotapes, transcripts and computer files, being stored in a locked cabinet within the university for a period of five years, and then destroyed.

The consent form was signed to take part in the research and returned to the researcher prior to the data collection. At the beginning of the focus group, interview or teleconference, permission to use a recording device to record the interviews was confirmed.

In the proposed study, the possibility of harm or risk could exist in relation to the interview participant’s career and perceived role potential within the organisation (at Ngala). The researcher’s role of Director of Services at Ngala could be perceived by staff as having influence over future decisions regarding employment opportunities, and thus had the potential to affect how participants responded. To negate this risk, a number of strategies were employed. Firstly, the researcher had no direct influence over the recruitment of participants. This was undertaken by the Ngala coordination group, who briefed staff on the study and encouraged participation and flexibility of roster allocation. The local coordinating group worked with the principal researcher to organise the data collection and assist with any recruitment or issues that arose. This group individually signed confidentiality agreements.

Secondly, an independent staff member (HR Manager) was present for the introduction of the focus groups by the researcher to validate the use of a professional ethical approach. Thirdly, maintaining anonymity of the participants
was important. Strategies were used such as coding, destroying all identifying data and not reporting demographic data that could potentially identify participants.

During phase two, the five participating nurses at each site signed a consent form prior to the teleconference. For phase three, consent was implied if nurses nationally agreed to participate in the study through the survey, although one state required a consent form to be signed prior to the participant undertaking the survey. The researcher did not perceive any issues to arise and ensured that any identifying data from individual nurses were kept confidential.

The study was framed so that the focus was positive. Any system issues or barriers to team work identified were considered from the perspective of solutions or enablers of change, rather than by focusing on any individual’s role in the process of change. Any reference to sites, individuals or individual actions implicated in the barriers or enablers were not included in any data analysis or the final research report.

2.6.3 The Stakeholders

The National Health and Medical Research Council (1999) position statement identifies research participants as anyone that the research may affect. For this study, the other stakeholders included nursing staff participants who were employed within national EPS and the University of Notre Dame Australia (UNDA). The researcher utilised several strategies to ensure the integrity of the study and the dissemination of information about the project to the other stakeholders. These included:

- Gaining ethics approval from the UNDA School of Nursing & Midwifery Research Committee and the UNDA Human Research Ethics Committee (see Appendix 1);
- Sending application letters to the Ngala CEO and Executive and Professional Advisory Committee, and the other nine national services (see Appendices 2 and 4);
- Gaining ethics approval from two states’ HRECs;
- Dissemination of the research by way of an organisational report, academic journals and conference presentations of the research process and findings.
This next section gives the researcher’s reflection on her nursing experience and connection with Ngala. This is necessary because of the researcher’s long history with Ngala and involvement in Child Health nursing work over many years.

2.7 Researcher’s Reflection on Personal Nursing and Midwifery Experience and Connection with Ngala

My nursing experience commenced with the achievement of a general nursing certificate at Sir Charles Gairdner Hospital (SCGH) from 1971 to 1974. I was a young 17 year old coming from a farm in a small country town of Gnowangerup, south west of Perth. I had spent two years in Perth at a senior high school completing my leaving certificate, prior to entering nursing. These pictures (Photos 2 and 3) are at the commencement of Preliminary Training School (PTS May 1971) which is a block of lectures (over a few weeks) before going into the wards.

Photos 2 and 3. SCGH PTS May 1971—Elaine (left) with Lesley and whole group
I was influenced in my choice to become a nurse from my aunt who was a missionary nurse in Nigeria. She became a midwife first and had undertaken Midwifery at King Edward Memorial Hospital (KEMH) before following on with general nursing, which she completed at Fremantle Hospital in 1958. The picture below (see Photo 4) was taken of my aunt in 2008 at Fremantle, with an exhibition celebrating 50 years of nursing at Fremantle with her cohort of graduates. She was always an inspiration to me and I wrote to her regularly in Nigeria. When she came back to Australia near retirement, she worked in Kalgoorlie and Laverton as a midwife until her late sixties.

![Photo 4. Amy Dusting 2008 at Fremantle Hospital](image)

My reflections of my experience of my three years as ‘a Charlies Nurse’ was that there was a very strong identity in being a nurse and attached to SCGH. The Matron at the time was Olive Anstey, a strong nursing leader in the WA context of nursing. During this time, nursing was still being influenced by the history of roots in the army. I remember that there were often inspections by senior nurses in which they would check the corners and folds of the bed linen, that the pillow case openings faced away from the door entrance and that the bed wheels were turned in, and no one was to be seen talking with patients. The three nursing years of training were task focused. The first year was very much basic work—in the pan room, taking temperatures, washing patients, laying patients out if they died, making beds and so on. The second year was an elevation of duties to include dressings, and during this year the focus was more on specialities—I went to PMH for three months, KEMH, and the Psychiatric ward. Third-year nurses could undertake drug rounds and were
given more responsibility for a team of patients with junior nurses; sometimes they were placed in charge of a ward on night duty.

Eighteen years is young to face major life issues of death and grief in other people’s lives without any theoretical component, professional support or debriefing. The hospital-based system had a large theoretical gap. It was very practical, but did not prepare nurses for issues like death and dying, or other issues of complexity. I remember having to lay out my first person following her death—it was eerie. On night duty as a first-year nurse, you were left on your own for tea breaks. I also remember not liking the study blocks much, although being paid for them and hanging out with everyone was fun. Living in the nurses’ quarters was very structured and there were curfews, but it was a very supportive network of colleagues. Three months of second year were spent at PMH with sick children. These are photos of us (see Photos 5 and 6) as nurses with an Aboriginal child, who was a delightful little character.

![Photos 5 and 6. Elaine with Helen and an Aboriginal boy at PMH 1973](image)
Photos 7 and 8 are of a placement in the psychiatric ward of SCGH in second year with a medical student.

Photos 7 and 8. Elaine with a medical student at SCGH, 1973

Following undertaking the general nursing certificate, I continued to work as a Registered Nurse at SCGH, before transferring to NZ and Gnowangerup District Hospital for the years 1974–6.

I undertook a Midwifery certificate at KEMH from 1976 to 1977. Miss Rosalind Denny was the Director of Nursing during this time, and she was another strong nursing leader in the WA community. I remember her being an influential advocate for the professionalisation of nursing. While I was there, Rosalind started to use the designated terms ‘registered midwife’ and ‘student midwife’ and moved away from the term ‘sister’. Nursing hats also disappeared. I received the Director of Nursing’s prize ‘for valuable contribution to the welfare of patients and colleagues’ from Rosalind Denny. I really enjoyed working in the midwifery field and started to feel that this type of work was meaningful.

The photos below (see Photos 9–12) show, respectively, my time in the neonatal nursery with premature babies, my class of colleagues 1976, and receiving the Director of Nursing’s prize.
Photos 9 and 10. Elaine in special care nursery, KEMH, 1976

Photo 11. Elaine at Midwifery graduation, 1977
Over the two years following completion of the midwifery certificate, I worked in the speciality areas of the delivery suite, neonatal special care nursing and on the postnatal wards, including an annexe called ‘Kensington’ that no longer exists. This annexe included babies waiting for adoption (see Photo 13). This was a good grounding for the next step in my nursing journey towards understanding what happens to the family following birth, and the development of children. During the 1970s, midwifery was still very mother-focused. Although fathers were starting to be more noticed in the birth suite, there was no family focus to the curriculum.

I commenced the Child Health Certificate at Ngala in 1978 (see Photo 14) with a desire to increase my knowledge of families following birth and the development of babies and small children. The Ngala buildings dated to the 1950s, making them
about 20 years old at this time. I do remember the tall pine trees overshadowing the buildings, many of which are now gone.

Photos 14 and 15. Elaine with colleagues undertaking the Child Health Certificate at Ngala, 1978; Elaine with two babies for adoption, 1978

I was a young child health nurse at 25 years old (see Photo 15) and my memory of my time of four months at Ngala was not all positive. I remember the cold, clinical facility, with its large number of sad stories of children. I did enjoy the placements in the child health centres over a two-month period, and this inspired me to continue in this field of child health nursing. At this time, there was much prestige for ‘triple certificate sister’ nurses. Other symbols of status and identity during the 1970s were badges (see Photo 16), stripes and hats that designated seniority. The only time I wore a veil was when I worked at Gnowangerup District Hospital in 1975. At the completion and graduation of each nursing school, there would be a ceremony and the presentation of a certificate and badge. There were badges from each School of Nursing and a badge that signified registration with the Nurses Board of WA.

Photo 16. Collection of badges from all training schools of nursing
The Ngala Annual Report for 1978 mentions that year’s graduating Child Health nurses. I was one of 19 for the year among 34 mothercraft nurses (see Figure 16).

Figure 16. Ngala 1978 Annual Report (Ngala, 1978)

I continued to work in the area of Child Health for the next three years. Initially, I worked for 10 months in the correspondence section, which involved writing letters to rural mothers who had questions about parenting. We had access to typewriters and I mostly used these, as I had done typing at school. I was eventually given my own centres in Perth metropolitan in low socioeconomic areas. I loved this area of work and found it very rewarding.
There were no options in those days for maternity leave—I was told that I had to resign after 31 weeks of pregnancy (1981) as it ‘wasn’t good role modelling to be a working mother and a child health nurse’. Following the birth of my first child, I worked night duty at Ngala part-time during 1981–82 as a Nursing Supervisor. This was a very solitary experience at Ngala and the environment had not improved from my experiences as a student. I was oblivious to the broader picture of what was happening at Ngala at the time and did not connect with anything that was occurring during the day.

My knowledge and experience of midwifery and child health greatly informed my experience of being a mother, and the experience of having children was a wonderful addition to my career in nursing. In 1981, I commenced my nursing degree part-time at the WA Institute of Technology (WAIT) and continued this while the children were small. In 1986, we left WA and moved to Tasmania, where we lived for the next 18 years. I transferred my degree across to the Tasmanian Institute of Technology (TSIT). Miss Meryl Parkes, a strong nursing leader in WA for nursing education, was the Head of School at WAIT and also moved to TSIT as Head of School. Overall, I undertook 26 units as part of the Bachelor of Applied Science in Nursing and graduated in 1988.

This degree was very comprehensive overall. In addition to the biology and science units, I undertook a number of psychology and sociology units. My major in Primary Health Care was quite unique at that time, to what was offered interstate. Through all my units in Tasmania, I focused and built on the area of adolescent pregnancy and parenting. Based in the strong focus on health promotion and community development, I established a non-government organisation called Pregnant and Young Parent Support (PYPs), working with a group of young women, and following them through pregnancy and well into their parenting with babies and young children. This was a very rewarding experience, as I was able to observe the growth and development of these young women and their relationships with their children.

During the time of undertaking my studies (1986–1988), I worked in general nursing on a casual pool at the Launceston General Hospital (LGH); it was an interesting time to return to this area of nursing. I found that the basics had not changed, and I
was also able to put the nursing process that I had recently studied during my degree into practice. Technology had advanced since I had last worked in a hospital, particularly in relation to equipment for lifting patients, computers, drugs, dressings, record keeping and how nursing was organised. During the years 1988 to 1990, I worked in community nursing and maintained my focus on adolescent pregnancy and parenting.

I worked full-time with the Department of Health and Family, Child and Youth Health in Tasmania from 1990 to 2004, at which time I returned to WA. During this time, I had very interesting and diverse experiences with different roles through the restructuring of services. My key roles were in clinical management, until I gained more senior management roles in this area of work. I also ventured into different areas, such as managing a small rural hospital and community health service, state-wide rural health, child protection, a state-wide project undertaking the Tasmanian Child Health Strategy, and a four-year project developing and implementing a Perinatal Mental Health model of care and training for Child Health nurses and other professionals.

In my first two years of a clinical management role, I did a percentage of nursing practice and flew to Flinders Island every fortnight to undertake school and child health services. I felt very privileged to perform this rural role, and felt I returning to my roots by serving this small isolated rural community (see Photo 17).

Photo 17. Flying to Flinders Island with colleague DON Dianne Kent, 1991

I commenced the Master of Nursing during 1993 and graduated in 1998 (see Photo 18). I enjoyed all aspects of the Master's Program, which included coursework and a
thesis. My writing and critical analysis skills improved significantly during this time, and the experience continued to develop my passion for research and practice development.

**Photo 18. Graduation of Master of Nursing with supervisor, 1998**

In 2000, I travelled to Berlin to the First Congress of Women’s Mental Health and presented a poster on the development of the Postnatal Depression program in Tasmania (see Photo 19). During the time of this project, the national Beyond Blue program also commenced, so synergies were developed nationally with what we were doing.

**Photo 19. Poster presentation at the First Congress of Women’s Mental Health in Berlin, 2000**
In 2004, I left Tasmania and returned to WA. For two months, I worked as an Agency Nurse in aged care and undertook a brief project at Ngala looking at quality accreditation systems suitable for Ngala. The following year, Ngala implemented my recommendation and became successful with ISO:9001 Accreditation. I then worked in the North West of WA in the remote rural communities of Newman/Nullagine (see Photos 20) and Exmouth/Coral Bay (see Photos 21). I was managing the health services at these locations, which was the most diverse, fascinating and rewarding experience I have yet encountered. The knowledge I gained of Aboriginal culture and issues in remote communities has changed me as a person and a practitioner. The gap between the wealth of the mining communities and Aboriginal cultures was stark. One memorable experience was travelling extensively to regional meetings on my own, and the diverse and spacious countryside and isolation of small communities.
Photo 20. Time at Newman & Nullagine

*Reflecting time at Newman, and Nullagine Health Service and long trips on my own to meetings in Port Hedland or Karratha*

The beauty of the land throughout the Pilbara stays with you: the contrast of the red dirt, blue skies and white gum trees; the Ningaloo reef; and the wildlife at Exmouth. Managing a health service in the middle of a cyclone is also a very different experience, as was driving seven hours in stormy conditions to a meeting in an isolated location, alone. I even had the opportunity to track turtles on the beach as part of a local research program.
During 2006, I left Exmouth and returned to Perth to work at Ngala as Director of Services, Education and Research. This role has evolved over time as the services have grown and expanded. Ngala has tripled in size, with a strong focus on developing a research agenda and establishing a sound evidence-base for its work in early parenting.

A highlight for 2012 was being awarded an Adjunct Associate Professor role with Curtin University School of Nursing and Midwifery (see Photo 22).
As I write this ending in March 2013, I reflect on the considerable amount of work done at Ngala and my contribution over the last seven years. This will be outlined in the following chapter under the Ngala section (see Section 3.15.5.5 onwards).

**2.8 Chapter Two Summary**

This chapter has outlined the methodology for the case study. A mixed methods approach was deemed most appropriate for exploring the past, present and future of nursing within EPS in Australia. The design of the case study in three phases was explained, as were the sampling, data collection and analysis methods for each phase. The planning for and subsequent abandonment of the webinar due to technical difficulties was disappointing. The methodology segment of the chapter finished by elucidating the process by which the findings were synthesised, and discussing the ethical considerations for this study. The chapter concluded with a reflection of the researcher’s experience of nursing and midwifery and her connection with Ngala. The following chapter details the case, including the historical EPS nursing context, the history of nursing at Ngala and the current picture of national EPS.
Chapter 3: The Case

3.1 Introduction

As indicated in Chapter One, EPS within Australia have a key role in providing services to support families with young children in the early years of life. Families present to EPS for a range of issues, including adjustment to parenting and isolation in the parenting role, an infant’s irregular sleep and feeding behaviour, behaviour management strategies, nutrition issues, poor maternal postpartum mental health, parenting assessments for child protection and much more (Fisher & Rowe, 2003; Phillips, et al., 2010; Turner, et al., 2006).

EPS have been in existence for over a century, and throughout this time nursing has been their major discipline. It is timely to focus on these services because a range of factors are influencing the potential national direction of EPS, such as family needs in presenting to services, the impact of government policy, the professional skill mix to meet the needs of today’s families and predictions of future nursing shortages. The case for this study was therefore identified as nursing within EPS in Australia (see Figure 17).

In this project, along with the process of identifying the research questions and the appropriate sources of data, it was necessary to identify an appropriate research design. The researcher identified that a case study using multiple sources of evidence was the approach of choice (Cresswell, 2007; Gangeness & Yurkovich, 2006; Punch, 2005; Yin, 2009). The choice of case study strategy is discussed in Section 2.2.2.
This chapter presents a historical context for EPS, including:

- The development of scientific motherhood;
- The European and NZ experience;
- How the child welfare movement and the rise of public health developed in Australia; and
- The development of EPS in Australia.

This movement simultaneously affected the development of the universal child health centre system and the development of mothercraft homes in each state. The overview of the history of each State is followed by an in-depth history of Ngala. Finally, the current context of national EPS is articulated.

### 3.2 The Development of Scientific Motherhood

As comprehensive, coordinated community interventions supported by social, educational and economic changes throughout Australia led to a dramatic decline in infant mortality, parental education became a significant factor in the improvement of children’s health (Davis, 1983). Dr Truby King from NZ founded the New Zealand Society for the Health of Women and Children (Bryder, 2001), and his book (King, 1923) was soon followed by an abundance of written material advocating that all women, irrespective of their socioeconomic background, could benefit from the guidance of an expert nurse in learning how to parent effectively.
For example, Sister Mary Jacob states:

By an intelligent study of mothercraft and availing herself of the help and advice of child experts in prenatal, baby, pre-school and child guidance clinics, a mother can do great to make a good job of being a mother. (Jacob, 1957, p. 11)

Ruth Park (1949), the NZ writer who spent most of her adult life in the inner city area of Surrey Hills, used the colourful landscape of Sydney slums to set the scene for the struggles of the fictional Darcy family. When her daughter died giving birth, Mumma Darcy was left to raise the newborn. Park summarises the nurse’s main focus on physical care that remained the role of child health nurses for many years:

Mumma knew everything about babies, but nothing according to the clinic. Dutifully she listened to the sister’s advice, and painstakingly laboured through the booklet of directions given to her. But to Mumma directions were only for bottles of medicine and tins of condensed milk. You couldn’t bring up a little live baby that way. Mumma knew that what babies need most of all is love. (Park, 1949, p. 138)

From the early 1920s, all centre sisters taught scientific child-rearing during consultation sessions. Surveillance of the infant with a sharp eye on milestones meant that babies were weighed, measured, examined for abnormalities and tested for variances from the norm. Sleep, settling, nutrition, management of toddlers’ behaviour and immunisation were some of the core business of nurses, who continued to strongly advocate for the benefits of breastfeeding and the early implementation of strict routines. All data collected was recorded on cards kept at the clinic. Those practices are still very much in place, supported by a plethora of documents, policies and practice guidelines that dictate what expert knowledge nurses will deliver to new parents, and how they will deliver it. Studies (McCalman, 1985; Mein Smith, 1997; Selby, 1992; Thorley, 2000) using women’s recall of their experience of the ‘centre sister’ during the middle of the twentieth century show mixed feedback due to the rigidity of routines and rules prescribed by Dr Truby

Centre sister/clinic sister was the terminology used for the specialist nurse who worked at the clinic.
King’s methods. Some women found the nurse helpful, and many found the advice unhelpful and felt they were blamed if things went wrong.

The rigid child-rearing teaching and surveillance practices expected from nurses and supported by government publications raised many concerns. Wilson (2003) in her examination of the discourses of scientific mothercraft and the monitoring role of the nurse within a nurse–mother relationship suggested a conflict between the two. She pointed out the potential risk of the mother ignoring the recommendations made by the nurse, rather than challenging or clarifying them. This in turn can impact negatively on health outcomes. Brennan (2007) contests that ‘scientific motherhood, with all that it entailed, was socially constructed, reinforced by philanthropic and professional groups and actively supported by women’ (Brennan, 2007, p. xi). Davis (1988) argues that the emphasis on the home and housewifely tasks was detrimental rather than beneficial to the contemporary status of women. The separation of work and home, and public and private spheres left many women without a stable and constructive niche, making them ‘vulnerable to exploitation by professionals who could claim superior knowledge’ (Davis, 1988, p. 162). Nurses during the first part of the century particularly ‘were reflecting the attitudes and values of their time’ (Brennan, 1998, p. 14).

This next section will detail the child welfare movement in Europe and NZ.

### 3.3 The European Experience

In 1939, Dr W.G. Armstrong, regarded as the architect of infant welfare in Australia from 1898 until his death in 1941, was compelled to clarify what he identified as many inaccuracies in the perceived origin of the Australian child welfare movement (Armstrong, 1939). His detailed account of the movement informs the following historical section.

For many years, Australia and NZ relied on the health knowledge and education experience of Europe to inform local practice changes. This was applicable to the area of infant welfare, in which mentors from England and more importantly from France, guided the new public health interventions aimed at controlling infant mortality. Dr Pierre Budin Professor of Clinical Obstetrics at the Charity Hospital in Paris in the late nineteenth century established the *consultation de nourrissons*
establishments (often shortened to consultations). The consultations became schools at which mothers learnt to adequately care for their babies (Armstrong, 1939). The clinics spread throughout England and North America, and were soon followed by the establishment of milk depots, where cow’s milk was modified to resemble breast milk. Mothers unable to breastfeed could purchase the milk at low cost. They were in return expected to bring the infant back on a weekly basis to be examined and weighed. In England, mothers who could not attend clinics were attended at home by health visitors⁴ (Reid, 2001a), who monitored the child’s health and provided health education (Welshman, 1997). These activities provided the foundations for preventive activities in infant welfare around the world, including in Australia and NZ (Bryder, 2003b).

3.4 The Royal New Zealand Plunket Society: Truby King’s Legacy

The review of the birth of the infant welfare movement would not be complete without commenting on the NZ experience.

In 1907 in Dunedin NZ, Dr Truby King, Director of Infant Welfare Services founded the New Zealand Society for the Health of Women and Children⁵ also known as the Plunket Society. King was responsible for the rapid development of a powerful national organisation that spread its teaching across the Tasman. According to Bryder (2001), a social historian at Auckland University (Bryder, 2001), King’s strong leadership shaped a robust model of care for well babies and their mothers that was organised and run by women outside of the medical jurisdiction that was the norm in other Western countries. Unlike Australia, where care was only provided at a low cost to women who deserved it,⁶ or England, where socially disadvantaged women were targeted, the Plunket Services were universal and free to all. The functions of the Society were to provide nurses who had been carefully educated in scientific approaches to nutrition and child care with an emphasis on breastfeeding, to deliver home care to mothers that requested support from Plunket nurses, to run

---

⁴ According to the Health Visitors’ Association administrative/bibliographical history 1902–1984, the title ‘women sanitary inspectors’ was changed in 1962 to become ‘health visitors’. They came from various professional health backgrounds and the emphasis of their work was public health education. This also involved an element of social intervention.

⁵ In 1980, it officially changed its name to become the Plunket Society.

⁶ Unmarried mothers and working mothers were excluded from welfare services established under the Armstrong leadership.
health clinics for older children, and to provide antenatal care (Bryder, 2003b). The Society owned six Karitane Hospitals, where the establishment of breastfeeding for babies who had feeding difficulties was supported and where nurses received specialist training as Plunket nurses. King’s commitment to educating new mothers, who he believed were fundamentally ignorant in the science of raising children, led him to write *The Expectant Mother and Baby’s First Month* (King, 1923), which was given to all couples applying for a marriage licence. King’s views were essentially to train mothers with fairly simple rules of hygiene and household order. An example of one of King’s rigid regimented parenting schedules is portrayed in Figure 18, taken from Bryder’s (2003b) book on the four-hour feeding clock, which also shows times to sleep, exercise and bath the baby.

![Figure 18. Clock Face for Four-Hour Feeding (Bryder, 2003b, p. 42)](image)

King’s innovative views of child care and his exceptionally good outcomes for infants who were failing to thrive, crossed the Tasman to Australia, where the first Karitane homes opened in NSW in 1924 (Tresillian) and in Melbourne (Tweddle). In Hobart, the school took the form of a mothercraft home on the Karitane model (Mein Smith, 1997, p. 131). The Plunket Society is still flourishing and leading the care of children in NZ.

In 2007, Plunket celebrated 100 years of operation. An exhibition of archives was held that showed aspects of Truby King’s life and work (Anonymous, 2007, p. 5).

---

7 Karitane is a small township north of Dunedin where Dr King and his wife owned a house and where they provided care to several malnourished children prior to King setting up the Royal Society for Women and Children in 1907.
Figure 19 is an excerpt from the newspaper article. Plunket (a not-for-profit agency) is the major provider of child and family health services in NZ. They provide both the universal system of child health checks, as well as other community-based parenting services akin to those provided by EPS in Australia. The exception is that they have no residential services in NZ and they have a very solid volunteer program of family support throughout NZ.

Figure 19. Plunket celebrates 100 years (Anonymous, 2007)

The next section will focus on the child welfare movement in Australia.
3.5 The Child Welfare Movement and the Rise of Public Health in Australia

Infant mortality rates indicate the number of deaths of children at less than one year of age per thousand live births in any particular year. It is viewed as a key indicator of a country’s health and is considered to reflect the social development, education and level of wellness of its population. Considering that access to prenatal and postnatal health services and maternal education have contributed significantly to the lowering of infant mortality rates, an examination of the Australian child welfare movement is now described to better understand the developing role of health workers, and especially nurses, in working with families in the last century.

Some of the original reforms emerged in the eastern states of Australia and New Zealand, where the pioneering work of Truby King led NZ to have the world’s lowest infant mortality rate in 1907 (Bryder, 2003a). Originally divided in their approaches to improving infants’ survival rates, Australia and NZ now share a strong collegial partnership and common practices in the field of family and child health.

In researching the historical accounts, there appeared to be some inconsistencies, as the history was informed by original reports and articles that were written by Australian health leaders in the early twentieth century and the work of Australian and NZ historians who researched the development of the child welfare movement in both countries. When faced with apparent contradictions, further information was sought, often revealing the contradictions to be different perceptions of writers who demonstrated great passion and commitment to the improvement of the welfare of children. These authors were faced with multiple challenges and had access to limited scientific evidence. They were also influenced by their professional education9 and had to rely on the European experience to guide them in their fight to achieve necessary social and health reforms.

The first half of the twentieth century continued to be a period in which infants remained a most vulnerable population group, with their chances of survival inseparable from maternal health during pregnancy, childbirth and lactation. According to the NSW Health Department Archives (NSW Health, 1972), the

---

9 They came from the diverse fields of public health, obstetrics and even psychiatry.
rapidly increasing urbanisation of Sydney, characterised by lack of sanitary control and sewerage, poor housing and limited and unsafe milk supply, led to an alarming increase in infant mortality. Young children were exposed to malnutrition caused by poor quality or insufficient food and infectious diseases including lung infections and the highly contagious and often fatal summer diarrhoea (Davis, 1988; Featherstone, 2009). Lewis (2003), in his history of public health in Australia, records the infant mortality rate between 1906 to 1910 at 77.6 per thousand births, with a steady reduction to 52 by 1930 (Davis, 1988; Exley, 1932; Lewis, 2003).

The awareness that a great country needed healthy growing children, combined with a significant decline in the NSW birth rate and a high mortality rate led to enough public concern for the establishment of the Royal Commission on the Decline of Birth Rate and on the Mortality of Infants (NSW Parliament, 1904). Several issues of importance were raised by the Commission. Children most at risk came from disadvantaged families, often cared for by mothers who were widowed, disabled through work accidents or unmarried. This last group of women was particularly stigmatised and ostracised, resulting in the abandonment of their infants. The lack of Government family support meant that women worked for low wages with young children left at home to fend for themselves. The Commission also heard about the high rate of abortions, the ill-health of poor mothers, the lack of maternal knowledge and, most of all, the disastrous impact of diarrhoea on infants who were fed with breast milk alternatives, particularly during the harsh summer months (Armstrong, 1939).

The findings of the Royal Commission were disturbing enough to provoke a strong response from various social groups that divided their attention in two broad directions. One group focused on childcare for when the mother was not able or not available to parent the child herself. The day nursery movement is now well established in Australia and is identified as early childhood education. The second group concentrated on the health needs of the mother and the child, which is now the core business of child health nurses. For the purpose of this study, the focus will be
examining the second group only, \(^{10}\) although Ngala’s origins incorporate both groups.

Various Acts were passed in Parliaments and Public Health departments were set up in Australia so that by the end of the interwar period in 1939 the growth of services included maternal and child health welfare, school health services and venereal disease, tuberculosis and immunisation clinics (O’Hara, 1988).

### 3.6 Early Parenting Services in Australia

As previously indicated, Truby King established NZ as a model during the 1920s for the training of infant welfare nurses. In three states, the mothercraft homes were modelled on that of Karitane, NZ. The Karitane NSW, Tweddel and Hobart mothercraft homes were adapted to Australian conditions. The nurse trainees were paid a low salary compared to the NZ nurses, and if nurses worked in baby health centres they were paid nothing (Mein Smith, 1997).

By 1920, the infant welfare movement was emerging in most states of Australia, with various Boards and Associations being established to oversee the management of baby health clinics opening in Tasmania, South and WA and Queensland (Kitchens, 2005a). Each state adopted different pathways to establish family and children’s services that reflected their political, health and social requirements, but a detailed examination of each individual state (other than WA) would be beyond the scope of this thesis. A description of the development of EPS in each State will be given and similarities and differences presented where possible.

The traditions of EPS were a part of the early child welfare movement and often a precursor was developed alongside the setting up of infant welfare clinics. Many were driven by women’s or church organisations. Organisations were often labelled ‘Homes’ (Lang; 1992) as was the case for Ngala, commencing as the House of Mercy. In Victoria, there was a ‘Centre’ and ‘House’, ‘Riversdale’ or Hospital; in SA, a ‘House’; and in Tasmania, a ‘mothercraft home’ (Blundell, 2009; Brennan, 2007; Crockett, 2000; Kane, 1980).

---

\(^{10}\) The curricula for early childhood education and child health nursing share several fields of knowledge, which indicates a strong overlap in the expected competencies of these professional groups.
Many of these homes were also part of the training of mothercraft and infant welfare sisters (child health nurses) until the transition of nursing training to the tertiary sector during the mid-1970s. Mothercraft training ceased in Victoria in 1978, and ended in WA during 1989.

It is interesting to note that the infant welfare movement was supported very strongly by community advocates, volunteers (mostly women) and fundraising. Queensland was an exception, where voluntary work or financial assistance was discouraged by government (Selby, 1992; Thorley, 2000)

3.7 The NSW Experience

3.7.1 The Organisation of Baby Health Clinics

In 1903, Armstrong was the medical officer to the metropolitan combined district and city of Sydney. He was strongly influenced by Budin’s work but had reservations about the real benefits of milk depots. Armstrong initiated a broad systematic public health campaign that differed from the French model of setting up milk depots. He chose the alternative of educating women in the skills of mothercraft and the importance of breastfeeding. One of his first undertakings as medical officer of health was to develop a broad education campaign for Sydney’s new mothers:

   . . . I had previously (in 1903) issued a brief pamphlet of ‘advice to mothers’, a copy of which I had sent to every address in the city at which a birth had been registered. (1939, p. 642)

In 1904, Armstrong trained the first health home visitor to instruct new mothers about the art of successful breastfeeding or, should breastfeeding not be possible, about the safe preparation of artificial feeds, about personal hygiene and clean environment. Over the following 10 years, he continued his public health campaign and kept meticulous data demonstrating a 50 per cent decrease in infant mortality

---

11 Baby health clinics replaced the terms baby clinics or infant consultation centres that were used between 1914 and 1918. This change in terminology coincided with the establishment of a coordinating body responsible for all community clinics attended by mothers and well babies. In 2009, Child and Family Health Clinics (or Child Health Centres) replaced the baby health clinics, reflecting a redirection of health services from child to family. This terminology is not consistent throughout Australia.

12 Historical writings do not indicate whether the health home visitor had a nursing background. All health home visitors are now registered nurses (Gimson, 2007).
rate (110 to 68 per 1000) and an increased breastfeeding rate from 72 to 94 per cent by 1914 (1939, p. 644). As the number of health home visitors increased, the care of mothers and infants became more systematic and organised with a series of complementary programs developing around Sydney.

The NSW infant welfare movement continued to grow and expand. An outpatient department opened at the Royal Hospital for Women, Paddington in 1905. Children born in the hospital could be monitored until two years of age. As new hospitals were built, more outpatient services for mothers and babies opened. This program was followed by the opening of community clinics independent from hospitals. Three ‘Schools for Mothers’ were established solely for the purpose of educating mothers who were perceived as lacking natural instinct. In 1914, the schools were replaced by the first baby clinic at Alexandria followed by clinics in other disadvantaged industrial areas such as Glebe, Newtown and Woooloomooloo. By 1918, 28 clinics were open. Clinics were also opened in Newcastle, a mining city in the Hunter region, in response to its high level of poverty, diseases and consequent high infant mortality rate. Broken Hill was the first country town to see the establishment of a baby clinic in 1918 (O’Connor, 1989b). Soon home visiting became integral to the role of nurses employed in outpatient departments and clinics, as it was noted that mothers from the most disadvantage backgrounds did not attend the clinics following the initial home visit in the first week of delivery. The nurse’s role also expanded to include advice to pregnant women and planning for their oncoming childbirth experience in hospital.

The public health campaign that from its inception had targeted disadvantaged families by 1920 had expanded to include all women irrespective of their socioeconomic background. The NSW Early Notification of Birth Act that took effect in 1915 ensured that the nurses were made aware of all births in their geographical area. The infant welfare movement had mushroomed to become a complex network of clinics, outpatient departments and charitable organisations, all committed to improving the health of babies. Coordination of the network was imperative.

In 1914, after extensive consultation, the Minister of Public Health established the Baby Clinics, Pre-Maternity and Home-Nursing Board. The Board was responsible
for the overseeing of the overall care of the woman and child from pregnancy until two years. The Board determined the structure, the governance, the clinical role of the staff and the definition of referral pathways.

At the 1918 Conference on the Welfare of Mothers and Babies in Sydney, the Minister of Public Health the Honorary J.D. Fitzgerald announced the establishment of the Society for the Welfare of Mothers and Babies.\(^\text{13}\) The society was incorporated in an Act of Parliament in 1919. Its function as a coordinating body also included responsibilities such as seeking public funds, providing direct intervention to mothers and sick children and most importantly managing the postgraduate mothercraft nursing education for NSW. In 1919, the members of the Baby Clinics, pre-Maternity and Home-Nursing Board joined the Council of the Society.

To guide the examination of the movement in both NSW and Victoria, two main texts were used: Our Babies the State’s Best Asset—\textit{A History of 75 Years of Baby Health Services in New South Wales} (O'Connor, 1989b)\(^\text{14}\) and Heather Sheard’s Master’s thesis \textit{All the Little Children—The Story of Victoria’s Baby Health Centres} (Sheard, 2007). While telling a similar story to that of NSW, Sheard gives an account of the slow-to-develop movement because of its limited coordination and the conflict of ideologies.

### 3.7.2 Tresillian and Karitane in NSW

\textit{Tresillian} was established in Petersham in 1921 by the Royal Society for the Welfare of Mothers and Babies, with the assistance of government funds (O'Connor, 1989a). Dr Margaret Harper was a Paediatrician committed to the infant welfare movement and wrote the \textit{‘Parents Book’} (a standard text in mothercraft) in 1926. Tresillian trained many nurses from around Australia. Tresillian expanded centres in Sydney that would accommodate special wards for premature babies. In 1956, Tresillian became involved in the production of educational films for parents, students, teachers and nurses, the first being \textit{‘Care of the Premature Baby’} and \textit{‘The Natural Feeding of Infants’}. These films received awards from international film associations (O'Connor, 1989a, p. 83). During the 1950s, the nurse’s role broadened to include

---

\(^{13}\) In this thesis, the Society for the Welfare of Mothers and Babies is also referred to as the Society. The Society still exists but is commonly referred to as Tresillian Family Care Centres.

\(^{14}\) Written at the request of the NSW Health Department to celebrate 75 years of service.
antenatal care and a look at the family, with more of an emphasis on the education of parents. Over time, the role again broadened to include interactions with the mother and its effect upon child development, emotional development and behaviour patterns in young children (O'Connor, 1989a, p. 84).

Harper was known to have adapted the Truby King Karitane training model in the early days to the ‘conditions and climate of Australia’, which was criticised by Truby King (O'Connor, 1989a, p. 35). The followers of Truby King formed the Australian Mothercraft Society (Karitane) and set up separate establishments in NSW.

Karitane Mothercraft Home was opened in 1923 (Ashton, 2009) and provided mothercraft and infant health training for registered nurses and midwifery nurses. The aim was ‘to help the mothers and save the babies’ (O'Connor, 1989a, p. 37). Reasons for admission included:

Mothers had been admitted with babies to increase or regulate the flow of breastmilk, and to learn about feeding and mothercraft. Babies were admitted suffering from malnutrition from weaning too early, wrong feeding and management. The Society promoted breastfeeding as the best feeding option. (O'Connor, 1989a, p. 36).

Karitane expanded with clinics around the city and products were also manufactured and sold by the Karitane Products Society. The Australian Mothercraft Society was a voluntary organisation and its income was derived from the fees of mothers and students, donations and annual subscriptions. It did not receive government assistance until the 1970s (O'Connor, 1989a). The educative role of the Society has been well known since its establishment. In the 1930s, the Society gave weekly talks on mothercraft over the radio. The Truby King Clinics grew from just one in 1930 to 10 full-time clinics at their peak of activity in 1948. In the 1960s, Karitane received financial assistance from the state, and since this time has increasingly relied on funding from the government (Ashton, 2009).

In 1976, Tresillian and Karitane developed a joint curriculum for mothercraft nurses. Tresillian and Karitane have been influential centres, both in NSW and around Australia.
3.8 The Victorian Experience

While high infant mortality rates were shared by all states, the infant welfare movement did not expand simultaneously or uniformly around Australia. Victoria’s infant health movement had its origins within both the local councils and the women’s committee, The Victorian Baby Health Centres Association (VBHCA) (Mein Smith, 1997).

Similarly to Sydney, Melbourne experienced a rapid expansion of its working-class suburbs and the infant mortality rate reached 87 per 1000 births in 1912. Babies and children of unwed mothers were most at risk, as they were frequently weaned early. In her account of the infant welfare movement in Victoria, Flood (1998) reports that even though Victoria shared the NSW’s concern of an alarming increase in the infant death rate, it chose a different approach. Whereas Armstrong advocated for the mass education of all mothers about breastfeeding, general hygiene and sanitation, his counterpart in Melbourne, Dr A. Jeffrey Woods, Medical Officer at the Children’s Hospital, focused on the treatment of sick children and the availability of clean safe milk. Following intense lobbying from Woods, the Lady Talbot Milk Institute was established in 1908. However, this initiative was not sufficient to produce the expected far-reaching effect that the provision of mothers’ education generated.

In 1917, the first baby health clinic, staffed by one welfare nurse and supported by women volunteers, was finally opened. By 1918, nine more clinics staffed mainly by volunteers were established in Melbourne’s industrial suburbs. This rapid expansion of welfare services required funding and coordination; the VBHCA was formed in 1918, followed by the establishment of a second infant welfare organisation with its own baby health centre in Coburg. The Society for Health of Women and Children of Victoria (SHWCV) was also inspired by the work of Truby King and it followed his strict instructions rigorously. The work and influence of Truby King on child-rearing practices and nursing education has been described in Sections 3.4–3.6. This influence was widely felt throughout Australia and NZ.

15 The original Victorian ‘welfare services’ are now called Maternal and Child Health Services.
3.8.1 Queen Elizabeth Centre, Tweddle and the O’Connell Family Centre

During the early twentieth century, baby health centres were being developed, as were three mothercraft institutions in Victoria. The Carlton Refuge Home 1854–1949 was a refuge for young pregnant girls (Crockett, 2000), similar to the House of Mercy in WA. Due to declining numbers of young women requiring this service, the Home was closed, and transferred in 1950 to the VBHCA, which refurbished the establishment to house the VBHCA training and mothercraft facilities. In 1951, it was named the Queen Elizabeth Maternal and Child Health Centre and later the Queen Elizabeth Hospital for Mothers and Babies (Crockett, 2000). It is now known as the Queen Elizabeth Centre, and moved from Carlton to a newly built site at Noble Park in 1998.

Joseph Thornton Tweddle (1865–1943) financed the establishment of the Tweddle Hospital for Babies and School of Mothercraft as the training centre for Plunket and Primrose nurses. The hospital opened in Footscray in 1920 (Tweddle Child & Family Health Service, 2011). The only historical resource available on Tweddle is a memoir by a mothercraft nurse (Blundell, 2009) who worked on and off at Tweddle from 1945 to 1960. Blundell (2009, p. 3) states that the Society for the Health of Women and Children of Victoria was managing Tweddle when she commenced work there in 1945.

The Mercy O’Connell Centre was established by the ‘Grey Sisters’, particularly Maude O’Connell, a teacher, social worker and nurse, at Daylesford House in 1931. It was established as a training school of social service and mothercraft, and was embedded in the work of the Company of Our Lady of the Blessed Sacrament Grey Sisters (that is, nuns) (Edman, 2010; Kane, 1980). The Grey Sisters trained in mothercraft and advocated for disadvantaged families with young children in the home environment (Kane, 1980). Lectures and demonstrations were conducted by a registered infant welfare sister (Edman, 2010). By 1945, the purpose of the work was in three distinct areas: practical care of mothers and children, training for marriage and motherhood, and extension work in parent education (Edman, 2010, p. 76). In 1975, the centre was registered as a public hospital, and in 1990, the Grey Sisters Mother and Child Centre was incorporated and became the O’Connell Family
Centre, an EPS. In 1997, the Sisters handed over the management of the Centre to Mercy Health and Aged Care.

3.9 The Queensland Experience

The first baby clinic opened in Queensland in 1913, followed by three further clinics by 1918 resourced by the State Government. Nurse Ellen Barron was a strong advocate of the concept of a mothercraft home, and from 1924, the Valley clinic operated some live-in facilities and training for nurses (H. Murphy, 1963). With the help of other nurses and an Honorary Paediatrician as medical advisor, the growth of clinics continued (McFarlane, 1968). In 1922, Barron undertook the Karitane course in NZ, studying under Dr Truby King. Upon her return to Queensland, she implemented four-month infant welfare training courses twice a year in Fortitude Valley.

McFarlane (1968) notes that the work of the early clinic sisters was subject to a great deal of criticism and general hostility, both from some in the community and from higher profile people. However, important advances were also made, and from 1929 a rail car equipped as a baby clinic with a lecture room and staff accommodation travelled to the West of the State and ‘helped educate mothers in the principles of infant care’. This initiative was supported by the Country Women’s Association (McFarlane, 1968, p. 3). This had the benefit of expanding centres over time through rural areas, until the onset of the Depression. The infant death rate had halved during this period, largely attributable to the work of the Department of Health (McFarlane, 1968).

The purpose of these mothercraft facilities was to provide support for mothers of breast fed babies to be in residence with their babies and learn how to manage them; the average duration for this was three weeks (McFarlane, 1968, p. 9). In 1942, the first Mothercraft Home opened at St. Paul’s Terrace and then in 1943 this was followed by the Home in Riverton Street at Clayfield (Berry, 2012a). Other Homes subsequently opened in Toowoomba (1947), Ipswich (1952) and Rockhampton (1952) (McFarlane, 1968). A Home in Sandgate opened in 1944, specially catering for the care of children up to 12 years of age while their mothers were in hospital. This Home ran until 1961 (McFarlane, 1968).
In 1968, Queensland had 280 clinics (McFarlane, 1968). These mothercraft facilities evolved separately to the Queensland nursing homes that cared for ‘illegitimate children and children of destitute mothers’ in the early twentieth century (Selby, 1992, p. 379). In 1920, there were 78 registered nursing homes caring for 193 children; by 1957, the number of homes registered had fallen to 33 (Selby, 1992, p. 391).

Three main resources were available to describe the history of the infant welfare movement in Queensland. McFarlane (1968) provided a brief account of the historical phases, outlined the achievements of many key nurses and change agents and listed the centre locations up until 1968. Selby’s (1992) thesis studied the period 1915–1957, looking at the impact of legislation and polices on motherhood. Thorley (2000) focused her study on the period 1945–1965 and explored women’s experience of infant feeding advice received from the baby clinic system in the context of the time. In addition, Health Department report documents revealed much about the experiences of Mothercraft Homes over time.

As at 1966, the six mothercraft homes mentioned above (that is, at St Paul’s Terrace, Clayfield, Sandgate, Toowoomba, Ipswich and Rockhampton) continued to operate. It was noted that at the Sandgate Home:

> The problem of caring for children of mothers who are suffering from nervous disorders is becoming difficult owing to the length of time these children have to remain in the Home … average duration of stay … five weeks. (Queensland Department of Health, 1966, p. 31).

As at 1971, a new Clayfield Home was under construction to accommodate more babies. Figure 20 gives the admission statistics for five Homes in Queensland for 1969 and 1970.
MOTHERCRAFT HOMES

Building of a new Clayfield Home to accommodate 18 babies under 18 months of age, and six mothers in near completion. It is interesting to note that 36 Aboriginal or Part-Aboriginal babies were admitted to the Rockhampton Home (manned from Woorabinda Settlement) during the year, and seven to the St. Paul’s Terrace, Rosslea, Home. To date, 1,236 students have graduated from their Child Welfare Certificate and 1,280 students have obtained their Certificate as Child Welfare Assistants.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Babies Admitted</td>
<td>241</td>
<td>305</td>
<td>278</td>
<td>253</td>
<td>101</td>
<td>90</td>
<td>146</td>
<td>158</td>
</tr>
<tr>
<td>Mothers Admitted</td>
<td>96</td>
<td>119</td>
<td>146</td>
<td>86</td>
<td>32</td>
<td>16</td>
<td>63</td>
<td>55</td>
</tr>
<tr>
<td>Daily Average</td>
<td>12.3</td>
<td>14.7</td>
<td>14.1</td>
<td>12.9</td>
<td>0.2</td>
<td>7.7</td>
<td>7.3</td>
<td>7.6</td>
</tr>
<tr>
<td>Mothers</td>
<td>2</td>
<td>2.4</td>
<td>0.7</td>
<td>1.3</td>
<td>0.57</td>
<td>0.4</td>
<td>2</td>
<td>1.6</td>
</tr>
</tbody>
</table>


As at 1986, three mothercraft homes existed, at St Pauls Terrace (Fortitude Valley), Clayfield and Ipswich, serving the needs of the community in the provision of residential care for families. Reasons for referral included feeding problems, parents seeking assistance in parenting skills, behavioural problems and family dysfunction. These Homes also undertook the training of child health nurses and child health assistants (Queensland Department of Health, 1986, p. 32). By 1991, families throughout Queensland accessed services at two Mothercraft Centres operating at Clayfield and Fortitude Valley, with an average length of stay of 7–14 days (Queensland Department of Health, 1991, p. 22).

From the early 1990s, Health Department reports were unavailable. There appears to be a gap of information in relation to the slow demise of family and children’s health services in Queensland. The mothercraft centre in Riverton St at Clayfield became the Ellen Barron Family Centre when the Riverton operations were moved to a new site in May 2007 (Berry, 2012a). The Ellen Barron Family Centre is now a residential service only. Other services, for example day stay are managed by the government universal community child health service.

3.10 The ACT Experience

Although the ACT EPS, the Queen Elizabeth II (QEII) Family Centre, did not participate in this study, a brief outline of their experience is presented here. The Canberra Mothercraft Society (CMS) commenced in 1926 when Canberra was a very young city. The people working within the new national capital often had no support from their extended families. The main focus of the Society in its early days was the
welfare of mothers and babies, but this has since evolved to include all partners, grandparents and other primary carers. Since 1926, CMS has brought Mothercraft Clinics, Home Help, Playgroups and Occasional Care Centres to the families of the ACT. Today CMS operates a diverse range of services including GrandJugglers, Relaxing into Parenting and the QEII Family Centre (Canberra Mothercraft Society Inc., 2012). The QEII Family Centre is classified as a public hospital (Canberra Mothercraft Society Inc., 2012).

3.11 The South Australian Experience

In 1909, Dr Helen Mayo, along with some women who shared a common concern for social problems, established the School for Mothers in Adelaide, which would eventually become Child and Youth Health. This School was instrumental in improving infant nutrition and hygiene. It promoted breastfeeding and instructed mothers who were unable to breastfeed in safe artificial feeding. Mothers also received support and advice in the treatment of minor problems and illnesses (Child and Youth Health, 2011).

The infant welfare movement in SA was advocated for and by women. Baby Health Centres were established in areas of high infant mortality with very little support from government. The first centre was opened in 1913 (Mein Smith, 1997), and by 1926 there were 39 clinics (Child and Youth Health, 2011). The School for Mothers in Adelaide became the Mothers and Babies Health Association in 1927 (Kitchens, 2005b) and set up Torrens House, a residential training school, in 1938 (Mein Smith, 1997). Other milestones were the introduction of the first baby health train servicing country areas (1931), the introduction of a correspondence section to assist isolated mothers (1935) and an ever-expanding preventive health service in the city and country areas. All of these combined to give SA the lowest infant mortality rate in the world in 1937. Over time, the declining birth and infant mortality rates and a reduction in the incidence of serious childhood infectious disease have reoriented services away from survival in childhood, to quality of life, parenting issues, prevention of illness and health promotion. These are the basic concepts of child health services today, with the development of a range of child health and parenting programs (Child and Youth Health, 2011).
3.11.1 Torrens House

A document providing some history of the Mothers and Babies Health Association was printed in 1959 (The Mothers & Babies Health Association Jubilee, 1959). It gives a brief summary of the Association’s key events. This facility initially provided accommodation for ‘five mothers, two premature babies, six babies and one toddler, for five infant welfare trainees and two mothercraft trainees, in addition to a matron, sister and domestic staff’. The establishment and continuation of breastfeeding was the most important part of the teaching at Torrens House, and many mothers were transferred directly to the House from the maternity hospital (The Mothers & Babies Health Association Jubilee, 1959, p. 26).

3.12 The Tasmanian Experience

In Tasmania, the first infant welfare centres commenced in 1918 in Hobart and Launceston and were strongly supported by women’s organisations, particularly the Child Welfare Association (CWA). At its formation in 1917, the CWA’s aim was ‘to provide facilities to help women before and after birth and to reduce the infant death rate’ (Brennan, 2007, p. 17). ‘[T]hrough fundraising, work circles, education and deputations to government, the Association was able to extend its work to projects ranging from the supply of pure milk to the organisation of school classes in mothercraft and infant hygiene’ (Waters, 2006). Photo 23 is of a mother in 1912, followed by the statement of desire of the CWA.

‘A mother and child in 1912: This was the ideal the child welfare movement wished for every baby’ (AOT, PH30/1/4988)

The Government paid for the nurses’ salaries and the CWA worked very closely with the nurses in the centres, supporting the nurses and the providing of material support for mothers (Brennan, 2007, p. 17). Brennan’s book, *The Fence on the Precipice: Child Welfare Nursing 1918–1930*, provided a rich history of child health nursing during this period, and particularly of the experience of one nurse activist, Myrtle Searle, who worked in Launceston. Brennan describes the role of nurses during this period as follows:

Child welfare nurses reached out to all the women in the areas in which they worked. They tried to reach as many pregnant women as possible and then after babies were born they visited them at home. They taught school-girls and girl guides, a future generation of mothers, as well as women’s groups. They spoke on local radio stations, after these were established in the 1920s, and wrote weekly articles for newspapers for Hobart and Launceston. They maintained a large and apparently growing correspondence with countrywomen and encouraged women to the centres by the provision of pure milk at minimal cost. (Brennan, 2007, p. 37)

### 3.12.1 Three Parenting Centres

The CWA, with the assistance of government grants, established the Hobart Mothercraft Home in 1925. The purpose of the home was to train nurses in child welfare and to provide a home for the teaching of mothercraft for mothers in residence. The hope was to help mothers to continue breast feeding (Brennan, 2007, p. 19). The State Government in 1947 assumed control of the Mothercraft Home, which had become a financial drain on the CWA (Brennan, 2007). The Government entered into a formal agreement with the CWA of Hobart (known as the Child Health Association since 1951). Like most States in which women in voluntary organisations were supporting child welfare organisations, the CWA’s intent was to work politically for the welfare of mothers and children and to assist in the reduction of infant mortality (although Tasmania’s infant mortality rate was lower than that in other states) and the suffering of women and children as a result of poverty and ignorance (Brennan, 2007).
In 1970, a Child Health nurse in Tasmania (see Figure 21) wrote the following about working mothers in the community in her assignment undertaken as part of the Child Health course at Hobart Mothercraft Home (Ducrow, 2011).

In 1990, the Beveridge report recommended the coming together of Child Health, School Health Services and the Mothercraft Home in Tasmania. The combined service became known as the Family and Child Health Service. During the early 1990s, the Mothercraft Home was decommissioned and three parenting centres (day stay centres) were established in Hobart, Launceston and Burnie. At the time of decommissioning, the Mothercraft Home provided accommodation (18 beds) and assistance to infants and mothers experiencing difficulties in parenting, as well as to infants requiring emergency crisis accommodation or respite care. There was also a 24-hour state-wide telephone service (Shaw, 2011).

The researcher worked in the Family and Child Health Service (Northern Region) from 1990 to 2004, from the beginning of the changes in Tasmania. In the early 1990s, a feasibility study was undertaken both in the North and Northwest regions, to identify the location of each day stay parenting centre facility and their model of practice. To this day, the Child Health Association remains very active within
Tasmania and works collaboratively with State Government as an advocacy body on behalf of parents with young children in Tasmania (Murphy, 2012, p. 2).

3.13 The West Australian Experience

Ngala was initially named the ‘House of Mercy’. It was established at a time of change in WA history, with the 1890s gold rush creating increased immigration and a subsequent rise in infectious disease, for which the State was unprepared (Hobbs, 1980). Planning commenced in the early part of the next century for the establishment of a maternity hospital by key community members in Perth, including the matron of the House of Mercy. It was noted by Reverend Kench in 1909 that with ‘the good work being done by the House of Mercy amongst single women, we should be conferring with the principals of that Home in regard to the proposed maternity hospital’ (Hobbs, 1980, p. 17).

The Commonwealth introduction of the Maternity Bonus occurred in 1913. This gave young women more choice in where they stayed for their confinement, and the numbers at the House of Mercy fluctuated accordingly (Lang, 1980). The transition of name change from the House of Mercy to the Alexandra Home for Women came at the same time as the opening of the KEMH in Perth. A pattern of interchange between the two facilities soon emerged for the girls for their confinement and then the birth of their baby (Lang, 1980).

During the first two decades of the twentieth century, Dr Roberta Jull was a champion for the infant welfare movement in WA, both at Ngala and with the Infant Health Service in WA. An infant welfare course was initiated at KEMH in 1927 after the then Matron, Agnes Walsh, visited Tresillian in Sydney to undertake the training. The course was recommended by the Infant Welfare Association in a report to the Minister and was approved to run at KEMH and to be incorporated into the Infant Health Clinic for the Subiaco area. It appears that this course was discontinued in 1946 (Hobbs, 1980), leaving a 13-year gap in courses offered in WA until Ngala began offering courses in 1959.

16 Roberta Jull (1940) undertook a summary of the history of Ngala by writing a précis of the minutes of meetings from 1890–1915 as well as a story of the Alexandra Home. 17 This initiative was not without politics from male medical representatives, who saw the infant welfare nurse as a threat to their practice (Hobbs, 1980).
Infant health centres were established from 1922 to assist in the movement to reduce morbidity and mortality and to teach mothers health and hygiene and promote breastfeeding (Hobbs, 1980). By 1949, extensions to Alexandra Home had been built and they had commenced training for mothercraft nurses (Lang, 1980). Planning for a new, larger facility began in the 1950s. The new building, Ngal-a Mothercraft Home and Training Centre, was launched in 1959 at Kensington and became a training facility for the infant welfare certificate. Ngal-a continued with accommodation for pregnant young women and out-of-home care for children up to five years of age. Preparation for parenting was given by nurses to families adopting children from Ngal-a. The care for mothers and children undergoing stressful parenting difficulties was maintained in a residential mother and baby unit (Lang, 1980). It was noted by Lang (1980, p. 82) that ‘many of the problems encountered in the early years of the home were fundamentally the same as those of today but the approach to them and the means of dealing with them are very different’ (p. 82).

In 1963, the mother of every new baby was visited by the infant health sister in her district as soon as possible after birth, and country mothers were written by the Service (Hobbs, 1980). The 1960s and 1970s saw strong participation in both child health and mothercraft training programs at Ngal-a, until the transfer to the tertiary sector during the 1980s. From this time, Ngal-a entered into a new phase of parenting services in the WA.
Photo 24. Nursing photos from Early Parenting Services 1950s–1960s (National Archives of Australia, 2012)

Barcodes in order: 7587335, 8925298, 11969374, 11868659, 8939921, 30922363.

107
3.14 History of Nursing at Ngala

Ngala is one of the oldest charities in WA. It has a long history, having commenced as the House of Mercy in 1890. The House of Mercy became Alexandra Home for Women in 1916, and a further name change, to Ngala, occurred in 1959. The period 1959–1980 was also of key importance to the history of Ngala; and the 1980s are worth discussing separately as a time of turbulence. From 1989 to 2011, the period leading up to the present day, is also described in this section. These time periods were identified because they fit with the name change of the organisation and its key periods of leadership. The nursing history at Ngala was gleaned from a range of documents archived at Battye Library in Perth and at Ngala. This comprehensive collection included minutes from Committee meetings, matrons’ records, nursing reports, annual reports, oral histories from nurses and Committee members, correspondence, recorded histories, constitutions, diaries and reviews/reports.

From the investigation of these records, two streams were identified, and both have been integrated into the periods over time:

1. Key milestones of history; and
2. Nursing milestones and recordings of the role of the nurse (in the context of nursing in WA).

These milestones have been captured in a visual timeline, presented in Appendix 7.


The House of Mercy was founded in 1890 (see Photo 25) by an Association for the establishment of ‘a Refuge for fallen women in Perth’. The instigator of the first meeting was a Reverend J. Young Simpson. A committed group of women, chaired by Lady Doyle, continued to develop and run the House of Mercy (Lang, 1980). The name ‘House of Mercy’ was chosen because:

The name reflected the attitude of many members of the committee, towards girls and women who had strayed from the path of moral rectitude; they had done wrong but were to receive the help of what they stood in need. (Jull, 1940, p. 1)
The House of Mercy was established during a time of turmoil in the history of WA, with the 1890s Gold Rush to the eastern goldfields resulting in increased immigration and infectious diseases. Hospital governance commenced with the passing of the first Hospital Act of 1894 in Parliament, which brought in regulations around hospitals and boards of governance (Hobbs, 1980).

A Matron was engaged to run the Home. She was not a certified midwife, so a doctor was called in for births (Jull; Lang, 1980). It was not until much later (1911) that midwives were called in to assist. Young women were admitted during their confinement, up to the child being six to nine months if required (Lang, 1980). The first note of a ‘probationer nurse’ being employed was 1907 (Mattinson, 1970). An Infants Home in connection with the House of Mercy was opened in 1904, which employed untrained nursing staff for the purpose of caring for the children. The purpose of the Home was to care for children ‘for a small fee, after their mothers had obtained situations and left the House of Mercy, as the boarding out system had in so many cases meant death of the children’. These children were often ‘malnourished, sick and/or convalescing’ (Lukin, 1904, p. 1). Volunteer women would come in to assist with the running of the home (Lukin, 1905).

A fee was charged wherever possible at the House of Mercy and some young women were able to help with the running of the Home or perform laundry work, with the Home taking in laundry from private hospitals and families. The Home was registered as a laundry during the year 1900 (Lang, 1980).
Excerpts from the Matron’s diaries 1894–1904 gave examples of young women or babies having infectious disease such as typhoid fever. The doctor visited each day. Women and babies often died in the home due to infections or neglect. Volunteer women would come in to assist with the running of the home. A report in 1905 stated:

The Matron reported the death of two babies Harold Edward and Billie Nottle on Jan 28th. They both died of consumption of the bowels although something possible had been done to save them both by the Doctor and Nurses. An Assistant nurse had to be engaged early in the month as all the children were ill and there was no help available from the House of Mercy. (Lukin, 1905)

The establishment of a maternity hospital was in planning by key community members in Perth, including the matrons of the Perth Hospital, House of Mercy and Children’s Hospital (opened in 1909, see (Piercey, 2006), as well as eminent doctors and high profile community members, including the clergy. A committee was established in view of the debate at the time about whether the Hospital should service both ‘married and single women’. It was noted by Reverend Kench in 1909 that with ‘the good work being done by the House of Mercy amongst single women, we should be conferring with the principals of that Home in regard to the proposed maternity hospital’ (Hobbs, 1980, p. 17).

The following Figures 22–25 are annual reports from the House of Mercy from 1911–1914. Figure 22 highlights the Matron’s position on the Midwifery Board of WA and the difficulty in being able to recruit ‘probationer nurses’. It also alludes to the potential amalgamation of the House of Mercy with the proposed maternity hospital. This was not agreed to by the Committee. Figure 23 highlights the cases that were admitted each year and the services of the Matron.
REPORT FOR YEAR ENDING 31ST OCTOBER, 1911.

Record of Cases. During the year twenty-seven cases have been admitted to the House of Mercy, including six married women, who were unable to pay the usual maternity fees. Four of the cases were admitted under the arrangements with the Government, by which two beds are reserved for emergency cases, and paid for out of the hospital funds. Twenty-five infants have been born, of these two were still-born, and two died—one premature birth, the other was malformed. There were no other deaths. Three girls were married during the year. The number of cases shows that there is still need for the House of Mercy to continue the good work which has carried on for so quietly and successfully.

Matron. The Matron (Mrs. Harris) still continues to give the Committee every satisfaction, both in her maternity work, and in the economical management of the institution. During the four and a half years in which she has occupied her position, 99 cases have passed through her hands, and without exception, the mothers have made good recovery. Of the infants born during that period five were still-born, one prematurely born (alive only four days), and two died in hospital from congenital malformation. Of the remaining infants, 99 in number, let the institution in good health and condition. This is a record which reflects the greatest credit on the Matron, and fully justifies her appointment as one of the members of the Board of Managers. The patients were generally well cared for, and the hospital funds are in a bonus position. The Committee is to be congratulated upon possessing such an efficient Matron. During Matron’s term of office 17 of the inmates have been married.

Behaviour of Inmates. On the whole, the inmates have been well-behaved, though, as might naturally have been expected, some of the girls have given a little trouble; the Matron’s firmness and kindness, however, has been all that has been required, and many of the girls have been very grateful for the relief afforded them by the House of Mercy in their hour of need, and they have promised to make subsequent behaviour, that “they have been more staid against than stirring.”

Visitors. The Rev. Archdeacon Hudson has continued his spiritual ministrations to the inmates, but as no official report has been received, it may be generally known that the clergy of all denominations are at liberty to see any inmates belonging to their churches, at any time, and that their visits are both welcome and valuable. The thanks of the Association are here tendered to the Rev. Archdeacon Hudson for the kindly interest which he has shown in the inmates. Very few admissions have occurred during the year, and the members of the House of Mercy Association do not seem to realize that good which can be done by visiting the House occasionally, and brightening the shadowed lives of the inmates by a few kind words.

Probationer Nurse. It has been found impossible to secure a suitable Probationer Nurse to assist the Matron, as the time served in the House of Mercy, unfortunately does not qualify as a part of the Midwifery training for Maternity Nursing, recognized by the Board. The Committee decided to deal with this matter during the coming year, to see if anything can be done to remove this difficulty, on the practical training under Matron Harris being of the highest order.

Church Street Property. The Church Street property has been sold during the year, and the sale resulted in £100 4s. 6d. being added to our funds.

Finances. The financial affairs of the House of Mercy are in excellent order, as appears in the Financial Statement submitted by the Treasurer.

Begging from the Padbury Estate. Under the Padbury Estate, the House of Mercy has received a yearly bequest from whom a first payment has been made amounting to £70 10s. 0d. per annum. Out of this amount a sum of £36 10s. 0d. (in addition to the other contributions and interest), has been paid to the trustees of the Estate of the late Lord Ponsonby, and this payment has finally extinguished all the debt on the House of Mercy. The Committee are carefully considering what it is best to do with the remainder of this legacy, in order that it may be of permanent benefit to the institution.

King Edward Memorial Hospital. The proposal to amalgamate the present King Edward Memorial Maternity Hospital, which has been approved by the House of Mercy Association, has not been carried out, and as present it is in operation, no report is submitted.

The House of Mercy Association.

REPORT FOR YEAR ENDING 31ST NOVEMBER, 1912.

Record of Cases. During the year twenty-three cases have been admitted to the House of Mercy; of these, three were married women who were not able to pay the usual maternity fees, and three were emergency cases, who were admitted under the arrangement with the Government. By which two beds are reserved for such cases, until the erection of the proposed Government Maternity Hospital. Twenty-two infants have been born in the institution of those two infants were still-born, and one died in the Infants’ Hospital, having been born with Hopeless Obstruction. The House of Mercy is still needed, as the result of several cases, and every effort has been made to fulfill its main object, which is to reform girls who have fallen for the first time, and to enable them to return to the right path.

Matron. The Matron (Mrs. Harris) still continues to give the Committee every satisfaction, both in the economical management of the institution, and in the firm but kindly control which she exercises over the inmates. In view of this fact the amount of her salary has been increased by £10 per annum, as better positions were open to her, and it is feared that the House of Mercy could not afford to lose the services of, probably, the best Maternity Nurse in the Western Association. She is now in residence. Notice will be taken and every satisfaction tendered to the Committee.

Behaviour of Inmates. The inmates, on the whole, have been well-behaved, and many have been grateful for the help given to them by the House of Mercy, and some, we have reason to believe, are returning to live virtuously and upright lives.

Visitors. The Rev. Archdeacon Hudson has continued his spiritual ministrations to the inmates, but no official report has been received, it may be generally known that the clergy of all denominations are at liberty to see any inmates belonging to their churches, at any time, and that their visits are both welcome and valuable. The thanks of the Association are here tendered to the Rev. Archdeacon Hudson for the kindly interest which he has shown in the inmates.

Probationer Nurse. It has been found impossible to secure a suitable Probationer Nurse to assist the Matron, as the time served in the House of Mercy, unfortunately does not qualify as a part of the Midwifery training for Maternity Nursing, recognized by the Board. The Committee decided to deal with this matter during the coming year, to see if anything can be done to remove this difficulty, on the practical training under Matron Harris being of the highest order.

Church Street Property. The Church Street property has been sold during the year, and the sale resulted in £100 4s. 6d. being added to our funds.

Finances. The financial affairs of the House of Mercy are in excellent order, as appears in the Financial Statement submitted by the Treasurer.

Begging from the Padbury Estate. Under the Padbury Estate, the House of Mercy has received a yearly bequest from whom a first payment has been made amounting to £70 10s. 0d. per annum. Out of this amount a sum of £36 10s. 0d. (in addition to the other contributions and interest), has been paid to the trustees of the Estate of the late Lord Ponsonby, and this payment has finally extinguished all the debt on the House of Mercy. The Committee are carefully considering what it is best to do with the remainder of this legacy, in order that it may be of permanent benefit to the institution.

King Edward Memorial Hospital. The proposal to amalgamate the present King Edward Memorial Maternity Hospital, which has been approved by the House of Mercy Association, has not been carried out, and as present it is in operation, no report is submitted.
Figure 24 describes the various donations made to the House of Mercy, and the services of the medical officer.

![Image of Figure 24](image)

**Figure 24. Annual report 1913**

Figure 25 highlights the impact of the maternity bonus and the case of the death of a woman at the House of Mercy.

![Image of Figure 25](image)

**Figure 25. Annual report 1914**
The Commonwealth introduction of the Maternity Bonus occurred in 1913. This gave young women more choice in where they stayed for their confinement; the numbers of women choosing to stay at the House of Mercy rose accordingly (Lang, 1980). In 1914, there was a well-documented emergency case of a woman dying of a ruptured uterus, known as ‘The Bellevue Case’. Although the House of Mercy was exonerated, the case was presented in the Press, and it demonstrated the need for a fully equipped maternity hospital (Lang, 1980, p. 34).

Infant mortality attracted much public attention in WA during the first two decades of the twentieth century. This period saw a far greater incidence of infant death in WA than in any other State in Australia, predominantly attributable to the Gold Rush. Death mostly occurred in younger infants, with the major causes being congenital debility, digestive illness such as diarrhoea, and respiratory problems such as influenza and whooping cough. Government strategies at this time were to ‘educate the mother in better methods of infant care as well as her basic household tasks’ (Davis, 1983, p. 11). The First World War commenced in 1915 and the KEMH\(^{18}\) opened in 1916 (Hobbs, 1980). Also in 1916, the House of Mercy changed its name to Alexandra Home for Women (Lang, 1980). During 1916, a Child Welfare Conference was organised by the Women’s Service Guild in Perth to:

consider in view of the present world crisis, the necessity for studying the best methods of awakening and of training the capacities of the child; to create a deeper interest in the moral question of child welfare, and to discuss the importance of child psychology and relation to social progress. (Davis, 1988, p. 169).


The above mentioned name change came at a time of shifting attitudes towards unmarried mothers and their babies (Lang, 1980). Nursing during this era was becoming increasingly professionalised, with advocacy at higher levels of nursing. The training of nurses became more regular, and regulations were introduced for the registration and training of nurses and midwives. The First World War and Depression and then the Second World War were features during this period, as was

---

\(^{18}\) KEMH is now WA’s leading tertiary maternity hospital.
the escalation of the infant welfare movement. Infant health centres were established from 1922 to assist in the movement to reduce infant morbidity and mortality, to teach mothers about health and hygiene and to promote breastfeeding (Hobbs, 1980).

The interchange between the two facilities, KEMH and Alexandra Home, soon developed for the girls during their confinement and then birth of their baby (Lang, 1980). Davis reflects on an article written in a magazine in 1917 called ‘Save our Babies! Our National Asset’. The quotation was from the Editor of ‘Western Woman’ and argued that:

> In view of the terrible strain the war makes upon the brightest and most physically perfect of our male population, it is a matter of national concern to do everything in our power to promote the physical and mental welfare of our future citizens … above all to lower the infant death rate which is largely due to improper feeding by the mothers or want of care due to ignorance on their part. (Davis, 1983, p. 13)

The above statement also reflected information emerging from the Health Department about contemporary infant and child rearing.

As mentioned earlier, Dr Roberta Jull was very active and influential in the community of child health. She contributed articles to the magazine ‘Western Woman’ and was able to balance advocating for the medical profession’s role in infant care and the instruction of mothers. At another level, she recognised the value of the experience of being a mother. The medical profession tended to see women as lacking in any sense of how to care for a baby. As such, Dr Jull was driven to write and publish advice articles, pamphlets and books. ‘The constant instruction to the mother was to ensure the cleanliness of herself, her baby and her home’ (Davis, 1983, p. 24).

There were four women’s organisations in WA that were instrumental in improving the conditions of maternal, infant and child care in WA—the Children’s Protection Society, the Women’s Service Guild, the National Council of Women and the Kindergarten Union. These organisations were representative of the contemporary
attitudes towards motherhood and infant care and were closely involved in the initiation of social reform pertaining to child welfare (Davis, 1983, p. 30).

The Infant Health Association (IHA) was established in 1922 with societal interest in the welfare and lowering of the death rate of young children (Davis, 1988). An article in the WA newspaper entitled ‘Save the Babies’ alluded to maternal ignorance, with the need to educate and increase the community and Government’s awareness of their responsibility for children (Davis, 1988, p. 170). The first Infant Health Clinic was opened in 1922 (Hobbs, 1980) and by 1925 there were 10 centres (O'Hara, 1988). The IHA worked closely with and sought advice from the medical profession, and Dr Roberta Jull was a strong advocate and link to gain cooperation from the medical profession, who at that time saw themselves as instructing the role of nurses in the health care of women and children (Davis, 1983). Davis, in her study, found a letter written to doctors and nurses from the IHA. A medical advisory committee of the IHA in 1923 provided advice and instruction to midwives and nurses:

The nurses are instructed that they are not to treat sick babies, but are to refer all cases of illness among the infants under their care to a medical practitioner and to aid the mother in carrying out his instructions. Under no circumstances are they to recommend any particular doctor. (Davis, 1983, p. 37)

The medical profession, with their ‘superior’ knowledge, saw themselves as vital in ensuring the health of the mother and baby.

The Alexandra Home occasionally conducted fundraising events. The West Australian presented an article (Anonymous, 1926) to remind the public of the reason the Home existed and to request funds to keep the Home going (see Figure 26).

---

19 Davis researched Infant Health Association files.
The WA Government was unable to afford to assume full financial responsibility for the baby clinics when the community-based centres were struggling to raise money during the Depression years. The Government did, however, provide subsidies, and to some extent used these as a means of control in the mid-1930s, such as to raise qualification standards—some of the nurses working in WA centres at the time were not trained in child health (Davis, 1988).

WA was also influenced by the infant welfare training commencing in other states, particularly in NSW. The first approved infant health training commenced at KEMH in 1927 under the guidance of Matron Walsh (1922–1956). She had previously travelled to Sydney (Tresillian) to complete the training. Upon her return to WA, she integrated the infant health training component into the four-month midwifery course. In the following year, the Nurses Registration Board reduced the age of entry into nursing from 21 to 18 years (Hobbs, 1980; O'Hara, 1988).

The Depression followed in the 1930s, and there was an increase in the building of small country hospitals administered by local boards of management and subsidised to some extent by the government. The Flying Doctor Service was also introduced during the Depression era. This was also the period during which the wages and conditions of nurses became the interest of nurses and the newly formed WA State Branch of the Australian Nursing Federation. At this time, the training of nurses was
based on tasks, and the delegation of specific tasks depended on the nurse’s experience (Hobbs, 1980).

The Nursing school set up by the WA Nurses Association (WANA) at Royal Perth Hospital was promoted by the West Australian press with the following article (see Figure 27) in 1935, explained by Hobbs (1980, p. 105). On the demonstration ward, there was a dummy baby and an adult as a resource for training the student nurses.

![A Dummy Baby](image)

*Figure 27. Newspaper article West Australian 1935 (Hobbs, 1980)*

The first year of general nurse training was limited to domestic work, while as the nurse advanced in seniority, the duties were more orientated towards nursing techniques and nursing care, although the trainee nurse continued to be responsible for some domestic chores (Hobbs, 1980).

In the Alexandra Home, births were still taking place, although less than before KEMH was opened. The Annual Report of November 1933 stated:

> The number of girls admitted during the year was 33. There have been 25 births, two girls being admitted with their babies. Of the 28 girls who were discharged, nine went home with their babies, and two girls were married, their husbands adopting the children. At present there are 19 girls in the Home and 14 babies. (The Alexandra Home for Women, 1933, p. 2)

During 1936, women were sent to KEMH for their confinement and then came back to the Home after the birth (Jull, 1940). Jull (1940, p. 4) described that in the same year, the Home had regular visits by a ‘child welfare sister’, who instructed the girls in modern methods of caring for their babies. Friends and volunteers assisted with
cooking lessons and assisted the girls to undertake personal interests and encouraged them to make things for themselves (Lang, 1980). The documents describe the Matrons employed as being engaged with a range of duties. In September, 1936 Matron Ferguson reported:

The urine is always tested twice a week and recorded if necessary. Girls dieted accordingly. Babies are weighed twice a week and same recorded. A certain amount of sterilizing is done every few weeks by me. Sick girls and babies are attended in the nursing ward. The usual interview takes about an hour. I have to sit and listen to tales of woe and sorrow, some of which there is no truth in. Mails are given out twice a day, and immediate answers sent. Take the girls to KEMH when in labour and go up again later to collect the bonus for each girl. There is quite a large correspondence from Mothers of girls from the country. The four sprinklers and hose are moved every hour by me in the summertime and a great deal in winter too. The motor is oiled and greased by me and in my spare time I garden. There are a lot of other duties but I cannot remember them. Numbers of the girls have breast massage and hot and cold foments. Time about half an hour twice a day. Other girls cannot express OR WILL NOT express their breasts. This is then done by me. (Lang, 1980, p. 41)

During the 1940s, the Committee planned the introduction of a training centre for mothercraft nurses, and they also embarked on an expansion of the facilities (see Photo 26). Matron Ulrich (1949a) (see Photo 27), when writing her report, was feeling the pressure of the enormous changes occurring with the renovations and the introduction of the new training course. She stated:

Mrs Snowball has made the nurses’ rooms look very inviting since she hung curtains. The aprons made are most useful to the nurses. So much has been done by ladies of Committee who have generously given time and strength to the point of utter weariness in preparing this Mothercraft Home. There is not space to give them the justice due … I have a vision for this place, or I should not be here, and I should not, certainly not be wearing myself out if I felt this trying time will
pass and out of the trials and confusion, noise and all the hindrances and difficulties will arise a School of which all who laboured to bring it into being will be very proud. (Ulrich, 1949a)

![Photo 26. The Alexandra Home 1951](image)

The Nurses Board approved the curriculum and registration for mothercraft training to occur and:

in June 1949 there were 15 trainees in residence for a period of 15 months training under the direction of Matron Ulrich, Dr Edwards, Dr

![Photo 27. Matron Ulrich with Nurses in 1949](image)
Cook, and a staff of three nursing Sisters and a Mothercraft Nurse.  
(Lang, 1980, p. 50)

The Matron’s report of April 1949 stated that there was an increase in demand for the Home:

Many babies have been refused admission during the month as our nurseries have been overcrowded. The work of the Home amongst the babies seems to be more widely known of recent weeks and we are having difficulty trying to cope with the numbers who would like to place their babies in the Home. If this demand keeps up I would suggest that the time limit be three months for keeping a baby in the Home. Where a child has parents, I think some other arrangement could be made after this time. (Ulrich, 1949b)

Meerwald (1995) was in the first training school of 1949. Prior to this time she had worked as a nursing assistant at the Home. She stated that during this time she was not sure of the qualifications of nurses, but said that the Matron was always a double certificate sister because of the mothers, and the others could have been child health trained, as this course was done at KEMH.

The first resource used during the training was Truby King’s ‘Mothercraft’. The second was ‘A guide to the care of the young child’ by Brown and Campbell (Meerwald, 1995, p. 8). Lectures were given by the Matron and different sisters and doctors from PMH (Paediatrics). Meerwald (1995) stated in her oral history interview:

A Sister Hack came … she was a wonderful woman. She taught us a lot, not only in caring for children but accepting of people and knowledge of people. She had guided us through and it was really very well done. She had a natural instinct to explain because you get, you know, for us country girls and most of us were country girls, incestuous children and that. I mean we’d heard ALL the stories you know, and everything about that, but she helped us understand how these things could occur, how to love the children—we loved the
children anyway, it was only people that had them we didn’t like.

(Meerwald, 1995, p. 9)

She said that the course initially taught the basics of caring for a baby, including hygiene, bathing, clothing, safety, play, feeding, breastfeeding, engorged breasts, infectious diseases and caring for children. The nurses spent time in pre-schools such as Meerilinga20 and various kindergartens and she stated that ‘my mothercraft training provided a good basic education that was built on in further nursing certificates’ (Meerwald, 1995).

In 1949, extensions to Alexandra Home had been built and they had commenced training for mothercraft nurses. Fifteen trainees were in residence for 15 months (Lang, 1980). In the early 1950s, ‘the need for a social worker occupied the thoughts of the Committee’ and the committee of management approached the Child Welfare Department for advice on ‘how to help unmarried mothers to rehabilitate themselves’ (Lang, 1980, p. 54). From the 1890s and up until 1951, medical input had been mostly on a voluntary or honorary basis, with doctors incorporated visiting Ngala as an interest in their professional work. The Commissioner for Public Health instigated a honorarium of 100 pounds per year to look after the babies and this was advertised in the BMA magazine (Lang, 1980, p. 54).

In 1950, His Excellency the Governor Sir James Mitchell visited the Home during his last week in office. The following promotional material was found that explained some of the detail of the Home and its activities (Alexandra Home for Women, 1950) (see Figures 28–33).

---

20 Meerilinga is a not-for-profit agency in Perth that has early childhood and family support services.
Figure 28. Brochure of the Governor’s visit to Alexandra Home for Women and Babies and Mothercraft Training School (1)

Figure 29. Brochure of the Governor’s visit to Alexandra Home for Women and Babies and Mothercraft Training School (2)
Figure 30. Brochure of the Governor’s visit to Alexandra Home for Women and Babies and Mothercraft Training School (3)

Figure 31. Brochure of the Governor’s visit to Alexandra Home for Women and Babies and Mothercraft Training School (4)
Details of the Home...

The Alexandra Home was founded in 1890, originally to care for unmarried girls expecting babies.

The need for Mothercraft Nuses became so apparent, it was decided to incorporate the two and in 1949, after the addition of the necessary Nurseries and Staff accommodation, the Training School was officially opened by Lady Mitchell on April 9th, 1949.

Seventeen trainees have successfully completed the course since the School first commenced. Approximately 300 babies and 160 mothers have been admitted to the Home and cared for since the beginning of 1949.

The Training School has incurred much greater overheads, due to the upkeep and maintenance of new buildings, equipment of the nurseries, and supplementary food for the babies. Laundry staff and equipment, fuel and heating.

However, the skilled care and attention given to babies the education of mothers in infant feeding and training of Mothercraft Nurses, has justified the additional expense and must ultimately be of great benefit to the community generally.

Babies are admitted to the Home for many and various reasons —

1. Dietary upsets and general management of routine.

2. Illness of the Mothers, in some cases necessitating a separation from the baby when the baby is admitted direct from the Maternity Hospital.

3. Inadequate housing accommodation.

There is accommodation in two modern nurseries for 20 babies and 20 babies up to the age of 12 months in one, and ten toddlers in the other from 1 to 2 years.

Each baby is mothered by its own individual nurse, who is responsible for its care, and records its daily progress on a special feeding and treatment chart.

Approximately 4 gallons of milk is used each day in the nurseries, each baby having a 24-hour supply of feeds made up, bottled and kept in the refrigerator ready for use. After use, the bottles are sterilised in an electric sterilizer.

On fine days, the tiny babies spend the day in prams in the garden, and the older toddlers play in their own enclosed play ground and sand patch.

This brief summary of the social service to the State performed by the Home is compiled to encourage your support of the 1951 Appeal. Your donation will be gratefully acknowledged.

Figure 32. Brochure of the Governor’s visit to Alexandra Home for Women and Babies and Mothercraft Training School (5)

Figure 33. Brochure of the Governor’s visit to Alexandra Home for Women and Babies and Mothercraft Training School (6)
Due to the inadequacy of the Alexandra Home facility in Lincoln Street in 1955, a vision for a new building was developed with a State Lotteries Grant and further fundraising ensued. The advertising brochure stated the new building would be called ‘Ngal-a’\(^{21}\) and explained how it would serve WA:

Ngal-a will board any babies up to three years of age while the parents have a holiday on medical advice;
Ngal-a will care for babies needing dietetic adjustment who have been entrusted to the home on doctors’ advice;
Ngal-a will care for and help unwed expectant mothers in distress and arrange adoptions when required;
Ngal-a boards and cares for any baby in WA from the age of 10 days to 3 years, regardless of the social or financial standing of its parents;
In the event of a mother’s sudden illness, absence or inability to look after her baby because of hospitalisation or domestic upheaval, her baby can still be looked after and loved by Ngal-a;
Ngal-a will have private rooms and special nurseries for mothers who, for leaving maternity hospitals, need postnatal care or convalescence before returning home;
Ngal-a will care for babies (State wards) who have been abandoned by their parents;
Ngal-a will continue to be the only centre in WA to train mothercraft nurses;
Ngal-a will be of value to the nursing profession as it will include a training school for Sisters to enable them to obtain their third certificate in Infant Health instead of them having to leave the State as they do now. This should mean that we lose fewer trained Sisters from our hospitals. (Ngala, 1955)

The years from 1949 to 1959 marked the attainment of unity within nursing, adjustment to changes in the pattern of nursing care and nursing education and the formation of the College of Nursing Australia in 1951 (Hobbs, 1980). During the 1950s and 1960s, there was a considerable increase in the population and a drop in

\(^{21}\) Note that Ngal-a has a hyphen that appears in documents inconsistently and is eventually dropped during the 1980s.
mortality rates. This rapid growth also generated economic development and growth in health facilities (Piercey, 2006). During this period, nursing training was still heavily influenced by an army style of education and a shortage of nurses generally. There was a movement during the 1960s to build a new curriculum for nurses that was more relevant to the time (Piercey, 2006). There was also a move towards improved nursing pay and conditions (Hobbs, 1980).

Two nursing oral histories (Ellis, 1995; Meerwald, 1995) describe the period of nursing from the 1950s (prior to the transition of Alexandra Home to Ngala) until the transition period into the 1980s, including the key role of the nurse. The sisters in training and the mothercraft nurse roles interfaced, as they often both worked together with the children. These are described in Chapter Four in more detail. One of the key roles of the nurse was as a ‘substitute mother’, and routines for children had to be established, such as for feeding, bathing, dressing, sleeping, walking, playing, cooking, preparing food, checking or supervising, toileting, cleaning, settling of children and making up of milk feeds. The following quotations explain this role:

Nurses undertook all activities that were related to the daily chores of looking after children. We did things that anybody else would do with their children. (Ellis, 1995, p. 9)

We were to care for any child whose mother was unable to care for it, whether she was ill or … while they went on holidays sometimes, or she might have been in hospital or the child could have been for adoption or fostering or for any reason whatsoever that the mother couldn’t care for the child. (Ellis, 1995, p. 7)

The nurses were fantastic … they would often come down when they were off duty and in the evenings, and often feed their babies. (Ellis, 1995, p. 16)

They were to create a homely environment and ‘look on as a home not an institution’; Treat children as individuals, and buy gifts for children and necessities like shoes and nice clothes (Ellis, 1995, p. 8).
Everybody was encouraged to have a baby or toddler that they loved … we had permission from Matron to take children out on outings when we were off duty … and sometimes for weekends (Ellis, 1995, p. 9) (see Photo 28).

Photo 28. Alexandra Home nurse and babies 1957 (Malloy, 2010)

You’d go into the milk room and that was … and you’d cook the children’s meals and you’d do the special diets for the babies as well as the milk bottles. The main kitchen would cater for the older children—2–3 year olds. (Meerwald, 1995, p. 11)

All feeds were worked out for babies in those days on the calorie intake—how many calories they needed for pound of body weight a day and all the feeds were worked out on that. You’d have a chart for each baby and when you’d finished your shift you’d have to check that the other nurses had all their calorie charts and that baby had had sufficient nourishment for the day. If it wasn’t you’d see that it was increased the next day or if the child was still hungry you’d have to work out another diet for the baby. That was the nurse’s job. Then the matron or the charge sister would come and check it over. (Meerwald, 1995, p. 12)
The other parts of the role are as follows; these are described in more detail in Chapter Four:

- Caring for sick child/mother;
- Caring for disability/special needs;
- Coordination of care;
- Health assessments;
- Doing mothercraft;
- Protecting children and advocacy;
- Giving psychosocial support;
- Training and supervision.

The Baillière’s Dictionary for Midwives (Worvell, 1951) used by Matron Grant exemplifies the context of the times and nurses’ work during this period (see Figure 34). The advertisement is for an ‘infant powder’ for teething.

Figure 34. Medical treatments advertised in 1951

Nursing notes regarding the children were brief and focused on the physical aspects of the child and any treatments given. Example of this are given in Figures 35 and 36.
Figure 35. Nursing notes 1959 (Ngala, 1959b)
During the late 1950s, planning began for a new facility to be built in George Street, Kensington. The promotion and fundraising campaign began for this during 1957–1958 (see Figures 37–41).
A wrongly fed baby is an unhappy one—it could become a sick baby. Very often a mother has considerable trouble finding the correct artificial feeding which suits her baby’s digestive system.

After many sleepless nights—for both baby and parents—the family doctor advises the mother that baby needs dietary adjustment.

At Ngal-a there will be room for more of these babies. In a modern nursery with the latest equipment the specialised staff will adjust the baby’s diet and return it contented to its parents.

Occasionally a baby is abandoned by its parents. Where else could it be taken?

It is not ill so it could not be admitted to a hospital.

It is too young for any of the children’s State Homes.

Until this little citizen’s future is decided it will receive the same loving care as the other babies on these pages.

Ngal-a will continue this community service.
This brochure was promoting both training for the mothercraft nurses and the child health course. Figures 40 and 41 highlight the problem of nurses having to go to the ‘East’ to train for the ‘Infant Health Certificate’. The shortage of nurses is identified and the Medical Officer of the Health Department and the Matron of KEMH discuss the benefits of a WA-based training school.

The name Ngala means ‘mother and child’ or ‘we two’ in the Aboriginal Bibbulmun dialect and was chosen by the Committee at the time ‘to describe the scope of the work of the Home in its new surroundings’ (Lang, 1980, p. 57). In Figure 42, Helen Duncan describes how the name came about in the context of their Committee.

---

Figure 41. Promotional brochure for Ngala 1958 (5) (Ngala, 1958, p. 10)

Figure 42. Excerpt from Oral History of Helen Duncan (Duncan, 1977, p. 18)
The Committee at Ngala sourced information on the attributes the Matron should possess (see Figure 43).

**Figure 43. Excerpt from Minutes of General Meeting—The appointment of the Matron at Ngala (Ngala, 1959a)**

Beryl Grant (see Photo 29) was employed in 1959 and served as Matron for the following 21 years (1959–1980). Prior to coming to Ngala, Beryl Grant had received a Florence Nightingale scholarship in 1956 to study at the College of Nursing Australia for a Diploma in Nursing Administration (Grant, 2009; Oliver, 1978). She was a strong advocate for children and families and a leader in nursing in WA. She went on to undertake a Churchill Fellowship in 1968, received an Order of the British Empire (OBE) in 1976 and the Queen’s Jubilee Medal in 1977 (Lang, 1980; Tanner, 2002).


The minutes of a general meeting of the Committee (see Figure 44) also gave some background on Ngala as being a C-Class Hospital, the decision-making process regarding special case admissions, and fees charged. The discussion about the admission of a ‘mentally retarded child’ is noted because ‘much discussion’ was required by the Committee (Ngala, 1959a).
In 1959, the Nurses Memorial Centre was established for all nurses in WA who had served in war and peace. Beryl Grant and other high profile Matrons in Perth were part of the initiating committee for this cause. This was also the time when Alexandra Home was transferred to new premises and became Ngala Mothercraft Home and Training Centre, undertaking the training and registration of mothercraft nurses and the infant health certificate for general and midwifery nurses (Hobbs, 1980).

The Twelfth Quadrennial Congress of the International Council of Nurses was held in Melbourne 1961. This was a milestone in the history of nursing, and many nurses passed through Perth on their way to the Congress. One of the major curriculum decisions from this Congress was that nurses were to broaden their practice experience to include the obstetric and psychiatric areas of nursing. During the 1960s, the Public Health Department introduced the first paid in-service courses for infant health sisters and school nurses to keep up with the trends in their field of nursing. Up until this time, few nurses married, and if they did, they typically left the nursing profession.

The 1960s also saw the introduction of television; change in the metric system and currency; introduction of the contraceptive pill; the introduction of disposable equipment and a central sterile supply department at major hospitals; the introduction of a manometer and stethoscope for measuring blood pressure; and allied health disciplines. During this time, consideration was also given by the Commissioner of
Public Health to the introduction of health visitors using infant health sisters in implementing this, together with those giving domiciliary care under the Silver Chain service. Nurses were not willing to participate in such an initiative, as it required extra specialised training not available in WA (Hobbs, 1980).

In 1963, the mother of every new baby was visited by the infant health sister in her district as soon as possible after birth, and country mothers were written by the service. A special project operated called the ‘Tea and Sugar Train’. Four times a year, two sisters (and occasionally a medical officer) travelled from Kalgoorlie to Port Augusta and back on the slow goods train that took provisions to people along the trans-continental line. They provided specialist advice and treatment along the way (Department of Health, 1963).

In 1960, Ngala celebrated 70 years of operation. Some promotional material describing the service’s various activities and roles is given in Figures 45–49.

![Figure 45. Ngala Promotion (1) (Ngala, 1960)](image)
Figure 46. Ngala Promotion (2) (Ngala, 1960)

Figure 47. Ngala Promotion (3) (Ngala, 1960)

Figure 48. Ngala Promotion (4) (Ngala, 1960)
The 1961 Annual Report highlighted the artwork in the entrance of Ngala. The word Ngala and its meaning was stated to have been ‘taken from a book in the Parliamentary library, written by a Captain Rey, published in 1840’ (Ngala, 1961). This artwork still hangs in the hall by the CEO’s office (see Photo 30).

Figure 49. Ngala Promotion (5) (Ngala, 1960)

Photo 30. Matron Beryl Grant with artwork at front entrance of Ngala
In the 1961 Annual Report (Ngala, 1961), toddlers were depicted waiting for their food in their chairs (see Photo 31). While this image is not at all ‘home-like’, in the same report, it was stated that:

during its two years of existence, Ngala has endeavoured to preserve as it can, the atmosphere of a ‘home’ and not that of an institution, and with the increase of population, there will always be little children for whom Ngala will be home for months or years. (Ngala, 1961, p. 4).

Photo 31. Toddlers at Ngala in Dining Room (Ngala, 1961)

The Medical Advisory Committee at Ngala oversaw any clinical practice activities occurring at Ngala. Two research projects were reported during 1963. Ngala was part of a wider growth study associated with similar work in Melbourne and Canberra to determine the nutritional requirements and needs for growth in Australian children. They measured the food intake of children and their growth changes. The other project was in conjunction with the Psychology Department of the University of WA. A researcher was undertaking observations of developmental standards in young infants at Ngala. It was found that there was little difference between Ngala babies and babies in domestic homes living with their parents. This was felt to be due to the ‘happy relaxed atmosphere at Ngala and the attitude of nursing staff who try to make up for the personal love and attention which these little children are in danger of missing from being away from their mothers’ (Ngala, 1963, p. 9).

As indicated previously, the major discipline represented in Ngala’s workforce history is nursing. Photo 32 shows registered nurses undertaking lectures at Ngala.
Although the work at Ngala necessitated the knowledge and skills of social work, the earliest recognition of this was in 1953, at which time the need for a social worker was considered by the Committee (Lang, 1980). However, not until 1963 was there a trial placement of a social worker at Ngala (Silver, 1963, p. 5).

I have mentioned the nursing and medical emphasis in a service which seems predominantly social welfare in character. It surprised me greatly when shown the Constitution of Ngal-a, to note that it had a business and medical advisory body but no social welfare advisory service. This would appear to me to be essential to a place like Ngal-a, it seems that to neglect the voice of those most active in the provision of social services in WA., could lead to the development of a one-sided service, particularly when plans for an extension of provisions are contemplated. (Silver, 1963, p. 5)

Silver’s (1963) report also indicated the dominance of a medical model within Ngala’s service delivery and suggested the commencement of a social welfare advisory service. It was also noticed through many of the Ngala documents that informal liaison did occur between nursing and the child welfare department, particularly with their adoption services, support with their pregnant young women and referrals into Ngala. During the trial placement of the social worker in 1963, the
report mentions that if a social worker was to be employed, there would need to be a re-distribution of tasks or roles from the Matron and Deputy Matron:

This does not mean that the services of a social worker are not required, it only means that her field of work is among the unmarried mothers in residence, and there is not enough work in this field at present to warrant the services of a full-time social worker. Duties part-time would be in the case work with the unmarried mothers and their families and any needy private cases of children and their families, plus lectures and liaison with other agencies … If a full-time social worker was appointed … she would need to be given some responsibility for the service provided so that her work would develop automatically rather than for much of it only delegated to her from time to time. This would mean that some of the duties now carried by the Matron and Deputy Matron would be transferred to the Social Worker. (Silver, 1963, p. 3)

In 1967, the Medical Advisory Committee advised and recommended the employment of a social worker (Ngala, 1967) (see Figure 50).

Figure 50. Excerpt from Minutes Medical Advisory Committee 1967 (Ngala, 1967)

However, it was only in the 1980s that the first social worker was employed, followed by the hiring of a small number of social workers during the 1990s for work in a variety of roles and programs.

Medical Practitioners were associated with Ngala from the beginning and came regularly in honorary positions to visit the children and/or mother. The Medical Advisory Committee was established in 1959 and met regularly with a roster system
of visitation. ‘Each specialist took his weekly turn, keeping continuity of service so that the baby always saw the same practitioner’ (Lang, 1980, p. 63; Ngala, 1959a). (see Figure 51 and Photo 33).

Figure 51. Promotional Ngala booklet—Excerpt from The Medical Advisory Committee (Ngala, 1960)

Photo 33. Dr Dugdale, an Honorary Paediatrician (Ngala, 1963)

For nursing in the 1970s, the expanding role of the community nurse was evidenced by the change of name from ‘infant health’ to ‘maternal and child health’. In 1974, the WA School of Nursing was formed next to Royal Perth Hospital. The building
opened in 1975 and the commencement of the first Bachelor of Applied Science (Nursing) at WAIT began in February of that same year (Hobbs, 1980).

Ngala commenced the services of a child care centre in 1971 on the Kensington site (see Figures 52 and 53). These facilities were staffed by mothercraft and student nurses with a sister in charge.

Figure 52. Promotion for opening of Ngala Child Care Centre (1)

Figure 53. Promotion for opening of Child Care Centre (2)
The Child Health Course was six months in 1978. Four months were allocated to practice at Ngala and two months were spent in child health centres. The curriculum for 1978 was separated into seven units combining theory and practice (see Figures 54 and 55).

**Unit 1. Child Health & Development:**

*Introduction:*

- The history, principles and purposes of Child Health and the role of the Nurse in practising Child Health in this Country.
- Pre-natal development.
- The emotional factors associated with pregnancy and childbirth which influence the health and development of the child.
- A knowledge of the normal growth and development of the child from birth to maturity, (to end of adolescence).
- Childhood: the foundation period of good mental health.
- Functional and behavioural deviations from normal and nursing skills required for recognition of these.
- The principles of good nutrition, their application to family living and the psychological importance of food.
- A thorough knowledge of breast-feeding.
- The principles of artificial feeding of infants and young children.
- Dental Health (Oral hygiene.)

**Unit 2. Parent/Child Relationships:**

- The awareness of maternal and paternal attitudes towards pregnancy and childbirth.
- The dynamics of the parent/child relationship including father's role and influence.
- Some factors affecting the parent/child relationship, e.g., race, culture, economics, relatives, physical or mentally handicapped child.
- The changing role of parent/child relationship - e.g., increase in the family, sickness, separation.

**Unit 3. Human Behaviour:**

- Introduction to psychology.
- The nature of human relationships.
- Some theories of personality development.
- An understanding and evaluation of self in helping to promote satisfactory working relationships with families and other health workers.
- The psychological development of the child and the adolescent.
- Theories on learning process of children and the importance of play.

Figure 54. Ngala Child Health Nurse curriculum 1978 (1)
Figures 55. Ngala Child Health Nurse curriculum 1978 (2)

Beryl Grant AO OBE, nurse and magistrate inductee to the Women’s Hall of Fame 2011 (International Women’s Day, 2011), retired in 1980 (see Photo 34), marking the end of an era. Her philosophy of life was: ‘I think life is what you make it. You don’t look back, you look forward’ (Phillips, 2011).
After her retirement from Ngala, Beryl Grant continued to work as a children’s court magistrate, was the WA Uniting Church’s first woman moderator, and chaired a community panel on prostitution. She received the Advance Australia Award 1993 (Phillips, 2011), the Centenary Medal 2000 and the Order of Australia 2001 (Australian Government, 2012; Grant, 2013).


The 1980s was a turbulent period for Ngala. During this decade, societal changes brought new perspectives on residential care, broader definitions of family and less critical views of single parenting, combined with the challenge to the organisation to shift its focus from mothers and children in isolation to the nature and functioning of children in the context of family. Firstly, the Booth Report (Booth, 1980) recommended a new way forward and the introduction of social work services. Secondly, as a not-for-profit organisation experiencing financial difficulties, the Committee undertook a functional review in 1984. Thirdly, the Department for Community Services undertook a significant review during 1985–1986 in which they examined Ngala’s finances and residential services. Finally, the Child Health course was transferred to WAIT, and mothercraft nurse training at Ngala ceased. At a national level, the traditional mothercraft training was also being replaced by TAFE courses that qualified students for a child care certificate. At this time, there was also evidence that employment opportunities for mothercraft nurses were decreasing and
that enrolled nurses were taking their place (Department for Community Services, 1986).

The Booth Report (Booth, 1980) was commissioned in 1980 before the retirement of Beryl Grant. The report described how social work services could assist in supporting the organisation to move forward (see Figure 56).

![Figure 56. Excerpt from Booth Report (1) (Booth, 1980, p. 2)](image)

The report also recommended the reduction in residential care for children. This was seen as no longer being best practice. Instead, a move to family support programs was recommended. Additionally, the report recommended the employment of a nurse educator and a change from a medical advisory to a professional advisory committee that incorporated less medical dominance and included social welfare. Booth also raises the issue of the nursing role being enmeshed with the medical model and communication styles being prescriptive rather than consultative (Booth, 1980) (see Figure 57).
Dr Trevor Parry, Paediatrician, was involved with services at Ngala for many years. For the 1980 Annual Report, Dr Parry contributed the Medical Advisory Committee report, shown in Figure 58. For that year, 409 children had been cared for, with low numbers for adoption. Seventy-nine children were cared for in the mother and baby unit. Dr Parry (Ngala, 1980, p. 8) outlined the reason change needed to occur at Ngala. He described the social dimension of health and the need for a team approach using all disciplines for the current nature and challenges in early parenting work.
Based on the Booth Report, some changes were made, including the employment of a social worker (see Figure 59).
The Functional Review Committee in 1984 questioned the continuation of Ngala as a private hospital with the associated high staffing costs. This finding was also supported by the Department for Community Services (DCS) Review in 1986 (Department for Community Services, 1986).\textsuperscript{22} The DCS Report shown in Figure 60 highlighted the role of the child health nurse and saw this as an important component of services at Ngala.

\textsuperscript{22} Ngala retains Private Hospital status to the present day.
At Ngala, much unrest coincided with and followed the Review process in 1986 as an implementation committee worked to apply the recommendations of the report. There was also unrest in the community and considerable lobbying with Members of Parliament. Questions were even asked in Parliament (see Figure 61). The Review was co-occurring with the transfer of Child Health nursing training to the tertiary sector and the cessation of mothercraft nurse training at Ngala.
Figure 61. Parliamentary papers—Questions without notice, July 1986

As shown in Figure 62, the DCS Report (Department for Community Services, 1986) also reinforced the importance of Ngala’s child health role, but recommended the closure of the residential unit and a shift to a community-based model of care.
The implementation committee recruited a new Executive Director of Services to take the organisation forward.


Mrs Rae Walter commenced as Executive Director with a Board of Management, and the name of the service was once again changed to reflect its new focus, becoming the Ngala Family Resource Centre. Rae Walter had a Bachelor of Economics. Her appointment represented a significant change for Ngala towards creating a business model of operation.
Figure 63. The DCS Review presented a different model for considering the flow of children and families

‘The road was very difficult in the first few years as there was no direction—the organisation was stuck in a time-warp’ (Walter, 2013). The DCS Review offered another perspective on the future of the service. For example, the Report presented a model on the flow of families and children (see Figure 63). The focus when Mrs Walter commenced was to overcome the ‘institution feel of the organisation’ and to begin to shape a family- and child-focused, multidisciplinary organisation (Walter, 2013). Nurses working during this time were from the era of the ‘old’ Ngala, ‘some looked on Ngala as their home’. They had also looked after many children and taken
them home during this time, so things were becoming very different (Walter, 2013). Walter (2013) stated:

one of the things nurses found difficult if they had been working in the children’s unit, was they had to learn how to relate to parents … they hadn’t worked with parents, only worked with children, so it was the children in isolation. (Walter, 2013, p. 5)

During this time, the training for the mothercraft nursing certificate ceased (see Figure 64) and a new Board of Management (see Photo 35) was formed, creating more uncertainty for Ngala.

Figure 64. The cessation of mothercraft nursing (Pringle, 1989)
Rae Walter was a visionary. An example of her thinking is given in Figure 65, from 1992–1993, wherein she sketched her thoughts on the future of the organisation conceptually. She completed a Churchill Fellowship in 1993.

Part of the change occurring for Ngala (from the culture of an institution) came with the demolition of the old building and its replacement with a family-friendly complex in 1995. Throughout the 1990s, there were many quality reviews that kept the organisation moving forward while trying to keep the focus on the reason for
Ngala’s existence. Rae Walter was interested in asking questions about the quality of practice and impact on families. Nurses found it difficult during this decade because the effect of nursing having moved into the tertiary sector had yet to take effect at Ngala, as there was no critical mass of nurses with degrees to make changes (Walter, 2013).

Nurses went on strike in 1997 (see Figure 66) to increase their pay and conditions. As a result, the first Enterprise Bargaining Agreement (EBA) was signed. This proved to be an opportunity for growth and development of the nurses over time and ensured efficiencies in practice (Ngala, 1997). From this time to the present, the ongoing EBA negotiation processes have run very smoothly.

Figure 66. Ngala nurses on strike, ANF Newsletter, 1997
The organisation began reaching out into the community with various programs to support and educate families with young children. Parent and professional education programs were also scheduled (Ngala, 2000a, 2002), and community development programs were initiated to expand the outreach of the organisation (Walter & Dawson, 2001). The development of systems was a priority, and was an ongoing challenge due to resources.

3.14.5.1 Fatherhood work and inclusive practice

Towards the end of the 1990s, a male child health nurse was employed in management, and the introduction of a new program focusing on fathers commenced with the employment of fatherhood workers to run a service called HeyDadWA. This began the challenge of changing the culture of the service to include fathers in programs in a primarily women-only workplace. Donald and Webster (2000, p. 5) stated in a conference paper that:

it was just over two years ago that Ngala appointed the first male clinical staff member. I am the first male child health nurse to be appointed in 108 years—a significant milestone. … a male GP, a coordinator, another CHN, a social worker and two male social work students. All occurring over two years. (p. 5)

Donald and Webster (2000) argued that this change in staff increased the involvement of fathers at Ngala.

3.14.5.2 Review of Services 2000

The focus on being in the new millennium in 2000 was a timely opportunity for Ngala to commence a quality review of how its residential and more intensive services were operating together. The focus was on interdisciplinary and family-focused change and continuity of care (Ngala, 2000b) (see Figure 67). Some of the changes being planned were a one care plan for use by all disciplines, joint meetings, shared leadership and joint training. The evidence used at the time was Documenting the Nursing Process (Hacker Chana, 1992) and The Patient-driven Interdisciplinary Care Plan (Gage, 1994).
3.14.5.3 Perinatal Mental Health and Infant Mental Health

These changes led to more challenges for nurses, with extra training required by the development of perinatal mental health services and a partnership with psychiatry at the KEMH. Regarding Ngala’s research involvement during this period, for over a decade ongoing work was conducted in partnership with Curtin School of Psychology on education and research around infant mental health and parent/child attachment. A therapeutic group work program was commenced towards the end of the 2000s, involving a series of nine groups to increase attachment between mother and child using videos on play scenarios (see Figure 68). Dr Lynn Priddis was the expert behind this project, and she provided a screening tool to enable practitioners...
to identify issues in parent–child attachment (Priddis & Wells, 2010a, 2010b; Priddis, Wells, Dores, Booker, & Howieson, 2008).

Figure 66. Tuned in Parenting poster presentation, 2008

3.14.5.4 Partnership approaches

The most substantial change experienced by nurses in the 2000s was the move away from the ‘expert approach’ by nurses to partnership approaches with families and the introduction of ‘C-Frame’. Ngala was involved in the national project partnership of
C-Frame’s development with the Victorian Parenting Research Centre (Victorian Parenting Centre, 2005) and three other national parenting centre sites. Following this, nurses undertook intensive training in moving to partnership approaches. This has been an ongoing journey:

The impact of this then for the nurses was how do we work with each other, and the challenges of that rub together, as well as it gave a common language. It also gave the organisation more of a culture of moving towards a problem-solving approach. (Walter, 2013)

Reflective practice was a crucial strategy incorporated into C-Frame.

Other collaborative partnerships began with universities during 2005. Two research studies were commenced. Firstly, a partnership study with Murdoch University and other agencies examined the issues faced by families involved in fly-in-fly-out employment and provided advice from the sample of families and from associated agencies as to the best way to manage those issues (Gallegos, 2005). The other research project was a Delphi study (Hauck, et al., 2007) undertaken by Curtin University School of Nursing, which examined the research priorities of clinical staff working at Ngala. The study identified seven main areas that Ngala practitioners perceived to be relevant research areas.

The Danae Corser Award had also been initiated a few years before. This supported a successful staff member to attend a conference or relevant professional development (Ngala, 2005). This is still operating to the present day.

3.14.5.5 Organisation Review 2005

In 2005, the Board initiated a major review (Cressida Consulting, 2005) of the structure and governance of Ngala, resulting in two new positions to commence in 2006 to look at specific recommendations and growth for the organisation. These were a Director for Corporate Services, to increase the capacity of support services to respond to service delivery, and a Director of Services (Elaine Bennett, the researcher).

Since this time, the organisation has grown considerably in size, and during 2008, Ngala divided into three companies to represent this growth and change, and for tax
purposes. The key changes for the organisation since 2006 are outlined in the following sections.

3.14.5.6 Documentation of Evidence-Base

The development of a service delivery model document (see Figure 69) was collated in consultation with staff to assist employees to understand the context of the organisation, the evidence for the work and the frameworks to guide practice (Ngala, 2012b). ‘[T]his was a significant milestone as it validated practice and service delivery’ (Walter, 2013).

![Service Delivery Model](image)

**Figure 69. Ngala’s Service Delivery Model 2012 (revised version)**

3.14.5.7 Professional Development and Reflective Practice

There was a new focus on staff development and the encouragement of a dynamic learning environment to assist the development of practice to align with the frameworks and models of care.

3.14.5.8 A Research and Development Unit

A research and development unit was established to assist working across the organisation to develop consistency of practice, collaboration and integration internally and practice development projects.
3.14.5.9 A Research Agenda

A research agenda was developed with key research partners and universities. An article was published on the action learning project in developing the interdisciplinary research framework (see Figure 70).

The process of writing up a framework for interdisciplinary research and practice was a very productive partnership between four professional disciplines—practitioners and researchers:

1. Nursing and Midwifery
2. Early Childhood
3. Psychology

Figure 70. Ngala research agenda—Article (Bennett, Hauck, Bindahneem, et al., 2012) and poster
What evolved from the project above was the development of unity and a common language when discussing early childhood and parenting work. It brought together the theories and approaches that informed nursing and midwifery, social work, psychology and early childhood education and assisted to prioritise research themes important in guiding the research plan.

3.14.5.10 Expansion of scope and programs

Many community programs were developed, including parenting support in Bandyup women’s prison, Aboriginal parenting support programs, early literacy programs to facilitate transition of disadvantaged children into school, psychosocial support for parents with children with a developmental delay and peer support programs for parents with a child with a disability. Ngala’s community services have also developed a strong community development focus, supported by many Commonwealth-funded programs.

Online technology services and resources for parents have also been created (see Figure 71). These include resources on sleep and nutrition, breastfeeding, the importance of fathers, and brain development for the early years. A separate website, ‘My Ngala’, was developed as a parent forum. Additionally, a ‘Healthy You, Healthy Baby’ mobile application for pregnant women was developed in conjunction with Edith Cowan University. Ngala also has a facebook page and is on Twitter.
3.14.5.11 Interdisciplinary team work

As mentioned earlier, during the 1990s, Ngala widened its range of disciplines to include social workers. Slowly, professionals from other disciplines were also employed. Early childhood educators were employed in services other than child care. Psychology was introduced in the 2000s, with the commencement of perinatal mental health work. Other professionals were employed such as Aboriginal support workers, health promotion staff and community psychology and occupational therapy workers. The introduction of C-Frame, strengths-based and solution-focused practice also enabled a smoother transition to interdisciplinary work.

As the service delivery model was first documented in 2010, it was reinforced that effective interdisciplinary environments were dependent on the team functioning as a cohesive group. It was thus expected that staff share a common philosophy of practice, recognise and freely exchange knowledge and skills, and work effectively together for the achievement of a set of common goals. It was noted that for an effective interdisciplinary team to develop, it is necessary for individuals to understand each others’ professional frames of reference. They need to be able to define for each other their specific expertise and the usefulness of this in the assessment and delivery of programs to parents and families. Roles and responsibilities can be accorded to team members on the basis of this understanding (Ngala, 2012b).

Increasing amounts of literature are becoming available on interdisciplinary education and practice. The World Health Organisation (WHO) (2010a) provided a
framework for innovative strategies that assisted policy and programs increase the global health workforce. The WHO emphasised the benefits of IPE and collaborative practice as strengthening service delivery systems and improving health and wellbeing outcomes for families and children. McWilliam (2000) recommended four principles to underpin practices in interdisciplinary services:

- collective responsibility—meaning that teamwork is needed;
- a trans-disciplinary approach—whereby team members exchange competencies between themselves;
- functionality—meaning that practice and intervention is based on the needs of service users rather than on those of the professionals; and
- practicality for service users—meaning that interdisciplinary services and strategies should be useful and relevant for service users and simple to implement.

A considerable body of evidence supports the way in which professionals relate to and support families, and this evidence can influence families’ sense of control over their life circumstances. Dunst and Dempsey (2007) discuss that relational helping includes practices typically associated with good clinical practice (for example, active listening, compassion, empathy and respect) and help-giver positive beliefs about family member strengths and capabilities. Straka and Bricker (1996) identify key principles of effective collaboration for early intervention teams:

- having a common goal of purpose;
- involving caregivers;
- developing joint outcomes from assessment;
- coordinating intervention and evaluation activities; and
- evaluating team functioning.

The purpose of Ngala in developing an interdisciplinary research and practice framework was to guide the service’s future research activity, to assist with identifying and developing priorities and to build a stronger and more coherent connection between current research and evidence and the practice that takes place within the organisation (Ngala, 2010b). Collaboration in research activity enabled a common understanding of what each discipline contributes, and considered:
o power and organisational culture;
o theories and concepts across disciplines;
o linkages between different forms of knowledge;
o ethical issues and processes;
o the creation of an environment enabling collaboration between researchers and practitioners (Dagenais, Ridde, Laurendeau, & Souffez, 2009).

Ngala (2010, p. 5) explained interdisciplinary team practice within their framework as:

a partnership between a team of professionals and a client in a participatory, collaborative and coordinated approach to shared decision-making around health (and wellbeing) issues. (Orchard, Curran, & Kabene, 2005b)

Strengthening organisations to implement evidence-based practice is enhanced through the presence of three interacting components: active leadership and commitment to quality, robust clinical process redesign incorporating evidence-based practice into routine operations, and the use of management structures and processes to support and align redesign (VanDeusen et al., 2010).

3.14.5.12 Celebration of 120 years

In 2010, Ngala celebrated 120 years of operation. Figure 72 is a poster presentation reflecting Ngala’s many years of history and the milestones along the way.
Figure 72. Ngala Celebrates 120 years
3.14.5.13 Ngala in Western Australia

Ngala has physical bases in Perth and outreaches to all parts of WA (see Figures 73 and 74). The main focus has been on the Pilbara, Wheatbelt, Kimberley and parts of the south west. Outreach is subject to funding.

Figure 73. Ngala rural and remote services in WA
Ngala has sites and/or a focus on service delivery in 12 areas of Perth (see Figure 74). Perth has now approximately two million people, and the 0–4 age population rate is growing. The population of WA has increased by 14.3 per cent since 2006 (Australian Bureau of Statistics, 2011).

Figure 74. Ngala services in metropolitan Perth
3.14.5.14 Finally

Photo 36 ends this section by showing the connection between the researcher and the two key influential women leaders in the history of Ngala. Beryl Grant continues to undertake volunteer work in aged care and is a member of the ‘Friends of Ngala’. Rae Walter retired in 2011.

Photo 36. Photo Rae Walter, Elaine Bennett and Beryl Grant, 2011

3.15 National Early Parenting Services: Current Context

This chapter so far has focused on the literature providing the historical context for EPS internationally and in each State of Australia. In addition, an in-depth overview of the history of nursing at Ngala was presented to the current day. This section now gives a brief overview of the current range of national services and the diversity of service contexts and State governance arrangements in EPS in Australia. All services are member organisations to the AAPCH and have collaborated on a number of projects over time. They are all committed to providing centres of excellence in early parenting work and all of their websites demonstrate an ongoing striving towards generating new evidence and evaluation of services.

3.15.1 NSW—Tresillian Family Care Centres, www.tresillian.net

Tresillian Family Care Centres is a third-schedule public hospital, providing specialised child and family health services. Tresillian’s role is:
• To work towards the promotion of Tresillian as a centre of excellence in child (0–5 years) and family health.
• To provide holistic family care within a primary health care framework through a range of services responsive to community needs. Primary health care includes specialised nursing care, medical support, psychosocial interventions, family advocacy, health promotion and clinical assessment of the growth and development of infants and young children.
• To provide child and family health education and associated resources in child and family health to health professionals and the community.
• To develop Tresillian’s advocacy and research role (Partridge, 2012).

Tresillian’s range of services incorporates:

• Primary services (universal support)—Tresillian Live Advice, Parents’ Help Line and group programs;
• Secondary services (prevention and early intervention)—Outreach and day stay services and education services;
• Tertiary services (complex needs)—Residential services and the Home Visiting Early Intervention Program (Tresillian, 2012).

Tresillian has also joined with the University of Technology Sydney to offer the Graduate Certificate for Child and Family Health Nursing. This allows the course to have a strong clinical focus, enhanced by a rigorous theoretical component. Health professional programs are also offered, including Keys to Care Giving, Family Partnership, tele-health and perinatal mental health.

Tresillian is actively engaged in research. The focus of Tresillian’s research activities include developing new knowledge about child and family health, service evaluation and turning evidence into practice (Partridge, 2012).

3.15.2 NSW—Karitane, www.karitane.com.au

Karitane celebrated 90 years of history in 2013. Karitane is a not-for-profit early parenting organisation providing the traditional services such as a helpline, residential and day stay services. They have a perinatal mental health unit that operates using a day stay model; and a focus on individual, family counselling and
therapeutic group work through to earlier intervention support for anxiety and stressful parenting matters. They also provide a range of community services and volunteer programs and a toddler clinic for young children experiencing behavioural issues with the aim to strengthen the parent–child relationship (Karitane, 2012).

Karitane have joined with the University of Western Sydney to offer the UWS Master of Nursing (Child and Family Health Karitane). They have a range of education services for volunteers and professionals in rural and remote areas and a clinical supervision program. They also offer an Advanced Diploma in Nursing for Enrolled Nurses (Karitane, 2012).

Karitane is actively engaged in research and the focus of their research activities include developing new knowledge about child and family health and perinatal mental health issues.

3.1.5.3 QLD—Ellen Barron Family Centre, www.health.qld.gov.au/rch

The Ellen Barron Family Centre is a residential State Government facility providing services for early parenting support through parenting education programs. Areas of education and support may include postnatal difficulties, breastfeeding and infant feeding management, child growth and development, behaviour management and parenting issues (Ellen Barron Family Centre, 2013). The Centre provides a service for well families with children aged birth to three years engaged with a primary carer or agency (Ellen Barron Family Centre, 2013).

The Ellen Barron Family Centre specialises in providing child and family health information, education, strategies and support in a multidisciplinary environment, with discharge planning aimed at linking families back into local resources within their own community (Berry, 2012b). The Centre has state-wide responsibilities and as such conducts training, professional development and support for child health services across Queensland. State-wide video sessions are offered to support child health staff in rural and remote areas of Queensland. The Centre also hosts a number of undergraduate and postgraduate students, including from the medical, nursing and allied health disciplines. The Centre works in collaboration with community-based child health services to offer training positions for registered nurses (Ellen Barron Family Centre, 2013).
3.15.4 ACT—Queen Elizabeth II Family Centre, Canberra www.cmsinc.org.au

The QEII Family Centre, which was not involved in this study, is the tertiary service of ACT Health’s primary health service, the Child Youth and Women’s Health Program. This is a residential centre that operates as a support and referral centre for community-based primary health services, providing day stay, sleep group and lactation clinic. Families are identified as high risk or as families needing additional parenting support after treatment for acute health issues. Cases might include infants and families experiencing complex health and behavioural problems including unsettled babies and children with disordered sleeping patterns, complex lactation and other feeding problems, at risk families, special needs families, mood disorders or failure to thrive. The service also provides parenting support and education.

The QEII Family Centre’s model of care is based upon the principles and practices of primary health care, health promotion and the social indicators of health. The platform for delivery of care is C-Frame. C-Frame complements the primary health care model and affords health providers the tools and strategies to work in partnership to achieve positive outcomes for families. The Centre is staffed with specialist child and family health nurses and midwives, as well as a counsellor, community development officer and medical officer. They also refer to other members of the interdisciplinary team whenever necessary (Canberra Mothercraft Society Inc., 2012).

3.15.5 Victoria—Mercy O’Connell Family Centre, www.mercy.com.au

Mercy Health O’Connell Family Centre is a registered public hospital and one of three early parenting centres in Victoria. Services support the whole family and can enhance parents’ confidence in parenting newborn babies and children up to the age of four. This service provides residential and day stay services through key outreach points. Parenting education sessions are provided to a range of target audiences and information, education and training is made available for health professionals and members of the community. Placements through universities are available for students undertaking Maternal and Child Health and Early Childhood studies (Mercy Health Care, 2010).
3.15.6 Victoria—Tweddle, www.tweddle.org.au

Tweddle is a registered public hospital and offers a range of evidence-based, accredited programs and services that aim to strengthen the family unit and build parenting skills and confidence. The residential and day stay programs (with outreach sites) support parents with guidance and problem-solving skills from experienced health professionals. Nursing and allied health professional services and community programs provide support in adjustment to parenting and in coping with many of life’s other challenges. Tweddle provides a preparation for childbirth and parenting program, and MyTime is a program for parents of children with a disability or chronic illness. Breastfeeding support in some regions of Melbourne’s west is provided. Tweddle works with a number of universities and social and welfare organisations to ensure they continue to innovate and deliver programs and services to those most in need (Tweddle Child & Family Health Service, 2012).

3.15.7 Victoria—Queen Elizabeth Centre, www.qec.org.au

The Queen Elizabeth Centre (QEC) is a registered public hospital with a mission to offer specialised support, care and education to families who have children up to three years of age, with the aim of enhancing the health and development of the family. They provide a range of EPS such as residential, day stay and home-based services, education and training for professionals involved with young children and their families including maternal and child health nurses, childcare or family support workers, general practitioners, psychologists and social workers. They offer professional education seminars and parenting skill development services. The QEC also works with universities, government and non-government organisations to ensure continuation of innovation and service delivery focus on those most in need (Queen Elizabeth Centre, 2012).

3.15.8 Tasmania—Three Parenting Centres, www.dhhs.tas.gov.au

The three parenting centres in Tasmania operate within the government provided universal child health system, the Child Health and Parenting Service (CHAPS). They offer intensive support for families experiencing difficulties with children 0 to 5 years of age through day stay services and a home visit program for adolescent parents (South) in the antenatal period and up to two years. Consultations and group
programs are available with social workers, psychologists and child and family health nurses (South only). Parenting centres provide intensive support for a range of parenting issues including postnatal depression, breastfeeding and relationship concerns that relate to early childhood (0–5 years).

3.15.9 South Australia—Torrens House, www.cyh.com

Torrens House is part of the Child and Family Health Service and operates within the government provided child health system. It is a service for parents and babies up to 12 months old. Torrens House is a residential facility with staff that assist with unresolved feeding, settling and sleeping issues by providing intensive support to address identified health issues. Located in Adelaide, Torrens House offers a three and a half day ‘live-in’ stay Tuesday to Friday for nine families each week. Day stay, helpline and other community-based and home visit programs are offered within larger centres of the Child and Family Health Service.

3.16 Chapter Three Summary

EPS have been in existence for most of the last century, if not longer. Throughout this time, nursing has been the major discipline of EPS, although the past two decades have seen the slow introduction of many more disciplines to complement the work of early parenting. A range of factors are influencing national directions, such as family needs in presenting to services, the impact of government policy, the professional skill mix to meet the needs of today’s families, and predictions of future nursing shortages and population growth in Australia, particularly in WA.

This chapter presented the historical background of EPS internationally and in Australia. It discussed the development of scientific motherhood, the European and NZ experience, and how the child welfare movement developed in Australia. This movement impacted simultaneously on the development of the universal child health system and the development of mothercraft homes in each State of Australia. The history of EPS in each State was briefly reviewed, followed by an in-depth description of the history of Ngala. Finally, the current situation of EPS in each State was discussed.

The following chapter now presents an analysis of the data for this study.
Chapter 4: Findings

4.1 Introduction

This study has sought to explore the past, present and future of nursing in EPS in Australia. EPS are currently a niche market of specialist nursing services, which include smaller numbers of allied disciplines. Chapter Three described how nursing has evolved through the history of EPS in Australia. This chapter will describe the current nursing role within the context of an interdisciplinary team using the findings of the three-phase study; and will focus on the future of nursing to give a framework and recommendations. The findings, with specific reference to the research questions, will be presented in three sections using the phases of the study.

The six key research questions for the study were:

1. How has nursing evolved within EPS at Ngala?
2. How do nurses perceive their role within the context of an interdisciplinary team?
3. How do allied professionals perceive the nursing role within the context of an interdisciplinary team?
4. How has nursing evolved within EPS in Australia since the inception of services?
5. What is the present situation of nursing in the context of EPS nationally?
6. What are the future changes required in EPS as perceived by nurses nationally?

This chapter will provide a description of participant demographics and the findings from the qualitative and quantitative data analysis during the three phases of the study. Nurses were the main participants in this study, with allied professionals participating in focus groups and interviews during phase one. It was decided not to include allied disciplines in the subsequent phases due to the variety of different contexts and often small numbers of allied disciplines working in EPS. There were a range of data sources based on the combination of methods utilised in this research, including:
Phase 1—document analysis of Ngala’s historical documents and recent service documents; focus groups and interviews with nurses and allied professionals; nurses’ written journals. This phase addressed research questions 1, 2, 3, 5 and 6.

Phase 2—document analysis of national historical documents for sites and recent service descriptions; teleconferences with sites, which included two group questionnaires for participants. This phase built on research questions 1, 2, 5 and 6 and addressed question 4.

Phase 3—an online survey and demographic information from sites; relevant literature sourced to provide context to the data. This phase built on all questions except question 3.

The researchers field notes added to the stated sources of data above.

To promote explanation and understanding, the chapter will now be organised into sections according to the three phases. For each phase, the demographics of the participants and the findings will be presented.

4.2 Phase One: Ngala

4.2.1 Introduction

This phase was an in-depth analysis of Ngala as an organisation, looking at the past, present and future for nursing at Ngala. In Section 4.2.2, the demographics of the participants are presented to give context to the findings, which are presented in Section 4.2.3.

4.2.2 Demographics

During phase one, the participants involved were nurses and allied professionals, with data collected through focus groups and interviews. In addition, other nurses who had worked at Ngala in the past, the previous Matron for the period 1959–1980 and the CEO for 1988–2011 were interviewed. Table 3 is the number of participants during phase one.
Nurses at Ngala are an ageing workforce, with an average age of 51 years. Sixty-seven per cent of nurses are 50–70 years of age, and many have worked at Ngala for a number of years. The age breakdown is displayed in Table 4. Most nurses work in close proximity to other professionals at Ngala within an interdisciplinary context. The organisation has been moving from a mono-discipline approach during the 1990s, to a more intentional effort to include other disciplines since the mid-2000s. This is a direct result of the evidence from research, and the ability of allied professionals to add value to nursing and medical services with the aim to provide holistic care for families and children in the early years.

Table 4. Current demographics of the nursing workforce at Ngala (as at Oct 2012)

<table>
<thead>
<tr>
<th>Age category</th>
<th>No. of nurses</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>20–29</td>
<td>1</td>
<td>2.0</td>
</tr>
<tr>
<td>30–39</td>
<td>5</td>
<td>9.0</td>
</tr>
<tr>
<td>40–49</td>
<td>12</td>
<td>22.0</td>
</tr>
<tr>
<td>50–59</td>
<td>24</td>
<td>44.5</td>
</tr>
<tr>
<td>60–64</td>
<td>10</td>
<td>18.5</td>
</tr>
<tr>
<td>65–70</td>
<td>2</td>
<td>4.0</td>
</tr>
<tr>
<td>Total</td>
<td>54</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The 10 allied professionals participating in the study were from social work, psychology, early childhood education and community development backgrounds. There were two males present in this cohort. The allied professional workforce at Ngala consists of a range of disciplines as per Table 5, making the clinical workforce equally divided between allied professionals and nurses.
Table 5. Current demographics of the allied professional workforce at Ngala

<table>
<thead>
<tr>
<th>Discipline</th>
<th>No. professions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social work</td>
<td>16</td>
</tr>
<tr>
<td>Psychology</td>
<td>7</td>
</tr>
<tr>
<td>Occupational therapy</td>
<td>2</td>
</tr>
<tr>
<td>General Practitioners</td>
<td>2</td>
</tr>
<tr>
<td>Early Childhood Education</td>
<td>16</td>
</tr>
<tr>
<td>Community Development</td>
<td>5</td>
</tr>
<tr>
<td>Nutrition</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>49</td>
</tr>
</tbody>
</table>

Note: Clinical staff working with nurses includes the leadership group and excludes early childhood centres and home tutors (as at October 2012).

The researcher also interviewed four nurses who had previously worked at Ngala during the 1970s and 1980s. The two past leaders at Ngala were interviewed because they were ‘matriarchs’ of the organisation, having each spent over 20 years in their key roles.

4.2.3 Findings of Phase One

4.2.3.1 Findings from document analysis

4.2.3.1.1 The evolution of nursing within Ngala

As described in Chapter Three, Ngala is one of the oldest charities in WA. Ngala has a continuous history, commencing as the House of Mercy in 1890. Alexandra Home for Women commenced in 1916 with the name changed to Ngala in 1959. A summary of the key periods in the history of Ngala are given below. These periods are discussed in greater detail in Section 3.15.

1. The House of Mercy 1890–1916

The House of Mercy was established at a time of change in WA history, with the 1890s Gold Rush creating increased immigration and a rise in infectious disease, for which the State was unprepared (Hobbs, 1980).

A Matron was engaged to run the Home, but she was not a certified midwife, so a doctor was called in for births (Jull; Lang, 1980). Only much later were midwives called in to assist. Young women were admitted during their confinement, up to the child being 6–9 months if required (Lang, 1980). The first note of a ‘probationer nurse’ being employed was in 1907 (Mattinson, 1970).
An infants’ home in connection with the House of Mercy was opened in 1904. It employed nursing staff for the purpose of caring for the children. Volunteer women assisted with the running of the home (Lukin, 1905).

Planning had been occurring for the establishment of a maternity hospital in 1909 by key community members in Perth, including the Matron of the House of Mercy (Hobbs, 1980, p. 17). The Commonwealth introduced the Maternity Bonus in 1913, which gave young women more choice in where they stayed for their confinement. As a result, the numbers at the House of Mercy increased (Lang, 1980).

The transition of name change from the House of Mercy to the Alexandra Home for Women came at the same time as the opening of the King Edward Memorial Hospital. An interchange soon developed between the two facilities for the girls during their confinement and then birth of their babies (Lang, 1980).


Nursing during this era was becoming more of a profession, with advocacy at higher levels of nursing. The training of nurses became more regular and regulation was introduced for registration and training of nurses and midwives. The First World War and Depression and then the Second World War were features during this period, as was the escalation of the infant welfare movement. Infant health centres were established from 1922 to assist in the movement to reduce morbidity and mortality and to teach mothers health and hygiene and promote breastfeeding (Hobbs, 1980). There was also a move in improved nursing pay and conditions over time (Hobbs, 1980), although as a result of the recent war, the influence of the army style training was still felt by nurses (Piercey, 2006). The 1960s saw the move to a new curriculum for nursing.

In 1949, extensions to Alexandra Home had been built and training for mothercraft nurses had commenced. Fifteen trainees were in residence for 15 months (Lang, 1980). It was noted in the early 1950s that ‘the need for a social worker occupied the thoughts of the Committee’ and the Committee approached the child welfare department for advice on ‘how to help unmarried mothers to rehabilitate themselves’ (Lang, 1980, p. 54). From the 1890s to 1951, medical input from doctors had mostly been on a voluntary basis, and they incorporated visiting Ngala as an interest in their
professional work. However, in 1951 the Commissioner for Public Health instigated a honorarium of 100 pounds per year to look after the babies and this was advertised in the BMA magazine (Lang, 1980, p. 54).

Due to the inadequacy of the Alexandra Home facility in Lincoln Street in 1955, a vision for a new building was developed with a State Lotteries Grant, and further fundraising ensued. The concern at the time was to establish a training course for infant welfare sisters instead of them having to leave the State for training (Ngala, 1955).


This period, 1959–1980 (21 years), was marked by the leadership of Matron Miss Beryl Grant OBE.

The new building was launched in 1959 at Kensington. The oversight of the health of children was by the Medical Advisory Committee, who met regularly and commenced a roster for a medical specialist visit. The facility continued with accommodation for pregnant young women and out-of-home care for children up to five years of age. Preparation for parenting was given by nurses to families adopting children from Ngala. The care of mothers and children undergoing stressful parenting difficulties was maintained in a residential mother and baby unit. Child care was commenced at Ngala in 1971 with the intent to provide accessible day care for ‘children of parents forced to work—deserted wives, single mothers and people in financial difficulty’. It was also another venue for the training of mothercraft nurses (Lang, 1980, p. 78). The training of mothercraft nurses continued and a post-certificate in infant health nursing commenced, with these being registered with the WA Nurses Board (Hobbs, 1980).

The years from 1949 to 1959 marked the attainment of unity within nursing, adjustment to changes in the pattern of nursing care and nursing education, and the formation of the College of Nursing Australia in 1951 (Hobbs, 1980). During the 1950s and 1960s, there was a considerable increase in the population and a drop in mortality rates. This rapid growth also generated economic development and growth in health facilities (Piercey, 2006). During this period, nursing training still replicated an army style of education and there was a shortage of nurses generally. The
movement during the 1960s was to build a new curriculum for nurses that was more relevant to the time (Piercey, 2006).

During the 1960s, the Public Health Department introduced the first paid in-service courses for infant health sisters and school nurses to keep up with the trends in their field of nursing. In 1963, the mother of every new baby was visited by the infant health sister in her district as soon as possible after birth and country mothers were written by the service (Hobbs, 1980). The 1960s and 1970s were years of considerable planning and negotiation in WA to change the face of nursing education and introduce a nursing degree in a higher education institution, which occurred in 1975 (Piercey, 2006).

A summary of key categories of the nursing role was developed through choosing documents that related to the nursing role and activities, through nurses’ descriptions of their work and interviews with nurses. Key themes were extrapolated from the documents for the period of the 1940s to 1980s. These are presented visually in Figure 75 and described below.

![Figure 75. Nursing role 1940s to 1980s at Ngala](image-url)
Nurse as ‘substitute mother’

Nurses undertook all activities that were related to the daily chores of looking after children. ‘We did things that anybody else would do with their children’ (Ellis, 1995, p. 9).

Routines for children had to be established such as feeding, bathing, dressing, sleeping, walking, playing, cooking, preparing food, checking or supervising, toileting, cleaning, settling of children and making up of milk feeds.

Caring for sick child/mother

Caring for un-well children or mothers was a part of life at Ngala. There were many infections such as tuberculosis, gastro-enteritis, scabies, chicken pox and measles. The mothers could have been recovering from an illness or surgery, multiple births or have a disability like multiple sclerosis (Ellis, 1995, p. 11).

Coordination of care

This role included all activities to do with the care of the children or pregnant young women or parents, and care of the staff and facilities. It involved case coordination with doctors, professionals and agencies and coordination and supervision of support staff, mothercraft and student child health nurses (Ellis, 1995; Meerwald, 1995).

Nurses would often liaise or refer to police and other community agencies such as Parkerville, Community Welfare, child care, kindergarten, hospitals, solicitors, KEMH, doctors’ clinics and general practitioners.

Health assessment

Nurses provided general health and wellbeing assessments. They ensured that the children’s immunisations were up-to-date and arranged appointments such as dental care (Ellis, 1995; Meerwald, 1995).

Nurses provided advice on parenting issues, child care and behaviour and a 24 hr phone service ‘after hours for the child health service or from previous parents who had been admitted’ (Meerwald, 1995, p. 43).
Caring for disability/special needs

Prior to 1959, children with special needs were often hidden away and not integrated with the other children. There were ‘mentally retarded children’ or others that were ‘not quite normal’ (Meerwald, 1995, pp. 7,12,24).

The autistic children were definitely the difficult ones to know how to handle. … it takes a lot of patience … we had to be firm but calm all the time and to protect the child from itself and to protect the other children from it. (Meerwald, 1995, p. 55)

We had a lot of aboriginal children in. We used to get them from PMH and they’d recuperate before they went back to their families up North. (Meerwald, 1995, p. 59)

Doing mothercraft

Nurses supervised women with mothercraft knowledge and skills and the supervision of mothercraft nurses. There was mothercraft for women fostering or adopting babies and for pregnant young women, supervised antenatal visits and appointments, hobbies, activities and homework (Ellis, 1995; Meerwald, 1995).

Protecting children and advocacy

Care for children traumatised through separation, accidents, neglect and family violence was also undertaken at the Home:

With neglect … you’d have a doctor … a paediatrician coming several times and if asked … they had to be assessed by a doctor first and you’d have to … when you sort of undressed the child you’d notice the things it had on, clean or dirty, if they had bruises, burns, bites or anything like that. (Meerwald, 1995, p. 44)

Advocacy for children. … when parent would come back to pick up their child. … it would be ‘pointed out to them the safety, the traumas for the child and the things that could happen to children in the home and had they thought about it?’ (Meerwald, 1995, p. 43)
Giving psychosocial support

The nurses would visit the young women in hospital and provide support, as they were often away from their families. They provided social support for the family, as some children had parents in gaol, broken marriages, deaths, abandonment of children and neglect (Meerwald, 1995, p. 42).

Training and supervision

A large part of the registered nurse’s role was to teach and to oversee all the activities related to the care of children.

An interview with Beryl Grant (Grant, 2013) validated the above description of the nursing role during this time. She reiterated the importance of nursing education and the professionalisation of nursing and was a strong advocate to the move to tertiary education. She stated that the nursing roles are exemplified by three key elements; that is, caring, education and a holistic approach to working with families (Grant, 2013).

As noted previously, the 1970s were a decade of considerable planning and change for nursing, with the gradual move of training into the tertiary sector. The broader influence internationally of the Alma Ata Primary Health Care Conference in 1978 was the beginning of change for health promotion into the 1980s (State Government of Victoria, 2012). This had a major impact on nursing and the gradual move away from the medical model over the following two decades.


This was a period of great uncertainty for Ngala. There were a number of management changes during this time, and nursing was feeling the impact of all the scrutiny and change. With the Booth Report (Booth, 1980), there was a reorientation from the institutional feel of the past towards a community approach. Ngala’s financial crisis of this period was analysed, and the volunteer management committee continued until the late 1980s. Subsequently, the Department Review (Department for Community Services, 1986) was a turning point, with a business model and Board of Management with an Executive Director (Rae Walter) being
appointed. The transfer of child health nursing training to the tertiary sector and the cessation of mothercraft nurse training at Ngala also occurred during this period.


This period, 1988–2011 (23 years), was marked by the leadership of CEO Ms Rae Walter. During the 1990s, the institutional care of children ceased and the services were transitioned into a contemporary model of service delivery for families with young children. A new discipline mix was introduced that over time influenced early parenting work and interdisciplinary models of care. It was noted by an allied professional who worked in the 1990s that there was a lot of fear by nurses:

The fear was against … authority, it was a very authoritarian system … I could not believe it of course as you know, based on the history of Ngala, it was based on an authoritative management structure, behaviours, there was a very simmering, kind of bubbling discontent underneath, and above that you don’t say anything about it, and it’s all quiet … and then the strike was over … (APInt4)

The strike in 1995 was a symbolic demonstration of change and a rising of the masses. Over time, nurses became much more involved in change management and the move towards contemporary approaches to family health care. In addition, more nurses were undergoing tertiary education, which influenced their thinking (Walter, 2013). The changes at Ngala up to 2011 have been described in detail in Chapter Three.

A summary of the history of nursing in WA was also studied for this period to place the findings into context. This has also been discussed in Chapter Three.

4.2.3.2 Analysis of data from various sources

The key categories of external influences and policy changes were extrapolated from the changes influencing nursing in EPS over time, and were discussed by both nurses and allied professionals during phase one and also found in documents, individual interviews and focus groups (see Figure 76). The sub-categories are explained below.
Figure 76. Changes influencing nursing in EPS

Each category will now be summarised, supported by quotations from the interviews and focus groups.

4.2.3.2.1 External influences

These external influences included societal factors, professional factors and health care factors. These have been explained below

1. Societal factors

Societal factors have changed enormously over the century. The older nurses in the study who had experienced nursing over 40–50 years stated examples such as:

Changes in families structure … incredibly and interesting that when I first was nursing there were grandparents on the scene and then there was a gap and its sort of come back again, and I think its economics … (FG2)

The complexity of the calls reflects the whole society. (FG3)
2. The professionalisation of nursing

This occurred in various phases during the 1970s and 1980s as nursing was transitioning from hospital-based training to educating nurses through universities.

Nurses described the past culture of nursing as ‘punitive’ and hierarchical with comments such as ‘it was an age when nursing was quite punitive’ and ‘it wasn’t always bad, but there certainly was some hard times and you weren’t expected to ask questions, and mainly you did what you were told’. Other reflections were about the army style culture, keys (symbols of power) and tasks being done correctly and punitive actions by those in charge:

The ‘sister’ thing and silly things like, you have the sister in charge, who wore the keys around the neck, you had to go and ask her for them and then you’d spend half your life running around asking for them, and then you have to find them and give them back and she’d put them back around her neck. (Int2)

Proficiency—I can remember, proficiency was ‘did you do this task right’, so then you were a good nurse! (FG2)

As mothercraft nurses, sort of almost at the lower end, but we were given the difficult clients to do and, but you know, if you complained about it, then the next time you requested days off, you didn’t get them. (FG3)

Nurses then moved to what had changed through the professionalisation of nursing:

I think professional accountability is one thing that has changed, and with the national registration and having to do professional development. I mean that’s what it is now, and it has been building. … and in terms of reflection it’s that part of professional accountability and interest in knowledge. (FG1)
3. Bio-medical influence to a primary health care focus in the community setting

The introduction of the ‘Ottawa Charter’ (State Government of Victoria, 2012) for health promotion and the incorporation of a primary health care focus into tertiary education assisted this process for nurses:

When I first started in community health many years ago, we still acted like a hospital nurse—we were still doing the medical model. (FG4)

So there is a lot more focus with the newer generation of nurses coming through on empowerment rather than disempowerment and I think that’s the difference between prescriptive nursing and empowerment and being a real advocate for the client and giving them the information so that they can decide what they do. (FG2)

4. Focus on women’s mental health

A change in focus was occurring during the 1990s and into the 2000s towards perinatal mental health, infant mental health and parent–child attachment and father-inclusive practice. The focus on the woman having postnatal depression gradually changed to incorporate the impact on the child, partner and broader family and the importance of the child–parent attachment:

How to help the parent battling with depression and anxiety and sleep deprivation. (FG2)

Issues of family mental health, attachment theory would be a good example, of really embracing that and saying it actually made sense and assimilating that into their practice, which is beyond really a nursing orientated practice, if you like. And certainly, I think over the years, it’s moved more from just child health concept more, and it’s like moved to a social view of health and way of working and how staff have actually built up their own skills within those multiple ways of doing—some doing their own reading and research and going through different conferences and building up that body of knowledge. (FG1)
The father-inclusive practice has had a big impact. (FG4)

5. Policy changes

Policy changes came about as a result of society changes and change in service systems, education, community expectations, new technologies and research. Nurses comment that:

There were social changes because the Equal Opportunity Act made a big difference toward working mothers, and there were payments to mothers—single parents. (FG1)

With the parents coming in it’s like they ask questions and there is a demand there of what they expect. (FG4)

We were taught to challenge the system and being more in tune to where the client is and then to empower and build on that rather than to push them down, and tell them what to do. (FG2)

6. Closure of mothercraft training schools

Mothercraft training schools closed around Australia for most states in the mid-1980s.

… it was much of a care giving role, anything that the mothers could do, we could train the mothercraft nurse to do it for a specific client. (FG3)

The nurses that worked in the nursery, they spent the whole time feeding and bathing and dressing babies. (FG2)

7. Transfer of child health nursing certificate to the tertiary sector

The transfer of child health nursing was in line with the move to the professionalisation of nursing and the closure or re-organisation of ‘mothercraft homes and training centres’.

When I did the Child Health course, we worked a 40-hour week. We got paid $12.00 per week; we did night duty. We folded a lot of nappies. So, a lot of it was just basic care. Basic survival through
food, clothing and taking them out for play. When you look back on it, it wasn’t a lot. Because I remember when I came to Western Australia, they had the Mary Sheridan book and I thought yeah this is really good, because we never had it in NSW. (FG1)

It was becoming more professional. Nurses had—there were more nurses who had been at University. (FG3)

… also more nurses now are being educated to a degree level and you’re incorporating research a lot more into your practice rather than saying this is how we’ve always done it that way at Ngala. Most nurses are degree level. (FG4)

8. The shift in focus from an individual client to a family focus

This coincided with a number of changes already discussed. The influence of moving to family-centred practice and the introduction of allied disciplines during the 1990s assisted this shift:

The sharing of that knowledge between the different disciplines within the team has actually enabled that broader focus of working with families, to have a much more holistic approach for the way they do things. (Int2)

Nurses always want to fix things and have things done and complete, but there’s been more acceptance of the fact that changes take time and it’s a step by step process. And so, if it’s giving families the confidence to make the changes themselves, then that sense of ownership or sense of having to have done something for this family, to make a big difference by the end of the day, end of the week or whatever is much, much reduced. (FG1)

9. Collaborative and partnership approaches

Recently governments and health service providers have shown interest in ‘partnership’ models of care. For example, most child health policies advocate for a collaborative approach to service delivery and across sectors; and documents also acknowledge the necessity for strong partnerships built with families, recognising
that the family is the expert in the knowledge of their child (Schmied, et al., 2011). Below, nurses describe this shift from the ‘expert’ model:

I think that’s particularly with older nurses within our workforce; it sort had been in the past, you know. Sort of been in the child health arena for a long time and viewed the members as being the experts and making that shift to a more holistic approach has been huge. (FG1)

Moving away from that expert model that we know all this information, we will tell you what to do. (FG2)

10. Commitment to practice based on evidence

Nurses described the past culture of nursing in which a nurse was not encouraged to think or ask questions. Therefore, an evidence-informed practice was often not possible until the culture changed with the shift to tertiary education:

One ‘sister’ so-and-so, I’d pick that baby up and we’d cuddle it away until it was asleep and put it down. But it was always, ‘You’re just making a rod for the mother’s back that is going to adopt,’ because a terrible lot of adoptions were done from there. (FG4)

You’ve got confidence if you’ve got more knowledge and understanding. (Journ4)

You’ve got that questioning and that critical analysis and doing research. (FG3)

I think the team has always managed to take on board, new ideas, new evidence-based information and applied that. (Int1)

11. Individual discipline focus to team approaches

Team approaches became more of an emphasis into the 2000s. The move from a multidisciplinary focus has taken time to develop stronger interdisciplinary approaches:
When I first started, we certainly didn’t have—very limited and that was just—there were people that were kind of given that role to do it, but there wasn’t the support. Where I think now from management role right down, we have been supported. (FG1)

When I first came, there were still quite discrete roles for mothercraft nurses, social workers, nurses. We still had the visiting paediatrician and psychiatrist—the visiting psychiatrist registrar. And so, it was still a lot of—it was working within a team but still quite discreet areas, if you like. (FG2)

The outcome now is we are all working towards that same goal for the client. We all might do it a bit differently, but I think the outcome is better. (FG4)

12. Information technology

Information technology has changed the face of health care. The Internet has opened up another world, making information available in a timely manner and increasing the diversity and breadth of available information:

We’ve got the database, which opens a completely different world. (FG2)

Information now comes from so many different sources, it’s hard to keep up with. … the internet and social media have changed the way we get information. (FG2)

The above themes were discussed as part of the focus groups, interviews, reflections and document analysis regarding what has changed over time for nursing. The next section will closely analyse how nurses perceive their current roles within an interdisciplinary team, and the areas unique to nursing. These findings are drawn from the interviews and nurses’ written reflective journals.
4.2.3.3 Nurses’ perception of their role within the context of an interdisciplinary team

Nurses were asked through focus groups, interviews (n 15) and written journals (n 8) to discuss their role within the context of an interdisciplinary team. Their responses generated three categories:

1. Early parenting nursing practice;
2. Application of evidence; and
3. Linking with others.

![Diagram](Image)

**Figure 77. Overall nursing role in Early Parenting Services**

The main categories were reduced from sub-nodes, explained in Figure 77.

4.2.3.3.1 Early parenting nursing practice

A number of elements were incorporated into early parenting practice (see Figure 78).
Figure 78. Category 1—Early Parenting Nursing Practice

The two main sub-categories under early parenting nursing practice were:

1. Building connection and relationship, and
2. Coordination and planning.

The category ‘building connection and relationship’ encompassed health assessment, advocacy, promoting health, and parent-craft and child development. The category of ‘coordination and planning’ contained anticipatory guidance, individual consultation and group facilitation. These are described below, together with examples of comments from nurses from the focus groups, interviews and nurses written journals.

1. Building connection and relationship

Nurses talked about the importance of connection and building relationships as a part of any therapeutic conversation with individuals, including the child, parent-carer, family or conversations with community or other service providers. This was achieved by developing a holistic picture of the family using the following components:

- Health assessment, which is in turn broken down into child, parent/carer/family, community and looking at risk;
- Advocacy;
- Promoting health; and
• Parent-craft and child development.

Building connection and relationship was summarised broadly by a nurse as:

> It is that circle—it is about relationship and working with the parents, and it’s about the parents doing that with their child, and us supporting the parent to do things, you know, in terms of do you want change, and how do you want it to be, and we go on supporting them and trying to involve them around making their decisions. (FG2)

This comment demonstrates the nurse’s commitment to a partnership approach, rather than being prescriptive when working with parents. C-Frame supports this approach:

> C-Frame that connects, collaborate and change, that whole basis of looking at things very differently in terms of your assessment and working on the relationship building, and working on client strengths. (Int2)

Trying to see things from the client’s perspective was important, as this was crucial to a successful therapeutic relationship. One nurse emphasised:

> Trying to see the world view of that person … we often are asking how and why they came to their world view; so, what informs that? … because to get change, you can’t just work with a world view and you have to find what informs that world view, and that particular approach. So, I think—and it’s about a relationship you’re meeting the families and building up a rapport. (FG3)

Nurses talked about their ‘Communication skills being very unique’ (Int3) and that having experience means they ‘have refined the questions’ (FG1) and are ‘constantly revising how things are going for parents. … I feel all of us are very skilled at asking questions … we can get there quickly, without tick boxes’ (FG3).

The theme of ‘building connection and relationship’ was important to establish effective partnership and work was to be undertaken with the client, family, group or community.
There was a recurring focus on health assessment throughout the focus groups, interviews and journals written by nurses. They described assessment for the various contexts of work in early parenting, including on the helpline, in parenting education and for community engagement and assessment. Further, as part of consultations, regardless of duration of contact, assessment can provide just a snapshot, or can be an ongoing process. They emphasised that ‘understanding normal baselines gives alerts to the abnormal … connecting and finding out what’s going on’ (FG1), and ‘taking a systems approach’ (Journ6) was important.

Nurses said that their ‘broad knowledge base gives greater contextual knowledge for early parenting work … and the length of time the practitioner has been working in the area’ (FG3).

With the many issues that families face in early parenting, there are a range of assessments that nurses may take when required. With their strong background in child development, the social determinants of health, and knowledge of the range of practical parenting issues that can occur on a daily basis, nurses are well prepared to hear the concerns of parents and offer strategies or guidance/education when required. These assessments may deal with breastfeeding, perinatal mental health, parent–child attachment, physical and behavioural issues, education and learning styles, child development, the couple and family and the strengths of individual, family and community. A broader contextual psychosocial assessment was layered between many different types of assessments that could have been specific or a blend of assessments. Experienced nurses were able to adapt to the issues being presented and were very versatile in how they approached assessment.

Nurses highlighted their varying perspectives on assessment, which can be categorised under:

- Child;
- Parent/family;
- Community; and
- Risk factors.
One nurse demonstrated how she approached assessment and her thought processes when trying to understand a situation. She said:

You’re just looking for that huge picture; it’s not just a matter of tick box. Okay, got that answer, got that answer, got that answer … because that answer then creates another question. So, what’s your perception on that? So, tell me more about that. Okay, so then you’re getting a picture that encompasses everything about that family, so you’re not just thinking of that child—you’re thinking about ‘Well, why?’ ‘Where did that come from?’ ‘How do you validate that?’ ‘Tell me more.’ Oh, so maybe it’s just an ear infection that your child isn’t speaking, or maybe it’s because they haven’t been spoken to, so you’re actually like a—probably, your heads always going a hundred miles and hour because you’re thinking, ‘Is it medical?’ ‘Is it social?’ Is it this … is it that, and for me, it’s that more thinking, thinking, but trying to get the right questions that you get a broad spectrum without making any assumptions in the beginning. So, to me, that assessment is different—it’s not like taking your car and well, tell there’s a noise here; tell me there’s a click. And so it’s that broad and encompasses so many things as in mental health, day-to-day wellbeing of the child, wellbeing of the parent. (FG1)

In regard to the child, some nurses emphasised the importance in assessment of understanding the ‘normal’ that informs the ‘abnormal’, and of always assisting the parent to understand the child:

… where you go back to the norm, about what’s classed as normal and healthy and bringing them back to that … like a two-year-old that isn’t walking or something. (FG2)

Well, it’s about feeding—whether it’s breastfeeding or formula. It’s—there is a component to do with sleep; child development, in terms of their understanding, for their age, they might have unrealistic expectations for a particular baby’s age, and assessing and reviewing the mother’s mental health, and these days, we’re looking at attachment, and how they’re interacting with their child. (Int5)
… to bring together your anatomy and physiology, mental health and
development and all the different parts of the body and how they work
together depending on what age you are, … and you have to know the
normal and the abnormal so you can balance it out. (FG1)

… and the social determinants of health. (FG2)

The majority of nurses work with the parent, carer or family during the assessment
and the following comments highlight a variety of perspectives on this:

The thing about early parenting is that you always have at least a
dyad, it’s like you’re not having just one person as your client, but
here you have two people so that it necessitates that you need to do
more interaction and then having an understanding of all those other
things that impact on them. (FG2)

In day stay you often spend a lot of time looking at the health of the
baby and the physical health of the mum. (FG2)

… and you’re listening to the mothers voice and there’s a quiver there
… what’s that associated with? Where’s the baby at the moment? Oh,
has he been crying and you just keep going through and through …
then you build this big picture in your head of ok now where am I
going from there? (FG2)

Trying to get the parents to recognise the needs and the wants and …
really picking up on those cues and, you know, that’s what a lot of
them miss. So, they can get their baby, it’s really distressed but, you
know, really matching up that body language to what they’re saying
and how they respond when we go to them—what are our best options
you know, and when you respond to them and all those sorts of things.
(FG1)

You use the genogram to look at the family structure and it’s that
ecological approach. (FG4)
Trying to get a snapshot of a person’s life and where they are up to … you are looking at the physical, the psychological and an overall look. (Int2)

You need more understanding and resources for grandparents as family structures have changed and the role yes … interesting, more social, and mental health, definitely mental health … and talking about early parenting and how to help the parent battling with depression and anxiety and sleep deprivation. (FG3)

Some nurses spoke of the community perspective of assessment and the necessity for an awareness of the services available and research data relevant to the community to gain a greater understanding:

Being aware of what’s out there because we all do that we can call it maybe community mapping and what services are around, and then doing something if it’s not. (FG1)

Looking at future trends, we are often looking at the SEIFA [Socio-Economic Index for Areas] index or AEDI’s [Australian Early Development Index] or just where populations are—typical service planning, research, either finding out about what the latest search is, doing research—me, you. (FG1)

Others explained that the assessment process in terms of researching was to create a holistic view of the family and where the risks might lie:

Two different parts of assessment so there has already been some data collected and you are assessing that data … so we open up the file … look at how many people live with the family, the family structure, dates of birth and ages of the parents, where they live, we already gleaning information just from the bookings sheet and how many services they have had, then we are looking at the call, the risk factors, the psychosocial factors and problems from the call. (FG2)

You’re coming from a research base, and you’re giving some information which is fundamental, I guess, to anything in Ngala,
which goes back to brain development, attachments, self-regulation and when you’re looking at any education, I think you’re thinking of that ecological model—of where the child is the centre and the parent, and then what’s beyond that for this group of people or whether its individual. (FG2)

Comments from nurses highlighted the importance of being alert for risk during assessment:

We have more of a wider antennae … the whole picture, and wherever you work acute or community you know your reference point. (FG4)

The importance of what has happened before the child has even come on the scene, how difficult it has been to get pregnant, was it a really traumatic delivery … are they still stuck back there … maybe that’s why they are not comfortable or getting on further than they should be. (FG1)

You might say … are you thinking of hurting your child, something really confronting to ask the parent but you don’t get people backing off … (FG4)

Yes and also mental health and people with mental health issues … people are calling because they haven’t got that support of someone to help them. (FG4)

Assessment is tied up with so many aspects of the role of the nurse because, as indicated previously, it can be one-off or ongoing. Interventions can be interspersed throughout the contact with the client or family, and combined with advocacy, health promotion, parent-craft and child development, and referral.

*Advocacy*

The nurse advocates for and with individuals, families, community and then at a broader level on early parenting issues. Advocacy occurs in the context of connection and relationship. Comments such as ‘the nurse is the advocate for the family and is that connection between services’ (FG4) and ‘the nurse also advocates on a broader
level on issues that face families on a daily basis … (Journ2) and ‘she also advocates for the father if he isn’t present. (Int1)

The voices of children can sometimes be lost when parents are distressed and sleep deprived. Nurses enable parents to ‘help them to see the child’s view … So, seeing behaviour as indicative of what’s happening with a child, so see through a child’s eyes. (Int3)

Promoting health

The nurse works within a lens of promoting health and wellbeing through early parenting work, which also occurs in the context of connection and relationship. Comments from nurses highlighted how nurses integrated the promotion of health in their everyday work with families:

Health promotion comes into it as well … healthy eating, sleep and matching that to the age of the child … you give that health promotion perspective. (FG1)

We have that level of health promotion and it’s about keeping well and keeping your baby well and developing well, and your relationship together. (FG2)

We are focusing on a wellness model, aren’t we? We are trying to be proactive to prevent illness. (FG2)

Parent-craft and child development

The understanding of children’s development provides an important base to working with the practical issues that parents face on a daily basis through the transition stages of parenting and childhood. Nurses utilise a range of strategies with assessment including role modelling, demonstration, normalising and validating the parent experience. Parent-craft and child development also occurs in the context of connection and relationship. Nurses talked about how they worked to enable the relationship as it develops:
A lot of role modelling. A lot of the families don’t have much of an idea of play or even expectations of a child or a baby or what they should be doing, developmentally for an age. (Int3)

There’s a practical component about what they want to get out of a day, and you’re working by demonstration or implementing certain things they want to do. (FG1)

Trying to get the parents to recognise the needs and the wants and really picking up on those cues and, you know, that’s what a lot of them miss. (FG2)

The other foundation of a really strong child development and child health-related issues; the breastfeeding, the whole midwifery context, if you like … the whole birthing process and those other things that lead up into that whole body of knowledge that they have. (Int2)

The themes under early parenting nursing practice were a large part of the nurse’s role. The second sub-category under early parenting nursing practice is described below (see Figure 79):

![Figure 79. Early Parenting Nursing Practice—Coordination and Planning](image)

2. Coordination and planning

Nurses have been the majority of the workforce in early parenting and have taken on the coordination role for health care. Nurses are the ‘front line professional’ (Int4) in primary health care work, often because of their larger numbers. With the
introduction of other disciplines, this is changing and, depending on the context, the coordination and planning role may not necessarily be taken on by a nurse.

Nurses working in parent education and community contexts operate with more autonomy, but do also work with teams of other disciplines. The intensive 24 hour services at Ngala have a larger nursing workforce. The shifts overlap with each other and nursing staff hand over to nurses and coordinate the overall care of clients. In some handovers, social workers are involved. Allied and medical professionals undertake sessional and part-time work. Nurses described coordination and planning in various ways, depending on their context:

The nurse is ultimately responsible for and ensures that all care is done, so you are really like a mini case worker for your client. (FG4)

The context where there is a 24 hour service this remains true but in other contexts this is changing. (FG2)

… organising the environment to do the job. (FG1)

So, whilst in theory I have a parent and a child, I might have four clients, six clients, plus there could be a colleague who’s also—or a student who’s asking for assistance or information. (FG1)

The way we work we try and achieve the same goals don’t we? And they are always involved with the handovers and communication stuff and care plan for that family. (FG2)

They need a doctor’s letter coming, there’s writing up of the doctor’s letter to send to him about the result of the day, if you like, of the day. And there would be follow-up phone calls, or returning phone calls, to previous clients who phone in as well—that would occur at the end of the day. (FG4)

**Anticipatory guidance**

Anticipatory guidance is linked closely with health promotion. It is a strategy used by nurses to improve the care provided in the practice setting and to meet parents’ informational needs and elicit their concerns in a systematic, standard way (The
Commonwealth Fund, 2012). Nurses often anticipate or use health promotion opportunistically to give guidance:

… and it is only a three minute process on helpline or it could be an hour process, obviously … I think though from a nursing point of view because of child health nursing, health promotion comes into it … healthy eating, with the sleep and everything else and matching that to the age of the child … so peppered throughout the assessment, the planning and implementation … you give … that health promotion I think it’s a child health nursing thing, rather than another discipline. (FG2)

I think that maybe it’s those communication skills with the other things in mind like the health promotion opportunities or the other things that are going on … I’m not just focusing on the issue I’m focusing on you as a family and if I’m going to suggest that, then there may be some other ramifications. (FG4)

Some of the education is about self awareness, some of that education is about health promotion or child development, some of that education is about expectations, beliefs … (FG2)

**Individual consultation**

Early parenting work has a range of entry points for parents or carers to make contact with Ngala. Working with individuals and groups are the main delivery streams, from brief conversations on helpline through to two-week parenting assessments for children at risk. No matter what the entry point, the following nurse sums up the intent and process:

It is that circle—it is about relationship and working with the parents, and it’s about the parents doing that with their child, and us supporting the parent to do things, you know, in terms of do you want change, and how do you want it to be, and we go on supporting them and trying to involve them around making their decisions. (FG2)
Group facilitation can be undertaken in a diverse range of contexts for both parents or carers and professionals. One nurse discussed her experience:

You’re coming from a research base, and you’re giving some information which is fundamental, I guess, to anything in Ngala, which goes back to brain development, attachments, self-regulation and when you’re looking at any education, I think you’re thinking of that ecological model—of where the child is the centre and the parent, and then what’s beyond that for this group of people or whether its individual. And again, I’m looking at this from an education point of view as in sessional groups or one-to-one work. We don’t know what their issues are, so we’re working with them in partnership and we’re looking at strength-based model of working on their strengths and looking at some information that might be useful to them. Because if it’s what they need, it’s important—not what we might think they need. And some of the fundamentals would never change as to that brain development and attachment and how that parent is coping in community. So, I think some of them core issues … I don’t know—there’s lots more to it, but I think looking at that and the information that you’ve given is warranted, I guess. And working with them rather than, it’s not for us to say what the needs and wants are; it’s discovering and assessing that and then it’s usually who else can help in this situation—who else can I refer onto—who else can I get involved, and is this client happy and are they willing to go in those directions or it might be just passing that information on. So, it depends on so many aspects but there’s probably some of the core aspects that I consider important … it is applying a systematic approach and you start with assessment really before you can plan and evaluate what you are doing. (FG1)

The first category that nurses identified as part of their role, early parenting nursing practice, has been described. Now the second category, ‘application of evidence’, is presented.
4.2.3.3.2 Application of evidence

The second category classified under the perception of the nursing role is the application of evidence (see Figure 80).

Figure 80. Category 2—Application of Evidence

This was seen by nurses as very important and integral to their work and contains four sub-categories (see Figure 81):

- Professional Development;
- Information Management;
- Reflection; and
- Evaluation and Research Application.

Figure 81. Category 2—Application of evidence, with sub-categories
The category of ‘application of evidence’ is achieved through professional development and the maintenance of an early parenting knowledge base through managing information, reflection and evaluation and subsequent application of research.

**Professional development** was seen as an accountability factor for being a registered nurse, and as a necessary part of life-long learning and growth as a professional. Nurses suggested the various ways they maintained their knowledge and skills with such strategies as modelling of skill sets by other nurses (for example, the helpline) and interdisciplinary team learning:

I think professional accountability is important with the national registration and having to do professional development … You’ve got confidence if you’ve got more knowledge and understanding. (Int3)

… in the helpline everyone has their you can hear skills … you can hear people talking about things and you take in little bits insidiously … you hear it and you take it in and use those words yourself, so you can learn without actively sitting on a call, you can hear things going on around. (FG2)

… and going back to the interdisciplinary team because we now work with more and more skill bases we are growing ourselves with that knowledge because we have picked up those social work skills, and we’ve learnt different ways to ask questions and because we are working with so many different people we are constantly evolving … (FG4)

Training and that conflict resolution stuff we are doing now we are able to deal with more difficult situations than we possible would have. (FG4)

We have really good resources at Ngala, and I think—and it was very interesting because I’ve just come back from the Conference and everyone was coming from everywhere, saying, ‘Oh, Ngala, you guys have great resources’. (FG3)
Information management is a broad term that describes the many functions that surround documentation and record keeping of client information, and the collection and analysis of information that informs the day-to-day role of nurses and that assists in community and program planning. This is a necessary part of the application of evidence and requires rigour and systems. Nurses stated that:

There’s a lot of recording of the information … because of the recording/reporting, we are building a picture over time. Instead of one assessment it’s a continuous assessment and plan, that goes from the telephone, and I think we should never forget one care plan. (FG2)

Reporting and record keeping is a big thing in my work with a community development role, so connecting with the community, advocacy. So, it might be for individuals, it might for community. (FG3)

Being aware of what’s out there because we all do that we can call it maybe community mapping … we look at trends in data from the community and study the AEDI to understand how well children are doing at a population level. (FG2)

Research application was described by nurses as embracing research and keeping informed and then working with others to understand the application. This provided improved growth in terms of best practice and evidence-based information:

Incorporating research a lot more into your practice rather than saying this is how we’ve always done it that way. (FG3)

Getting research into manageable size bits so they can understand and use in their lives so it’s about interpreting research. (Int3)

Recognition of the value of an evidence base and that we all contribute, and so the intent is common I think there is, I think we have to value people. (FG1)

Issues of mental health, attachment theory would be a good example, of really embracing that and saying it actually made sense and
assimilating that into their practice, which is beyond really a nursing orientated practice. (FG1)

The Team has always managed to take on board, new ideas, new evidence-based information and applied that. (Int3)

Research application is also tied up with ongoing reflective practice and evaluation.

**Reflective practice and evaluation** have changed the practice at Ngala. The nurses discussed the changes, which included more rigour in their daily work:

The relationship with listening skills … and reflective skills because you are doing things and then you sit down and write about it, cos you have to think it through. (Int2)

The way we work we try and achieve the same goals don’t we? and they are always involved with the handovers and communication stuff and care plan for that family. (FG3)

We’ve gained that knowledge so whether that’s through other disciplines … I’m not sure I think we’ve recognised it as an issue and certainly at the moment we are looking at mental health first aid because we need more knowledge, so on top of what’s presenting and hopefully that’s a good match so when we are reflecting, we are using that and we’ll continue and I think within the health professions it’s become more apparent so. (FG3)

The change of C-Frame coming in was less directive and more reflective. (FG1)

It’s constantly revising how things are going for them … usually there’s an opportunity to practice and reflect on the first part of the day; and you’re also looking for … looking to finalise the day by means of reflecting and getting them to make an assessment of the day—getting them to reflect, and what they’re going to do, you know, to follow through with what they’ve got out of the day, if you like finish it up by evaluations, questions, closure. (FG4)
When you work in the helpline, you reflect every day and that’s a really important part of the day. And because of the kind of calls that come in there and I guess, being for want of a word, ‘old school”—I really thought, ‘What’s this reflection about now?’ I’d get more upset than anyone if we don’t do it. So, that to me has been a huge change—I love reflections. (FG1)

I think for most new staff coming in, that’s one of the things that really does amaze them, is that capacity to share knowledge and to grow also helped in terms of reflection, sessions that we actually have, and so that enables different viewpoints to be expressed. (Int2)

The second component of ‘application of evidence’ that nurses identified as part of their role has been described. The third component of ‘linking with others’ is now presented.

4.2.3.3.3 Linking with others

The third category classified under the perception of the nursing role is ‘linking with others’ (see Figures 82 and 83).

![Diagram of nursing roles](image)

**Figure 82. Category 3—Linking with others**

Nurses link their clients back out to the community via referral, or to a range of resources available locally or via the Internet. They network and link internally and externally to the organisation. The support for team, colleagues and students is a large part of this role. The key sub-categories within this component are:

- Team connection;
- Mentoring colleagues;
• Preceptoring students; and
• Referral.

Figure 83. Linking with others, with sub-categories

*Team connection* has gradually come about through the shift in team approaches and is enriched by the longevity of the workforce. Nurses describe team connection as follows: ‘the sharing of that knowledge between the different disciplines within the team has actually enabled that broader focus of working with families, to have a much more holistic approach for the way they do things’.

Other nurses described the meaningfulness of the team and the support that they received:

… there is acknowledgement there … of other disciplines … and I think the move towards a research base that is common across disciplines and when you match that with intent … (Int5)

There’s a lot of teamwork, and this also builds a lot of collegial support, which I like. (Int2)

I think it’s the C-Frame, that it also helps with your colleagues as well as your clients … C-Fame gave a common language. I don’t necessarily think it is the answer to everything, it just gives permission and a language. (Int2)
You know, when you’re having a more challenging day, the other staff know and it’s sort of, you know, when I walk back in and come and I’ll make you a cup of tea … and I think that really helps that—to feel connected. (FG4)

Keeping up-to-date in terms of, am I relevant to practice? and I would say all of my colleagues, we consult with each other, so you’ve got a lot of cross-pollination, in terms of some people have skills that you don’t. (FG1)

Team connection is crucial to ‘linking with others’ and the success of interdisciplinary work.

*Mentoring colleagues* is also a sign of good collegial team relationships within interdisciplinary work. It was seen by nurses as something important in their role in terms of assisting with the professional development of their colleagues, as demonstrated by the following comments:

We work together and its preparation and it’s yeah. I’m amazed how well they do do, because I’ve come here with all this background knowledge and when they come for the first time how can they suddenly just be getting it all, bit of a process for them … but at the same time you can use their skills to maximise those social work issues. (FG4)

I’m a professional and if I haven’t got the skills I can ask the right questions and guide them through that … the other thing is having the skills to ask the right questions … I think that’s where our work support of those people is so vitally important … our people skills to ask the questions. (FG3)

I think it’s with a lot of things, it’s knowing what you don’t know and so what do the other people need to know, which is the challenge I think. (FG3)
I think it’s because you’re listening all the time, you can sense when there’s something not quite right and you can turn around and say are you ok? … it’s quite intriguing how that works. (FG2)

You might have skills that they haven’t, so you’ve also got that education role towards other colleagues. (FG1)

I think I’ve gotten a lot better at doing it, and for me the way I spoke my C-Framing helped me, in the gate keeping. (FG1)

Mentoring others assists in understanding the needs of others and how they work. This also enables appropriate referral to others.

Nurses refer both internally and externally. Recognition of the scope of practice and their strengths and weaknesses in their role also assists in the development of the interdisciplinary team and provision of a holistic service:

… do you know about the local resources in the community, rather than saying I think you should go to a PND support group, it’s, do you know about the local services, here is five phone numbers and five different services, one might be a group situation, one might be a one-to-one counselling situation, another one might be a pottery class just to get them out of the house. (FG2)

You’re looking at all the extended services that are available, as in social work and psychology and the GP and, you know. I’m referring them on. (FG3)

Then it’s usually, again, within Ngala with who else they can help in this situation—who else can I refer onto—who else can I get involved? (FG2)

Good team relationships, mentoring and referral to others also aid in developing students.

Preceptoring students is something a large percentage of registered nurses undertake at Ngala as part of their position description. It is key to supporting students and provides stimulation to nurses with new and fresh perspectives:
We have lots of students through and there is never any issue. (FG1) … and I always ask if they can have a student … that’s about respecting. (FG4)

We get our nursing students coming to Ngala they really have a great time, they can see the benefit of it. (FG2)

We preceptor students as well. It’s a part of our role; they are intermittent, certainly, but that is an added workload if you like, because they also asking questions. (Int3)

4.2.3.4 The uniqueness of the nursing role within an interdisciplinary team context

The overall nurse’s role has been described within EPS. It is a very broad role, and over time experienced practitioners develop very comprehensive skills. This will need to be given consideration in the framework for the future. The next section describes the uniqueness of the nursing role in the context of an interdisciplinary team.

The current nursing role has been summarised. Nurses and allied professionals, through focus groups and interviews, were then asked what was unique to the nursing role within an interdisciplinary team. This question stemmed from the identification of some overlap described between the work of nurses and other disciplines in working with children, parents, families and communities. Nurses and allied professionals described standard or shared skills and knowledge that was expected of all professionals working within the area of early parenting.

Figure 84 demonstrates the interface between nurses and allied professionals, with an overlap segment. A nurse summed up this interfacing by saying ‘you are working alongside each other and you are sharing and by osmosis’. ‘Osmosis’ was seen to occur when skills were shared and each role became part of developing an overall strategy for assisting each family or group.
These general statements from nurses and allied disciplines demonstrate the concept of overlap:

… going back to the interdisciplinary team because we now work with more and more skill bases we are growing ourselves with that knowledge because we have picked those social work skills, and we’ve learnt different ways to ask questions and because we are working with so many different people we are constantly evolving …

(NFG1)

Maybe that way when you add them together—the two parts are greater than the one … Yeah, the sum of it … the whole package that you provide for the client. (APFG)

I do think the nurse is the advocate for the family and is that connection between services, but then I think there might be an overlap in the roles as well because we do a lot of listening, counselling and listening to parents to try and identify where problems are. (NFG3)

In explaining the uniqueness of the nursing role, Figure 85 demonstrates the congruence between how the nurses and allied professionals described the unique role of the nurse.
Figure 85. The uniqueness of the nursing role within an interdisciplinary team

When nurses and allied professionals were asked what is unique to the nursing role, they gave very similar responses. These were categorised under three headings: the nursing role, the experienced practitioner and professional identity. Each of these is described below.

4.2.3.4.1 The early parenting nursing role—what is unique?

The nursing role is outlined in five sub-categories:

1. Parent-craft and child development;
2. Health promotion;
3. Health assessment;
4. Holism; and
5. The coordination of care.

Both groups identified the everyday practicalities of working with parents in their parenting role, which operates alongside their knowledge and application of child development. Health assessment and promotion were also identified, but the coordination of care was only mentioned by nurses.

1. Parent-craft and child development

Allied professionals’ statements below reflect their thoughts about the nurse’s unique role in the early parenting area. They were able to articulate in-depth how they
viewed the unique role of the nurse. The allied professional statements were consistent with statements from nurses:

I can give examples, like about feeding and nutrition—just an understanding of what’s appropriate for ages, aside from just the normal developmental milestones. It’s about relating to feeding, growth parameters, what’s normal—a lot of normalising, if you like, of normal growth and development of children. So, they have got quite a good foundation in there too. (APFG)

The way that, they actually work with families is quite unique, in that, building relationships, health and development—development of the child. (APFG)

… more understanding about not just development wise, as in ages and stages, but, about different sensory processes and about attachment processes … (APInt3)

I think that understanding parents and child development is a vital component of the role, particularly when you’ve got anxious people coming in who are concerned about every little thing that’s happening for their child. (APInt1)

That’s very important in the neonatal period where I feel much more comfortable with nursing input with helpline calls, in the first six weeks of the baby’s life, where they are being taken by a child health nurse who’s aware of some of the issues that can be health-related in most newborns. And part of their role is also referral to community or other Ngala programs that parents might find helpful to achieve their goals for their children. (APFG)

2. Health promotion

The health promotion role was discussed as being the lens through which nurses viewed their early parenting role and the way they approached individuals, parents, families and communities.
One nurse stated:

It’s ok to see a child health nurse because we have that level of health promotion and it’s about keeping well and keeping your baby well and developing well, and your relationship together. (NFG1)

An allied professional stated:

I suppose when I first came to Ngala, I learnt a lot more about the breadth or the generic nature of the child community health training and approach a bit, and concepts around primary health and health promotion, and where they came from. (APFG)

3. Health assessment

The following statements from allied professionals were also reflected by nurses. Health assessment was seen as an important part of the nurse’s early parenting role. The issues facing parents with young children are often multifaceted. Nurses work with parents to elucidate their immediate concerns or issues by using a number of strategies within assessment, such as asking the right questions, observation and clarification. Some of the comments that described assessment are as follows:

First is their abilities of assessment of early childhood health and parental health and wellbeing. I think about assessment as the first part of the role. (APFG)

I’d say, given that the core component of parents with young children is basically physiological, brain wiring and on nutrition and relationship. I’d say, to be an early parenting organisation, you need people with the skills that deal with physiology, to deal with nutrition, and deal with relationship and our brain development, and all those—and the ability to look at a child and go, ‘Something not quite right here’ and I think if we lost those particular component parts, then it makes us no different from an organisation that can just talk the theory, but not be able to provide any of that clinical ability to really deal with those particular issues. (APFG)
I think health assessment—the assessment around development, feeding, nutrition and around the parent, around that sort of adjustment, so, which would parallel with the social worker. I don’t think in some of those areas, there’s a great deal of difference, but it’s about, like I said, a set of knowledge in relation to the nurses. I mean, I think that—think of them as demonstrators of things, teachers, educators—health education, health promotion is part of the role I have observed, most frequently. (APFG)

Nurses are very good observers and have developed skills in observation, and that’s where I think that the people on the helpline have an additional skill that they can observe remotely sometimes, which is hard, but I see nurses as observers in terms of assessment, in terms of their role; so that observation. (APFG)

… and just looking for factors and preventing a child from losing too much weight because they’re working with the parent on nutrition, so that they don’t get to a point where it’s a failure to thrive or whether it’s a developmental concern because they are actually looking for those milestones—trying to work with the parents in these things. (APFG)

4. Holism

Both groups highlighted the holistic nature of the nurse’s approach to the client, family or community:

I think that aspect in itself is being able to have that broader view outside of the very narrow nursing window, if you like, is a more holistic approach, and using all the different models. (APInt2)

I think one of the things that’s quite unique to the nurses here is how they work, it’s a more holistic framework of how you view the family. Whereas, other nurses I’ve worked with at other places, it’s been very much at times, child-focused, but more about let’s fix the ‘problem child’ rather than what’s happening in this whole family that’s
creating the situation for the child. So, I think that’s very different skill set that the nurses have here. (APInt1)

5. Coordinator of care

The nurses highlighted the role of coordination as being important to their overall role in early parenting work. This is because other professionals tend to focus on their part of the work rather than on the larger picture of care. The allied professionals did not articulate this role of the nurse (Figure 86 demonstrates this visually). This was surprising, as this appears to be a very strong role taken by nurses at Ngala. However, this might be explained by the fact that allied professionals have increasingly been taking on coordination roles. Nurses reasoned that allied professionals in some contexts have a more defined and narrow role.

![Coordinator of care diagram](image)

**Figure 86. Some differences in the perception of the Early Parenting Nursing Role**

The coordination role was only described by nurses. Their greater participation as coordinators is possibly due to there being more nurses available, often over longer hours through shift work, to take on the coordination role in the early parenting context, particularly in the more individual and intensive service teams. Moreover, the current nurse cohort is very experienced.

4.2.3.4.2 The experienced practitioner—what is unique?

The nurses at Ngala had been there for many years and were very experienced practitioners with a broad knowledge base and range of qualifications:
Many of us have midwifery and child health and some have post graduate quals … (NFG1)

I actually think we are confident in our expertise. (NFG4)

The allied professionals held a stated deep respect for the nursing role and their broad knowledge base. They highlighted that the majority of nurses at Ngala have life experience and are also very experienced practitioners, having been there for many years:

All those nurses come with years of life experiences … having an awareness of the mental health issues of the people who are presenting; having an understanding of how they impact on people’s parenting and how they actually present. (APInt2)

The other foundation is of a really strong child development and child health-related issues; the breastfeeding, the whole midwifery context, if you like … the whole birthing process and those other things that lead up into that whole body of knowledge that they have. (APFG)

They’ve just got that extra sort of health dimension, I guess especially working with young children. They just have that sort of broader awareness of what else might be going on … in a family. … and, yes. It’s—parents just often really love—they sort of graduate to—they want to … not graduate—that’s not the right word—move towards talking to a nurse. And often health and behaviour is inter-related. So, they might start off talking about an allergy or a high temperature or something like that. And, they’ve got the skills to deal with the health issue but … get it—take it broader and deeper as well. So, it’s just that it’s another dimension to work with. (APFG)

And those that are midwives as well, the birth experience and then the infant mental health and the mother as well; and the impact of medications or non-prescribed drugs and that sort of thing. They are pretty well clued up on that sort of stuff. (APFG)
Particularly, their experience, they’re not a new practitioner with a child health background. I think it makes a huge difference to have them based in the community doing community work because they see things through another prism. I’ve worked quite a lot with child health nurses at other services, and they’re understanding of this is not as developed as the nurses here. (APFG)

4.2.3.4.3 Professional identity—what is unique?

Professional identity was a strongly held perception from all disciplines. Nurses talked about being ‘safe to talk to’, ‘respected by the public’, ‘holding a health promotion focus’ rather than ‘come to me for a problem’ focus (like a social worker or psychologist). They also described professional accountability—national registration as a nurse and the need for ongoing professional development. It was emphasised that nurses have good relationship-building skills and are confident with their expertise:

Isn’t there something about the title of nurse that almost gives us … the term the golden scales … I’m the child health nurse I’ve got the golden scales … there is trust. (NFG2)

It’s definitely an identity, it’s a role … it’s a safe place and I think it’s not threatening … (NFG3)

I think it must be something about the body … in terms of nursing … It’s that understanding of the personal and the personal body. Social workers and other professional haven’t got to go into the idea of toileting … its personal … there’s that intimacy … (NFG3)

Health promotion opportunity rather than you’ve got a problem, so I think that is why I think we are safe. (NFG1)

Allied professionals talked about the legislative and statutory responsibilities that nurses have, and that as a group of nurses, they hold a strong identity:

They hold on to this really strong identity and set of skills about certain things which of course they do have, and that’s what we all
admire and lean on and learn from … but it’s also held very tight in their identity as a professional. (APFG)

The following statements reflected the current demographics of nurses and what they expected for the future:

The generic nature that the child health training tended to give people still doesn’t take away from that—you could still identify it as that nursing, but I don’t mean that in a negative sense, but it’s that strong identity somehow … I don’t know how else to describe it … (APFG)

Yeah, I mean … I think you’re right but I wonder if that is a product, particularly being so evident at Ngala because of the age of the practitioners we have. We have really experienced, you know, professional people who have been doing this work for their whole professional lives. And I wonder if we bring in younger and newer practitioners, if their identities wouldn’t be so tightly wound up in that or whether or not the new nurses they would cling to that even more? (APFG)

The role that is ‘unique’ to nursing has been described by nurses and allied professionals. This next section will now describe how nurses and allied professionals currently work together and their concerns and issues in thinking about the future for EPS.

4.2.3.5 Nurses’ and allied professionals’ perceptions of working together

Nurses and allied disciplines were asked how they work with each other (see Figure 87). They described the benefits of working within a team, the gaining of new knowledge and the influence from other disciplines. All participants discussed the strategies of working collaboratively, which involved a one care plan (in some contexts) and reflective practice. The allied professionals also talked about the whole package for families and the strong identity of nurses.
Figure 87. Nurses’ and allied professionals’ perceptions of working together

4.2.3.5.1 Changes over time

Many of the nurses and allied professionals had been working together for many years. They described what had changed over that time, and this was congruent across the discussions. For example, nurses discussed that they used to ‘gate keep’ the early parenting work:

I think we gate keep … especially CHNs … So, I think we did gate keep, and that’s something I have let go of. I think I’ve gotten a lot better at doing it, and for me the way I spoke my C-Framing helped me, in the gate keeping. (NFG2)

We might now direct to a different discipline so they get more support rather than gate keeping. (NFG2)

Certainly, a lot of gate keeping, if you like, about information as well, about certain clients and our—the role—the need for nurses to know some things, which was interesting sort of shift that we’ve managed over the years, and being able to say that this is actually important, everybody needs to know this information. (NFG1)
Allied professionals noted the ‘gate-keeping’ as well, with comments such as:

When I first came to Ngala 12 years ago, there was a bit of gatekeeping that went on for a male practitioner to have access to parents, you know, which were mothers. It was difficult breaking through some of that ground, and I’ve certainly seen that changed. (APFG)

The following quotation eloquently describes the shift seen by an allied professional:

I think we’ve seen a shift with nurses, who have traditionally held the position that, ‘I have the client’—that they have that authority to work with the client and the other professionals were allowed to engage the client through them, like they were the primary worker, I guess we were additional functionaries to their work, to add value and then I think over the shift in time has come, is that they now through interdisciplinary work, have actually been influenced by the fact is, that they could be challenged. They can no longer hold that role as though all that client contact must come and go through me, and I’m the holder of all that knowledge; and that has been challenged through the work of the fatherhood team and other social workers coming in, and they’re seeing the value of it. And I’ve actually seen, I think it’s become more of an interdisciplinary approach where I feel there is now more genuine respect and genuine understanding about the different skill sets that people hold, rather than it being—actually I don’t want to deal with that stuff so I will just give it to you—like the handball, ‘Oh, that’s a social worker issue …’. It was very clear demarcation about what they saw; it was very obvious what was our area of work and I think that’s become more intra-disciplinary now, because I think we now, we all hold some shared knowledge and some shared ways of practicing, which means, there isn’t such a demarcation around boundaries and practice, so that sure we know our core business and what our core training is, and we know now what their areas of core expertise are. But, it’s like we can refer to each other without their being any demarcation, and actually use each
other’s strengths, as opposed to ‘Well, that’s my area of work’ and like automatically feeling that you are being hand-balled on. (APFG)

Other changes occurring with nursing were noted, such as:

I see that as the biggest change for the nurses at Ngala, is that push to move away from the expert model … that clinical, actual diagnosis to being more holistic and putting more power back into the parents—both parents—and actually asking them what they think and what they feel solutions would be, rather than a nurse deciding what the best course of action should be. (APFG)

When I first came, there were still quite discrete roles for mothercraft nurses, social worker’s, nurses. We still had the visiting paediatrician and psychiatrist—the visiting psychiatrist registrar. And so, it was still a lot of—it was working within a team but still quite discrete areas, if you like. (NFG3)

Going back to the trans-disciplinary, interdisciplinary, and the multidisciplinary, I still think that we still have all three at Ngala. There’s some nurses who see the social worker as an add-on, and there’s some who respect other people’s knowledge and call that in, when they think it’s necessary. I think, in the helpline, the trans-disciplinary stuff happens really, really well, because everyone is learning from each other so much that if there is a crisis call a nurse or a social worker would feel comfortable to take it—even a breastfeeding issue—whatever it is. And there are certain pockets where there’s lots of resistance to actually acknowledge strengths-based. (APFG)

everyone is learning from each other so much. (NInt3)

Is it because they have been working within an interdisciplinary team that, you know, absorbed those full strength-based approaches? (APFG)
It was noted by nurses and allied disciplines that ‘The sharing of that knowledge between the different disciplines within the team has actually enabled that broader focus of working with families, to have a much more holistic approach for the way they do things’ (AP). One of the greatest benefits discussed of working together was the gaining of new knowledge.

4.2.3.5.2 Collaboration

Alongside gaining new knowledge, working collaboratively was seen as a benefit of working together, as demonstrated by the following comments:

I think a lot of that is the same way we work with families, because it is about relationship. It’s about developing a relationship. (NFG1)

Geographical co-location was a way to unite. (NFG4)

Our collaboration and team work … we work together and it flows, sometimes I have much more one-to-one contact with the nursing team and/or the nurse with the family, and I have to communicate a real lot, and sometimes it is not much needed to do that, but see because they have worked so long together, there is such a fantastic understanding between us and of each other, we know who is doing what and we don’t need to necessarily to communicate as such, there is a real flow about it. (APInt2)

With the components of early childhood and the nursing component as well. … I honestly believe that we really complement one another. (APInt1)

Working within a team, you know. … and taking all those skills and working with that … it’s very successful. (APFG)

That partnership model from an academic perspective and their ability to translate that into understanding where my skills and expertise were and where theirs lie and how we complement each other, has been really, really good. So I think if there’s that understanding, we do work really well together being held in a team, if you like, and being able to deliver a service, and learn things. (NFG1)
4.2.3.5.3 Gaining new knowledge

The variety of ways that both nurses and allied professionals discussed gaining new knowledge was demonstrated through these very rich conversations:

I’ve really enjoyed working with the psychologist here, that has been fantastic and I suppose that for me as a nurse I have a lot more affinity with her and what her discipline is … some of the skills I have picked up from her, but in the way I ask questions about them, as I haven’t done my mental health training, and that psychology that she brings to the table. (NFG2)

Because we use reflective practice as staff members within that multidisciplinary team, we, as early childhood people, learnt from that—the nurse, and how she approaches parents and so on. (APFG)

I have learnt heaps from them every day about what the nurses are talking about over 17 years and settling etc. I can talk about settling, but there is no way I can talk about breast feeding or how much a baby has to have, or the weight gain. (APInt5)

Our social workers in that their skills have gone up so much on the health side, because we have worked so closely together, that they will have their antennas out while they are talking … they will go … when they’ve finished their consult and they will go up to the colleague they are working with and say … have you noticed or while that baby was feeding it was making a funny noise or something like that cos they’re ears are open as well as their eyes. (NFG3)

The interdisciplinary team because we now work with more and more skill bases we are growing ourselves with that knowledge because we have picked those social work skills, and we’ve learnt different ways to ask questions and because we are working with so many different people we are constantly evolving. (NFG4)

… like somebody would say to you—you might pick this out of that conversation and the exact same conversation, I might pick that out of
it. And a social worker, the exact same conversation, exact same facial expression, would pick something else out of it. So, again, I think that’s why it’s really helpful to have all these different disciplines, but working as a team. (NFG1)

I think that really primary health care principles are probably a place where people can connect in that wellness model and health promotion … and that whole concept of family interaction and also promoting health and wellbeing—that whole thing can be the connecting point. The principles of PHC [Primary Health Care], they are still there behind the practice, and we as an organisation are a really good example of the principles which were laid out in the Ottawa Charter. (APFG)

And the notes … and that’s an interesting skill to have because the way a social worker takes notes compared to a nurse, is different. (APFG)

4.2.3.5.4 Reflective practice

Reflection and, in some contexts, developing a ‘one care plan’ also facilitated working collaboratively and the gaining of new knowledge:

If people, you know, have an issue with the client or what’s getting triggered for them—I’ve had people drop into my office quite often to talk about that. (APInt2)

I normally do reflections as a one-on-one, most by whoever’s referred? That’s more specific to that client. (APInt1)

It’s also helped in terms of reflection, sessions that we actually have, and so that enables different viewpoints to be expressed. (NFG2)

I’ve noticed there was a reluctance and there is a reluctance amongst nurses to engage with the Department of Child Protection because of the fear that the child is going to be removed and being aware of attachment, perhaps, and the importance of attachment, but not seeing child protection as a support for this family in this situation at the
moment, but, and so there has been a reluctance, which I think could be dangerous at times … holding off from engaging with child protection and I think, more recently, what I’ve seen in the helpline, that there is a growing awareness of child protection-type issues—when to engage child protection. (APFG)

They are always involved with the handovers and communication stuff and care plan for that family. (NFG3)

When the families come on board, we have a bit of a plan for those who will be involved. (NFG2)

Making the best fit for family, using the broadness of the team that we have, to work with them. (NFG1)

4.2.3.5.5 Nursing identity

Nursing identity was raised again by allied professionals when discussing how the disciplines work together. New employees noted that nurses can be ‘quite daunting’ when they first start. Others remarked:

Nurses have a very strong identity—as I’m a nurse and what I’m registered as is a child health nurse—these are interesting conversations that I’ve had … But, if you’re a nurse this strong identity of a nurse, it’s that allied scientist that is that superior thing. (APFG)

If someone new is coming in and observing it, I think that’s quite a difference between the way we practice. There’s a difference, I’m sure, at the way we’re practicing, which I think the nurses are quite sure of why we go about it and how we go about it, but then their expertise when it comes down to the nuts and bolts of things, so yes—there is a different way of practicing. (APFG)

That’s also problematic because they have a language of their own and even just the use of abbreviations; you know that we social workers need interpretation for what we do. And so, sort of trying to
encourage them not to use abbreviations—you know, let’s write out what they’re trying to say. (APFG)

We don’t have to be registered, whereas, nurses do. They do a child health qualification. That’s their identity with—same as psychology. If you try and water down a view of their profession because it’s tied up with pay and prestige and whatever else. (APFG)

Most of the nurses that I see here—the way that they think about clients and then the way that they interact with clients is—incredibly respectful as well, and very client-based. (APInt2)

But you do hear comments [chuckle] that if the other professions came up to the same level as the nursing profession, there would be a walk-out, you know, which would be disappointing. But there is, possibly, a few that say that nursing is a higher profession—a higher, skilled, qualified profession. (APFG)

4.2.3.5.6 The whole package

Allied disciplines discussed working as a team as ‘the whole package’. It was emphasised that:

The team works all together and the different parts make up the whole package. (APInt7)

Yes I agree … all the sum of the parts are greater than the one, like a package that is for families. (APFG)

Having discussed how nurses and allied professionals work together during phase one, the next section presents their perceptions of the present and suggestions for the future.

4.2.3.6 Nurses and allied professionals perceptions of the present situation and future suggestions for nursing in EPS

Both nurses and allied professionals, through focus groups and interviews, expressed concern about the present situation and gave suggestions for the future of nursing within EPS. The Ngala workforce has a large number of ageing nurses who will be
leaving within the next decade. It was also noted that families presenting to EPS are of a higher complexity than ever before, requiring a rethink of the workforce’s skill mix.

The suggestions for change were categorised under four headings:

- Planning future education and qualifications;
- The skill mix;
- Resources required for recruitment and retention; and
- The concept of a new EPP.

4.2.3.6.1 Planning for future education and qualifications

Nurses felt that immediate and longer-term planning for future education and qualifications was of considerable importance. The suggestions were for a postgraduate certificate for enrolled nurses in early parenting (6–12 months). The enrolled nurse would mean the introduction of a regulated worker into the workforce. There were a couple of suggestions for a nurse practitioner role for EPS, but no thought had occurred as to how this could work. The other suggestion that came forward was for an ‘early parenting professional or practitioner’, which is discussed in more detail below. This was seen as a practical solution to the decreasing nurse workforce and the move to interdisciplinary ways of working in EPS.

4.2.3.6.2 The skill mix

Clarification of the ideal skill mix was suggested to meet the needs of today’s families. It was felt by allied professionals that nurses were needed particularly where the baby was less than one year of age, and to maintain a skill mix in which nursing could input a strong child development, parenting and health perspective to the team.

All disciplines reinforced the necessity of maintaining expertise in the organisation, and discussed the need for a planned and flexible phasing out of the ageing baby boomer nurses, to retain their knowledge and experience through the mentoring of younger staff coming in.
4.2.3.6.3 Resources for recruitment and retention

To sustain a multi-generational workforce into the future, it was felt that comprehensive orientation programs and professional development needed to be provided.

Other suggestions included nursing graduate positions for EPS. Trying to attract younger nurses into this field was seen as important. It was felt this could be done by providing scholarships for nurses finishing their three-year Bachelor programs and then spending a year at Ngala in addition to undertaking their postgraduate certificates in child health. Other scholarships could be developed for allied professionals, and different types of scholarships could be offered for innovation and research.

4.2.3.6.4 The concept of a new EPP

As indicated above, the concept of an EPP or practitioner was suggested by nurses and allied professionals as a solution to the future skill mix and workforce development. This professional would have a tertiary degree prior to undertaking a postgraduate qualification in early parenting.

The concept of the EPP was explored through a number of the focus groups and interviews. Comments such as that below began consideration of the possibilities:

Given there is quite a bit of overlap in roles, there could be a type of qualification like the child health nurses do, for other disciplines wanting to work in this area, to give them a lot more practical knowledge about child development and parenting. (APInt3)

Initially when I first came here, there was a lot of gate keeping by nurses and for example, social workers felt very undervalued … it was very fragmented and not much sharing of knowledge. Now it is a different picture with the sharing on both sides and allowing other disciplines to have knowledge on things like feeding and nutrition, an understanding of what’s appropriate for ages, aside from the normal developmental milestones. It’s amazing how much knowledge they gain from working with nurses and vice versa. (FG3)
This concept was the result of both groups describing the overlap that occurs in early parenting work, especially given the complex nature of working with families. Further questions through focus groups and interviews were asked as to what this would look like and what would be the knowledge and skills required.

The proposal was to offer a postgraduate qualification in this area of work for a range of allied disciplines such as occupational therapy, psychology, social work, speech therapy, physiotherapy and early childhood education. This would not replace nurses or any current discipline mix but add value to the current workforce and a new dimension to interdisciplinary team work. Nurses have a broad range of skills and experienced nurses who have had many years of experience and educational up-skilling can do this role. The sense was though that other allied disciplines could also do this work once they have the appropriate qualifications; they could be frontline practitioners along with nurses. An allied professional stated that:

… it will be necessary when these experienced nurses leave that we will have a less experienced workforce which could do with further knowledge and skills through a postgraduate qualification. (FG6)

Allied professionals remarked that ‘in the current system nurses have taught us a lot and vice versa’ (FG6). They also noted that:

… the family partnership model from an academic perspective and their [nurses’] ability to translate that into understanding where my skills and expertise were and where theirs lie and how we complement each other, has been really really good. (FG6)

… we could easily move into more a trans-disciplinary team model in some of the aspects of our work at Ngala because those of us who have been here a long time have expanded our knowledge base just like the nurses, so we can see where there is certainly the possibility of a generic EP worker where they are or could be the first line of contact in a team and expected to know when to call in the others. (FG6)

The sense from the allied professionals was that they would not be the same as a nurse because of their background, but could understand the broader concept of
working with parents and have a deeper understanding of the practicalities of parenting, some health implications, the psychosocial issues, child development, perinatal and infant mental health and child protection. One allied professional noted that:

You know with all the areas we deal with in early parenting I don’t think there is anything magical around any of those areas that anyone is holding onto anymore. I think what—where the extremities are, is that sort of different assessment frameworks around you know, where people are at, and that brings the two lots of expertise together, the family functioning the psychosocial and physical development. (APInt5)

One nurse described how she saw the overlap in knowledge over time, and how a social worker had benefited from nursing input using her observation skills:

The other day the social worker was seeing a woman who had presented with a range of issues and was undertaking a psychosocial assessment as the presenting issue. She was noticing the baby breast feeding while they were talking and the unusual noise the baby was making while feeding and had picked up an attachment issue. She was then able to get the nurse to do a further assessment. (Int4)

The point above indicates that other disciplines are able to accommodate basic knowledge on a range of parenting issues that can also provide an initial first contact. In a trans-disciplinary setting with intensive or specialised work in early parenting, professionals can often be the first point of contact for the initial assessment within a team context, with other disciplines responding to specific needs such as a lactation consultant or child health nurse. The skill mix consideration still needs to be dependent on the early parenting context, but an EPP could be developed to take on a range of early parenting work in early childhood, community and parent education settings.

Figure 88 demonstrates the addition of an EPP who would work alongside nurses and other disciplines within an interdisciplinary team.
Nurses and allied professionals were asked what skills and knowledge would be required for this role. Figure 89 lists the knowledge and skills that might be offered during a postgraduate qualification in early parenting.

**Figure 88. The concept of the EPP**

**Figure 89. The skills and knowledge for an EPP**
It was envisaged by some nurses and allied professionals, that if an allied professional were to undertake a postgraduate certificate or diploma in early parenting, then this would be modular-based and undertaken by external studies and/or face-to-face block studies. Depending on the background of the professional, they may receive recognition of prior learning if, for example, a social worker had done work and studies previously in the perinatal mental health area. The key components of a postgraduate qualification were considered to be:

- Child development and early brain development;
- Parent development and transitions;
- Working with parents—individual, groups and community;
- Primary health care practice, health education and promotion;
- Perinatal mental health and parent–child attachment;
- Family partnership approaches;
- Interdisciplinary approaches and team leadership;
- Assessment—individual, parent and child, and family;
- Families and children at risk;
- Interdisciplinary research and evaluation.

4.2.4 Summary of Phase One

In this section, the demographics of the participants in phase one were described, and a summary of the nursing role through Ngala’s 121 years of history was presented. This period reflected influences from a range of factors and changes that have made nursing in EPS what it is today.

The perception of both allied professionals and nurses of the uniqueness of the nurse’s role and how they work together was also described in this section. The focus groups, interviews with staff at Ngala and the written nursing journals all provided a rich description of the uniqueness of the nursing role within an interdisciplinary team. In addition, a number of suggestions for consideration in future workforce planning were made by the participants.

Following phase one, the findings were summarised and presented via teleconference to nine EPS in Australia. The findings from the discussions that comprised phase two of this study are presented in the following section.
4.3 Phase Two: National Teleconferences

4.3.1 Introduction

This phase drew on the data collected during the first phase to create a synthesis of the findings to present to national EPS. A national webinar was planned, but due to technical difficulties was abandoned. Teleconferences were then organised as an alternative for each national site. In this section, the demographics of the participants involved in phase two are given to provide a context for the findings. The findings from the data collected during this phase are then presented.

An analysis of key documents was undertaken for each State, to determine how the services involved in the study had originated, and the current service context. Chapter Three discussed the past and present of these services in detail, and the following is a summary for each State.

1. Western Australia—Ngala is the only service of its kind in WA and is unique in being registered as a private hospital rather than a not-for-profit organisation. Ngala originated in 1890 as the ‘House of Mercy’ in Perth and is one of the oldest charitable organisations in the State, with a long history as a nursing organisation until the 1990s when other disciplines were introduced. It has been growing exponentially over the past decade with its interdisciplinary team, and is a well-known brand in WA, providing a range of universal, specialist/intensive and targeted services (Ngala, 2012a).

2. South Australia—Torrens House is the only service in SA. It is a government service aligned with other women’s and children’s services. Torrens House was established in 1938 as a mothercraft home and training facility. It is now a community residential unit located in Adelaide and offers a free service to families with infants aged up to 12 months. Families are admitted to Torrens House when requiring additional assistance with unresolved feeding, settling and sleeping issues (Parenting & Child Health, 2012).

3. Tasmania—The Mothercraft Home and Training Centre in Hobart was established in 1925 (Brennan, 2007). The Home was decommissioned in the early 1990s and three day stay parenting centres in each region were established as part of the broader universal child health system.
4. **Victoria**—There are three EPS in Victoria, which together provide state-wide services: Tweddle Child and Family Services, The O’Connell Family Centre and the QEC. Tweddle was established in 1920 as a hospital for babies and school of mothercraft and Plunkett nurses. The O’Connell Centre was established in 1931 by the ‘Grey Sisters’ as a training school of social service and mothercraft. The QEC commenced as the Carlton Refuge Home in 1854 and changed to the QEC in 1951. All services now provide residential and day stay facilities, group sessions and information sessions and individual services (Mercy Health, 2012; Queen Elizabeth Centre, 2012; Tweddle Child & Family Health Service, 2012). These services are closely associated with government but stand alone as services in their own right.

5. **New South Wales**—There are two services in NSW, which together provide state-wide services: Tresillian Family Care Centres and Karitane. Tresillian was established in 1921, and trained nurses in mothercraft and infant welfare. Karitane Mothercraft Home opened in 1924 and also provided training for nurses. Both services now provide residential and day stay services and a range of other early parenting community services (Karitane, 2012; Tresillian, 2012). These two services are well aligned with the government service system, although they stand alone in their own right.

6. **Queensland**—The Ellen Barron Family Centre is the only service in QLD. A mothercraft home was set up by government in 1941 at the Lady Lemington Hospital and others were set up throughout QLD during the 1940s to 1960s (McFarlane, 1968). The Ellen Barron Family Centre evolved from the Riverton Parenting Centre and now provides a free 24 hour specialist residential service to Queensland families with children aged from birth to three years who are experiencing parenting issues of a complex nature (Community Child Health Services, 2012). This is part of a broader universal community child health system.

The national setting informs the study demographics, as presented below.
4.3.2 Demographics

The national cohort of nurses working within EPS is given in Table 6. The total group for phase two was 45 (up to five at each of the nine sites), with 38 nurses participating through the national teleconferences.

The Tasmanian South Parenting Centre was excluded from this study because they employ only nurses (n 9) through their centre. Therefore, the total cohort was 438 nurses nationally.

Table 6. National numbers of nurses in EPS (January 2011)

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>WA</td>
<td>52</td>
</tr>
<tr>
<td>NSW</td>
<td>227</td>
</tr>
<tr>
<td>QLD</td>
<td>54</td>
</tr>
<tr>
<td>VIC</td>
<td>81</td>
</tr>
<tr>
<td>SA</td>
<td>16</td>
</tr>
<tr>
<td>Tasmania N/NW</td>
<td>8</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>438</strong></td>
</tr>
</tbody>
</table>

During phase two, a teleconference was held with each of the nine national sites. Prior to the teleconference, the nurses completed a group demographics survey from their site, indicating their age, qualifications, number of years worked within EPS and how long they anticipated to continue working within EPS. Data collected from this survey are displayed in Table 7 below. The 38 nurses participating were all female and the demographics were congruent with the national cohort of nurses within EPS.

Table 7. National teleconference participants

<table>
<thead>
<tr>
<th>No. sites</th>
<th>Participants</th>
<th>Average age</th>
<th>Length of time with EPS</th>
<th>Intention to stay?</th>
<th>Qualifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>38</td>
<td>52</td>
<td>5–20+ yrs</td>
<td>3–20 yrs</td>
<td>RNs (child health nurses) and mothercraft nurses</td>
</tr>
</tbody>
</table>

A presentation of the proposed research via teleconference (see Appendix 12) to the group of nurses at each site was undertaken to give a background of the researcher and the study. The findings from phase one were presented, including the role of the nurse from the 1940s to 1980s, an overview of the current context at Ngala, what had changed for nurses over time, the interdisciplinary team context compared with a
multidisciplinary one, a breakdown of perceptions of the nurse’s role, the perceptions of what is unique to the nurse’s role when working with other disciplines, the overlap in roles, and the proposal of a postgraduate qualified EPP. Ideas for the future were also presented from phase one, and feedback was obtained on what knowledge and skills would be required for an EPP and other workforce considerations.

A second group questionnaire (see Appendix 15) of nine questions was completed during the teleconference. These questions were initially designed for the webinar and comprised specific statements and questions to elicit key information from participants. The group participants were to come to a consensus during the teleconference on all nine questions and then email the results to the researcher following the teleconference.

4.3.3 Findings of Phase Two

The nine questions posed during the teleconference are presented in Table 8, with the percentage of agreement from the total sites.

Table 8. Summary teleconference questions

<table>
<thead>
<tr>
<th>No.</th>
<th>Statement or Question</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Nurses working within EPS over the past 10–15 years have moved from an expert approach to working in partnership with families.</td>
<td>100.0</td>
</tr>
<tr>
<td>2.</td>
<td>Nurses are more open to working collaboratively with other disciplines.</td>
<td>100.0</td>
</tr>
<tr>
<td>3.</td>
<td>Nurses now integrate evidence and reflective practice in their daily work with families.</td>
<td>100.0</td>
</tr>
<tr>
<td>4.</td>
<td>Nurses working in EPS are confident and experienced practitioners.</td>
<td>100.0</td>
</tr>
<tr>
<td>5.</td>
<td>Does this description of the nursing role fit within your context of nursing within EPS?</td>
<td>100.0</td>
</tr>
<tr>
<td>6.</td>
<td>Do you agree with this summation of the uniqueness of the nursing role?</td>
<td>100.0</td>
</tr>
<tr>
<td>7.</td>
<td>Do you agree with the concept of the EPP or practitioner?</td>
<td>78.0</td>
</tr>
<tr>
<td>8.</td>
<td>Have all the knowledge and skills been captured?</td>
<td>100.0</td>
</tr>
<tr>
<td>9.</td>
<td>What other issues and considerations need to be thought about for the future?</td>
<td></td>
</tr>
</tbody>
</table>

The first four survey items were statements or assumptions arising from phase one. These were agreed to by all nurses.

It was commented on by the nurses that nationally all sites have progressed or realigned their philosophical approaches in terms of strengths-based practice and working in partnership with families. Nurses were also open to working
collaboratively with other disciplines and supported reflective practice approaches and the commitment to evidence-based practice.

The fourth statement was ‘Nurses working in EPS are confident and experienced practitioners’. Nurses agreed on the whole that most nurses working within EPS are confident and experienced. Although this was a point of discussion, nurses explained it was due to the longevity of current staff within EPS. Many nurses were from the ‘baby boomer generation’ and many had undertaken a combination of hospital-based and tertiary qualifications. Most nurses agreed that it takes approximately two years to become confident with the area of work within EPS. They reinforced the need for mentoring, whereby ‘we need a small number with a skill mix of inexperienced staff, as that is how they best learn and grow working alongside experienced practitioners’.

Some sites in one State had a greater ratio of inexperienced staff and discussed the difficulties of lack of experience in their training. This State produces a two-year graduate certificate from Swinburne University—‘Graduate Certificate of Social Science in Prenatal and Postnatal Family Support’. The staff with this qualification are added to the skill mix in these three EPS. The other difference in this State is that child health nurses must have a midwifery and child health qualification to work in maternal and child health centres. This is different to all other States.

For survey question five, there was agreement by all nurses that the nursing role presented and described in the presentation was reflective of their own site context of nursing.

Question six was also agreed to by nurses at 100 per cent. The only addition by one site was the ability to perform emergency intervention and look after children with complex medical needs. While this was only necessary very occasionally, it was emphasised that this was justification for requiring nurses in the event that it should occur.

A concept that evolved from the first phase was the role of the EPP (see Section 4.2.3.6.4). A description of the concept was presented at each teleconference and nurses were asked for their views in question seven. There was general agreement with this concept (78 per cent). Two out of the nine sites did not agree (22 per cent) with the concept of the EPP (that is, a professional with a baseline degree such as
social work, occupational therapy, speech therapy, psychology, early childhood education undertaking a graduate diploma in early parenting practice).

Generally nurses agreed that it was necessary to find new ways of looking at the workforce. The issues that were in opposition to this concept were statements such as:

- ‘Nurses do this work in EPS’ (TC4);
- ‘Nurses need to work in this field and have a range of qualifications available and upgrade their current qualifications to a Master’s level’ (TC3); and
- ‘It is a specialist field for nursing’ (TC4).

As well as the above, concern was expressed by a few nurses that, over time, there could be a push for lower-level workers in EPS, which would reduce the overall quality of care for families and result in less nursing positions being made available.

In response to question eight, all nurses agreed that the list of knowledge and skills developed from phase one were comprehensive for the EPP role. The following sections outline the findings from the teleconferences as elicited by question nine:

**What other issues and considerations need to be thought about for the future?**

4.3.3.1 Workforce planning

Participants spoke of the need for workforce planning around a number of issues. These centred around the following concepts:

1. Increased availability of professional development and education;
2. The need for a mix of skills, dependent upon the context within EPS;
3. The retention of ageing nurses and the need for a mentorship program;
4. Changes in technology; and
5. The need to promote and increase research in the area of EPS.

These concepts for workforce planning are presented in Figure 90 and discussed in greater detail below.
4.3.3.1.1 Increase availability of professional education for the EPS sector

Overall, nurses thought there was not enough education in relation to further skill development for communication and family partnership processes, reflective practice and working with challenging behaviours. An increased focus on early interprofessional cross-training in degrees for disciplines was identified as necessary to ensure less mono-discipline focus.

4.3.3.1.2 Skill mix

The ratio of the nursing workforce was considered to depend on the context in EPS. Nurses gave examples such as:

- Residential facilities may have a higher ratio of nurses because of the 24 hr care required compared to that of the requirements of a parent education team.
- When establishing breastfeeding and in addressing parenting issues, complex medical issues come from paediatrics (for example, naso-gastric feeds), and it is necessary to teach families to care for the child in the community (for example, the transfer of families into the unit for parent education). As such, a different skill mix is required.
- Although not common, antenatal mothers sometimes require transfer for methadone assessment and parenting education.
Nurses encouraged the establishment of graduate programs and an allocation of new positions each year ‘to ensure we get in early in a nurse’s career and enable security of positions rather than casual’ (TC2).

The addition of a postgraduate certificate for enrolled nurses would add to a tiered system: ‘The history and training of mothercraft nurses throughout EPS has been a good idea—the future addition to the workforce of enrolled nurses with an additional certificate in early parenting would be a welcome resource’ (TC7).

4.3.3.1.3 Staff retention and Mentorship

Nurses encouraged the establishment of a sustainable mentorship system and the development of an innovation fund for scholarships and other strategies to attract and retain nurses:

At present there is still too much difference in approaches and philosophies but would be helpful to unite and build influence nationally. There is a need for mentorship and experienced nurses imparting to new graduates. Graduate positions and scholarships would assist in recruitment and retention. (TC1)

4.3.3.1.4 Technology

Some of the discussions emphasised that a ‘Move towards technology-based parenting services as the level of change … requires an investment in this area. Many older staff are already finding this often quite difficult. Blogging, Twitter, Facebook, Apps etc.’ (TC1), and it was deemed important to ‘Mak[e] sure resources out there are reputable and informed by evidence’ (TC2). Skill development for the workforce and the understanding of technology needs to be factored into future service planning:

Moving client records and nursing documentation from paper-based systems to use of technology-based systems. Many current staff find it difficult to keep up with the change in technology, even basic computer skills. (TC5)
4.3.3.2 Promotion of EPS work and increase research

Nurses also recommended promoting the profile of nursing within and external to EPS as potentially beneficial to a number of stakeholders. In addition, they suggested a greater focus on research in EPS: ‘the narrative of the history of the nursing profession and showcase our speciality in EPS as an ongoing thing for the future’ (TC5).

4.3.4 Summary of Phase Two

Phase two built on the findings from phase one by using a summary of the phase one findings to elicit level of agreement and further input from a national cohort of nurses working in EPS. The nine site teleconferences resulted in rich data from each group of nurses.

In this section, the demographics of the national participants were outlined, as were the findings from the data analysis from the teleconferences. The questionnaire used had nine questions for each group, which on the whole validated the work in phase one. The feedback from the nurses participating in phase two was consistent with that gathered through phase one.

The findings from this phase were synthesised to inform the development of the questionnaire for implementation in phase three.
4.4 Phase Three: National Findings

4.4.1 Introduction

The findings from phases one and two were used to develop the third phase. It was decided to have three major components of focus in the questionnaire: the demographics, the current context of nursing and future directions for the next 3–5 and 5–10 years.

The ‘current situation’ section needed to validate assumptions and agreement from previous phases. It thus included statements of:

1. whether it was essential for nurses working within EPS to be experienced;
2. whether nurses maintain a unique role within an interdisciplinary context; and
3. whether there were concerns for nursing nationally.

The third component of future directions considered statements related to:

1. national professional development;
2. the development and availability of innovative options for post-qualification education;
3. further research;
4. a workforce development strategy;
5. skill mix considerations for the various practice contexts;
6. marketing, recruitment and sustainable strategies for a multi-generational workforce; and
7. retention strategies for the ageing workforce.

The first part of this section presents the demographics of the phase three participants to give context to the findings from the data analysis.

4.4.2 Demographics

The survey was distributed nationally. Participating States included WA, SA, Queensland, NSW, Tasmania (North and Northwest) and Victoria. Reminders were sent regularly over the six-week period during which the survey was open, and the response rate was 37 per cent. See Figure 91 and Table 9 for a breakdown of the individual State response rates.
A total of 447 nurses work within EPS in Australia. Given the exclusion of the Tasmanian South Parenting Centre (n 9) and the 13 nurses involved in the pilot test of the questionnaire, the total number that could participate in the survey were 425. The response rate was 37 per cent.

### Table 9. Response rate to the survey by State

<table>
<thead>
<tr>
<th>States</th>
<th>Total number of nurses</th>
<th>Number responding to survey</th>
<th>% response rate by State</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td>227</td>
<td>53</td>
<td>23.5</td>
</tr>
<tr>
<td>VIC</td>
<td>81</td>
<td>40</td>
<td>49.5</td>
</tr>
<tr>
<td>WA</td>
<td>52</td>
<td>36</td>
<td>69</td>
</tr>
<tr>
<td>QLD</td>
<td>54</td>
<td>15</td>
<td>28</td>
</tr>
<tr>
<td>SA</td>
<td>16</td>
<td>9</td>
<td>56</td>
</tr>
<tr>
<td>N/NW TAS</td>
<td>8</td>
<td>4</td>
<td>50</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>425</strong></td>
<td><strong>157</strong></td>
<td></td>
</tr>
</tbody>
</table>

For the first six questions there was a 100 per cent response rate (that is, responses from all 157 nurses). The response rate to question seven onwards was less than 100 per cent, and respondent numbers will be indicated with each question.

Tasmanian nurses in the Southern Parenting Centre were surveyed separately because they do not employ allied professionals. This was to ascertain whether their perceptions of the current and future of nursing differed from the main body of respondents. Thirty-three per cent (n 3) responded and their responses were similar to the larger survey. Their age range was between 40 and 64 years and they were qualified as child health nurses. Two out of three respondents stated they worked closely with other disciplines; that is, they worked in a multidisciplinary context and
refer, liaise or consult with other professionals for a variety of reasons during their daily work (Moon, 2012).

### 4.4.2.1 Age of nurses participating nationally

The ages of 69 per cent of respondents were between 50 and 70 years. The breakdown into age categories is given in Table 10 and Figure 92.

#### Table 10. Age of respondents

<table>
<thead>
<tr>
<th>Age categories national sites</th>
<th>Number of respondents</th>
<th>Percentage (%) respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>20–29 yrs</td>
<td>3</td>
<td>2.0</td>
</tr>
<tr>
<td>30–39 yrs</td>
<td>11</td>
<td>7.0</td>
</tr>
<tr>
<td>40–49 yrs</td>
<td>35</td>
<td>22.3</td>
</tr>
<tr>
<td>50–59 yrs</td>
<td>82</td>
<td>52.2</td>
</tr>
<tr>
<td>60–64 yrs</td>
<td>22</td>
<td>14.0</td>
</tr>
<tr>
<td>65–70 yrs</td>
<td>4</td>
<td>2.5</td>
</tr>
<tr>
<td>70+</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>157</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

As shown in the table above, the largest cohort of nurses were in the 50–59 age group, followed by the 40–49 age group. The 60–70 age group was at 16.5 per cent.

![Figure 92. Response to ‘Please indicate your age category’](image)

#### 4.4.2.2 Longevity of work in EPS

Nurses were asked how long they had worked within the EPS context. Figure 93 and Table 11 highlight that 85 per cent of the nurse respondents were very experienced in EPS, having greater than five years’ experience. Sixty-five per cent had worked in EPS for more than 10 years, indicating a considerable knowledge base in early parenting. Currently, EPS is seen as a specialist area of work by the nursing
profession. The workforce’s longevity of involvement in the same area of work is consistent with current workforce figures, being primarily comprised of generation X and baby boomer generation workers (that is, 40–70 years old). This may have implications for future workforce considerations.

<table>
<thead>
<tr>
<th>Longevity of work in EPS (years)</th>
<th>Number of respondents</th>
<th>Percentage (%) respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–4</td>
<td>23</td>
<td>15.0</td>
</tr>
<tr>
<td>5–9</td>
<td>31</td>
<td>20.0</td>
</tr>
<tr>
<td>10–14</td>
<td>32</td>
<td>20.0</td>
</tr>
<tr>
<td>15–19</td>
<td>25</td>
<td>16.0</td>
</tr>
<tr>
<td>20+</td>
<td>46</td>
<td>29.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>157</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

**Figure 93. Response to ‘Longevity of work within EPS’**

**4.4.2.3 Nurses’ indication of how long they will continue to work within EPS**

Nurses were asked to state how long they expected to work within EPS. The results are indicated in Figure 94 and Table 12. Fifty-six per cent of participants will be leaving in the next nine years (n 88). This finding was not surprising, as 50 per cent of nurses in a national study indicated that ‘half are set to leave the profession in the next decade’ (Nursing Review Online, 2012). In the next 14 years, 77 per cent of the nursing workforce will be leaving EPS.
Figures 94. Response to ‘Nurses indicating continuation of work within EPS’

Table 12. Nurses indicating continuation of work within EPS

<table>
<thead>
<tr>
<th>Continuation of work within EPS (Years)</th>
<th>Number of respondents</th>
<th>Percentage (%) respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–4</td>
<td>37</td>
<td>23.5</td>
</tr>
<tr>
<td>5–9</td>
<td>51</td>
<td>32.5</td>
</tr>
<tr>
<td>10–14</td>
<td>33</td>
<td>21.0</td>
</tr>
<tr>
<td>15–19</td>
<td>18</td>
<td>11.5</td>
</tr>
<tr>
<td>20+</td>
<td>18</td>
<td>11.5</td>
</tr>
<tr>
<td>Total</td>
<td>157</td>
<td>100.0</td>
</tr>
</tbody>
</table>

4.4.2.4 Qualifications

Nurses were asked to provide their qualifications. Out of 157 nurses, there were 118 registered nurses, 42 per cent had a Bachelor degree, and of these 38 per cent had a Master’s degree.

Of the total number of RNs, 89 per cent were child health nurses (n 106) and a large percentage of RNs had undertaken midwifery (n 96). There were also five mental health nurse respondents. Sixteen per cent of respondents were mothercraft nurses (n 25) (see Figure 95).
Given the age of the participants, almost half of the registered nurses had been through the hospital-based training certificates and then possibly undertaken tertiary qualifications. Fifty-eight per cent of the respondents had not undertaken a degree following their hospital-based training. This dimension of the skill mix will not exist 10 years from now once the baby boomer generation have left the workforce. ‘Other’ qualifications listed were predominantly certificates in lactation consultancy and paediatrics.

4.4.2.5 Nurses working with other disciplines

Nurses were asked whether they worked closely with other disciplines. Prior to the survey, it had already been ascertained that all sites in Australia employed allied professionals in varying numbers, with the exception of the Southern Parenting Centre in Tasmania. All sites had a commitment to strengths-based, solution-focused work and family partnership or C-Frame philosophies. As represented in Figure 96, 91 per cent of nurses within EPS work closely with other disciplines.
The nurses that did not report working closely with other disciplines were in management roles, casual positions or in other roles such as night shift or education, in which they saw themselves working independently of other disciplines.

The researcher wanted to understand the depth of work that nurses undertook with allied professionals; that is, whether they:

- worked closely on a daily basis with allied professionals, as well as experiencing reflective practice in teams;
- worked with allied professionals regularly but did not undertake reflection in teams; or
- referred only to allied professionals.

Out of those nurses that indicated they worked closely with other disciplines:

- 67 per cent did so on a daily basis;
- 22 per cent did so regularly, but with no reflection in teams; and
- 11 per cent referred only (see Figure 97).
Figure 97. Response to ‘indicate how you work with allied professionals’

Overall, the demographic data revealed that there were similar characteristics throughout national EPS. The discussion below will present the findings obtained from phase three of the study, which are divided into two aspects: the current situation of nursing with EPS, and the future.

4.4.3 Findings of Phase Three

4.4.3.1 The current situation

In this section of the survey, nurses were asked about the current situation of nursing within EPS. Certain issues were discussed by a percentage of respondents from phases one and two, and it was thought important to include these in the national survey to gain clarification and follow up. The three elements requiring a national perspective are highlighted in Table 13. These questions were responded to by 152 nurses.

Table 13. Three issues on which a national perspective was sought

<table>
<thead>
<tr>
<th>No.</th>
<th>Statement</th>
<th>Number of respondents</th>
<th>Percentage agree/strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>It is essential that nurses working within EPS are experienced</td>
<td>123</td>
<td>81</td>
</tr>
<tr>
<td>2.</td>
<td>Nurses maintain a unique role when working within a collaborative partnership model with other disciplines</td>
<td>136</td>
<td>89</td>
</tr>
<tr>
<td>3.</td>
<td>There are concerns nationally for the future of nursing in EPS</td>
<td>102</td>
<td>67</td>
</tr>
</tbody>
</table>

Each of the three above statements will now be explored in more detail.
4.4.3.1.1 Agreement that nurses working within EPS should be experienced

As noted during the phase two data analysis, there was discussion about the experience level of nurses working within EPS. As seen in Section 4.4.2.3, a large percentage of nurses within EPS are very experienced due to their age and length of time working within EPS. Respondents agreed or strongly agreed at a rate of 81 per cent (n 123) that it is essential that nurses working within EPS are experienced. Figure 98 below gives the response breakdown.

![Response to ‘It is essential that nurses working in EPS are experienced’](image)

**Figure 98. Response to ‘It is essential that nurses working in EPS are experienced’**

The qualitative responses elicited by this statement (n 60) fell into three categories. In order of priority, these were:

- The skill mix should reflect more experienced numbers of staff;
- Mentoring systems need to be in place for inexperienced staff; and
- Personal attributes are as important as experience (see Figure 99).
Figure 99. Qualitative response categories for ‘nurses working in EPS are experienced’

Nurses expressed the need for nurses with experience to be in the majority due to the complex nature of clients:

The skill mix needs to have the majority of experienced nurses and smaller numbers of new grads or inexperienced.

Nurses have to have experience as the issues are so complex for a beginning practitioner.

However, it was noted that experienced nurses can then mentor less experienced nurses. The following are quotations from the nurses describing these themes:

I feel good support in the workplace from more experienced colleagues will encourage this experience.

This would depend on the how ‘experienced’ is defined—having years working in an area may not mean a person’s practice or skills have evolved. Knowledge may be mediated by skills and personal attributes.

Overall, 19 per cent of nurses felt ambivalent or disagreed strongly that it is essential that nurses working within EPS are experienced. The negative responses referred to the current situation not requiring nurses to be experienced in the area.
It was also evident that some viewed ‘experience’ in itself as not as important as how one works in partnership and whether leadership skills are evident:

Yes working with vulnerable families so the skill mix has to be majority experienced.

I think personal attributes are as important as experienced … Experience can mean inflexible …

This disagreement also related to the fact that some nurses felt the workforce needed a different skill mix to encourage younger staff and to focus on attributes or best fit for the job:

I think the nurses and allied health need to have a good sound knowledge base for all the areas of both clinical and professional domains regarding best practice when working with families and young children. However when employing staff, I would rather recruit staff with the knowledge and evident helpful interpersonal skills and qualities and no experience in the field over someone who had good experience but could not demonstrate the qualities of humility, genuineness, honesty, respect, some positiveness or enthusiasm.

The next section discusses the responses from nurses about the uniqueness of the nursing role within an interdisciplinary team context.

4.4.3.1.2 Agreement that nurses should maintain a unique role

Nurse respondents who agreed/strongly agreed to this statement were 89 per cent (n 136). As discussed in phase two, this concept of ‘uniqueness’ was raised during the first phase and then again in phase two. This came about as a result of nurses and allied professionals discussing their perceptions of the nursing role, and noting the overlap between disciplines. They were then asked what was unique to the nursing role and a description was developed and agreed to by nurses in phase two. The following graph in Figure 100 depicts the response breakdown to this statement.
The qualitative responses to this statement (n 42) engendered rich data. The key categories arising were:

- The importance of collaboration with other disciplines;
- The specific knowledge base of nurses is child health, development and parenting;
- Nurses have a strong health perspective; and
- Linking role;
- Nurses take a holistic view;
- Nurses have a strong coordination role;
- Nurses are trusted in their role;
- Nurses’ perception of value by others.

These categories are presented visually in Figure 101, and will be described in order of priority.
Figure 101. Qualitative responses to ‘nurses maintain a unique role within EPS’

1. Collaboration with other disciplines was seen as important to the nurses.

In regards to collaboration with other disciplines, nurses reinforced that ‘early parenting crosses a broad section of concerns and no single discipline can possibly offer the range of support that a group of disciplines can’. They also stated that ‘nurses need to realise where their expertise ends and where other allied health professionals can support the families in partnership’.

Emphasis was placed on the holistic nature of what can be achieved ‘together’ rather than separately. One nurse stated ‘It provides an opportunity to provide more holistic care and support for parents if multidisciplinary teams can work together harmoniously and respectfully of each other’s profession’. The reason that teams collaborate is to achieve the goals of the family in partnership. ‘Nurses need to see that we are all working to the same goal the welfare of the parents and children. Our communication needs to reflect that open partnership model’.

2. The specific knowledge base of nurses is child health, development and parenting.

The views of nurses on their specific knowledge base were that ‘Nurses bring specific professional knowledge of child health, development & parenting to working with families’, and ‘generally CHNs have a rounded training and have a holistic
approach to care which complements their knowledge in maternal health and child
development’.

They have a:

broad knowledge on child, family and community health and
wellbeing [that] enables them to make skilled assessment and
implement comprehensive plan of care.

One nurse stated that:

all disciplines bring different strengths and knowledge. Nurses
maintain strong child health knowledge.

3. **Nurses have a strong health perspective.**

On the topic of nurses’ strong health perspective, comments included that ‘Nurses
come from a background of understanding health and ill health and recognise the
body’s physical reactions related to the above’, and ‘nurses have a more holistic
approach as they cross the dimensions from child health to psychosocial issues,
health promotion and illness prevention and intervention’.

Other statements included:

Nurses can look at many aspects prevention, promotion, times of
illness and health.

Nurses with the background in illness can be more aware of possible
underlying medical issues that in the young will impact on their
ability to settle, eat and behave etc.

4. **An emphasis on nurses having a linking role.**

Statements from nurses reflected their linking role: ‘nurses in my experience are
often the “lynch pin” between all services’, and ‘nurses are the link for the parent and
the child with the allied professionals’.

5. **Nurses take a holistic view.**

The following quotation typifies the nurses’ responses on their holistic view:
I think that nurses tend to hold the broader overview of the child and family understanding their physical, mental, emotional health while understanding nutrition, development, relationships etc. Nurses tend to see the whole picture from a wide perspective—I believe that the other practitioners, while specialists in their own areas, have a narrower view.

6. **Nurses have a strong coordination role.**

Nurses have had a long history of coordination being a strong component of their role. Statements reflecting this were:

… and they are the main coordinators between services …

Nurses are at the forefront of clinical services and awareness of the day-to-day running of a ward/unit which places them in a unique position to work in consultation and collaboratively with other disciplines, especially considering their training and experience.

This has often come about due to the nature of nurses providing round-the-clock services. As one nurse stated:

Agree with what has been noted re the nursing role with its broad knowledge base and professional identity. Also it’s nurses who do the majority of continuing of practice of care with the families.

Another nurse stated:

Usually able to bring their experiences with their clients often over a larger number of contact hours.

7. **Nurses are trusted in their role**

Nurses felt they were trusted:

Nurses are perhaps the only discipline that works so closely with families on a day-to-day basis, are trusted and allowed into a family’s life on such a personal level.
8. Nurses’ perception of value by others

The question of value by others was not evident within the first two phases of the study. The researcher did not observe nurses to feel a low level of value or worth by other disciplines. Concern had been expressed by nurses on actual and potential funding cuts to services and the need to profile the work of EPS, but not in terms of being less valued by other disciplines.

Below are quotations from nurses from this phase, reflecting this perception of value. There was a contradiction, as some nurses felt valued by others while some did not:

Nursing input at our meetings is unique and highly regarded as important.

… although we do not always feel equal

This can be true, however I feel that the nurses role is sometimes diminished by other disciplines. Everyone has taken a slice from the nurse’s pie and there seems to be not much left for EPS nurses to do.

It is possible that nurses have not been able to articulate what nurses bring to the interdisciplinary context, as reflected in the following statement:

Although nurses have a great deal to offer within a multidisciplinary partnership other disciplines are not yet recognising or acknowledging the level of nursing expertise and skills that nurses provide. There is very little professional courtesy from other disciplines often requiring nurses to prove their professional value.

Eleven per cent of nurses disagreed that nurses maintain a unique role when working within a collaborative partnership model with other disciplines. It was not clear whether they had read the background paper for the study prior to completing the survey. Some of the comments reflected positive statements and some may have misunderstood the word ‘unique’. Below are examples of this:

They may have a unique perspective however I am not certain their role is any more unique than any of the other disciplines.
I am not sure what you mean by unique I did read the document attached to the email. I think the idea of uniqueness actually is a barrier to collaborative work, that everyone in a team brings with them, from their experiences in their role/s and their formal training a sense of meaning from their interactions and understanding of the families story, and together these views help to get a sense of a clear picture of what is happening for a family and the what possibly is the best way forward. I am not sure if suggesting that nurses are unique is trying to imply that allied health don’t work in a collaborative partnership model? From my experiences that is not how they see it. However what is evident is that not everyone regardless of the discipline has the same construct of what collaborative practice and working in partnership actually looks like in practice, it seems to me that there is still a lot of nice experts from all disciplines, which makes genuine and effective team collaboration difficult.

The following is the last statement under the section of ‘the current situation’. It looks at nurses’ perceptions of and concerns for the future.

4.4.3.1.3 Agreement that there are concerns nationally for the future of nursing in EPS

During the first two phases, concerns were raised about the future of EPS. It was deemed important to determine whether such concerns were evident through the national survey and whether there were any additional concerns that had not been raised in the earlier phases.

Although a majority of respondents (67 per cent) agreed with the statement that there are concerns for nursing, a further 23 per cent were ambivalent and neither agreed/disagreed that there were concerns. The following graph in Figure 102 depicts the responses to this statement.
Figure 102. Responses to ‘There are concerns nationally for the future of nursing in EPS’

The qualitative responses will be presented for those who agreed and those who expressed ambivalence. A number of categories of concerns were highlighted and these are presented visually in Figure 103. A description of these responses (n 55) in order of priority follows.

Figure 103. Qualitative responses to ‘there are concerns nationally for the future of nursing’

1. Budget constraints within EPS

Funding issues have been highlighted throughout the feedback from nurses. Statements such as ‘with emphasis on budget control it is easy for preventive health
initiatives to be undervalued and be in fact the first to go’ and ‘I think they are trying to bring in untrained people to cut costs’ reflect this.

One nurse reflected that:

In an era of reduction in health services funding, family services and child and family nursing services are commonly subject to funding cuts in my experience of working. … for many years. The people in many cases, families in need, generally don’t have the energy or funds to lobby for continuation of services.

2. Promotion of EPS work

This was another area raised consistently throughout the study which nurses felt there was a need to be more active in profiling the work done in the early parenting sector. One nurse stated that:

Nurses are not proactive enough in articulating what they do and the importance of their work within EPS.

Another stated that:

Families accessing EPS today not only need experienced and knowledgeable practitioners in many disciplines but also those practitioners who are able to nurture them during times of challenges in their parenting role. Nurses are needed for all of their skills in EPS.

Other nurses raised the importance of ‘an increased focus on prevention/early intervention’.

3. Workforce

Three points came out under workforce: an ageing workforce and retention of nurses, the need to increase the enrolled nurse workforce and the need to increase interdisciplinary approaches. These are discussed in turn below.

An ageing workforce and retention of these nurses

Nurses expressed their concerns that ‘the ageing, experienced work force [that] will be leaving the profession over the next 5 to 10 years, will leave a significant gap in
the workforce with seemingly less people being trained in the area of child and maternal health’ and ‘how will we retain these nurses and attract new staff?’

Need to increase the enrolled nurse workforce

The concern about increasing the enrolled nurse workforce was a feature through all phases of the study. One nurse stated:

There will always be a need for registered nurses in EPS, however as there is no longer training for mothercraft nurses, and they were a valuable resource, there is a need for other staff—currently we have early childcare workers with a certificate in pre- and post-family support.

Increased interdisciplinary approaches

A statement by one nurse emphasised the importance of moving to interdisciplinary approaches: ‘If not seeking to learn from other discipline approaches and skills, nurses can be left behind still expecting to “fix” problems’.

4. Increasing role clarity

The theme of increasing role clarity presented some ideas for the future. Some nurses felt that their discipline should have control over early parenting work: ‘part of EPS must be assessment of health and development of parents and children, therefore nurses must be head of the team’.

The following two statements reflect a shift towards thinking differently:

I think that parenting support/education is vital, whether I believe categorically that it has to be a nurse to do the role I am not sure. I think that RNs bring with them leadership skills, physical assessment skills, dealing with conflict, facing emergency situations that are very valuable. The role of the nurse also engenders with the parents a sense of trust.

There are possibly other ways to manage this e.g. have a nurse available to clarify some of the child health development concerns, and other (trained) parenting staff could do the close work with
parents regarding a behaviour management issue. However, I do think those RN experiences (not just training from working in a hospital) do add to the role and quality of service for parents.

Nurses felt that much more attention needed to be given to documenting the work of early parenting:

The early parenting services are hard to quantify and therefore data is difficult to interpret and issues such as number of clients seen per day and caseloads can be difficult to define.

Nurses also mentioned the complex nature of the work, the need to critically evaluate what we do and the shift to specialisation:

The complex nature of the work tends to make each case unique requiring a different combination of support

there is also a need to shift from an historical way of doing things and all nursing practices should be examined and questioned on a regular basis.

I think staff are concerned the positions may become more specialised.

5. Erosion of the nursing role

This category reflects similar statements to those above whereby nurses felt undervalued:

Yes Nurses have commonly been replaced with the ‘expert’ in the field and historically have given away to other disciplines who are discipline specific. Nurses have the ability to capture a holistic view which contributes to a balance. However often professional knowledge is not valued.

This is an interesting perspective and not one conducive to collaborative teamwork and how the overall team contributes to the total client experience. Another nurse commented that:
This is true because our role has been changed, eroded and diminished. More and more of our work has been given away to other services.

6. Increase outcome-focus for families

Nurses reinforced the limited amount of research that is focused on how EPS are meeting the needs of families: ‘We need more research that is outcome-based’.

Sometimes, workplaces focus on professional issues instead of on the reason that practitioners do early parenting work. This was reinforced by one nurse:

We need to remember why we do the work we do … outcomes for families and their children. … let’s put aside professional/industrial issues.

7. The consumer voice is silent

This category reflects nurses’ concern that consumers in EPS are not having their voices heard. Nurses stated that:

Women and children are not often seen or heard of in the first few years of parenting and therefore do not have political imperative.

Women are expected to just get on with it and we presume they have support and childcare is natural and easy and enjoyable—it is not always experienced as such and poor parenting leads to more social disharmony than is reported and mental health issues for both parents and children.

Comments in response to the question about whether there were concerns nationally for the future of nursing that differed from the above responses included:

I thought this would be a growing area given the evidence base of brain development and attachment so I am unaware of this concern in NSW.

Are there?

Nurses are underprepared for the future.
The following section now presents the second group of findings from phase three—those related to the future of nursing within EPS.

4.4.3.2 The future

This survey also asked nurses about the future of nursing within EPS. This was done in three ways. A list of eight statements (see Table 14) was provided to which respondents had to agree or disagree. They were asked about the priorities in EPS for the next 3–5 and 5–10 years, and a set of open-ended questions elicited any further strategies or comments from the responding nurses.

The following eight questions were asked in the survey (see Table 14 and Appendix 15). These were designed based on the findings from phases one and two. Participants were asked to agree or disagree on a Likert scale, from ‘strongly disagree’ to ‘strongly agree’.

Table 14 summarises the rate of positive response to the eight statements. A strong positive response was given by nurses to each of these statements. Interestingly the highest agreement (94 per cent) was for the development of a workforce strategy that would include all the other factors.

Table 14. Rate of positive response about the future of nursing in EPS

<table>
<thead>
<tr>
<th>No.</th>
<th>Statement</th>
<th>Percentage agree/ strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Increase the development and availability of innovative options for post-qualification education in the early parenting sector.</td>
<td>88</td>
</tr>
<tr>
<td>2.</td>
<td>There is a need for innovative national professional development opportunities.</td>
<td>90</td>
</tr>
<tr>
<td>3.</td>
<td>Identify further research areas relevant to the EPS workforce.</td>
<td>90</td>
</tr>
<tr>
<td>4.</td>
<td>To plan for the next 5–10 years there is a need for a workforce development strategy in EPS.</td>
<td>94</td>
</tr>
<tr>
<td>5.</td>
<td>Identify the skill mix for the various practice contexts of EPS.</td>
<td>92</td>
</tr>
<tr>
<td>6.</td>
<td>Develop marketing and recruitment strategies for a future multi-generational workforce.</td>
<td>83</td>
</tr>
<tr>
<td>7.</td>
<td>Consider sustainable strategies to support a future multi-generational workforce.</td>
<td>92</td>
</tr>
<tr>
<td>8.</td>
<td>Develop retention strategies for the ageing workforce in EPS.</td>
<td>87</td>
</tr>
</tbody>
</table>
4.4.3.2.1 Agreement to increase the development and availability of innovative options for post-qualification education in the EPS sector

This statement was developed due to the suggestions from the first two phases regarding the postgraduate EPP and a certificate on early parenting for the enrolled nurse. Figure 104 shows that a large number of nurses (88 per cent) agreed with this statement. In total, 147 nurses responded to this question.

![Bar chart showing responses to 'Increase the development and availability of innovative options for post-qualification education in the early parenting sector'.](image)

**Figure 104. Responses to ‘Increase the development and availability of innovative options for post-qualification education in the early parenting sector’**

The categories of the qualitative responses to this statement (n 28) are presented visually in Figure 105 below. They are then described in order of priority.
Figure 105. Qualitative responses to ‘increase the development and availability of innovative options for post-qualification education’

Overall, as stated by one nurse, there was:

Strong support for a national approach to developing qualifications in early parenting for people of varied disciplines who work with parents.

Others stated that:

A multidisciplinary course is a good idea—this would make different disciplines to cross pollinate yet maintain their own integrity. Also builds team rapport and respect.

This will enable the development of a relevant workforce for the future.

Other statements varied from general comments to specific ideas for inclusion (including cost accessibility for courses) such as:

Options like family counselling, child development and child protection.

Access, motivation and creation of specific interesting post grad courses in EPS.

It would be nice if it was not all user pays too!
We can’t lower the level of overall qualifications for this complex work due to the cost cutting concerns—skill mix is important.

1. Currently there are many options for registered nurses but not for ENs. Need more post-qualification options for them. Increase the profile of EPS nursing

The need to increase the profile of nursing was a common thread throughout the study. As one nurse commented: ‘we need to increase the profile of the work that currently occurs within EPS, and take from it the strengths into the future’.

2. The need for innovation and flexibility

Below are examples of nurses’ views on the need for innovation and flexibility:

   Yes need to provide interdisciplinary education in the early parenting area and be innovative.

   Flexibility of model of delivery/online access.

   Innovative is the key word—helping people to integrate evidence-based knowledge is essential and doesn’t always occur.

3. Creative recruitment and human resources practices

Nurses commented on creative recruitment and human resources practices in the following ways:

   We need to think creatively of ways to attract nurses and allied disciplines to EPS—I think like the Magnet hospitals approach.

   We need to start forward planning as intellectual property will disappear with the future retiring population; therefore we need to create new opportunities for sharing knowledge and offering alternatives to up-skilling etc.

   Need to creatively attract more staff and maintain standards currently operating.

The following section explains why nurses considered professional development opportunities as important.
4.4.3.2.2 Agreement for the need for innovative national professional development opportunities

Due to the small numbers of staff within EPS nationally (compared to all nurses), it was felt that there could be opportunity for innovation, particularly with the advances of new technologies and initiatives.

It was mentioned by nurses that interprofessional education is developing momentum through universities and has potential for innovation in early parenting.

Figure 106 demonstrates the large number of nurses (90 per cent) that agreed with the statement that there was a need for innovative national professional development opportunities. In total, 147 nurses responded to this question.

![Figure 106. Responses to ‘the need for innovative national professional development opportunities’](image)

The qualitative responses to this statement (n 28) are presented by category visually in Figure 107 and then described in order of priority.
Figure 107. Qualitative responses to ‘the need for national professional development opportunities

1. *Increase options available for professional development*

Nurses supported increased options available for professional development:

It would be great to see national PD [professional development] for Early Parenting Centre staff to exchange ideas between centres to enhance the outcomes for families.

The problem is often being able to access this education, due to cost and time off work.

2. *Develop and maintain national standards*

Below is an example of nurses’ thoughts around national standards and professional development as a means of achieving consistency of nursing practice:

Providing national professional development will assist in establishing national standards of care required for working in the area of EPS.
3. Increase interprofessional learning opportunities

Below is an example of nurses’ willingness to increase their focus on interprofessional learning:

These need to continue to extend and integrate the perspectives and knowledge of nursing with those from other perspectives.

4. Increase leadership in the EPS sector

Nurses felt that, to be able to achieve many of the new initiatives needed to plan ahead, there needs to be more leadership at all levels. In this way, a dynamic early parenting workforce into the future can be achieved. The following are comments around motivation, training and competencies, and supervision:

To increase and motivate staff to continually improve their skill base.

Not just innovation. But the shift to AHPRA [Australian Health Practitioner Regulation Agency] has left us confused about what sort of PD is necessary. AHPRA seems unclear about what level of training, skill or competency is required from someone working in this field.

Supervision is the area that requires more attention and leadership education.

This study was initiated because there had not been any focus to-date on the EPS workforce. It was seen as important to include a statement on further research for future directions of the EPS workforce.

4.4.3.2.3 Agreement for the need to identify further research areas relevant to the EPS workforce

Figure 108 shows that a large number of nurses (90 per cent) agreed with the statement that there is a need to identify further research areas relevant to the EPS workforce. A total of 145 nurses responded to this question.
Figure 108. Responses to ‘the need to identify further research areas relevant to the EPS workforce’

The qualitative responses (n 29) to this statement were divided into two categories, visually represented in Figure 109 and described below.

Figure 109. Qualitative responses to ‘the need to identify further research areas relevant to EPS workforce’

1. Developing a research culture

Developing a research culture was seen by nurses as a crucial starting point to increased leadership in this area. One nurse stated:
This could also have a national focus and is a helpful way to increase the level of awareness of evidence/implementing evidence across the workforce.

Another nurse said that:

Encouraging a research culture is essential—just doesn’t happen enough and part of the reason we are not well acknowledged.

The research culture was seen to enhance the overall commitment to practice development based on the best possible evidence in this area of work. One nurse stated:

… maybe we should be focusing on increasing research literacy amongst the nurses so they can incorporate evaluation into their everyday work in the form of quality activities, identification and use of existing data under the name of quality improvement and evaluation rather than research.

Others gave more specific ideas such as:

This could also have a national focus and is a helpful way to increase the level of awareness of evidence/implementing evidence across the workforce, for example perinatal and infant mental health and early brain development. We need to stay relevant for best practice for working with families. There appears to be very little research on the effectiveness of EPS work and interdisciplinary approaches.

Follow-on work from this study. More research on interdisciplinary approaches to working with parents with young children.

2. Focus on client outcomes

The importance of a focus on client outcomes was reinforced by some nurses as crucial to our work and knowing what kind of difference the staff in EPS are making. Below are examples of this:

How best to support working with vulnerable families?
Does a nurturing environment impact on and increase positive outcomes for families accessing EPS?

There needs to be further research into all areas supported by EPS, especially on what inspires change in behaviour and outcomes for clients.

As stated previously, the statement discussed in the following section, on the need for a workforce development strategy in order to plan for the next 5–10 years, is the umbrella statement for all other statements posed to respondents about the future of nursing in EPS.

4.4.3.2.4 Agreement that in order to plan for the next 5–10 years, there is a need for a workforce development strategy in EPS

Figure 110 demonstrates that a large number of nurses (94 per cent) agreed with this statement. In total, 145 nurses responded to this question.

![Figure 110](image)

**Figure 110. Responses to ‘in order to plan for the next 5–10 years there is a need for a workforce development strategy in EPS’**

The qualitative responses (n 31) for this statement are presented as categories visually in Figure 111 and are described below. This quotation summarises the responses:
Speaks for itself—our problem is we’ve never had such a strategy—no strategic thinking or vision.

Figure 111. Qualitative responses to ‘the need to develop a workforce development strategy’

The two categories of retention and recruitment issues and the future requirements of early parenting practice were noted as important under a workforce development strategy.

1. Recruitment and retention issues

Comments from nurses on recruitment and retention issues included:

   There is a need for mentorship and experienced nurses imparting to new graduates.

   Identify what skills elements are needed to work in strengths-based practice.

   The need to increase professional development and training requirements.

2. The future requirements of early parenting practice

The issue of future requirements of early parenting practice generated a range of comments that included discussion about raising the profile of EPS work, developing
national standards for consistency and the need to focus on client outcomes. Below are examples of this:

At present there is still too much difference in approaches and philosophies but would be helpful to unite and build influence nationally.

Increase the profile and the professionalism of the EPS. Advertise to the community the work we are doing. Advertise to the government the prevention strategies that EPS brings into the community. That we are in the field of core prevention and education of the community into the future.

Investigate what knowledge, experience and skills are needed for those in other disciplines to become an EPP.

To evaluate our options and to see where our future lies as EPS nurses. If there is a future at all?

The need for a residential style of intervention needs review as there are many cost effective and effective interventions based in the home that offer families support before they reach the stage of needing EPC, see USA models.

The next statement to be presented, on the need to identify the skill mix for the various practice contexts of EPs, has also been based on a thread running through the discussions in the first and second phases.

4.4.3.2.5 Agreement for the need to identify the skill mix for the various practice contexts of EPS

In considering a future workforce, there is no one-size-fits-all solution for the varying contexts of EPS. However, there are methods of capturing the various contextual requirements, given the common presenting family issues and needs.

Figure 112 shows that a large number of nurses (92 per cent) agreed with this statement. A total of 145 nurses responded to this question.
Figure 112. Responses to ‘the need to identify the skill mix for the various practice contexts of EPS’

The qualitative responses (n 35) for this statement are presented as categories visually in Figure 113 and then described below.

Figure 113. Qualitative responses to ‘the need to identify the skill mix for various practice contexts of EPS’

1. Assisting a broader understanding of skill mix

Regarding assisting a broader understanding of skill mix, comments from nurses included the idea of planning and flexibility, such as ‘good idea but it would be extremely important that these organisations should be included in the planning’ and
'ideally, it is useful for all staff to be flexible and be able to work across all areas of practice’.

Other nurses recommended a focus on clarity of roles and specific skills:

Each discipline needs to be clear about their role and function and supported by professional body and standards.

All are required as all parenting situations need different solutions.

However different EPS could concentrate on specific of skills.

Another suggestion was the abolition of the more intensive services, with a reorientation to primary prevention:

The need for EPC could become a thing of the past if there were adequate use of parent education, community supports, and helplines as a form of primary intervention.

The following nurse view puts the client and the way of work first, rather than the need for specialisation and the application of a skill mix principle:

I believe we need to stay focused on the shared skills, knowledge and learning and how the nurse generalises and adapts the shared knowledge and practice to a particular family in a context is the role of the workers, practice development staff and the organisation. Developing skills for contexts means we focus on us first and families fit into our definition of that … we need to be developing staff skills to match the practice evidence rather than the context to do otherwise would create factions within EPS and diminishes the role and the profession.

For example, the principals, knowledge and skills of the family partnership model of C-Frame underpin how our work unfolds and beyond that individuals may hold specialised knowledge or advanced skills—ideally these are spread throughout an organisation rather than the idea they congregate in one part of an organisation.
2. A greater mix of staff

The category of having a greater mix of staff captured the view that a nursing focus is maintained at the expense of including other disciplines, whereas others embraced an interdisciplinary context and a greater mix of staff.

A variety of other responses were obtained also:

yes it should be considered and developed as clear practice contexts, rather than a generic approach—however it shouldn’t turn into silos of speciality either. All these skills are required in this work. Day stay and residential need a strong nursing base with skills in child health and development, psychology, social work & early childhood skills. One-size-fits-all never works.

Important as families have different needs.

Careful here. This approach has the potential to over-prescribe what solutions and models are ‘best’ for certain communities, settings.

There is great variability in what families and communities need.

I believe we have already identified the skill mix but this is constantly under question or subjected to forced changes. For example, we have had maternal and child health nurses working with mothercraft nurses for many years with good success but mothercraft nurses are no longer being trained so we have employed child care workers (2-year qualification) instead but they don’t have the same knowledge base. We have also had difficulty employing MCHNs for many reasons and have employed midwives and other Division 1 nurses with mixed success.

We need to work collaboratively … having a national task group from all the EPS to develop an understanding of the skill mix and training requirements is essential.

I believe we need mental health, lactation consultant, psychology, social work, nursing, enrolled nursing and child care in our mix.
The next section discusses nurses’ views on the need to focus on marketing and recruitment strategies for a multi-generational workforce.

4.4.3.2.6 Agreement for the need to develop marketing and recruitment strategies for a future multi-generational workforce

This statement came about from the first two phases, as it was noted by nurses that, because the current workforce is composed predominantly of baby boomer and generation X nurses, there was a need to think differently about the workforce composition into the future.

Figure 114 demonstrates that a large number of nurses (83 per cent) agreed with this statement. In total, 145 nurses responded to this question.

![Figure 114. Responses to ‘the need to develop marketing and recruitment strategies for a future multi-generational workforce’](image)

The qualitative responses (n 35) to this statement were divided into two categories: the need to recruit from a range of generations, and the need to create awareness of the role of EPS. These are presented visually in Figure 115 and described below.
1. Recruit a range of generations

Below are examples of nurses’ views of the benefits of a multi-generational workforce:

Everyone brings their own professional and life experience.

Diversity of experience, life skills, ideas, enthusiasm and energy improves service.

Need to have younger people with skills coming into workplace for continuity and team health.

A multi-generational workforce allows for more experienced staff to mentor less experienced staff.

Yes promotes creativity, talent management and succession planning.

Need to balance experience with investing in younger workforce.

Nurses felt before marketing can occur there needs to be clarity of EPS work and then awareness-raising.
2. Create awareness of the role of EPS

This raising of the profile of EPS work was consistently raised throughout the phases of this study. Nurses suggested the following:

Most MCHNs not really clear about EPC work so publicise it more at Uni.

Feel there needs to be more awareness of what this job encompasses in the general community and its importance to assist the community.

Can’t get left behind—should have a facebook page and tweet stuff.

Not enough people really understand what EPS do—need to broaden the marketing.

Nurses need to be guided into this work with full knowledge of what it entails—myths surround this work—that is, ‘easy’ etc.

4.4.3.2.7 Agreement to consider sustainable strategies to support a future multi-generational workforce

The statement on sustainable strategies relates to how to support the various needs of a multi-generational workforce once marketing has enabled the recruitment of a range of generations.

Figure 116 demonstrates that a large number of nurses (92 per cent) agreed with this statement. In total, 136 nurses responded to this question.
The qualitative responses (n 19) to this statement were predominantly around ideas that would enhance flexible human resource practice and support processes. This single category is presented in Figure 117 and described below.

Figure 117. Qualitative responses to ‘consider sustainable strategies to support a future multi-generational workforce’
Nurses suggested a range of strategies that would assist in sustainability. These included:

Staff to job share say one week on three off so say four people job share. Take on relief for holidays in one area only so projects mentor staff.

There needs to be such a workforce as everyone is then able to support and learn from the others. … Mentoring system, preceptorship program, clinical supervision.

Care needs to be taken that full-time workers don’t lose out as they usually do carrying the work of part-timers who can’t get involved because of time limitations.

Practical input from practitioners; and research is required to develop any sustainable strategies.

Employment of training staff and supporting staff who work at EPC is essential.

Greater understanding and tolerance of how different generations approach work.

The health department will have to get more flexible with hours etc and using social media perhaps to reach clients (My early childhood nurse on twitter perhaps?).

This discussion on flexible HR practices continues with the statement on the need to develop retention strategies for the ageing workforce.

4.4.3.2.8 Agreement on the need to develop retention strategies for the ageing workforce

Figure 118 demonstrates that a large number of nurses (87 per cent) agreed with this statement. A total of 136 nurses responded to this question.
Figure 118. Responses to ‘the need to develop retention strategies for the ageing workforce’

The qualitative responses (n 41) to this statement are presented in Figure 119 as one category related to flexibility and resourcing. The category continues and repeats thoughts from previous statements. These highlight the need to be flexible about hours of work, the competencies and skills of nurses and their leadership and mentorship abilities.

Figure 119. Qualitative responses to ‘develop retention strategies for the ageing workforce’
1. Flexibility and resourcing to accommodate an ageing workforce

Below are examples of statements from nurses:

Yes we also need to commit to retaining staff given retirement is 65 years. However there is a general slowing down physically and workloads may well need to be rearranged.

Yes, although need to be confident that the experienced workforce is given training on mentoring/coaching and has competencies able to continue work as get older.

For nurses to be retained in the workforce they must demonstrate a life-long learning approach and be positive mentors.

Equally important to attract new staff—but the positions have to be valued. We cannot rely for ever on staff working because of the passion to help someone.

Strategies for self-care and building up of professional self-esteem and self-efficacy would help.

This concludes the presentation of the participant responses to the eight statements on ‘the future’. The following section discusses nurses views on ‘the priorities for the future’.

4.4.3.3 Looking to the future—Priorities for the next 3–5 and 5–10 years

This section of the survey asked nurses to rank the priority of the previous eight strategy statements over the next 3–5 years and 5–10 years, to gain an understanding of their priorities. A total of 136 nurses responded to these two questions.

4.4.3.3.1 The ranking of the top three priorities for the next 3–5 years

Table 15 shows that the majority of nurses thought that all strategies were of high or medium priority.
Table 15. Responses to ‘rank the above mentioned strategy statements according to your perception of their priority for the next 3–5 years’

<table>
<thead>
<tr>
<th>Statements</th>
<th>High priority</th>
<th>Medium priority</th>
<th>Low priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Increase the development and availability of innovative options for postgraduate qualification education in the EPS sector.</td>
<td>76</td>
<td>54</td>
<td>6</td>
</tr>
<tr>
<td>2. There is a need for innovative national professional development opportunities.</td>
<td>68</td>
<td>60</td>
<td>8</td>
</tr>
<tr>
<td>3. Identify further research areas relevant to the EPS workforce.</td>
<td>56</td>
<td>70</td>
<td>10</td>
</tr>
<tr>
<td>4. There is a need for a workforce development strategy for EPS.</td>
<td>88</td>
<td>43</td>
<td>5</td>
</tr>
<tr>
<td>5. Identify the skill mix for the various practice contexts of EPS.</td>
<td>66</td>
<td>59</td>
<td>11</td>
</tr>
<tr>
<td>6. Develop marketing and recruitment strategies for a future multi-generational workforce.</td>
<td>67</td>
<td>50</td>
<td>19</td>
</tr>
<tr>
<td>7. Consider sustainable strategies to support a future multi-generational workforce.</td>
<td>67</td>
<td>61</td>
<td>8</td>
</tr>
<tr>
<td>8. Develop retention strategies for the ageing workforce in EPS.</td>
<td>77</td>
<td>44</td>
<td>15</td>
</tr>
</tbody>
</table>

The top three highest-ranked were:

I. Workforce development strategy;
II. Retention for ageing workforce; and
III. Availability of postgraduate qualifications in EPS.

These priorities are presented in Figure 120.

![Diagram](image)

**Figure 120. Three highest-ranked priorities for the next 3–5 years**

Nurses (n 16) elaborated on this question, confirming that the top-ranked priorities for the next 3–5 years were important.
One nurse commented that the ‘high priority is for the workforce development strategy as the other points will be included in this’. Others stated that everything was important: ‘it’s all important; we need to work with these strategies to improve EPS’. For others, ‘identifying the skills/knowledge base required for working in EPS would be a priority’ and ‘research, development strategy and skill mix needs to be organised first’.

4.4.3.3.2 The ranking of the top three priorities for the following 5–10 years

Regarding the priorities for the next 5–10 years, Table 16 shows that the majority of nurses felt that all strategies were of high or medium priority.

**Table 16. Responses to ‘rank the above mentioned strategy statements according to your perception of their priority for the next 5–10 years’**

<table>
<thead>
<tr>
<th>Statements</th>
<th>High priority</th>
<th>Medium priority</th>
<th>Low priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. There is a need for innovative national professional development opportunities.</td>
<td>73</td>
<td>58</td>
<td>5</td>
</tr>
<tr>
<td>2. Identify further research areas relevant to the EPS workforce.</td>
<td>68</td>
<td>61</td>
<td>7</td>
</tr>
<tr>
<td>3. There is a need for a workforce development strategy for EPS.</td>
<td>89</td>
<td>44</td>
<td>3</td>
</tr>
<tr>
<td>4. Identify the skill mix for the various practice contexts of EPS.</td>
<td>63</td>
<td>66</td>
<td>7</td>
</tr>
<tr>
<td>5. Develop marketing and recruitment strategies for a future multi-generational workforce.</td>
<td>71</td>
<td>55</td>
<td>10</td>
</tr>
<tr>
<td>6. Consider sustainable strategies to support a future multi-generational workforce.</td>
<td>72</td>
<td>59</td>
<td>5</td>
</tr>
<tr>
<td>7. Develop retention strategies for the ageing workforce in EPS.</td>
<td>81</td>
<td>44</td>
<td>11</td>
</tr>
</tbody>
</table>

The three highest-ranked priorities were:

I. Workforce development strategy;
II. Retention for the ageing workforce; and
III. Innovation for professional development in EPS.

These priorities are presented in Figure 121.
The qualitative responses for the top priorities for the next 5–10 years (n 9) included general comments that reinforced the necessity to immediately work on the workforce development strategy to lay the foundation for the next 5–10 years. Any workforce development strategy should feature ongoing research and evaluation to inform future directions.

One nurse stated:

This is a long-term issue; the benefits of the work we put in now will be seen in the years to come. The very fact that you’re doing this survey and speaking with other CHNs is valuable.

Another nurse stated:

Due to the expertise and uniqueness needed for working in this profession more training and post-qualifications are definitely needed so as to be able to maintain a viable and fully trained workforce in EP.

The following section will now summarise the qualitative responses given in relation to the final question of the survey, which asked for any other thoughts or strategies for the future. In total, 136 nurses responded to this question.

4.4.3.3.3 Themes from open-ended question identifying any further strategies

The responses to this question were divided into two major categories: current workforce issues and a focus on national directions. They are presented in Figure 122 and described below.
Figure 122. Qualitative responses to ‘identification of any further strategies’

1. The issues for current workforce

This covers the many issues that nurses felt needed immediate consideration within the current workforce. Each issue type is listed, followed by example quotations from nurses.

Consideration of future roles for the ageing workforce

perhaps keeping older nurses on as mentors and supervisors and consultants.

Promotion of the role in EPS

Continue to develop community awareness of this specialised service. Use the media to inform the general public on the role of early parenting provided in the community, i.e. television and advertising. The general public are only aware of EPS after they have had children. Have greater exposure in other health services, e.g. hospitals and GP clinics.

Incentives for training

more affordable ongoing educational opportunities.

well skilled trained multicultural staff.
**Interdisciplinary training**

Universities are focusing on more interprofessional education but students go into workplaces that have not been trained this way.

education together will help promote team approach and skill mix and collaboration.

**Increasing the evidence base, evaluation and a quality focus**

update of current policies to reflect research and current evidence-based practice.

evaluation processes to make sure strategies are meeting needs.

**Supervision**

look after your workforce by having regular clinical supervision.

**Increasing participation with decisions for the future**

Input from all staff to assist with development of strategies and inclusion of all staff in education.

more decision making should include clinical practitioners not just CEOs and managers who do not work directly with clients.

**Pay and conditions**

strategy for better pay!

more affordable ongoing educational opportunities.

2. **A focus on national directions**

**National consistency**

National consistency was raised by a number of nurses, including the suggestion of national standards and national professional development to create consistency across jurisdictions. Other comments included:
Having a national task force from all the EPS to develop an understanding of the skill mix and training requirements is essential.

developing national standards and standardisation across states e.g. prerequisites to practice as a MCHN should be the same from State to State.

Promote the national integration of information and training so skills and expertise can be developed further. National conferences could be beneficial.

Develop a universal Qualification in EPS.

Develop closer integration of EPS throughout Australia on a clinical level.

Some nurses suggested ‘Scholarships—maybe the AAPCH could provide a national research scholarship for postgraduate studies on the further development of the workforce’.

Focusing on outcomes for families

Focusing on outcomes for families has been a recurring theme throughout this study. Comments include:

    Going into the different services that provide EPS and asking those that work in these areas what we need to do to improve outcomes for these families.

    Thought needs to be given to what outcomes we are trying to achieve, what are the presenting issues and risks and then who best to work within that practice context.

Valuing and promoting EPS work

Valuing and promoting EPS has been another repetitive theme throughout the phases of this study. Nurses stated that:

    We need to market ourselves more—who we are, what we do. I think there needs to be a strategy regarding the integration of EPS in the
broader service system. I think this is one of the greatest risks to the future and certainly the growth of EPS. The further development and diversification of EPS workforce is essential to assist in the integration of services—this is also a problem to national unity as some see themselves very much as part of health and others are part of the community sector.

Skill mix and qualifications for EPS work

The following statement by one nurse summarised this theme:

More opportunities for multisite professional development opportunities and research strategies are needed. Strategies to attract more males in to EPS would be valuable. If a future workforce of an interdisciplinary team, then need thought to pay rates if doing similar roles. What is the base level? More scholarships need to be available for this area and academic career pathways.

Following the analysis of the data there appeared to be a strong recommendation by nurses for an overarching workforce development strategy. As indicated, one salient feature of the recommended framework was a workforce development strategy. It was decided to present a separate section on this to bring together the discussion by nurses.

4.4.3.3.4 Workforce development strategy

Phase three culminated in a workforce development strategy, which is presented in Figure 123 and summarised below.
Figure 123. Workforce development strategy for EPS

The workforce development strategy has key domains necessary for providing workforce solutions and priorities for moving EPS into the future. Nurses considered this as very important and requiring of urgent attention. Although all strategies are important, some points were seen as of greater priority, with the three highest-priority areas being options for post-qualification education, retention strategies for the ageing workforce, and innovative professional development. These are now discussed in turn.

1. Increase the availability of innovative post-qualification education in the early parenting sector

Two options were given emphasis: the EPP role and a postgraduate certificate in early parenting being made available to enrolled nurses.

In phase one, nurses and allied professionals generated ideas for the future, including the concept of an EPP (a concept with which the majority, 78 per cent, of nurses nationally in phase two agreed). As demonstrated in Figure 124, this position would add value to the mix in staff at an EPS. It does not replace the need for nurses or
allied professionals but tries to solve the issue of spreading the knowledge of early parenting to a greater professional base. This EPP would have a baseline health, social science or early childhood education degree and undertake a postgraduate diploma in early parenting. Nurses already undertake a postgraduate qualification to work in these services nationally and it seems reasonable that there should be one available for allied professionals. The EPP would not only benefit EPS, but also be an asset when working in a range of government and family support roles in the non-government sector.

This role not only solves workforce issues but considers the need to have holistic services that meet the needs of today’s families and the many issues they face. As indicated in Chapter One, it also works towards less mono-discipline approaches and moves the workforce into interdisciplinary and trans-disciplinary teams working with families. As interprofessional teams work closely together with a greater skill mix, there is a degree of overlap that creates a sharing of knowledge and skills that can only benefit the client. This is demonstrated in Figure 124.

![Figure 124. The early parenting professional](image)

**Figure 124. The early parenting professional**

The skills and knowledge of an EPP were outlined in Chapter Four and, as described, a very experienced child health nurse has this level of knowledge and skills. Allied professionals also have some of these knowledge and skills and could benefit from a postgraduate qualification in this area. As discussed previously, many of the nurses that currently possess the requisite experience will be leaving the EPS workforce over the next 9–14 years. The future will look quite different and require new approaches. Many nurses and allied professionals in the study discussed the
importance of the traditional mothercraft role and its role in EPS. Very few of these
mothercraft staff remain in services now (n 4 at Ngala), but they could add a level of
skill mix and provide important practical support for families. Enrolled nurses are
also registered by the Australian Health Practitioner Regulation Agency (AHPRA).
Figure 125 demonstrates the overlap resulting from the addition of an enrolled nurse
with an early parenting certificate to the skill mix in EPS.

![Diagram of nurse, enrolled nurse, and allied professional](image)

**Figure 125. The addition of an Enrolled Nurse with EPS certificate**

2. *Develop retention strategies for the ageing EPS workforce*

Ideas for retention strategies focused on flexibility for nurses transitioning into
retirement. Resourcing needs to accommodate this transition, given the potential
benefit that could be made of the knowledge and skills of outgoing staff in
supporting and retaining younger and less experienced nurses and other allied
professionals. Many nurses reinforced the need for some assessment of the attributes
and skills required by those providing leadership and mentorship.

3. *Develop innovative national professional development strategies*

It was felt that given that EPS is a niche market and generally has smaller numbers of
staff nationally, there is an opportunity for innovation in this area, particularly with
the advances of new technologies. IPE would be one area that could be given
consideration to assist to move the culture of nursing from a mono-discipline
approach towards an interdisciplinary perspectives and models of work. National
standards, curriculum and clinical supervision would also assist, as would strong leadership in this area.

The following section discusses the priorities that fell after the top three.

4. Develop sustainable strategies for a multi-generational workforce

The focus on a multi-generational workforce includes two aspects:

- Developing marketing and recruitment strategies for a future multi-generational workforce; and
- Sustainable strategies to support a future multi-generational workforce.

Currently the main EPS nursing workforce consists of baby boomers and generation X nurses. It is important to understand the characteristics of each generation and the requirements needed to support the recruitment and retention of staff from a range of generations. Nurses also encouraged an increase in graduate positions and scholarships as part of this overall strategy.

5. Identify the skill mix for the various practice contexts of EPS

Nurses commented that it was important to develop a broader understanding of skill mix and pursue a broader mix of staff. The various contexts of EPS need to be considered as well involvement of staff of the rationale and need to plan. It was felt that understanding and articulating the various contexts would give clarity to the range of disciplines that can work together in those contexts.

6. Identify further research areas relevant to EPS

Research on Australian EPS has been limited overall, but is starting to develop momentum and importance, particularly in the last decade. Nurses thought that developing a research culture and focus on practice development whereby the client is held uppermost would assist in making a difference for EPS and contribute to a dynamic learning environment. Other suggestions from nurses reinforced the importance of this study and the conducting of further research on interdisciplinary approaches.
7. Market EPS work

Raising the profile of EPS work was seen as very important by nurses. It was recommended that the strengths of EPS be articulated, and that the important role that services play, particularly in supporting the universal child health systems, be marketed to the public. Nurses talked of the silence of the consumer in EPS, and of the need for greater awareness in other health and welfare services of the work done by EPS.

4.4.4 Summary Phase Three

Phase three was built on the first two phases of data collection and analysis and a questionnaire was developed for distribution nationally with a 37 per cent response rate. The demographics of the national survey respondents were described in this section, and the findings from the survey were presented in two parts: the current situation and future directions. These have brought together rich data that will inform the design of a future workforce development strategy.

4.5 Chapter Four Summary

This chapter has presented the findings from the three phases of this study, with reference to the key questions outlined in the introduction.

The first section addressed the first phase, providing a historical overview of nursing within Ngala and the current situation and role for nurses as perceived by nurses and allied professionals.

The second section presented the findings for phase two, which was informed by the first phase. The findings of the first phase were discussed with nurses nationally via teleconference, with their responses constituting the findings for the second phase.

The third phase involved the development and distribution of a national survey to nurses within Australian EPS. The survey was informed by the findings from the previous two phases. The third phase findings also generated a workforce development strategy used to inform the framework for the future.
The results have provided a rich collection of data, with themes being consistently raised throughout each phase of the study, resulting in clear evidence of nurses’ perceptions on early parenting work and their ideas for the future directions of EPS.
Chapter 5: Discussion of Findings

5.1 Introduction

The purpose of this study was to explore the past, present and future of nursing within EPS in Australia. To achieve this aim, the study answered six questions, as posed in Section 1.5. These were:

- How has nursing evolved within EPS at Ngala?
- How do nurses perceive their role within the context of an interdisciplinary team?
- How do allied professionals perceive the nursing role within the context of an interdisciplinary team?
- How has nursing evolved within EPS in Australia since the inception of services?
- What is the present situation of nursing in the context of EPS nationally?
- What are the future changes required in EPS as perceived by nurses nationally?

Each question was addressed through the phases of the study, with varying depth and focus, as described at the beginning of Chapter Four. The first phase focused on Ngala as a single site, with the findings from that phase being applied to the national setting in phase two. Phase three focused more on the future and developed a framework of future changes that were perceived by nurses in all three phases as important. These were divided into the top priorities for 3–5 years and 5–10 years.

This chapter will provide a summary of the past, present and future of nursing in Australia. These findings will be compared against other research and theory on the role of the nurse. The new knowledge will culminate in the design of the future framework for nursing in EPS, with each of the framework components articulated in relation to relevant literature.

This case study is about nursing in EPS in Australia. The implications for nursing in this niche market are explained within an interdisciplinary perspective, to outline a
way forward for the future that considers the sustainability of outcomes for families, workforce recruitment and retention, education and practice.

5.2 The Role of the Nurse in Early Parenting Services

The role of the nurse in EPS will be summarised and presented in three sections—the past, the present and the future. This follows the phases of the case study, which have built on each other, from the perspective of one site at Ngala to the national context (see Figure 126).

5.2.1 The Past: The Evolution of the Nursing Role over Time (1890–1989)

Ngala was first established in 1890 as the House of Mercy to assist young single women having babies without the support of family, under difficult social circumstances. Nurses were employed at the turn of the twentieth century, prior to which midwives would come to the house and assist with the births. From 1904, other infants were cared for at the House of Mercy and over time Ngala became one of the key places in Perth, WA for the institutional care of children and the adoption of children, up until the 1980s. Nurses also cared for young pregnant women, and from the 1990s, for parents, with the shift to a family focus.

Nursing was the predominant discipline employed at Ngala up until the 1980s. The medical profession had visiting rights since inception and this continued until the 1990s, at which point a paid general practitioner commenced. Visiting social workers to Ngala were mentioned in the documents from the Department of Welfare from the 1950s, but were never employed until the 1980s.

The nursing role was strongly influenced by the army and the first part of the 1900s with the two World Wars. Many of the tasks described by nurses were aspects of ‘women’s work’ around the home and the role of a mother in looking after a child. These are visually represented from the period 1940s to 1980s in Figure 75 and were summarised in Chapter Four. Nursing at Ngala was in the context of what was occurring in WA and nationally, as many nurses went East to train in infant welfare nursing up until 1959, when the course was introduced at Ngala.
The Future Framework for Nursing in Early Parenting Services in Australia – Elaine Bennett

**PAST**
Ngala—the nursing role

**PRESENT**
The current national nursing role within an interdisciplinary team

**FUTURE**
Future positions adding to skill mix in Early Parenting Services

Figure 126. A visual representation of the past, present and future of nursing in EPS
The regulation of nursing began in WA with the introduction of Parliament in 1890 and the Hospitals’ Act in 1894. Regulation appeared more informal initially, with the formal title of ‘nurse’ being used and the wearing of a uniform symbolic of being a nurse. The Australian Trained Nurses Association was formed in 1907 and provided a framework for the regulation of nursing training until the Nurses Registration Act in 1921 (Hobbs, 1980).

As described in Chapter Three, the influential infant welfare movement emerging in Australia around 1920. The traditions of EPS were a part of the early child welfare movement and often a precursor or simultaneous development to the setting up of infant welfare clinics. Many such clinics were supported very strongly by community advocates and volunteers (mostly women) and women’s or church organisations.

The education and training of infant welfare nurses commenced in the 1920s in Australia. At Ngala, a training course for mothercraft nurses began in 1949, followed by a training course for infant welfare nurses in 1959. These were continued until the mid-1980s until the move to tertiary education. The first Australian degree in nurse education was established in 1975 (Piercey, 2006). The professionalisation of nursing through the tertiary sector had major implications for nursing, affecting nursing at Ngala over time. The effect was not fully realised until the 1990s, by which time more nurses had undertaken the bridging degree from the hospital-based certificate.

The professionalisation of nursing affected how nurses approached their work. The rise of formalised professionalism created developments of theoretical frameworks, the introduction of the ‘nursing process’, legal parameters, professional boundaries and ethics. Many of the symbols that designated nurses such as hats, badges, uniforms and terminology (such as the word ‘sister’ or ‘matron’) disappeared gradually during the 1970s and 1980s.

In terms of community nurses specifically, the WHO defined community nurses as, among other things, ‘identifying the community’s broad health needs and involving the community in development projects related to health and welfare’ (World Health Organisation, 1974). In Australia, community nursing has encapsulated a range of care contexts, providing health promotion, community development, health education and disease prevention within a framework that recognises the broad
social, economic and environmental determinants of health (World Health Organisation, 1978). Over time, societal changes to family structures and the introduction of technology started to change the nature of work in EPS, and the international impact of the ‘The Ottawa Charter’ and the influence of primary health care during the 1980s saw a shift away from the medical model to community health models of care. This continues to be important in nurses’ practice today.

5.2.2 Current Role Defined: Profile of the Role of the Nurse in EPS (1990 to Current)

Kemp, Harris and Comino (2005) noted in their study that, for the period 1995–2000, the balance was shifting to specific, short-term clinical care, resulting in a loss of holistic primary health care. The change of the nursing role in child health has undergone a considerable shift over the past 17 years, particularly in the area of perinatal and infant mental health and change to family partnership, strengths-based and solution-focused approaches to family care (Borrow, et al., 2011; Briggs, 2007; Chavasse, 2010).

The cohort of nurses within EPS is very experienced and many nurses (85 per cent of respondents) have been with EPS for 5+ years. EPS nurses are an ageing workforce with the largest numbers being in the age category of 50–59 years.

Given these demographics, the EPS nursing cohort holds an immense knowledge and skill base that will be lost from the workforce as the baby boomer generation retires. There is also a need to consider other recruitment and retention approaches and skill mixes due to younger nurses being more mobile and changing careers more frequently (Nursing Review, 2012). Younger nurses also approach work differently to the baby boomer generation and place more emphasis on quality of work/life balance (Arrowsmith, 2007; Wilson, Squires, Widger, Cranley, & Tourangeau, 2008a).

The broad knowledge and skill base of nurses in EPS, described in phase one of Chapter Four, has developed as a result of the decades of experience of the current workforce. The key categories describing the role of the nurse included ‘early parenting nursing practice’, ‘application of evidence’ and ‘linking with others’. These were then reduced into sub-categories that explained in more detail the role of
the nurse in EPS (see Section 4.2.3.3). All the categories are supported by the work already done in Australia on child and family nursing competency standards, although different terminology has been used at times (Australian Nursing and Midwifery Council, 2006; Child and Family Health Nurses Association (NSW) Inc., 2009; Community Nurses Special Interest Group, 2001).

5.2.3 The Unique Role of the Nurse When Working Closely with Other Disciplines in EPS

Multidisciplinary work has been part of Ngala since the 1990s, with a more concerted effort of moving to an interdisciplinary approach during the 2000s. Nurses nationally validated the description of the unique nursing role, identified by nurses and allied disciplines during phase one as comprising the three categories of ‘the early parenting nursing role’, ‘the experienced practitioner with a broad knowledge base’ and ‘professional identity’ (see Section 4.2.3.4). This description can be utilised to assist in articulating the unique role of the nurse within an interdisciplinary team and will enable clarity of discussion when a variety of disciplines continue to work closely together with families.

The ‘early parenting nursing role’ is the essence or core of the nursing role, which is peeled back when working with other disciplines. For example, nurses may do less of a psychosocial support role if a social worker or psychologist is working closely with them. The other two categories may change over time, as they relate closely to the history of nursing, which continues to evolve. The ‘broad knowledge base’ is consistent with the current cohort of nurses in this niche market. In 10–14 years, this may no longer be the case, as a younger, less experienced cohort of nurses replaces the older, experienced generation. Nurses’ ‘professional identity’ may also change over time as the skill mix of disciplines competent in early parenting work shifts.

5.2.4 The Framework for the Future of Nursing in EPS

The key elements of the framework articulate the shift of the nursing role from the past and present to the future and the clarity for the unique role of the nurse when working within an interdisciplinary team. There is an overlap of roles between disciplines, creating ‘osmosis’ and a sharing of knowledge and skills of all practitioners. This benefits the team and provides a collegial environment that can
enhance the outcomes for families with young children. However, there is inconsistency nationally to the degree of commitment to interdisciplinary approaches, given the very small numbers of allied disciplines working in some services.

A vision for nursing in EPS for the future is divided into two time categories: the next 3–5 years, and the next 5–10 years. These are now discussed in turn.

Over the next 3–5 years, some baby boomers will be leaving the workforce. Nurses will be transitioning out with flexible work practices. Understanding the current workforce is crucial to planning and training for a new workforce, and developing a mentoring and leadership program for practice development. Preparation for a multi-generational staff mix and future interdisciplinary models of care for families will be necessary. Planning and recruitment of graduate positions and funding for scholarships for early parenting work need to be resourced, and national and local priority should be placed on the creation of innovative professional development opportunities. Systems that support flexible workplace recruitment and retention of staff need to be established.

During this time, national consistency will ensure that the postgraduate certificate and diploma are clarified and standardised to ensure adequate clinical placements. Planning for the national development with universities and organisations to produce a post-qualification education in the EPS sector for allied disciplines and a certificate for early parenting for enrolled nurses will be important. Nursing and allied disciplines will need to endeavour to encourage a majority of skill mix, with the addition of more males, life experience and experience in the EPS sector, due to the age cohort of many parents being older, and the increased use of services by fathers. This will add to the credibility of services, and maximise outcomes for families seeking assistance.

Over the next 5–10 years, as baby boomers continue to transition out of the workforce, EPS will begin to look quite different. Generation X will be the senior workplace cohort, but there will be less of them as compared to the previous baby boomer generation. The generation Y and X nurses will be beginning to emerge and new graduates will be more frequent. Pathways for child and family health nurses will be established to include younger, less experienced nurses and enrolled nurses.
Baby boomers will continue to work in a mentoring and support role for the workforce, and there will need to be a very flexible HR system, continuing to support a part-time workforce and family-friendly philosophies for a multi-generational workforce. The technology that drives the system now will have evolved, and some services to parents will change or the options available will diversify. During this period, the establishment of post qualifications in early parenting work will be taking shape and interdisciplinary work will be a priority for all services, with adequate professional development, the supervision processes and reflective practice consolidated. Research in EPS will be increasing and greater knowledge of the outcomes being achieved by this work will be known.

The workforce development strategy outlines priorities and strategies for the next 10 years and offers suggestions to assist future workforce development in EPS. A visual framework summarising the role change in nursing in EPS and the future workforce strategy is outlined in Figure 126.

5.3 Comparison of Findings with the Literature

5.3.1 The Nursing Role within EPS

5.3.2 National Workforce

The aim of this study was to explore the past, present and future of nursing in EPS in Australia. There had been no literature exploring this workforce context to-date, and this study was undertaken during a time of immense change and uncertainty about health workforces into the future. Workforce shortages exist across most of the health disciplines in Australia. There are projections that by 2020 there will be a shortage of 40,000 registered nurses in Australia (Karmel & Li, 2002). Duffield (2008), in her workforce article, raises questions that need to be answered for the early parenting context; including, what are the appropriate professional disciplines best able to meet the needs of families and children with vulnerabilities today.

Health Workforce Australia (2012a) released projections for nursing for 2025. Modelling of projections was done for acute nursing, aged care and mental health nursing sectors. Health Workforce Australia was unable to project workforce for the area of community child health nursing, due to difficulties in obtaining relevant data. However, they anticipate that their 2012 report is the first step, and that more
projections can be expected for the future. The CEO of Health Workforce Australia has stated that:

New technology and competing trends are making us drastically rethink the roles of health professionals—and hence what skills they need and how they are trained … training of health professionals will be more technology savvy and more about communication and partnership … Meeting this future challenge is complex but if there is anything that gives me heart it’s the fact that the next generation of health leaders are keen to embrace these changes and work in different ways—much more so than the current generation. (Cormack, 2012, p. 1)

Nurses in EPS (n 450) are a very small workforce nationally within the child health system, which comprises about 5,800 nurses, or 2 per cent of the nursing workforce in Australia (Productivity Commission, 2011). These numbers are inclusive of universal child health and services such as EPS. Hence the resources or expertise in the workforce to-date have not focused on workforce planning and research in the area of EPS. The Productivity Commission report states that on average, nurses who report working in child and family health are older than nurses working in other areas of clinical practice, are more likely to be female, to work part-time and to be registered nurses (as opposed to vocationally trained, enrolled nurses or Division 2 nurses) (see Table 17).

Observations made within the above report about the child and family health nursing workforce were made, for example, in Victoria, where it was reported that, of the 925 nurses employed in maternal and child health services in Victoria in 2010, 72 per cent worked part-time and 14 per cent were aged 60 years or older. Only one male child and family health nurse was reported in Tasmania, and 13 per cent were aged 60 years or older (Productivity Commission, 2011).
The findings above are consistent with this study, although the age cohort of the respondents within EPS was older, with 52 per cent of nurses within the 50–59 category and 16.5 per cent being 60 years or older, giving a total of 68.5 per cent at 50 years and over.

The nursing skill mix in this study was registered nurses who are child and family health nurses, midwives, mental health nurses and mothercraft/enrolled nurses. Given that the majority in the nursing skill mix within EPS was child and family health nurses, it was decided to compare any literature available within child health mostly in Australia and the UK that looked at roles and workforce-related issues. EPS are often a major source of referral from child and family health nurses in the universal community setting. These referrals are often due to the time restrictions on child and family health nurses, and the increasing population and demand for services.

### 5.3.3 Comparison with Child Health Nursing Role and Issues within the Universal Child Health System

The contribution of nurses to child health and child health services was found to be broad-ranging and diverse (Forbes, et al., 2007). Nurses in the universal child health system often work in isolation, and this presents challenges for nurses (Schmied, et al., 2011). The reform of the Victorian Maternal and Child Health Service found during the pilot study that maternal and child health nurses were resistant to change (Fairbairn, 2010), possibly because of their isolated work practices. A study of WA community child health nurses (Borrow, et al., 2011) explored the breadth of the role in the universal system and noted the expansion of the child health nurse’s role over
time due to a range of factors. This has become an unreasonable expectation, and nurses expressed the issues and challenges of their work.

Some similarity of issues was noted with a small proportion of nurses within this study, such as nurses stating the need for clinical supervision and professional development, the increasingly multifaceted nature of their role, and the lack of acknowledgement of their specialist role by colleagues. The question that is raised here by these comments is whether, in the case of a closer working relationship with other nurses and allied disciplines, this lack of perceived value is not such an issue. Lack of being valued did not appear to be a perception of nurses at Ngala, possibly due to the close collegial working relationship, an ageing workforce and longevity of staff. Munns, Downie, Wynaden and Hubble (2004) found in their study that nurses needed to reaffirm their reflective practice role and consider what actually contributes to health gains for families and communities, as this is often overlooked in the business of practice.

The increasing population of Australia and their corresponding health needs has increased workloads around Australia. This has not been matched by adequate resourcing (Kemp, et al., 2005; Schmied, et al., 2011). This lack of resourcing has at times led to an increasing emphasis on targeting services, which then limit the capacity of service providers to meet the needs of all children and families. Most states are experiencing resourcing issues (Belardi, 2011a; Murphy, 2012) that also came out in this study. In WA, there have been multiple reviews and parliamentary enquiries over the years that have indicated that government has not been resourcing the child health sector for almost 30 years. This phenomenon of under resourcing has led to the direction of the limited funds to target those in need (Education and Health Standing Committee, 2012; Mayes, 2011; The Community Development & Justice Standing Committee, 2009; WA Auditor General's Department, 2010). All reports have recommended increasing resourcing in the child health sector. A WA Auditor General’s report recommended partnerships with other government agencies and non-government agencies, resourcing for facilities and different models, providing nurses with administrative support and technology. The report also demonstrated that in WA, the scheduled child health checks have progressively deteriorated in terms of reaching the whole population (see Figure 127) (Education and Health Standing Committee, 2012; The Community Development & Justice Standing Committee,
A UK study showed that parents reported that if they were not assessed as being ‘in need’, then they felt excluded from ongoing services (Roche, et al., 2005).

The decline in child health checks in WA is due to funding remaining static despite the rising population, particularly over the past decade with the mining resource boom in WA. Government policy in WA has recently been shifting towards contracting out service arrangements that have traditionally been the domain of government, such as universal health checks and parent groups, to the non-government sector. This situation is evolving and still remains a developmental process to be observed. If Ngala is successful with their tender bid, this will change the face of Ngala in WA, as a different model is being proposed that would see nurses working within interdisciplinary teams rather than in isolation.

5.3.4 Broadening Scope of the Child Health Nurse Role

The broadening scope of nursing practice mentioned above is consistent with the age of the workforce and nurses having been in this area of work a long time. The essence of the child and family health nurse role and traditional practice was described by Borrow et al. (2011) and Kruske et al. (2006) as being ‘embedded in
health education/promotion and support for maternal wellness along with health
assessment of the child throughout growth and development stages’ (Borrow, et al.,
2011, p. 84). The expansion of the role over time has been in response to the
changing nature of family needs and issues, and often occurs because of a lack of
others able to do or assist with this work to meet demands (Barnes, et al., 2003;
Borrow, et al., 2011; Harmer, 2010; Woollard, Abetz, Baker, & Jacobs, 2012). This
situation has certainly been described by nurses during this study in regards to their
role. Therefore, by necessity, nurses’ roles have expanded (Chavasse, 2010; Kemp,
et al., 2005; Kruske, et al., 2006; Munns, et al., 2004; Rossiter, et al., 2011).

Child health policies around Australia have promoted a change away from the
traditional focus of clinic contact with the child and family health nurse that tended
to best meet the needs of professionals (Schmied, et al., 2011). This focus often
failed to engage those most in need. In Queensland, Barnes et al. (2003) described
the changes for traditional services offered to a more contemporary model, with the
addition of day stay services, which have traditionally been the domain of EPS in
most states. This study explains the expansion of the role and the priority given to ‘at
risk’ families, as well as how the services continue to provide support and
information for families as they adapt to their new parenting role (Barnes, et al.,
2003). The authors in this study expressed concerns for the future in balancing
individual and population health approaches to meet the health needs of all clients,
and in providing appropriate education and support for nurses working in this area
such that they may collaborate with others. Similar concerns have been expressed by
other authors (Cameron & Christie, 2007; Kemp, et al., 2005; Rowe & Barnes, 2006;
Schmied, et al., 2010).

It is also noted that while child health policies advocate that nurses access and
engage families in the first two weeks post-birth, it is yet to be demonstrated in
Australia or internationally that universal home visiting at this time improves
engagement and outcomes for families (Schmied, et al., 2010). However, this study
also found (through the voice of nurses and allied professionals) that the tension with
diminishing resources for services means that the focus can reorientate to the most
disadvantaged or ‘at risk’, despite there being clear evidence in the literature of the
importance of maintaining a universal platform of access to all families with a focus
on prevention and early intervention.
There is a need for planning into the future for creating a career pathway for new graduates in nursing. If nurses are placed within interdisciplinary teams with adequate support by experienced nurses and other disciplines and support staff, then this would be less onerous and provide a range of disciplines to meet the needs of families, which nurses cannot do on their own. This is particularly so in relation to issues such as child protection (Land & Barclay, 2008; Vimpani, 2000), mental health (Buist et al., 2007; Michael, 2008), the impact of separation and divorce (Fägerskiöld, et al., 2000) and the high needs of migrant/refugee (Community Paediatric Review, 2012; Grant & Luxford, 2008, 2011; Phiri, Dietsch, & Bonner, 2010; Vimpani, 2004) and Aboriginal families (Grant & Luxford, 2008; McMurray, 2004). Creating career experience pathways is already occurring in SA (Women's & Children's Health Network, 2011). Often, one of the barriers to this development is the fact that government services have cumbersome structures and are locked into pay scales for very experienced practitioners who work in isolation. Planning needs to occur to develop levels relevant to experience and competency before the large cohort of the baby boomer generation leaves the workforce (Stanley, 2010). Schmied et al. (2011) reviewed Australian State and Territory maternity and child health policies and found congruency, suggesting that it is time to consider the introduction of a national approach to universal maternal and child health services. A national perspective and standards of practice and education in EPS were also recommended by nurses in this study and by Kruske et al. (2006).

As indicated above, child and family health nurses are confronted with a multitude of complex issues in their work. The ability of nurses in child health services responding to families within a framework of ‘cultural security’ has been discussed in a number of studies of child health services in Australia, yet this discussion was absent throughout this study. Therefore, it seemed appropriate to explore the literature further.

A paper has recently been released on a review of cultural diversity and child protection (Kaur, 2012), and the summary of findings highlights the need for frontline workers to develop cultural competence when working with these families, and the need for early intervention and prevention strategies focusing on ‘accepted parenting practices in Australia’ specifically targeting physical discipline and neglect. Two recent studies have looked at refugee families’ interactions with child
protection services (Lewig, Arney, & Salveron, 2009) and child health services (Riggs, et al., 2012). Both studies highlighted practice areas that are of particular concern to professionals working with refugee families: facilitating access and maintaining engagement with services were crucial. The challenges inherent in culturally competent practice include the use of interpreters.

Both studies offer insight into the experiences of families from refugee backgrounds and the findings can offer insight for the child health workforce. Flexible models of care need to be provided locally (Centre for Community Child Health, 2012). Other studies have highlighted the need for child health services to improve the cultural appropriateness of services for Aboriginal and Torres Strait Islander and migrant and refugee families (McMurray, 2004; Schmied, et al., 2011). Despite specific educational support in working in partnership with families, research suggests this does not appear to have resulted in staff having the necessary skill or sensitivity to work constructively with families, particularly those from Aboriginal and culturally and linguistically diverse communities (Grant & Luxford, 2008, 2011). This could be a gap for nursing in EPS.

The above scenario of broadening the child health nurse’s role in the universal system over time is in direct contrast to some nurses in EPS perceiving an erosion of the role due to the increase in other disciplines in this area of work. To put this into perspective, the majority of national nurse respondents in EPS thought it was important to plan for the future and think differently about the workforce. There was also a perception expressed by a small number of nurses that other disciplines did not value the nursing role in EPS. This was also found in the study by Borrow et al. (2011). This view is most likely related to changing the status quo. As Barnes et al. (2003) found in their study on moving from the traditional forms of practice to contemporary approaches, it does create uncertainty. It is also consistent with a proportion of the baby boomer generation ostensibly preferring to see EPS stay as a predominantly nursing workforce.
Part of the change in child health nursing practice has been the move to family partnership approaches by all States. As discussed in the introduction and description of C-Frame, this approach moves nurses from the ‘expert’ model to working ‘with’ families. As indicated by many studies, this has taken some time, particularly since a large number of ageing nurses had been socialised into the expert model (Schmied, et al., 2011). The view is that if there had been the availability of more professional development, supervision models, and less working in isolation, then the change for nurses may have been easier and faster (Borrow, et al., 2011; Chavasse, 2010; Eronen, et al., 2010; Grant & Luxford, 2008, 2011; Kruske, et al., 2006; Marron & Maginnis, 2009; Roche, et al., 2005; Rossiter, et al., 2011; Schmied, et al., 2011; Schmied, et al., 2010; Vimpani, 2004).

As indicated, nationally the majority of nurse respondents wish to move forward, although the researcher sensed through the study process that some nurses found this thinking difficult at times, or not within their comfort zone. Resistance to change is attributable to the demographics of staff, when many have been in the workforce for a long time. It will be necessary to involve nurses in the planning and changes in service delivery systems and processes because of the varied contexts in each State and because the different cultures are difficult to break into (Chavasse, 2010). These tensions were captured by Duffield (2008, p. 7) when she stated that the way forward was for ‘all professionals working with children and young people [to] work together to focus on the needs of children and young people rather than those of professionals’ (p. 7).

5.3.5 Recruitment and Retention of Multi-generational Nurses

No matter the generation of nurse, variations among individuals exist. Working with individual nurses to find what is of value to them and how their values fit with the organisation is critical to advancing the goals of the organisation (Baker, 2012a; Stanley, 2010). Attracting generation Y to team models will be relatively easy, as their school and university education was also focused on group learning. Retention will be more difficult unless there is greater effort to attract graduate positions (Bail & Schreuders, 2011) into the primary health care system and hence assist their

---

23 Another framework used is ‘strengths-based, solution-focused practice’. C-Frame is used by some EPS and child health services in Tasmania. C-Frame incorporates all these approaches.
integration into the workforce. The baby boomers were not educated this way and many have found the transition to team approaches quite difficult. This was also reflected during this study.

New generation Y graduates are now having IPE at a large number of universities, which promises to make their transition to interdisciplinary teams easier. The difficulty for most new graduates is that workplaces do not often have cultures that support interdisciplinary practice, especially in the absence of key organisation support from all spheres of influence (Missen, et al., 2012).

It is interesting to note that in 2002 Ngala presented a paper to a parliamentary inquiry into ‘the role and interaction of health professionals in the WA public health system’. In the submission by Ngala, it was proposed to educate and recruit younger nurses interested in the early parenting area of work so that they would have direct access to qualifications. The report stated that:

Currently Post Graduate Nursing Students and some undergraduate nursing students attend Ngala. However there is no comprehensive training program that will enable recently graduated baccalaureate nurses to gain the skills to support families. Generally Registered Nurses have to complete a midwifery qualification prior to enrolling in a Child and Family Health post-Registration Qualification. There has also been uncertainty in relation to the continued funding for these courses. The ageing population of Community/Child Health Nurses needs to be addressed to ensure younger staff can assist in meeting the needs of families (Ngala, 2002, p. 4).

5.3.6 Articulating the Advanced Practice Role

The nursing role within EPS as perceived by nurses was descriptive and not designed to identify discrete competencies. However, the researcher reviewed these in light of available descriptions of nursing roles and competencies. The key domains of nursing practice as outlined in the baseline competencies (Australian Nursing and Midwifery Council, 2006) are professional practice, critical thinking and analysis, provision and coordination of care and collaborative and therapeutic practice (Australian Nursing and Midwifery Council, 2006). Advanced competencies for
nursing in child and family health have been written in some states (Australian Confederation of Paediatric and Child Health Nurses, 2006; Australian Nursing and Midwifery Council, 2006; Community Nurses Special Interest Group, 2001; The Child and Family Health Nurses Association (NSW) Inc., 2009b). The findings on the role of the nurse from this study were broadly consistent with existing advanced competencies.

A few minor comments from nurses throughout the study demonstrated their lack of understanding and confusion between advanced nursing practice in a speciality role and practitioner nursing roles. Laperrière (2008) notes that the definition of advanced practice is still ambiguous and raises some questions. Given the diversity of explanations, Laperrière (2008) suggests that ‘the achievement of a mutual recognition of a common terminology might be a threat to independence, autonomy and diversity … the formalisation, normalisation and instrumentation of worker’s practice threaten their professional standing’ (Laperrière, 2008, p. 395). Gardner et al. (2007) explain the difference and offer an operational framework to identify, establish and evaluate advanced and extended nursing positions. The lack of national consistency was highlighted through this study. Schmied et al. (2011), in their review of maternity and child health policies, found that these were consistent across Australia and recommended the consideration of a national framework for universal maternal and child health services (Schmied, et al., 2011) to enable roles and education to become unified and consistent.

Homer et al. (2009) looked at the role of the midwife in Australia and found, among other issues, an invisibility of midwifery in regulation and practice, workplace shortages, and no clear understanding of midwifery within the wider community. These issues were reflected within this study. The authors (Homer, et al., 2009) recommended that the assessment of competency standards should be mindful of the assessment for fitness to practice, cultural sensitivity and ability to reflect the complexity and multidimensional nature of nursing care, and enhancement of client outcomes (Francis, Carswell, & North, 2010, p. 52).
5.3.7 The Role Within an Interdisciplinary Framework

Duffield et al. (2011) raise pertinent issues for nursing to move forward within an interdisciplinary framework. The issues are in relation to the strong nursing identity around titles; the varying number of positions for nurses, such as clinical nurse consultants, specialists or nurse practitioners; and the lack of consistency nationally of these issues. Duffield et al. (2011) suggests that:

Our professional nursing practice is not defined by a title, or the number of roles we have. Rather, our practice is defined by the impact of a new role or position classification on patient outcomes should be the primary consideration when considering whether or not there are grounds for introducing new positions or changing titles. (Duffield, et al., 2011, p. 48)

This first phase of this study demonstrated through nurses and allied disciplines working closely together that there is a clear ability to articulate the unique role of the nurse, despite there being a sharing of skills or ‘osmosis’ of knowledge and skills in collaborative practice. Nurses also maintain a strong sense of boundaries and professional identity. Brown et al. (2000) discuss blurred roles and permeable boundaries when different disciplines work within mental health services. Some see this as role erosion and a threat, while others see it as an opportunity. Brown et al. (2000) purport that ‘boundaries between professions are actively encouraged by the experience of interdisciplinary modes of working’ (Brown, et al., 2000, p. 425). These also emphasise the benefits for all team members, saying that ‘a less precious approach to disciplinary boundaries needs to be explained and a culture that facilitates flexibility needs to be promoted’ (Brown, et al., 2000, p. 433).

Working within a team does challenge the limits of what one can and cannot legitimately be required to do. In a study by Wuest (1998, p. 39), she encourages nurses to attend to one’s own professional ‘voice’, which then allows workers to ‘limit the number and extent of caring demands as well as to draw on self-knowledge to order their caring’. It is suggested that the ‘clearness of a nurse’s professional identity’ is linked with his or her personal growth, ability to progress and determination to enrich his or her knowledge and skills (Harmer, 2010). The important attributes required for interprofessional collaboration identified by Miers
and Pollard (2009) included communications skills, interpersonal relationship skills, teamwork skills, knowledge of roles, respect and tolerance, experience and personal maturity, and being able to inspire trust and work across professional boundaries.

Duffield et al. (2011, p. 47) raised the issue of role blurring, which can be a problem of ‘role confusion’ more in the context of industrial relations. The various awards and pay scales for different professionals can create some unrest when practitioners from different disciplines work alongside each other and are perceived as doing similar roles. Brown et al. (2000) found some evidence of role blurring in their study with mental health community professionals. This was found to be welcomed by a few respondents, whereas others sought to preserve their own professional identity within the multidisciplinary environment. Brown et al. noted that the lack of managerial direction and the encouragement of generic working seemed to make some respondents more insistent on separate professional identities. This reinforces the need for broader policy and support at all levels to ensure interdisciplinary approaches.

Moore and Skinner (2010) consider an integrated approach to early childhood development and argue the case for a more concerted effort for the collaboration of services with a focus on early childhood, to change the service system at a local level to focus on outcomes for children and families. The authors also argue that trans-disciplinary teamwork is the preferred model in early childhood intervention services (Moore & Skinner, 2010, p. 18). In an interdisciplinary team framework, professionals coordinate services and have limited crossing of discipline boundaries. This is how EPS operate. The definition of trans-disciplinary teamwork by Briggs (1997), mentioned in Chapter One, means that several disciplines can work together in an integrated team environment, with any one of the professionals acting as a conduit of services for the team. This means there is a sharing of roles and responsibilities, information and knowledge by team members, while still maintaining the integrity and resources of each primary discipline. This is where the concept proposed in this research study of the EPP could be considered. The argument is that specialist services on the whole create long waiting lists and can be reconfigured to provide earlier support to families and develop better linkages with the universal system to improve collaboration and coordination of services at the local level (Moore & Skinner, 2010).
5.4 The Workforce Development Strategy

As mentioned previously, Australia’s health and community sector workforce is facing significant challenges. Such challenges are well documented and include an ageing population, increased demand for health services and increasing expectations for service delivery, changing burden of disease and broader labour market issues. In addition, health expenditure as a percentage of gross domestic product is rising and is projected to increase significantly in the coming decades. It is critical that these challenges are addressed together to ensure a sustainable delivery of health services that support the health and wellbeing of Australia’s population (Health Workforce Australia, 2012b). The Health Workforce Australia (2012b, p. 4) report recommended the following steps towards a sustainable workforce:

- Understanding the existing workforce;
- Projecting future workforce demand and supply;
- Scenario modelling to enable further examination of the above;
- Identifying any gaps between supply and demand under each of the scenarios; and
- Developing a plan to close the gaps.

Similar workforce issues are being experienced in other sectors such as the family relationship support sector, and future workforce strategies are being considered to develop and meet their needs (Cortis, Chan, & Hilferty, 2009; Department of Families Housing Community Services and Indigenous Affairs, 2009; Family & Relationship Services Australia, 2012). Workforce issues are complex, multifaceted, interlinked and dynamic, and manifest in various ways in different community services sub-sectors and in different organisational, cultural and geographic contexts. Research is only beginning to unpack the context-specific nature of these challenges, and to explore the different models and strategies required to respond to these challenges in various community services contexts (Cortis, et al., 2009; Roche & Duffield, 2007; Stuart et al., 2010). There are also concerns that education programs do not currently prepare the workforce adequately and there is a lack of standardisation of education programs across the country (Kruske, et al., 2006; Schmied, et al., 2011). Authors (Cameron & Christie, 2007; Doggartt, 2012) reinforce the need for nursing leadership to ensure change is initiated and sustained.
A buy-in from two major stakeholders, the consumer and staff, is reinforced by Francis et al. (2010). The authors recommend that if transformational change are desired in models of care and the client journey, there needs to be generational investment in the skills and capabilities of all health workers (Francis, et al., 2010).

The key priorities that comprise the workforce development strategy were presented in Figure 122 of Chapter Four. The strategies included seven areas that are now described with reference to the current literature:

1. Increase the development and availability of innovative options for post-qualification education in the early parenting sector;
2. Develop retention strategies for the ageing workforce in EPS;
3. Develop innovative national professional development strategies;
4. Develop sustainable strategies for a multi-generational workforce;
5. Identify the skill mix for the various practice contexts of EPS;
6. Identify further research areas relevant to EPS; and
7. Market EPS work.

The first three strategies are the key priorities for the next 3–5 years. The other strategies are also important and need to be considered in the overall development of the workforce.

5.4.1 Increasing the Development and Availability of Innovative Options for Post-Qualification Education in the Early Parenting Sector

Post-qualification education in early parenting already exists and is offered around Australia for registered nurses at postgraduate certificate and graduate diploma levels to work within child and family health contexts. There are no standardised levels of competency for graduates completing these programs in Australia. While the nurse practitioner role has been well defined in most countries, there is no clarity internationally on the service potential and domains of practice for advanced practice nursing roles (Chang, Gardner, Duffield, & Ramis, 2010; Kruske & Grant, 2012). Chang et al. (2010) validated previous research towards developing an operational framework and tool for assigning advanced practice nursing roles and defining the core activities required to ensure more appropriate adoption and evaluation of these roles. In addition, Kruske and Grant (2012) investigated the educational preparation
of child and family health nurses in Australia and found that there was a marked
difference in name, clinical exposure and award title across the 12 institutions
offering relevant postgraduate courses. The authors emphasised the importance of
consistency of definitions to facilitate comparable university data and for national
workforce planning. They also questioned whether the preparation of child and
family health nurses was sufficient at a graduate certificate level, and whether the
required clinical hours were assigned to ensure this.

Other related postgraduate studies offered in Australia include a Master of Nursing in
Child and Family Health (Karitane) in NSW (Karitane, 2012). There are new
multidisciplinary postgraduate qualifications being offered in NSW for very complex
families. The Graduate Certificate and a Master’s in Family Studies provides
students with comprehensive multidisciplinary knowledge and skills to undertake
policy development and service delivery directed towards strengthening families in
need of dispute resolution or counselling, or suffering the stress of disability, drug
and alcohol abuse and other complex issues that arise in varied cultural, social and
political contexts (University of Newcastle website, 2012). Another course in
Victoria is designed for people working in the child protection and family services
sectors who hold a degree (Department of Human Services Website, 2012).

The above scenarios indicate that there is much work to be done, both from the
university and organisational perspectives, in the move towards national consistency
of a nursing profession that has been around since the early twentieth century. If
further options are to be offered, it would be prudent to gain national consistency in
nursing and a great deal of commitment to forge ahead with interdisciplinary work in
EPS.

For an additional skill mix to add to EPS and to replace the mothercraft nurse, there
is an Advanced Diploma of Nursing (enrolled/Division 2 nursing) offered in parent-
craft and family health in NSW (Karitane, 2012), and in Victoria, a Graduate
Certificate of Social Science in Prenatal and Postnatal Family Support is offered at
Swinburne University of Technology, Melbourne. Such two-year certificate workers
are used in the skill mix for the three EPS sites in Victoria. This is a qualification that
could be developed nationally, with an online component and workplace assessment
tailored in each state.
Overall, around Australia, there are limited options to equip a range of disciplines to work closely with families in the early years. Moore (2008) from the Centre for Community Child Health in Melbourne has identified core knowledge and skills for working in early childhood intervention and has provided a useful guide for setting up new courses or qualifications for a range of professionals in the early childhood and parenting field.

Two options for postgraduate qualifications recommended during this study were the EPP role, and a certificate in early parenting for enrolled nurses. These are discussed below.

5.4.1.1 The proposed EPP role

An EPP role would add value to the mix in staff at an EPS. It would not replace the need for nurses or allied professionals, but would try to solve the issue of spreading the knowledge of early parenting to a greater professional base. As discussed in Chapter Four, this EPP could have a baseline health, social science or early childhood education degree, and the graduate could undertake a postgraduate certificate/diploma in early parenting (yet to be developed). The knowledge and skills expected to result from such a qualification are currently demonstrated by child and family health nurses due to their longevity of experience and knowledge base.

As has been shown by this and other studies, this broad knowledge base requires an investment in professional development and clinical supervision that many nurses on the whole have not had in universal services or EPS. Some studies have shown that the depth to parts of the child and family health nurse role require ongoing development and collaborative interdisciplinary approaches, such as in child protection, perinatal mental health and other complex issues facing families including family violence, separation and relationship difficulties (Chavasse, 2010; Land & Barclay, 2008; Vimpani, 2000).

As indicated, this proposed role will not only assist to solve workforce issues but will provide for the needs of today’s families and the many issues they face. EPS is a workforce that could accommodate a greater skill mix with nurses. Duffield (2008) challenges the neonatal, paediatric and child health sector in Australia, given the small number of nurses, to rethink the nature of the workforce in terms of future directions. She asks several questions:
• Which health discipline is best able to meet the needs of this particular child and who will provide the care?
• Who are the members of your workforce and is this appropriate given future demands?
• What do nurses contribute that no other health discipline can?
• What do nurses currently do that someone else could do?
• How do you define and measure the impact of what you do?
• How do we know we are making a difference to a child’s health status?

(Duffield, 2008, p. 7)

Duffield (2008) does suggest that these specialties could benefit from a greater mix of multidisciplinary postgraduate courses. She states that ‘universities need to consider these issues … there may well be better ways of preparing this specialised workforce in a country of this size’ (Duffield, 2008, p. 7). Another point raised by Duffield et al. (2011) was about the speciality of child and family health nursing and the costs to education providers of small numbers of students annually. Duffield recommends considerable debate and planning on the introduction on new positions and the need for a national approach to defining practice (Duffield, et al., 2011). Duckett (2005) encourages the redefining of the health workforce in Australia and recommends options for new roles. Duckett suggests that the emphasis should not be on providing more of the same, but rather the roles of health professionals will need to change and a stronger emphasis be applied to workforce substitution; that is, a different mix of responsibilities (Duckett, 2005, p. 201).

5.4.1.2 The enrolled nurse and a qualification in early parenting

Authors have recently explored the role and scope of practice for the enrolled nurse (Cubit & Leeson, 2009; Gibson & Heartfield, 2003; Gibson & Heartfield, 2005; Jacob, Sellick, & McKenna, 2012). Certificate programs for the enrolled nurse will be phased out in 2014 and become a Diploma of Nursing. Through their employment arrangement, enrolled nurses need to be guided by the principles of determining scope of practice and the agreed principles of delegation and supervision, as set out in the national Board’s professional practice framework. All nursing activities must take place in the context of agreed principles of delegation and levels of supervision at the local level. These should be supported by the policies, procedures and
protocols that have been developed in accordance with service needs and intended outcomes of the workplace (Nursing and Midwifery Board of Australia, 2012). Predominant issues in practice have been role blurring and supervision requirements by registered nurses (Gibson & Heartfield, 2003; Jacob, et al., 2012). Small numbers of enrolled nurses are employed by EPS in Australia. Nurses through all phases of this study recommended more options for postgraduate qualifications for enrolled nurses, to improve the skill mix for EPS. Currently, courses are limited to two states in Australia. A qualification in early parenting could be developed with an online component for use nationally, with placements arranged in state contexts.

5.4.2 Develop Retention Strategies for the Ageing Workforce in EPS

Staff shortages in the health system generally, high turnover and the ageing workforce have been well documented in Australia (Duffield & O'Brien-Pallas, 2002) and internationally (Thompson, Young, Heller, & Farrow, 2001). For EPS, a high turnover of nurses is not a major issue at the moment with the employment longevity of many of the nurses. The Productivity Commission also made an assumption that ‘while some concerns were raised about the ability of child health services to replace the ageing workforce, the relative attractiveness of the specialty, evidenced by strong demand for postgraduate child health courses, suggests that workforce turnover should be manageable’ (Productivity Commission, 2011, p. 316). In WA, anecdotally the major issue is that the interest and demand for courses is outweighed by an unmanageable process in the Health Department to get permanency of positions, or by no positions being available.

It is important that flexibility for ageing nurses supports their transition into retirement and allows them to mentor inexperienced nurses. Nursing is predominantly a female profession. Many nurses have taken time off to have a family, which limits their earning and pension capacity. More recently, in increasing numbers, these same staff are now relied on to provide care for elderly parents (Graham & Duffield, 2010). There is little evidence to suggest that nurses are currently working or prepared to keep working until the age of 65 because of the challenges and related health issues experienced in today’s work environments (Graham & Duffield, 2010). A number of studies have focused on the needs of the
ageing workforce internationally (Falk, 2007; Fitzgerald, 2007; Kear, 2011; Keller & Burns, 2010; Sorrell, 2010; West & Maguire, 2012).

A Canadian study (Lavoie-Tremblay, O'Brien-Pallas, Viens, Brabant, & Gélinas, 2006) looked at retention strategies in the form of incentives for nurses to stay. These ranged from workplace culture and respect to tailoring of workloads, abilities and needs. Resourcing will need to accommodate this transition, given the large benefits of knowledge and skills required to support and retain younger and less experienced nurses and other allied professionals (Stanton, 2011). It was reinforced by many nurse respondents that there needed to be some assessment of the appropriate and necessary attributes and skills to provide leadership and mentorship (Anonymous, 2011). This point was also stressed as important by Stanley (2010) because the leadership approach is linked with the retention of nurses and job satisfaction from all generations. The author emphasised ‘congruent leadership’ as that style in which leaders’ actions are matched with their values and beliefs, making this a suitable approach when working with a range of employees from different generations (Stanley, 2010, p. 850).

In a qualitative study by Kruske et al. (2006) of child and family health nurses, she found that the overall educational achievement (in terms of tertiary education following from hospital-based certificates) of the nurses in the research was low. Kruske argues that in this case, it is difficult for nurses to demonstrate leadership and research into the profession. This is consistent with the general absence of literature around child and family health nursing in Australia. Kruske et al. (2006) suggest that this issue requires key decision-makers in both services and education to collaborate with leaders of the profession to address challenges in future models and service redesigns.

### 5.4.3 Develop Innovative National Professional Development Strategies

Workplaces that facilitate educational opportunities for their staff promote a culture of excellence, which assists with staff satisfaction, staff retention and quality care (Levett-Jones, 2005). Opportunity for innovation in this area, particularly with advances in technologies, has great potential nationally. Fowler et al. (2009) in their study of NSW child and family health nurses recommended that:
Education programs at graduate level and continuing professional development require a significant shift from information laden courses, to programs that also provide graduate attributes of: Information accessing and processing, critical thinking and reflective capacity, ability to work in partnership, a population approach to practice and a commitment to rigorous evaluation. Having these qualities enables the C&FHN [child and family health nurse] to shift from the ‘expert’ model of practice to a model of partnership that acknowledges and draws on parents’ existing knowledge and resources. These new skills and enhanced attributes contribute to the family’s empowerment to manage their health needs more effectively. (Fowler, et al., 2009, p. 7)

IPE needs leadership that is committed to sustaining this approach within the workforce. In a study by Carlisle, Cooper and Watkins (2004, p. 545), it was found that in some settings committed to providing comprehensive collaborative care, it was more rhetoric than reality. They stated that ‘staff often pay lip-service to the principles of interdisciplinary teamwork, and understanding of basic concepts can be poor which may be due to lack of adequate teaching of the principles of team working in pre- or post-qualification training’. Missen et al. (2012) reinforce the necessity of workplace commitment for undergraduate interprofessional learning through student placements. This will also assist to move the culture of nursing in some areas from a mono-discipline approach to interdisciplinary perspectives and models of work. National standards, curriculum, clinical supervision and reflection also enable a dynamic culture of life-long learning.

One of the major changes from the past that presents as a strength of EPS is the move to team and partnership approaches and reflective practice and the benefits that these influences bring to organisations, albeit at various stages around Australia. The isolated practitioner in the community child health nurse model, in which nurses were placed out in small buildings on their own, has not always been conducive to the nurse’s growth and learning (Borrow, et al., 2011). Governments around Australia are starting to realise this, but are often constrained by available buildings and the history of these locally in the community. Institutional care at Ngala up until the 1990s was also still very individual focused when working as a practitioner with
a family. Therefore, the benefits to the context of the EPS interdisciplinary environment are considerable (Nemeth, 2008).

A combination of increasing the family partnership approaches, clinical supervision (Chavasse, 2010), increasing the discipline mix and encouraging interdisciplinary reflective practice can only move organisational cultures towards a greater focus on the families they serve. A range of strategies at all levels will enhance this change. Ngala has, for example, found a number of successful strategies that are enabling a cultural shift towards an interdisciplinary approach. A concerted effort in implementing C-Frame throughout all levels of the organisation was a successful method of ensuring everyone speaks the same language about how they work together. A staff development program that commenced at orientation was built on four levels, and components were tailored or contextualised for specific team areas such as administrative support and child care centres (Ngala, 2008). ‘C-Frame champions’ were important to embed the C-Frame culture. In developing the interdisciplinary research agenda, a discussion paper was written to involve staff across the disciplines (nursing and midwifery, social work, psychology and early childhood education) in discussing the key theories and approaches that inform early parenting research and practice, and gain their feedback (Ngala, 2010a). Other research activities have also focused on involving staff to increase their project and practice development skills and experience in interdisciplinary team work (Bennett, Hauck, Bindahneem, et al., 2012; Bennett, Hauck, Carter, et al., 2012; Bennett, Wells, et al., 2012; Hauck, et al., 2011; Hauck, et al., 2007; Priddis & Wells, 2010b).

The area that requires work nationally is the implementation of effective supervision models. Currently, these are offered in an ad hoc manner around Australia in EPS (Bennett, 2008). Ngala has commenced a project to develop and implement a framework for supervision in 2013.

5.4.4 Develop Sustainable Strategies for a Multi-Generational Workforce

This priority of a sustainable multi-generational workforce has been combined to include the two aspects that were explored through phase three: developing marketing and recruitment strategies, and sustainable strategies to support a future multi-generational workforce.
Given that the current main workforce consists of baby boomers and generation X nurses, it is important to understand the characteristics of each generation and the requirements needed to support recruitment and retention of staff. Multi-generational workforce issues and trends significantly affect recruitment and retention, as do demographic and societal trends such as the ageing nursing workforce concurrent with an ageing population (Sherman, 2006; West & Maguire, 2012). Nesley and Brownie (2012, p. 197) state that effective leadership is required to build a cohesive workforce by ‘utilising the strengths and skill sets that characterise different generations of nurses, and create the conditions in which all nurses feel supported and valued’. Working with these different generational groups requires leaders and managers that can adapt themselves or the environment (Bail & Schreuders, 2011), or who can harness the attributes of each generational group to meet the needs of their respective organisation (Sherman, 2006; Stanley, 2010).

There is increasing literature on this topic. Table 18 is an example that demonstrates the characteristics of each generation (Baker, 2012a, p. 232).
Table 18. Example of generational characteristics

<table>
<thead>
<tr>
<th>Generation names1,3</th>
<th>Birth years</th>
<th>Archetype1</th>
<th>Remembered for1</th>
<th>Endowments2</th>
</tr>
</thead>
<tbody>
<tr>
<td>GI</td>
<td>1901-1924</td>
<td>Hero</td>
<td>Collective coming-of-age triumphs and hubristic older achievements</td>
<td>Community influence and technology</td>
</tr>
<tr>
<td>Silent</td>
<td>1925-1942</td>
<td>Artist</td>
<td>Quiet years of rising adulthood; middle, flexible, consensus-building leadership</td>
<td>Pluralism, expertise, and due process</td>
</tr>
<tr>
<td>Baby Boom (Boomers)</td>
<td>1943-1960</td>
<td>Prophet</td>
<td>Principled older stewardship</td>
<td>Vision, values, and religion</td>
</tr>
<tr>
<td>Generation X (Gen X, Xers)</td>
<td>1961-1981</td>
<td>Nomad</td>
<td>Rising adult years; hell-raising; and middle, get-it-done leadership</td>
<td>Liberty, survival, and honor</td>
</tr>
<tr>
<td>Homeland (Generation Gen Z, Gen Z)</td>
<td>2005-2025?</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
</tbody>
</table>


An example given of a characteristic of generation Y (Millennial) nurses was that they expect more coaching and mentoring than any other generation in the workforce. They are optimistic and goal-orientated, but also want structure, guidance and extensive orientation. They also value flexible workplaces, and organisations can expect a high turnover if their needs are not met (Sherman, 2006). The emphasis of the literature encourages the workplace to generate a collaborative team culture that will be beneficial across the diversity of generations. Authors such as Baker (2012b) and Stanley (2010) highlight five priorities of focus for any generation:

1. An opportunity to advance within the organisation;
2. Better work–life balance;
3. Better remuneration benefits;
4. Respect and recognition; and

Graduate positions need to be given a high priority in EPS, as nurses are often unable to obtain positions in the health system. Nurses have not traditionally been encouraged to undertake placements in community nursing. There is now a proportionate decline in graduate nurse programs, despite the increase in the actual
number of nurses entering the system and needing urgent planning at all levels of government (Belardi, 2011b).

The last, fifth, point is important and was seen as a crucial factor of retention throughout this study. The ever-increasing pace of technological change, increasingly complex client care needs, and rapid changes or developments in knowledge should cause organisations to consider carefully the impact of continuing education. Environments that are conducive to learning and development will improve staff satisfaction, staff retention and quality care (Holland, Allen, & Cooper, 2012; Levett-Jones, 2005). This environment is also supported by accommodating generational preferences in areas such as coaching and motivating, communicating and resolving conflicts, as this assists to promote an environment of retention (Sherman, 2006).

5.4.5 Identify the Skill Mix for the Various Practice Contexts of EPS

In practice, skill mix involves achieving a balance between trained and untrained, qualified and unqualified staff, various occupational groups, and supervisory and operative staff in a context of cost and care considerations (Hennessy, 1995). Nurses in this study responded that it was important to develop a broader understanding of skill mix and increase the mix of staff. Some national sites have large percentages of nurses compared to other disciplines, and this appears to be historical. The WHO (2010b) advocates for interprofessional collaboration through teamwork, which has the potential to strengthen health service provision and improve outcomes for clients by enabling access to a broader cross section of skill sets in addressing their often complex health issues. AHPRA provides information about accreditation under the National Law Act, in force in each State and Territory, to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners (Australian Health Practitioner Regulation Agency (AHPRA), 2010).

Nemeth (2008) advocates for a strategy of using family partnerships training to bring together different disciplines to enhance the provision of collaborative care for families. The challenges confronting contemporary society demonstrate the effect of a range of social, economic and political factors on health and wellbeing. These are frequently discussed as the determinants of health and include issues such as poverty, drug use, our changing global climate and environment (Keast & Mandell, 2009) and
the increasing impact of chronic disease on the global population (Humphris, 2007). Of significant concern is the need to pre-empt a global crisis in the health workforce due to the ageing workforce population (World Health Organisation, 2010b).

The various contexts of EPS need to be considered as the mix of staff can vary as well as the involvement of staff of the rationale and need to plan around skill mix. It is felt that understanding and articulating the various roles can give clarity to the range of disciplines working together. Carr and Pearson (2005), in their study, focus on the exploration of nurses’ experiences of engaging in delegation practices within an actual or potential skill mix environment. They address debates about the appropriate care responsibilities for different types of health care worker from the perspective of how this affects the delegation process. The limitations of the study indicated that more research is required for contexts other than the community context, as differences may exist in teams that work closer together where supervision and interprofessional communication is immediately available. A study at Ngala is exploring the social work and nursing role when working jointly with a family (Bennett, Hauck, Carter, et al., 2012). This further adds to the evidence base around workforce and roles in early parenting.

5.4.6 Identify Further Research Areas Relevant to EPS

Overall, research and application of evidence to practice throughout EPS in Australia is limited and is just starting to develop momentum and importance over recent years. Even the evidence base used for practice needs a much greater focus on the rigour of having clinical guidelines for every aspect of practice, there are now good examples of best practice guides for perinatal mental health, child protection, home visiting and some other aspects of work. This issue was also identified by a British study (Appleton, 1997) and a review of a Victorian EPS (Fisher & Rowe, 2003). The argument was that, because of the absence or generally poorly defined guidelines for working with ‘at risk’ or ‘vulnerable’ groups, professionals often use subjective clinical judgement. Nurse respondents in this study thought that developing research cultures that encourage practice development was crucial, as was the need to keep the client uppermost in importance, to ascertain the difference the EPS make with the various contexts of their work. Other suggestions from nurses reinforced the importance of this study, and called for more research on interdisciplinary
approaches. Rickard et al. (2011) suggested that nurses need greater access to resources such as computers, research software and quiet workspaces to support a research culture.

An interdisciplinary research framework was developed for both research and practice at Ngala (Bennett, Hauck, Bindahneem, et al., 2012). This approach could be an example of best practice for other sites wishing to develop a research culture. From the initial project and set up of a research group with various university research partners, an interdisciplinary framework was developed with research priorities and strategies to develop a research culture. An action research project sought to identify the barriers for staff to undertaking research. Encouraging a research culture requires ongoing effort to include practitioners in different research and practice development activities. A number of studies have investigated why nurses find it difficult to strive for increased understanding to address the issues that affect their practice. New and Bogossian (2008) looked at the experience of generation X and baby boomer generation neonatal nurses and found that they often feel they have not got the skill, knowledge or support to undertake research in practice. Organisations will need to consider how to involve young practitioners in practice development from the beginning, so that they form a new culture of practice development. Workplace cultures and support from management are also crucial in the development of positive research cultures (Bennett, Hauck, Bindahneem, et al., 2012).

Ngala staff have continued with further activities and now have preliminary findings from current research projects. One project is investigating the effectiveness of Ngala’s family partnership approaches (C-Frame) on practice undertaken by nurses (Bennett, Wells, et al., 2012). This project aims to determine how nurses use evidence-based information in their practice and process of care. Consumers are also being asked how they experienced the process of care.

Another study in progress is exploring nursing and social work roles when working jointly with a family at Ngala. The initial findings are revealing the challenges practitioners often face with boundary issues. These boundary issues have to be worked through when practitioners from different disciplines commence doing joint work with a client. If this is recognised from the beginning, then practitioners can
commence planning and reflection to enable more effective communication with the client (Bennett, Hauck, Carter, et al., 2012).

5.4.7 Marketing of EPS Work

Raising the profile of EPS work was seen as very important by nurses in this study. It was recommended that the strengths of EPS be articulated, and that the important role that services play, particularly in supporting the universal child health systems, be marketed to the public. McMurray (2010, p. 117) reinforces that ‘the contributions by nurses and midwives need to be articulated in the policy area … the challenges are many but we need to ensure our voices become an inspiration to the next generation’ (p. 177). For the current workforce to gain a voice, there must be increased involvement of nurses in the workplace in policies to create a supportive work environment and professional development to meet their needs (Bail & Schreuders, 2011; Stanley, 2010). The professional identity of nurses is changing, and it is imperative that nurses find their voice, combine this with confidence and intelligent conversation and connect with the media (Harmer, 2010; Kemp, et al., 2005). Spence (2008, p. 2) also presents a challenge to nurses in her article in which she comments that ‘child health nurses remain a small speciality and need to unite with their goals of providing expert nursing care and move the speciality forward’ (p. 2).

Nurse respondents in this study talked of the silence of the consumer in this area and the greater awareness required in other health and welfare services of this type. A UK Delphi study (McKenna & Keeney, 2004) asked general practitioners, community nurses and members of the public how the public perceived community nursing. The study recommended that nurses promote and encourage the public to be involved in the planning and delivering of services. Further, community nurses were advised to involve consumers of health and social services in ways that increased their resources, promoted their capacity and power to influence factors affecting their health and wellbeing, and enhanced their understanding of community nursing services. They also argued that nurses have a special relationship with the public and that this demands a readiness to ask people about their experiences of health and how they want their care needs met. The authors also stated that organisations ‘must create a climate and culture that is responsive to public involvement, and this must be
reflected in the resources, timescales, information exchange and willingness to support individual practitioners in their public engagement’ (Francis, et al., 2010; McKenna & Keeney, 2004, p. 23). Child health nurses must be ‘eclectic and dynamic’ in their search for the best ways of developing the profession and helping children and families achieve their potential (Kenny, 2002, p. 310).

Having considered relevant literature, it is now prudent to discover relevant theory that is pertinent to the findings.

**5.5 Comparison of Findings with Theory**

Both role theory and IPP theory are important in the reflection of the comparison of findings with theory. Each will now be described.

**5.5.1 Role Theory**

When role theory was developed during the early part of the twentieth century, there were strong correlations with the nursing role, given the societal context and that nursing evolved with strong influence from the army. Nursing was also strongly dominated by the medical model and control was task driven until the move to the tertiary sector, which began to create a stronger voice for nursing. Nursing in EPS had influential medical advocates alongside volunteer advocates, and hence differed from the hospital context. Nurses in child health centres and EPS were very strong and autonomous women (and still are), and they also had a strong identity and role expectation as nurses. This was identified in the present cohort of nurses by the allied professionals in phase one of this study, and it can be suggested that this is consistent with nursing being the largest health discipline in Australia (Duckett, 2005) and the public perception on the role of the nurse in society (McKenna & Keeney, 2004).

One of the critiques by feminist writers is that role theory perpetuates the notion of categorical separation of work and leisure and has been linked to the experience of the traditional males employed within western industrial societies. The idea of ‘multiple awarenesses’ is ‘the ability to attend to those issues and needs that may appear to be in the periphery of life simultaneously with those that are presumably in the centre’. In this way, the theory needs to reflect the experiences of men and women (Jackson, 1998, p. 54). Jackson (1998) stated that the role theory perspective of human agency minimises the creative nature of humans as they adapt on a daily
basis to their environments; how people improvise to reach their goals or life choices, given the constraints of their particular situation against a backdrop of social, economic and familial forces has not been sufficiently explored (Jackson, 1998, p. 53).

As indicated, in terms of the profession of nursing being possibly consistent with role theory, this has a correlation whereby the strong identity of being a nurse was very influential on the majority of nurses. The change from hospital-based nursing to the tertiary sector created role conflict, requiring the renegotiation of roles to conform to the changes. This is consistent with organisational role theory, whereby the organisation takes on an employee with the assumption or expectation that the nurse will comply to the behaviour that is expected, with role conflict arising when expectations are not consensual or congruent (Biddle, 1986; Wickham & Parker, 2007). Since the 1980s, advanced practice roles started to evolve, and since then roles have been emerging as a result of changing health care needs and workforce requirements, with societal forces such as economic climate, changes in technology and health care delivery influencing its evolution (Hamric, Spross, & Hanson, 2009; Holloway, Baker, & Lumby, 2009). Variance in approach to collecting data and in defining specialty practice areas and specialist nurse numbers is challenging, both nationally and internationally (Furlong & Smith, 2005; Holloway, et al., 2009). A nursing specialty such as EPS requires a national framework to develop a base of evidence for understanding consistency. Clarity around specialty areas and specialist-level practice will give descriptors and an education framework to assist with data collection and to provide enhanced information for both workforce planners and stakeholders in the health care system (Furlong & Smith, 2005; Holloway, et al., 2009).

A most important stakeholder is the family and child as consumer, because the development of a professional nursing workforce must always be linked to the health care needs of communities. Consumers expect service providers to be knowledgeable in assisting them to manage their complex health needs. A framework that provides clear identification of specialist nursing practice also enables closer examination of the relationship to client outcomes and clinical effectiveness. Duckett (2005) also pointed out that in addition to health care consumers and nurses themselves, there are four other parties to consider in nursing workforce issues: education providers who
design curricula; health service providers who employ nurses; health service regions that make decisions about pay and conditions; and the government, which funds education and regulates migration. In the absence of a consistent national framework, small organisations such as EPS are often reactive and have created multiple and isolated approaches that are not effective or sustainable in the long term for EPS nursing workforce planning.

Educational preparation for the health workforce generally has not kept pace with changes in the environment. Although education of health professionals has been by no means static, new needs have typically led to the development of niche professions rather than reorganising professional boundaries to meet new needs (Duckett, 2005). This is certainly true of nursing. Reform to promote teamwork, interdisciplinary ways of working and flexibility in the workforce has been recommended by many reviews. An example given by Duckett (2005) reminds us that the 2004 first national Health Workforce Strategic Framework recognised that realignment of existing workforce roles or the creation of new roles may be necessary. Nurses generally have reconstructed their role to fit the status quo of nursing, particularly in terms of interdisciplinary work. It is now time for increased leadership in nursing and creative opportunities for nurses, to engage them in new skills to successfully challenge this status quo.

Nurses in EPS have navigated change over time, but there is still some evidence of role conflict as nurse leaders try to resolve the potential difficulties that lie ahead in terms of workforce composition, and how they will articulate the role of the nurse in that context. Nurses need not be limited to the historical notions of role theory, but can forge a more contemporary approach to inclusion of broader social forces and consider the role in EPS in terms of societal changes for families and sociopolitical agendas. Organisations also need to accommodate a multi-generational workforce, with flexibility required to support all workers in their role so that development to their full potential is possible (Wickham & Parker, 2007). Role theory would say that, while nurses are being challenged with their role expectations during a transition phase, the support of organisations is crucial for them to generate a sense of meaning and purpose that contributes to their own psychological well-being. Nurses must then modify their attitudes and expectations through anticipatory socialisation and adapt through training and professional support in their new defined
roles (Burnett, 1999). Sherman (2006) suggested that generational differences with nurses can present leadership challenges, but that these differences in attitudes and behaviours should be viewed as potential strengths. A flexible leadership style will enhance quality and productivity, reduce conflict and maximise the contributions of all staff.

In terms of professional identity being strong in EPS, this can be a barrier in interdisciplinary team work. Such professional identity is a process of socialisation within professional role development and has been shown to play a large part in the development of ‘tribal’ attitudes. To avoid the detrimental effects of this, IPE needs to begin early in a nurse’s pre- and post-professional education and nurses need to be supported to feel comfortable in their own role, which leads to acknowledging other people’s roles (Atkins, 1998).

This begins the link between role theory and IPP theory, which will now be described.

5.5.2 Interprofessional Education and Practice Theory

Before discussing IPP, it is necessary to view briefly the main theories driving IPE. IPE is defined as occasions when two or more professionals learn from, with and about each other, to improve collaboration and the quality of care for families and children (Hammick, et al., 2007; Nisbet, et al., 2011). The policy drivers for IPE have been occurring globally and reflect the increasing pressure on the health care system, such as from changing demographics, new models of health care and the need for teamwork, quality and safety agendas, and health workforce shortages (Nisbet, et al., 2011).

Craddock, O’Halloran, Borthwick and McPherson (2006) presented an overview of four educational theories that they think are important for IPE: reflective practitioner theory, adult learning theory, theories derived from social psychology and systems theory. Firstly, the ‘reflective practitioner theory’ attributed by Schon (1987), has been described as being crucial to any professional education program because of the focus on the application of theory to practice. By professionals and/or teams reflecting on the processes of working together for the improvement of client care, they can achieve an appreciation of the roles and underpinning values and models of
both or all of their professions. Reflective practice facilitates the natural occurrence of interprofessional work as disciplines complement and support each other (Craddock, et al., 2006).

‘Adult learning theory’ has been attributed to Knowles (1980) and has become the standard by which continuing health education is measured and appraised. This is based on the premise that a key element of good teaching is the ability to stimulate self-learning. Learning, as it occurs, can change conceptualisations of phenomena and the world can be seen differently. A number of teaching strategies can be employed to facilitate self-directed and collaborative adult learning. For example, problem-based learning uses team learning theory, which has a focus on collaboration within the group and group dynamics. Individual learning here is necessary but collaborative learning is essential for an effective organisation (Craddock, et al., 2006). Kolb’s cycle (Kolb, 1984) and experiential learning has been utilised to inform IPE. This learning cycle involves a cyclical sequence of four elements deemed to be fundamental to learning; that is, concrete experience, reflective observation, abstract conceptualisation and active experimentation (Craddock, et al., 2006).

The group development theory is characterised by forming, storming, norming and performing stages that span the life of all groups. It emphasises the need to address relationships between learners in an IPE initiative (Tuckman, 2003). Time spent reflecting as a group through collaborative work via ongoing discussions can therefore help teams to become reflexive, integrated and better coordinated (Craddock, et al., 2006). These authors also recognised that the application of adult learning theories alone is not enough to support IPE.

Thirdly, theories derived from social psychology have been utilised to inform the development of IPE initiatives (Craddock, et al., 2006). Two such theories are now explained. To facilitate collaborative learning and reduce stereotyping, ‘contact theory’ looks at outcomes when two opposing groups are brought together. This was developed from the work of Allport (1979), who proposed that three conditions had to be met before prejudice between different social groups could be reduced: equality of status, group members working towards common goals and cooperation during contact. To facilitate IPE, other conditions were added: positive expectations by
participants, successful collaborative activities and a focus on understanding differences and mutual similarities to positively influence stereotypical attitudes. It has been found that IPE cannot by itself remove the attitudinal barriers between members of professions (Craddock, et al., 2006).

The other example of a theory derived from social psychology is ‘social identity theory’. This theory, based on individual self-concepts, explains intergroup discrimination where one group favours their own group over another (Mandy, Milton, & Mandy, 2004). Such a self-concept is centred on social identity, which is influenced by membership of a group and by the values that the group shares (Mandy, et al., 2004). Social identity theory describes an interpersonal–intergroup continuum along which individual health professionals define themselves according to their occupational group, and individuals strive to uphold and augment their personal and collective identity (Luhtanen & Crocker, 1992).

Fourthly ‘systems theory’ developed by Engel (1977) is an application of systems thinking that relates the individual to the environment. Systems theory has been used to provide a clear appreciation of the complexity of the interactions involved in establishing an integrated service (Meads, Ashcroft, Barr, Scott, & Wild, 2005). Here it is recognised that intervention by one profession at one point in the system affects the whole in ways that can only be anticipated from multiple professional perspectives. It gives an overall understanding and a commitment to real-life conversation and listening in which issues of difference need to be positively addressed via empowerment exercises, with a shared stance towards person-centred planning (Craddock, et al., 2006) When using systems theory with IPE initiatives, it is necessary to have a framework for addressing values, ideologies and differences in a team that can lead to trust of other disciplines and supersede those that constitute individual professions (Meads, et al., 2005).

Hean, Craddock and O’Halloran (2009) focused on learning theories and have considered the behaviourist and constructivist frameworks used within IPE, particularly from the individual and collective levels, from a situated learning or socio-cultural perspective. The authors highlighted the relationship between the range of theories and their evolvement and how this can be presented as a tool to understand the theories for practice application.
The authors argued that there is a need to explain and test theories that explain the socio-cultural perspective of learning to assist with the differentiation of uniprofessional and interprofessional learning (Hean, et al., 2009). Hean et al. also suggested that there is still a gap in the appropriate application and testing of these theoretical models in practice.

Therefore, when the focus of IPL shifts from how the individual learns to the context of the team or organisation, then Sargeant (2009) suggests that ‘complexity theory’ may be more appropriate as a lens to explore the interaction among various components of the environment. The author stated that:

complexity theory encourages us to look at continuing professional education differently as it moves the focus from the individual professional and how he or she learns and changes in response to education, to the health team, health system, and environment. Complexity theory also moves us from a reductionist or linear view of education and practice, which overlooks the interaction of individual elements and considers processes value-free; ie, personal and social influences did not intervene. (Sargeant, 2009, p. 179)

D’Amour and Oandasan (2005) developed a conceptual model linking IPE and IPP. This model demonstrates the multiplicity of interactions and relationships among individual learners and practitioners, teams, education, health systems and organisations, environments and cultures, all of which influence what is learnt and what is applied in practice.

Social psychology and complexity theory provide a rationale for an expanded vision of continuing education to accommodate IPE because IPE occurs through social exchange in complex environments (Sargeant, 2009). The theories that propose specific approaches to learning and teaching IPE are seen as critical to effective interdisciplinary teams seeing IPE as transformational learning enabling better appreciation of the need for a new way of thinking and knowing. These are social theories explaining social identity, professionalism and stereotyping; communities of practice; reflective learning; and transformational learning. Cooper et al. (2004) consider how complexity theory can provide IPE with a coherent theoretical foundation that ensures a direction for practice, intervention goals and what might
explained any outcomes for the intervention. In consideration of the application of theories to practice in EPS, the framework presented by D’Amour and Oandasan in Figure 128 is valuable.

![Collaborative Practice Process and Outcomes](image)

**Figure 128. Collaborative practice process and outcomes (D’Amour & Oandasan, 2005, p. 15)**

The C-Frame (Victorian Parenting Centre, 2005) process of care discussed in Chapter One (that Ngala and some other EPS have integrated within their frameworks) is consistent with this model. Ngala has C-Frame to working with colleagues as well as clients. Care to families and children is central to this model and has an interdependent relationship with professionals. Practice takes on various forms depending on the context and complexity of client needs and the composition of each team. The circle also presents the interactional processes and organisational factors that have to be taken into account when professionals work collaboratively (D’Amour & Oandasan, 2005). Congruence with organisational commitment to collaboration is vital for success. Curtin University in Perth have developed their ‘interprofessional capability framework’, which brings the model down to a discrete team (see Figure 129).
There are three core elements situated in this model; that is, client-centred, client safety and collaborative practice. To achieve these outcomes, students are asked to acquire five collaborative practice capabilities: communication, team functioning, role clarification, interprofessional conflict resolution and reflection (individual and team). There are now assessment tools available for students and evaluation of programs (Nicol, 2013). The Ngala experience of interdisciplinary team practice certainly works to achieve the five key outcomes in this model.

![Collaborative Practice Map](image)

**Figure 129. Interprofessional capability framework (Nicol, 2013, p. 24)**

According to Nicol (2013), the WA report was an exploratory study using WA as a case study in recognition of the scope and range of IPE activities occurring in universities and institutions. Four key aspects were identified as pivotal to the acceptance and implementation of IPE in WA in the future. These were funding, accreditation and registration bodies (flexibility in health professional criteria), educators (current divergence on scope of content), and changing requirements in the delivery of health services. The latter involved issues of change requiring systemic adjustments in remuneration, response to increased demand for primary care and the need for health professionals’ roles to adapt. The report also found that many health professionals supported IPE, while many others were not prepared to engage with it. These attitudes were also found to have a direct influence on students (Missen et al., 2012). Other factors affecting attitudes were fear of role substitution and insufficient
evidence to persuade health professionals to adopt IPP; these fears were certainly expressed in this study.

In moving forward, Sargeant (2009) suggests that much consideration is needed in developing and implementing IPE. Specific implications of complexity theory for continuing IPE include realising that IPE is complex: ‘It encourages us to be thoughtful and careful as we move ahead. Understanding and being responsive to the practice setting within which interprofessional teams are working are critical to success’ (p. 180). This leads to the final point of emphasising leadership and resourcing organisations when embarking on interdisciplinary research and practice and embedding it into organisational culture (Begun, 2008; Bennett, Hauck, Bindahneem, et al., 2012; Clancy, Effken, & Pesut, 2008; Engum & Jeffries, 2012; Missen, et al., 2012).

5.6 Chapter Five Summary

This chapter discussed the findings of this case study with reference to other literature and the applicability of theory to the findings. A conceptual framework for the past, present and future of nursing was presented with an explanation of a workforce development strategy that will inform national directions for nursing and interdisciplinary contexts in EPS in Australia.

The following chapter will consider the limitations of the study, give recommendations and discuss some implications for the future.
Chapter 6: Conclusions and Recommendations

6.1 Introduction

This study has produced new and informative knowledge and understanding of the past, present and future of nursing in EPS in Australia. The three phases of the study have resulted in a framework for the future workforce development of nursing within an interdisciplinary context. This final chapter will summarise the most significant findings generated and the importance of these findings for nursing practice, education, research and organisations. Subsequently, some limitations will be presented, followed by some concluding reflections.

6.2 New Knowledge Generated from this Study

This study has explored the spectrum of EPS in Australia across three phases of past, present and future. The past role of the nurse was considered at one site during phase one. The current role of the nurse in EPS within an interdisciplinary context was also explored during phase one and then validated through phase two nationally. The future of nursing within EPS was explored through all three phases, with a framework being developed through phase three.

Previous to the study, little evidence was available on this context and area of nursing. Information on the child health nursing role has been studied in various contexts and mainly in the universal system of child health. Therefore the new knowledge is how nurses and allied disciplines described their role in an interdisciplinary context with a focus on what was unique to the nursing role. In addition, this study has been future-orientated, given the pressure of an ageing workforce and the potential threat to a niche market of service delivery around Australia. The intent of this study was to gain knowledge of where nurses see the future and a way forward to assist national organisations in their challenging task ahead. A number of key findings are important to mention in this concluding chapter.

Previous to this study, the nursing role at Ngala over a period of 122 years had not been described. The rich history of nursing in this context has given a greater understanding of how nursing has evolved and changed over time and how nurses
continue to contribute to the health and wellbeing of families in the early parenting context.

Secondly, no previous work existed on the role of nurses in EPS in Australia in the context of an interdisciplinary team. Exceptions are that there are descriptions of competencies available for child health nurses in some States in Australia, and the NSW Health Department has introduced its Child and Family Health Nursing Professional Practice 2011–2016 framework. This study, along with these descriptions of the child and family health nursing role, provide some detail of the interactions that occur when nurses work closely with other disciplines. There is an overlap of roles that has a positive contribution to working with vulnerable families and support of their colleagues in the early parenting context. Nurses also describe some unique aspects to their current role, including their work in parent-craft and child development, health promotion, health assessment, holism and coordination of care. They were also identified as experienced practitioners with a broad knowledge base and a strong professional identity.

The final area of new nursing knowledge generated from this study was for the future. Rich data emerged through mixed method approaches during the phases of the study that provided a greater understanding and knowledge for the way forward for the future. Prior to this study, nursing workforce issues and the implications of the ageing workforce had been studied, but not for this cohort of nurses. Recommendations for the future have been written into a framework describing the changes that nursing has experienced over time in its role in EPS, and the unique role of the nurse within an interdisciplinary team. A workforce development strategy has been developed, including priorities for the next 3–5 and 5–10 years.

Overall, the new knowledge gained from this study will assist EPS in Australia to consider this workforce development strategy and contemporary alternatives to the development of workforces into the future. Further, this study represents a significant contribution to the evidence base of nursing within EPS contexts.

6.3 Significance of the Findings for Nursing

As a result of new knowledge gained from this study, subsequent clinical implications have emerged. The key implications from this study directly affect the
Ngala site being studied, but can also have ongoing ramifications for other EPS in Australia.

6.3.1 Implications for Clinical Practice

Firstly, the nursing role in EPS described was consistent with current literature in relation to child health nursing roles and competencies. The strengths of nursing for the early parenting context are documented through various sources, and this study documents nursing’s history at Ngala, which had not been previously undertaken. The respect held by the public for nurses has also been well documented in the public domain. The uniqueness of the nursing role in EPS when working closely with other disciplines has been identified and will assist nurses to articulate their role with other disciplines in a team environment.

The breadth of experience of the current nursing workforce in Australia is acknowledged. The experience of the baby boomer generation of nurses has included hospital- and tertiary-based training. This component of the uniqueness of their role will not be present when most of these nurses leave the workplace over the next 14 years. Therefore, HR processes, particularly in relation to retention and flexibility, will be important as these ageing nurses transition from the workplace.

The questions asked by Duffield (2008) about the workforce required for the future in paediatrics and child health are partly answered in this study. Nurses continue to be a profession needed for this area of early parenting work, along with other allied disciplines. Due to the threat of looming shortages and the loss of an experienced current workforce, it is necessary to rethink the skill mix. The proposed EPP role is partly a solution, as is the increased utilisation of enrolled nurses with the development of a postgraduate qualification in early parenting.

Secondly, the future nursing workforce needs to focus on outcomes for families rather than the preservation of established nursing positions at the expense of increasing the number of allied disciplines within early parenting work. Due to the vulnerable nature of families seeking assistance from EPS, mono-discipline approaches can exist no longer. Clinical supervision, reflective practice and increasing professional development are necessary to sustain the dynamic learning environments required to lead and drive change in services for the future.
Thirdly, the benefits of collaboration within an interdisciplinary team have been well demonstrated by study phase one at Ngala and the agreement of nurses nationally. The challenges presented by working closely with other disciplines also represent strengths in collegial approaches and learning that can only benefit families with children in the early years. The changing nature of the work needs a diverse skill mix and multi-generational workers that can take services into a new phase of planning and development for the future. Although the nurse’s role has expanded, it is consistent with being a very experienced practitioner. In the future, it cannot be expected that workers will stay in this area of work as the current senior cohort of nurses have. Hence, it is important to include a range of disciplines to support the unique role of the nurse in EPS, rather than continuing to rely on the much expanded role that has become challenging, onerous and a burden for many nurses.

As one of the major disciplines of a health service for communities, nurses (along with their practice) must be linked to the health care needs of those communities. Consumer pressure for specific services, technological changes, changes to other roles in the health workforce and resultant government policy will continue to contribute to increasing specialist service requirements. The specialist nursing service demand will continue to grow, requiring supply strategies. There is an opportunity in the current environment, with indicative professional organisational support and government strategy direction, for the development of a national specialist nursing framework. Such a framework would provide consistency in articulating this level of practice and support more effective workforce planning into the future.

Finally, this study has highlighted the need for nurses to take up the challenge of leadership and contribute to the redesign of EPS for the future. Further, through change management strategies, nurses can become involved in developing leadership potential in the up and coming workforce of new graduates.

6.3.2 Implications for Education

The findings from this study also have implications for national education in child health and parenting, with calls for the development of new qualifications and innovation in continuing professional development in early parenting work. Nurses are not the only ones that work with parents in this kind of work. There is a large not-
for-profit sector already supporting the universal child health system and early parenting services. This sector could be assisted with extra qualifications to enhance relevant knowledge and skills to enable consistency of service delivery for parents. The demand is such now that new approaches have to be considered and the use of social media and online education is part of this solution. National standards and competencies would assist child and family health nurses and allied professionals to develop consistency in their approaches.

Secondly, interdisciplinary team education has been taught at a large number of universities for some years but there remains room for improvement in this academic discipline. Commitment is required for workplaces to provide the right environment for the application of IPE theory and practice to be successful. Support and education at all levels of an organisation are necessary to move interdisciplinary frameworks and collaboration forward. The commitment of partnerships means persistence and consistency in this area from individuals, organisations and universities.

Thirdly, an investment in strategic professional development is essential to moving nurses forward to embrace innovation and change in early parenting work. The support for online approaches, coaching and mentoring programs is also necessary as the baby boomer workforce transition out and multi-generational workforces are created.

Finally, a range of qualification pathways need to be considered in early parenting work to enhance the overall skill mix for EPS. Both NSW and Victoria offer qualifications for enrolled nurses and these could be explored with the offer of an online component and placements being offered interstate.

6.3.3 Implications for Research

This study has initiated a research journey into the future of the workforce in EPS, but more work is needed. Firstly, this study focused in-depth on one organisation and one State context, and further questions arise as to whether there is overall commitment by some organisations in EPS to interdisciplinary work. There is commitment on the whole to multidisciplinary approaches, but if one considers the ratios of other disciplines to nurses at some sites, where there are either no (at one site) or very few allied professionals working alongside nurses, gaps may exist.
Nurses are gate-keeping this area of work to their own detriment, and to that of effective outcomes for families with young children.

Secondly, developing research cultures and practice development approaches takes time and investment in terms of resources. There are a number of best practice strategies that can be employed, but commitment is paramount at all levels of an organisation to achieve success. Small projects could be undertaken, for example, to elicit the gains from an interdisciplinary team approach, particularly for client outcomes.

Thirdly, the workforce development strategy developed here will need to be implemented and evaluated, and research projects that seek new knowledge on the various elements of the strategy will need to be devised.

Finally, the contemporary role of both the child and family health nurse and the enrolled nurse (Diploma of Nursing) with qualifications in early parenting can generate further research into how enrolled nurses work with an interdisciplinary team and navigate their decision making and supervision elements. Moreover, increased pathways and competencies for child and family health nurses commencing at level one for newer graduates could be considered, such as is already done in SA.

6.3.4 Implications for Organisations in Early Parenting Services

AAPCH now has the resources of a workforce development strategy that can assist in providing a way forward to create national consistency and standards. While there are variations in the contexts of each State, there are basic principles that can be adopted to guide services and potential future innovations that can maximise efficiencies such as online professional development and research into early parenting approaches. Given the small number of EPS employees nationally, this should be possible.

A framework for collecting workforce data to identify current supply and enable the development of a clear career pathway would greatly enhance future nursing workforce planning. The absence of a clear framework for articulating the demand for specialist nursing practice nationally has important consequences for the quality of future workforce planning, the essential development of appropriate educational
programs for the workforce and the provision of services. The ‘lack of’ is an indication of the complexity of the task, the diversity of the current professional organisation approaches and the health care context. The acknowledgment of the need for political support at the professional organisational or government level to effect change for nursing is widely reflected in the literature.

Secondly, change management approaches need to be considered to facilitate the development of leadership in the current workforce so that champions are developed and assisted to lead the way forward as the current senior cohort of nurses transitions out of the workforce. Nurses in EPS have a strong professional identity and thought needs to be given as to ‘what’s in this for me’ as well as trail blazing a new multi-generational workforce and skill mix for the future.

6.4 Summary of Recommendations

A summary of the recommendations are as follows.

6.4.1 For Clinical Practice

- Strengthen and resource clinical supervision models and reflective practice activities in interdisciplinary teams;
- Source relevant and implement leadership development programs for nurses;
- Explore strategies to increase the consumer voice in services;
- Refocus service delivery to focus on outcomes for families; and
- Explore strategies to promote nursing within EPS.

6.4.2 For Education

- Develop innovative professional development programs nationally;
- Explore the concept of an EPP;
- Develop national standards and competencies; and
- Explore a post-certificate qualification in early parenting for enrolled nurses.

6.4.3 For Research

- Develop sustainable research cultures in EPS; and
- Conduct follow-on research activities, including an evaluation of the workforce development strategies.
6.4.4 For Organisations

- Implement a workforce development strategy at Ngala, and through AAPCH. This includes the immediate implementation of strategies for the transition out of the workforce of the baby boomer generation and plans for national professional development;
- Continue the focus on the development of interdisciplinary team approaches when working with families with young children; and
- Continue to invest in and evaluate family partnership or C-Frame approaches, which are crucial to working with families with young children.

6.5 Study Limitations

One of the limitations of this study was the potential for a perceived unequal power differential between the researcher, who is the Director of Services of Ngala, and the nurses as participants at Ngala. The researcher anticipated possible harm or risk to participants and in the study the possibility of harm or risk could have existed in relation to the interview participant’s career and perceived role potential within the organisation. Every attempt was made to minimise the impact of this potential risk.

As indicated previously, this study focused in-depth on one organisation in one State during phase one, and while there was support from nurses nationally, organisations are not an homogenous group of services nationally—variations of organisational contexts and funding sources influence diversity in nurse perceptions. There are also variations of interdisciplinary team work and commitment to this nationally. This limitation was minimised by structuring the study in three phases and including nurses nationally in phases two and three.

The teleconference research strategy included a small sample of five or less self-selected nurses from nine services. They can therefore be considered as having a strong interest in the study and their contributions may not have captured other views of nursing. This limitation was minimised by all nurses nationally being invited to participate in phase three.

Nurses in the cohort of this study were also a homogenous group of participants, who were predominantly of Caucasian background and felt more comfortable with
families of similar ethnicities. This might have influenced their perceptions and/or their approach to their work. For example, an interesting observation is that there was very little mention from nurses as to the cultural security emphasis on their role, which also could indicate that the focus on multicultural work with migrant, refugees and Aboriginal families is limited, or that nurses did not think that different strategies needed to be used for different groups of people. Moreover, the number of enrolled and mothercraft nurses were small in this study, and this role was not specifically considered.

Participation in phases one and two exceeded the researcher’s expectations. The national survey in phase three had a response rate of 37 per cent. This was considered acceptable, although a higher response rate would have enhanced the findings.

As indicated through the study, the voice of the consumer is often missing in studies that directly affect them. There is a need to be mindful of this in the future.

6.6 Final Reflections

This study has made an important contribution to nursing knowledge in the area of EPS in Australia. The past nursing role in EPS has been explored, with comments made on how the changes in history have influenced the current state of EPS nursing in Australia. The future remains unknown, although workforce predictions give some certainty about a large cohort of nurses leaving EPS over the next 14 years. A concerted effort and focus on workforce development approaches will thus be needed for the next decade. Addressing educational preparation and the professional development of child and family health nurses may be one way to address some of the concerns raised in this study. Providing nurses with the skills to negotiate active participation in decision making, to plan and develop programs based on needs and outcomes for families, and to demonstrate the value of their practice through research would, in the longer term, go some way in addressing their concerns.

The interdisciplinary context in this area of work has been developing over the past two to three decades but still has a long way to go in EPS. Students having undertaken interprofessional learning through universities need to be able to experience consistency and congruence in workplaces to apply their learning. The
strengths displayed by collaborative team approaches were demonstrated by participants in phase one, and there was overall support from nurses nationally during phase two and three to develop innovative approaches for the future workforce framework.

As articulated in the introduction to this study, EPS in Australia is crucial, as is the need for these services to provide comprehensive prevention and early intervention services and programs for children and their families that have long-term benefits for children’s physical and mental health, educational achievement and emotional functioning. The consumer of these services is an important stakeholder and should be considered as central in further research and in relevant education and training. This study was about exploring the past, present and future of nursing in EPS. While a framework for the future has been recommended, the test will be whether it can be explored further and implemented nationally to assist the development of consistent practice to benefit families with young children.
References


Berry, K. (2012b, 21 March). [Ellen Barron Family Centre].


Carlisle, C., Cooper, H., & Watkins, C. (2004). "Do none of you talk with each other?": the challenges facing the implementation of interprofessional education. *Medical Teacher, 26*(6), 545-552. doi: 10.1080/61421590410001711616


365
Education and Health Standing Committee. (2012). Inquiry into improving educational outcomes for Western Australians of all ages. Perth.


Grant, B. (2013, 27/2/13). [Interview Beryl Grant].


King, T. F. (1923). *The Expectant Mother and Baby’s First Month*. Sydney: Angus &Robertson Ltd.


Ngala (2000a, 4 July). [Meeting Minutes for Interdisciplinary Case Management & Care Planning].


Ngala (2002, 30/8). [Submission - Parliamentary Inquiry into 'The role and Interaction of Health Professionals in the Western Australian Public Health System'].


Ngala website Retrieved 30/11/12, from www.ngala.com.au


Shaw, J. (2011, June 8). [Personal communication].


Melbourne: Queen Elizabeth Early Parenting Centre.


Walter, R. (2013, 30/1/13). [Interview with Rae Walter].


Appendices
Appendix 1a: Ethics committee approval letters, Notre Dame University, Dean of School of Nursing & Widwifery, UNDA 18/11/10

18th November 2010

Elaine Bennett
20/1 Stirling Street
South Perth WA 6151

Dear Elaine,

On 8th November the School of Nursing Research Committee received your application for ethical clearance for your proposed research to be undertaken for the thesis component of your degree.

The Title of the project is: An exploration into the past, present and future of nursing in early parenting services in Australia

Your proposal has been reviewed by the School Research Committee to assess the extent to which it complies with the Guidelines for Low Risk Ethical Clearance.

Your application has been assessed as having met all expected ethical standards that are relevant to the nature of your intended research and the instrumentation you have chosen to use. Your proposed research project has been granted ethical clearance by low risk ethical review and consequently your research project may now commence.

Clearances granted by risk ethical review are subject to confirmation by the Human Research Ethics Committee [HREC]. The HREC may elect to review the School Research Committee’s decision or request for further information and/or amendments to the research project.

Should the design of the study, the choice of instrument, or its manner of administration be altered in any significant way as your study progresses, you must provide an update of your clearance application for renewed consideration.

On behalf of the University, I wish you well with what promises to be a most interesting and valuable research project.

Yours sincerely,

[Signature]
Professor Selma Alliex
Dean, Fremantle campus
School of Nursing

[Signature]
Assoc Prof Adrian Morgan
Chair, School Research Committee

Cc: Caroline Balsara – co-supervisor
Ms Lorraine Mayhew, Executive Officer, Human Research Ethics Committee
Appendix 1b: Ethics committee approval letters, Notre Dame University, The Human Research Ethics Committee for Low Risk Ethics Clearance 11/1/11

11 January 2011

Ref. #: 010154F

Elaine Bennett
20/1 Stirling Street
South Perth WA 6151

Dear Elaine,

I am writing to you in regards to your Low Risk Application for Ethics Clearance for your proposed research project, to be undertaken for the research component of your course at The University of Notre Dame Australia.

The title of the project is: "An exploration into the past, present and future of nursing in Early Parenting Services in Australia."

Your proposal has been reviewed by the University’s Human Research Ethics Committee, and based on the information provided has been assessed as meeting all the requirements as mentioned in the National Statement on Ethical Conduct in Human Research (2007). I am therefore pleased to advice that ethical clearance has been granted for this proposed study.

Please note the following conditions of approval which apply to your research project:

- Ethics approval for this project is valid for 3 years. Under the National Statement you are required to report on the project's progress on an annual basis and the first annual report is therefore due in January 2012. Once your project is completed you are required to complete the Annual Report as a Final Report on your project. You are also required to notify the HREC Executive Officer in writing if this project is abandoned. The Annual Report form can be found at: http://www.nd.edu.au/research/hrec/apply.shtml.

- As a researcher you are required to immediately report to the HREC Executive Officer anything which might warrant review of ethical approval of the project, including unforeseen events that might affect continued ethical acceptability and any complaints made by participants regarding the conduct of the project.

- If the design of the study, the choice of instrument, or its manner of administration is altered in any significant way as the study progresses, you are required to submit an amendment in regards to the changes for ethical consideration to the HREC. The Amendment Form can be found at: http://www.nd.edu.au/research/hrec/apply.shtml.

On behalf of the Human Research Ethics Committee, I wish you well with what promises to be a most interesting and valuable study.

Yours sincerely,

[Signature]

Nicolette van Dijk
Executive Officer, Human Research Ethics Committee
Research Office

cc Professor Selma Aliex, Dean, School of Nursing
Dr Caroline Bultara, Supervisor
Appendix 2: Ethics approval from eight national sites. Letter sent to organisations

PO Box 1225 12 January, 2011
Fremantle
WA. 5969

NATIONAL SITE

Dear

Re: Support for Doctorate of Nursing studies

I have enclosed a copy of my research proposal entitled An exploration into the past, present and future of nursing in Early Parenting Services in Australia. I now have ethics approval from the UNDA Ethics Committee to proceed with this study.

I am requesting support from yourself to invite nurses at XXXX to participate in the proposed study. To assist with the dissemination of information to your organisation I would appreciate if you could provide me with a nominated contact person to be a coordination point for your site.

Assistance with the data collection will include the following:

1. Access to any key documents available that provide a historical context for nursing from your organisation (whenever possible);
2. Distribution of research study information (when available—info sheet, consent form [webinar] and survey information) to all nursing staff;
3. Assistance in the recruitment of Nurses invited to participate in a national webinar of 1.5 hr duration—five nurses for each national site (Planning for August 2011);
4. Assistance in the recruitment of O’Connell Nurses and support to complete an online questionnaire which will be distributed through early parenting services in Australia. (Planned for end Jan 2012).

It is hoped that the first phase of the case study of Ngala will inform the webinar (Phase 2) and the national survey (Phase 3). The data collection for all phases will occur between Feb 2011 and Feb 2012.

My hope is that this study will assist in planning for future directions in workforce requirements for early parenting services in Australia. Thankyou for considering this request.

Elaine Bennett
Appendix 3: Case study protocol

Phase 1

Archived documents Ngala

- Write request to CEO Ngala—Sept 10
- Obtain permission from Ngala to view Ngala records archived at Battye Library—Aug 10.
- Go and look at overall documents to ascertain scope—Sept 10.
- Register Researcher permission for obtaining and handling documents—Aug 10.
- Decision of what important and how to collect data—Keep in mind rigour and discipline—Sept- Dec 10.
- Questions to ask are adapted from (Finnegan, 1996 in (Punch, 2005, p. 185)
  I. Are the existing resources relevant and appropriate for the research subject?
  II. Have you ensured that documents selected have taken account of any ‘twisting’ or selection of the facts in the sources used?
  III. What principles will guide the selection?
  IV. How far does the source describing a particular incident or case reflect the general situation?
  V. Is the source concerned with recommendations, ideals or what ought to be done?
  VI. How relevant is the context of the source?
  VII. With statistical sources: what were the assumptions according to which the statistics were collected and presented?
  VIII. Is this a reasonable interpretation of the meaning of the source?
- Data collection—read through all the available documents and oral histories—Feb-March 11. What were the major milestone periods at Ngala from inception? Questions—
  I. What were the key words & descriptions nurses used to explain their role?
  II. When were allied professionals employed at Ngala and what was the rationale and process for introduction of other health disciplines to the organisation?
  III. What was their role?
  IV. How did Nurses work with other professionals?
  I. Familiarisation with data
  II. Generating initial codes
  III. Searching for themes
  IV. Revising the themes
  V. Defining & naming the themes
  VI. Producing the report.
- NVivo9—do training course 2 days—Feb/Mar 2011

Current documents Ngala

- Write request to CEO Ngala to obtain permission from Ngala to view internal Ngala records—Sept 10.
- Gain permission for overall study CEO/ Professional advisory Group—Nov 10.
- Data collection—read through all the available documents—April—June 11.
  Questions—
  o What is the current staff demographic?
• Breakdown of nursing type and nos. & %
• Allied Health staff breakdown of discipline nos. & %
• How is the nursing role described through documents?
• What were the major milestones?
• What were the changes for nursing?

• What documentation for an interdisciplinary framework exists?
  • What documentation is provided to articulate the role of the interdisciplinary team (IDT) and roles of different disciplines?
  • How do nurses describe their role working within an IDT?
  • How would you describe the key components of your role?
  • How do you work together within an interdisciplinary environment?
  • How do allied professional staff describe the nursing role in the context of an IDT?
  • How would you describe the key components of the nurse’s role?
  • How do you work together within an interdisciplinary environment?

• Data analysis—Framework Braun & Clarke (2006) as above

Focus Groups/Interviews Nurses

Briefing to staff re study end of Dec 2010—establish interest and rapport for study, discuss the research and aims, discuss consent and confidentiality, role of researcher and recruitment, ethics.

End Jan 11- Set up coordination group—manager, coordinator & research officer. Brief on purpose and role of group.

Feb 11- prepare details for focus groups—see Protocol for Focus Groups (Appendix 8).

  i. Photocopy invitations, research outlines, ethics
  ii. Work out advertising and recruitment process with coordinating group
    a. Decide on criteria for type of nurse make-up of groups
    b. 21 out of 53 nurses will join in focus groups (7x3)
  iii. Set up dates for groups—April 2011
  iv. Working grp recruiting for groups held—between XX and XX. Interviews if can make Focus Grp
  v. Equipment—organise and ensure operational
  vi. Pilot -Practice group session with coordinating group and refine questions
  vii. Nurses journals
    • Purchase journals for nurses who would like to be involved
    • Guide for journal entries and time frame for collection
  viii. Focus groups—Questions: How do nurses describe their role working within an IDT?
    a. How would you describe the key components of your role?
    b. How do you work together within an interdisciplinary environment?

Focus Groups Allied professionals

• 7 out of 14 allied professionals will join in one focus group. Interviews if cant make FG.
• Brief working grp- coordinator, manager, project officer SPD re recruitment of group
• Develop flyer/invitation and distribute to staff by XX
• Briefing by working grp to staff for recruitment by XX
• Wking grp recruiting for group held—between XX and XX
• Set up dates for groups—May 2011
• Group questions: How does allied professional staff describe the nursing role in the context of an IDT?—See Appendix 8 Protocol for Focus Groups
  a. How would you describe the key components of the nurse’s role?
  b. How do you work together within an interdisciplinary environment?

**Data analysis**—Framework Braun & Clarke (2006) as above

**NVivo9**

**PHASE 2**

**National Documents**

- Presentation to Australian Association of Parenting & Child Health—Oct 10.
- Write request to CEO’s National early parenting services x9—Dec 10
- Write to Directors of services for key documents available from each service and state—Dec 10.
- Collect overall documents to ascertain scope—Feb 11.
- Register Researcher permission for obtaining and handling documents—Aug 10.
- Decision of what important and how to collect data—Keep in mind rigour and discipline—Feb 11.
- Data collection—read through all the available documents—Feb 11. Questions—
  1. How has nursing evolved in each service?
- Current analysis from Directors of current services
  1. What is the current staff demographic of all national EP services?
- Write up summaries of history
- NVivo9.

**Webinar**

I. Investigate best approach to conducting webinar and relevant set up technology:
   o The availability of a technician/facilitator;
   o The cost and best site for WA to have control centre;
   o The resources available for a webinar at each national site;
   o Key contact people at each site and responsible for recruitment of nurses;
   o Collecting and recording the data;
   o Develop a protocol for sites (See Appendix 11) to understand the technology and a training session for key people and a test run prior to webinar.

II. Employ facilitator and technician to oversee

III. Develop advertising material and research overview and consent forms

IV. Plan with Directors of Services—Date in August 2011, numbers and process of recruitment into groups

V. Directors to delegate a key person for each site

VI. Organise a date for test run of webinar procedure with each delegate

VII. Work out format of webinar
   o Initial orientation to webinar process to the group
   o Initial polling 5 questions to collect demographics
o Collate results on line
o Presentation from researcher
o Discussion via video conference and blogging
o Polling of priority questions, such as:
  ▪ How similar to Ngala is the nursing role within an interdisciplinary team?
  ▪ How different to Ngala is the nursing role within an interdisciplinary team?

VIII. Arrange details for webinar facilitation and technical support and details with Telstra
IX. Conduct test run and review and revise format
X. Conduct webinar.
XI. Debrief with facilitator and supervisor and document process of what worked well and what would do differently next time. Document memos of each of the segments of the session.
XII. Receive data and enter into NVivo8 for analysis.

**Teleconferences**

See Protocol for national teleconference (Appendix12) and pre-reading package (Appendix 14)

Develop groups questionnaire and teleconference questions (Appendix 16 and 17)

**Data analysis**—Framework Braun & Clarke (2006) as above

Summarise findings.

**Phase 3**

**Survey**

Using Creswell (2004) development of survey design instrument to collect and analyse data for phase 3. The key themes arising from Phase one and two will inform one component of the questionnaire along with relevant literature, demographics and future directions.

The questionnaire will initially have a welcome statement with an overview of the survey such as how long it will take to complete, results are de-identified, purpose of the survey, completion date by and acknowledgement of time and input. Then it will have most likely four parts. Firstly, the demographics such as age, qualifications, nursing type, how long employed at the early parenting service and the State of employment.

The second part will ask a range of questions depending on the themes arising from phase one and two. The third part will consider the literature on workforce and ask questions. Obtain expert assistance in all phases. In setting up the design of the questionnaire Punch (2003, pp. 49-67) provides useful guidelines for development and implementation of a questionnaire; and maximising response rates in a survey p43. Monterosso et al. (2006).

Pretest the questionnaire with ten people—experts for validity and a reliability test-retest with nurses not involved in the study.
Use a key contact in each ten organisations via both telephone and letter. They will consent to organise distribution of the study information letter and response via an online internet based service- survey monkey (www.surveymonkey.com) within a four week timeframe. Hard copies sent if requested.

See Protocol for planning and process for data collection—Appendix 19.

**Analysis**

Survey Monkey responses are tabulated by online software and then placed into a data spreadsheet for further analysis. The data will be presented in a simple graphic format as percentages of respondents (Levine, 2004).
Appendix 4: Letter to organisation—site of study

Approval from CEO received 25/1/11.

4 January, 2011

Chief Executive Officer
Ngala
9 George St,
Kensington WA 6151.

Dear

Re Permission to have access to Ngala staff and records for data collection for Doctorate of Nursing studies

I have enclosed a copy of my research proposal and entitled *An exploration into the past, present and future of nursing in Early Parenting Services in Australia.*

I wish to request access to Ngala documentation, and other appropriate documentation as part of informing my study. I will also need to undertake about 4 focus groups—3 with nurses and 1 group with allied professionals. The access to documents and focus groups will be supervised by a delegated representative of Ngala who could be part of the internal coordination team to enable observation of any ethical issues or conflict of interest and as well to assist to resolve any research-based ethical concerns in collaboration with the Supervisor Selma Alliex.

I have ethics approval from the University Notre Dame Australia (UNDA) Ethics Committee to proceed with this study, and also enclose my ethics application for your information. This gives all the necessary contacts for the supervision of this study by UNDA. The time frame for data collection will be between Feb 2011 to Feb 2012.

Thankyou for considering this request.

Elaine Bennett
Appendix 5: Confidentiality form

An exploration into the past, present and future of nursing in Early Parenting Services in Australia

CONFIDENTIALITY FORM

Your role as the Site Coordinator will give you access to information which relates to the above research study. This confidentiality form is related to this information. Please sign and return to Elaine Bennett. Your assistance is appreciated.

I, (participant’s name) ______________________________________ hereby agree to keeping all details strictly confidential.

SITE COORDINATOR SIGNATURE: ____________________________ DATE: __________________

RESEARCHER’S FULL NAME: _______________________________

RESEARCHER’S SIGNATURE: _______________________________ DATE: __________________

If you have any complaint regarding the manner in which this research project is conducted, it should be directed to the Executive Officer of the Human Research Ethics Committee, Research Office, The University of Notre Dame Australia, PO Box 1225 Fremantle WA 6959, phone (08) 9433 0943.
Appendix 6: Approval for access to archived records, Battye Library, Perth

Elaine Bennett

From: 
Sent: Wednesday, 28 July 2010 11:13 
To: rosalyn.mchale@slwa.wa.gov.au; helene.charlesworth@slwa.wa.gov.au 
Cc: Elaine Bennett; 
Subject: FW: Permission re access to Ngala Records Battye Library

Dear Rosalyn and Helene,

Re: Access to Ngala Records

This email is to provide my consent for officers of the Battye State Library and for Ngala Director Early Parenting Services, Ms Elaine Bennett to undertake research in the Alexandra Home, House of Mercy and Ngala records for the purpose of the research project being undertaken by Ms Bennett as part of her studies.

This permission is provided with the strict understanding that the privacy of all persons within the records must be respected and no personal information can be published without further consent from myself.

Regards

- Chief Executive Officer - Ngala
E: name@email.com.au | T: 08 9368 9362 | Nro: 0417 934 125 | F: 08 9368 9361

Ngala
Parenting with Confidence

Support Ngala - Help us help WA families with babies and young children.

Please consider the environment before printing this email.

CONFIDENTIALITY and PRIVILEGE NOTICE: This e-mail message from Ngala, and any attachments to it, is legally privileged and confidential. You are not the intended recipient, you must not review, copy, disseminate, disclose to others or take action in reliance of, any material contained within this e-mail. If you have received this e-mail in error, please inform the Ngala staff member of the mistake by reply e-mail and delete all copies from your computer system. Confidentiality and legal privilege are not waived or lost by reason of mistaken delivery to you. Any views or opinions presented are solely those of the author.
Appendix 7: History of Ngala in the Western Australian context

<table>
<thead>
<tr>
<th>Ngala Milestones</th>
<th>WA – Nursing and societal factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>1826</td>
<td>1st European settlement in Albany.</td>
</tr>
<tr>
<td>1829</td>
<td>Settlement in Fremantle.</td>
</tr>
<tr>
<td>1835</td>
<td>Perth Hospital commenced in 1835.</td>
</tr>
<tr>
<td>1876</td>
<td>Robert Koch discovered a positive relationship between bacteria and disease.</td>
</tr>
<tr>
<td>1880</td>
<td>House of Mercy – a refuge for young destitute women. (Established by Rev. J. Simpson &amp; Lady Doyle, President of Committee 1890-1900.) Matron &amp; non-matures. Doctors were called in for births.</td>
</tr>
<tr>
<td>1894</td>
<td>Hospitals Act 1894.</td>
</tr>
<tr>
<td>1896</td>
<td>House of Mercy Association registered under the Associations Incorporation Act 1896.</td>
</tr>
<tr>
<td>1897</td>
<td>Colonial Hospital established in Perth.</td>
</tr>
<tr>
<td>1898</td>
<td>Kaikoura Hospital established as a nursing training school.</td>
</tr>
<tr>
<td>1899</td>
<td>Council for the Australian Training Nurses Association (ATNA) was formed.</td>
</tr>
<tr>
<td>1901</td>
<td>Midwives would have a period of training for 6 months and General Nurses would be 3 years.</td>
</tr>
<tr>
<td>1910</td>
<td>Midwives Board constituted.</td>
</tr>
<tr>
<td>1911</td>
<td>Introduction of the Commonwealth maternity bonus.</td>
</tr>
<tr>
<td>1914</td>
<td>1st world war 1915-29.</td>
</tr>
<tr>
<td>1916</td>
<td>Change name to &quot;Alexandra Home for Women&quot;.</td>
</tr>
<tr>
<td>1921</td>
<td>Nurses Registration Act of 1923.</td>
</tr>
<tr>
<td>1922</td>
<td>1st child health centre opened 1922 and Infant Health Association established. Medical Officers involved with infant health centres. ANF formed.</td>
</tr>
<tr>
<td>1926</td>
<td>The Depression.</td>
</tr>
<tr>
<td>1927</td>
<td>Matron Agnes Walsh commenced a child health training at KEMH (2-3 months).</td>
</tr>
<tr>
<td>1928</td>
<td>1st approved infant health training commenced KEMH 1927.</td>
</tr>
<tr>
<td>1929</td>
<td>The discovery of penicillin in 1929 by Fleming.</td>
</tr>
<tr>
<td>1933</td>
<td>The first PTs at Perth Hospital.</td>
</tr>
<tr>
<td>1934</td>
<td>The Infant Health Certificate was accepted under the Nurses Act.</td>
</tr>
<tr>
<td>1934</td>
<td>2nd World War 1939-45.</td>
</tr>
<tr>
<td>1946</td>
<td>Infant Health course at KEMH ceased.</td>
</tr>
<tr>
<td>1948</td>
<td>Two year Tuberculosis nursing training introduced.</td>
</tr>
<tr>
<td>1949</td>
<td>Children's Hospital established.</td>
</tr>
<tr>
<td>1950</td>
<td>Change name to Ngala Mothercraft Home and Training Centre Inc.</td>
</tr>
<tr>
<td>1956</td>
<td>Change name to Ngala Mothercraft Home and Training Centre Inc.</td>
</tr>
<tr>
<td>1958</td>
<td>Opening of first medical school at UWA.</td>
</tr>
<tr>
<td>1960</td>
<td>Opening of Ngala Women's Opportunity Shop on Albany Hwy. Victoria Park called 'Bargain Bazaar'.</td>
</tr>
<tr>
<td>1961</td>
<td>Infant health course began.</td>
</tr>
<tr>
<td>1962</td>
<td>Prime Minister Menzies visits Ngala.</td>
</tr>
<tr>
<td>1963</td>
<td>2nd world war 1939-45.</td>
</tr>
<tr>
<td>1964</td>
<td>Expansion of all hospital facilities.</td>
</tr>
<tr>
<td>1965</td>
<td>Shortage of nurses was felt.</td>
</tr>
<tr>
<td>1966</td>
<td>Women nurses in WA began to question the monopoly of medicine dominance over nursing education.</td>
</tr>
<tr>
<td>1969</td>
<td>The first Independent Nurses' Congress held in Melbourne, VIC.</td>
</tr>
<tr>
<td>1971</td>
<td>Birth of the first independent nurses' association.</td>
</tr>
<tr>
<td>1974</td>
<td>Introduction of television, change in metric systems &amp; currency, introduction of contraceptive pill and disposable equipment, Blood pressure equipment.</td>
</tr>
<tr>
<td>1975</td>
<td>The 'Sea and Sand Train' commenced operation to Kaikoura &amp; Port Augusta - specialist advice and treatment. 2 nurses and a Dr.</td>
</tr>
<tr>
<td>Year</td>
<td>Event</td>
</tr>
<tr>
<td>------</td>
<td>-------</td>
</tr>
<tr>
<td>1966</td>
<td>Ngala Hall Opens</td>
</tr>
<tr>
<td>1970</td>
<td>South Wing added to Ngala building.</td>
</tr>
<tr>
<td>1971</td>
<td>Ngala Child Care Centre opened.</td>
</tr>
<tr>
<td>1975</td>
<td>Book report recommends a new way forward.</td>
</tr>
<tr>
<td>1980</td>
<td>Booth report recommends a new way forward.</td>
</tr>
<tr>
<td>1981</td>
<td>First social worker appointed.</td>
</tr>
<tr>
<td>1982</td>
<td>Change of title DON to Administrator</td>
</tr>
<tr>
<td>1983</td>
<td>MC Training - 800 nurses have been trained to date.</td>
</tr>
<tr>
<td>1984</td>
<td>Functional Review of Ngala - financial difficulties</td>
</tr>
<tr>
<td>1985</td>
<td>Final Child Health nursing students graduated. Transfer to WAIT.</td>
</tr>
<tr>
<td>1986</td>
<td>Submission to Western Australian Government for new suite of family services accepted.</td>
</tr>
<tr>
<td>1989</td>
<td>Last graduation for Mothertouch nursing.</td>
</tr>
<tr>
<td>1990</td>
<td>Ngala’s first regional base opened in Rockingham.</td>
</tr>
<tr>
<td>1995</td>
<td>New purpose built modern facility opened on 31st March.</td>
</tr>
<tr>
<td>1997</td>
<td>Psychiatric Registrar service commenced (from KEMH)</td>
</tr>
<tr>
<td>1998</td>
<td>Family Services Review - services to be provided in 3 program areas.</td>
</tr>
<tr>
<td>1999</td>
<td>Introduction of Hey Day WA program.</td>
</tr>
<tr>
<td>2000</td>
<td>Review of Services</td>
</tr>
<tr>
<td>2004</td>
<td>Project on selection of Accreditation tool - ISO</td>
</tr>
<tr>
<td>2005</td>
<td>Introduction of C-Frame training.</td>
</tr>
<tr>
<td>2006</td>
<td>Integration of services under a ‘One Ngala’ banner. Two new Directors appointed 2006 - Corporate and Services.</td>
</tr>
<tr>
<td>2007</td>
<td>Construction work commences on Alexandra Village on the old Ngala site.</td>
</tr>
<tr>
<td>2008</td>
<td>June - Ngala Inc. ceases operation to NGALA</td>
</tr>
<tr>
<td>2009</td>
<td>Introduction of Indigenous programs in Midland and Bankstia Grove.</td>
</tr>
<tr>
<td>2010</td>
<td>Ngala’s 120th year of operations.</td>
</tr>
<tr>
<td>2011</td>
<td>CEO Rae Walter retires</td>
</tr>
</tbody>
</table>

**References**
- Ngala documents (Annual reports).
Appendix 8: Protocol for focus groups

Focus Groups

Briefing to staff re study end of Dec 2010—establish interest and rapport for study, discuss the research and aims, discuss consent and confidentiality, role of researcher and recruitment, ethics.

March 2011- Set up coordination group—manager, research officer and myself. Brief on purpose and role of group. Group to sign confidentiality form.

March/April—prepare details for focus groups.

i. Prepare invitations and relevant forms

ii. Work out advertising and recruitment process with coordinating group
   a. Decide on criteria for type of nurse make-up of groups
   b. 21 out of 53 nurses will join in focus groups (7x3)
   c. 7 out of 14 allied professionals.

iii. Manager to ask nurses what incentives they need to be involved in study.

iv. Set up dates for groups—May 2011

v. Working grp recruiting for groups—held—between 6–13 May and allied professional group on 17th May.

vi. Equipment—organise and ensure operational

vii. Pilot -Practice group session with coordinating group.

viii. Book external venue.

ix. Nurses’ journals
   - Purchase journals for nurses who would like to be involved
   - Guide for journal entries and time frame for collection—give out at end of group.

Process for engagement/recruitment:

1. Research Officer (RO) to send email to nurses/allied team individually with information sheet and consent form.

2. Staff to email response/ signed consent form back to RO or in pigeon hole.

3. Send out invitation with dates of focus groups. Staff then to book into group via email.

Running the Focus groups:

HR Manager to come into each focus group at introduction. Introduction of project and clarity that everyone has had information sheet and signed consent form. Indicate recording of information and reinforce confidentiality of information, can leave at anytime or withdraw from the study. Availability of Employee Assistance Program.

Questions for Nurses:

Describe a typical day.
How would you describe the key components of your role?
How do you describe your role working within an IDT?
What is unique to the nurse in this context?
How do you work with other disciplines?
What is common across disciplines?
What are your thoughts on the concept of the Early Parenting Professional?
What has changed in relation to your role over time?
What are your thoughts/concerns about the future of nursing in EPS?
Questions Allied Professionals:

How does allied professional staff describe the nursing role in the context of an IDT?
How would you describe the key components of the nurse’s role?
How do you work together with nurses within an interdisciplinary environment?
What is unique to the nurse in this context?
What has changed with the nurses role over time?
What is common across disciplines?
What are your thoughts/concerns about the future in EPS?
Appendix 9: Information sheets for focus groups/interview and teleconference

INFORMATION SHEET

NGALA NURSE OR ALLIED PROFESSIONAL

Dear potential participant,

My name is Elaine Bennett. I am a student at The University of Notre Dame Australia and am enrolled in a Doctor of Nursing degree. As part of my course I need to complete a research project.

The title of the project is An exploration into the past, present and future of nursing in Early Parenting Services in Australia. My research concerns how nursing has evolved, the current situation and how nurses perceive the future direction of nursing to be, within early parenting services in Australia.

The purpose of the study is to explore how early parenting nurses and allied professionals describe the nurses role within the context of an interdisciplinary team. The study has important implications for the future workforce development both at Ngala and more generally throughout Australian early parenting services.

Participants will take part in a 60-90 minute tape-recorded focus group. Information collected during the focus group will be strictly confidential. You will be offered a transcript of the focus group, and I would be grateful if you would comment on whether you believe we have captured your experience.

Before the focus group I will ask you to sign a consent form. You may withdraw from the project at any time.

Data collected will be stored securely in the university's School of Health Sciences for five years. No identifying information will be used and the results from the study will be made freely available to all participants.

There are no physical risks involved in taking part in this study but some people may find the interview questions of a sensitive nature and being a participant of the focus group may raise some difficult feelings for you. If this happens you may make contact with the Ngala Employee Assistance Service (PPC Worldwide) on 1300 361008. If there are any questions which you are unable or unwilling to discuss you can choose not to answer them, and you can also decide to stop the interview at any time.

The Human Research Ethics Committee of the University of Notre Dame Australia has approved the study.

Professor Selma Alliex of the School of Nursing is supervising the project. If you have any queries regarding the research, please contact me directly at Dr Alliex by phone (08) 9433 0996 or by email at ealliex@nd.edu.au.

I thank you for your consideration and hope you will agree to participate in this research project.

Yours sincerely,

Elaine Bennett

Tel: 0448776626 Email: elaine.bennett1@my.nd.edu.au

If participants have any complaint regarding the manner in which a research project is conducted, it should be directed to the Executive Officer of the Human Research Ethics Committee, Research Office, The University of Notre Dame Australia, PO Box 1225 Fremantle WA 6959, phone (08) 9433 0943.
INFORMATION SHEET TELECONFERENCE PARTICIPANT

Dear potential participant,

My name is Elaine Bennett. I am a student at The University of Notre Dame Australia and am enrolled in a Doctor of Nursing degree. As part of my course I need to complete a research project.

The title of the project is An exploration into the past, present and future of nursing in Early Parenting Services in Australia. My research concerns how nursing has evolved, the current situation and how nurses perceive the future direction of nursing to be, within early parenting services in Australia.

The purpose of the study is to explore how early parenting nurses describe the nurses role within the context of an interdisciplinary team. The study has important implications for the future workforce development both at Ngala and more generally throughout Australian early parenting services.

Participants will take part in a 60 minute tape-recorded Teleconference session with a small group of nurses from your site, as well as 8 other sites around Australia. Information collected during this session will be confidential.

Before the Teleconference I will ask you to sign a consent form. You may withdraw from the project at any time.

Data collected will be stored securely in the University’s School of Nursing and Midwifery for five years. No identifying information will be used and the results from the study will be made freely available to all participants.

Due to being a participant of the national Teleconference there may be some sensitive issues that may raise some difficult feelings for you. If this happens please contact the line manager of your service directly and you will be offered support and a relevant employee assistance service contact.

The Human Research Ethics Committee of the University of Notre Dame Australia has approved the study.

Dr Selma Alliex of the School of Nursing is supervising the project. If you have any queries regarding the research, please contact me directly or Dr Alliex by phone (08) 9433 0999 or by email at alliex@nd.edu.au.

I thank you for your consideration and hope you will agree to participate in this research project.

Yours sincerely,

[Signature]

Ms Elaine Bennett

Tel: 0448776626   Email: elaine.bennett1@my.nd.edu.au

If participants have any complaint regarding the manner in which a research project is conducted, it should be directed to the Executive Officer of the Human Research Ethics Committee, Research Office, The University of Notre Dame Australia, PO Box 1225 Fremantle WA 6959, phone (08) 9433 0943.
Appendix 10: Consent form for focus groups/interviews and teleconference

An exploration into the past, present and future of nursing in Early Parenting Services in Australia

INFORMED CONSENT FORM

I, (participant’s name) __________________________________________ hereby agree to being a participant in the above research project.

- I have read and understood the information sheet about this project and any questions have been answered to my satisfaction.
- I understand that I may withdraw from participating in the project at any time without prejudice.
- I understand that all information gathered by the researcher will be treated as strictly confidential.
- I agree that any research data gathered for the study may be published provided my name or other identifying information is not disclosed.

PARTICIPANT’S SIGNATURE: ___________________________ DATE: ___________________________

RESEARCHER’S FULL NAME: ___________________________ ___________________________
RESEARCHER’S SIGNATURE: ___________________________ DATE: ___________________________

If participants have any complaint regarding the manner in which a research project is conducted, it should be directed to the Executive Officer of the Human Research Ethics Committee, Research Office, The University of Notre Dame Australia, PO Box 1225 Fremantle WA 6950, phone (08) 9433 0049.
Appendix 11: Pre-reading for the webinar

**WHAT IS A WEBINAR?**

‘Webinar’ is a union of the terms ‘web + seminar’ which simply means a seminar transmitted over the internet. This technology is a remarkable innovation which allows people to interact and collaborate over vast geographical boundaries through the Worldwide Web (www). Webinars offer two-way communication leading to higher effectiveness and involvement by the audience.

Typically a webinar consists of a presentation hosted on a web server. A link for the webinar is provided to the attendees who can log on to the site and listen to the presentation as well as participate in various ways described below.

The Webinar platform has already carved a niche for itself in the arena of business and has now started being used in the education arena as well.

To date there has not been a lot of research conducted via webinar. During Feb, 2010 a webinar was used for research by the Association of Parenting and Child Health on the topic of ‘Fathers and Families–Evaluating Frameworks for Working with Fathers Final Report’ see link http://www.aracy.org.au/index.cfm?pageName=publications_library.

**Characteristics and requirements of webinars** are discussed below:

**A. Characteristics**

- *Sharing Application*—Presenters are able to share their screens, desktops, applications, slide show presentations, etc to help the audience get a better understanding of the topic.

- *Chat Window*—Attendees can ask their queries via a text chat window during the session without disturbing the flow of the discussion or presentation. This allows for private interactions with the presenters, panellists and other participants or interaction with all the participants in one go.

- *Session Recording*—The webinar session can be recorded for re-use or to share with students or other participants in the form of CDs, etc. This is an out-of-box feature in webinars and also aids in archival of valuable information.

- *Survey*—The presenter can choose to conduct polls and surveys for the audience.

**B. Infrastructure Requirements**

Participants require:

- One dedicated personal computer (PC)
- Dedicated direct phone line
- LCD projector (optional)
- High quality speaker phone with amplifier and mute button (optional).
We will be using Web-ex from the ARACY site in Fremantle and XXXX will be the facilitator for the session, along with myself. The website on Web-ex gives the following information on a webinar and you can view a brief video on the link below.

Cheers

Elaine Bennett

**What is WebEx?**

WebEx is an easy way to exchange ideas and information with anyone, anywhere. It combines real-time desktop sharing with phone conferencing, so everyone sees the same thing as you talk. Some people call this web conferencing because of the web + phone sharing. Others call it online meeting because they take care of business online like they do in in-person meetings. No matter what you call it, WebEx is a great way to work with people in other locations.

[Learn more in this quick tour](https://www.webex.com.au)

**How does it work?**

You will simply click a link in your invitation (via email) to join online, where you will get visual prompts to join the phone conference.

The Facilitator of the webinar will give you a quick overview of how the sessions will work and the various functions of the webinar.

Dear participant,

Thankyou for agreeing to be part of this research webinar. The purpose of giving you pre-reading is that you are informed of the study and come prepared with your thoughts. We may not have time during the webinar for much discussion so it’s important you have access to the information prior to your participation. I am hoping you will find this an interesting way to do research and hear about my study phase 1 to-date, as well as contribute to Phase 2.

The agenda will be over 1.5 hours. Your group will contain up to 5 nurses with you from your organisation. There are 9 sites participating around Australia. They are:

I will be operating the website from the ARACY (Australian Research Alliance for Children & Youth) site in Fremantle.

Before the webinar begins you will have a questionnaire on your desk for all to complete jointly as a group. This will need to be given back to your site coordinator to return to me.

The agenda will go as follows:

1. Introduction—XXX the facilitator will give you a brief overview of the technology and the features of a webinar. He will keep the agenda on track.
   I will be doing a series of short presentations throughout with polling occurring after sections of the slide presentations.
   Polling is a way of undertaking brief survey questions and receiving answers back from the group with an immediate result being available to you on line that you can see.
   To answer each question you will need to go with the majority consensus of the group. For those who disagree there is a CHAT facility that participants can blog anything on the screen. This will be saved as qualitative data from the webinar.

2. Overview of the study
3. Case study of nursing at Ngala (120 yrs) POLL 1–4
4. The current situation—The nursing role within an Interdisciplinary team in early parenting services in Australia POLL 5–6
5. The future POLL 7–9
6. Conclusion

Cheers

Elaine Bennett
Appendix 12: Protocol for webinar

Protocol for planning and conducting the Webinar at each national site

Study—The past, present and future of nursing in Early Parenting Services in Australia—Elaine Bennett

1. Preparation for Site coordinators:
   JULY 19th

   ✓ Site Coordinator to sign a confidentiality form and return email to Elaine
   ✓ Details sent to you by Elaine in July for requirements and instructions for webinar

Preparing for the equipment: What do you need?

   ✓ A room large enough for 5 nurses to sit
   ✓ A computer, screen and phone
   ✓ Arrange permission with your IT Department that the phone doesn’t have a bar on it and we can have a quick test ring in August to see if connecting OK.

JULY 22nd

✓ Process for Selection of participants:—send out an EOI this week to all nurses and back to you by 5th August. (Elaine has a draft template you can adapt); information sheet on study. Elaine will send you the forms to go out with the EOI.
THEN when you receive EOI’s from nurses:
✓ Put all the names in a hat and pick out 5. Selection of nurses. A safeguard is to pick 2 extra names in case of sickness etc. and they can be on standby if required.

AUGUST

✓ For those successful nurses give out consent forms to sign—ie. 5+2 nurse participants for your site and give to you by 5th August.
✓ The consent forms can be scanned and sent through to Emily Essex
   essex@ngala.com.au via email by 15th August.
✓ After received consent forms—Elaine will send pre-reading and agenda to site Coordinators to send to nurses involved.
✓ You will be sent a log-in instruction and Date to be confirmed for quick log in to check the phone link /computer up ok.
PTO

2. Webinars
   a. SEPTEMBER 9th Practice Webinar—Half hour—same times as 23rd
   b. September 23rd Webinar 1.5 hours
3pm EST

2.30 South Australia

1pm Western Australia

PLEASE NOTE: Site Coordinators are unable to be present during the webinar. I would really like to have a teleconference with you all individually at a date to be determined during Oct—Dec.
Appendix 13: Protocol for national teleconference

Site Coordinator

Protocol for planning and conducting the TELECONFERENCE at each national site

Study—The past, present and future of nursing in Early Parenting Services in Australia—Elaine Bennett

Preparation for Site coordinators:

Preparing for the equipment: What do you need?

✓ A private room large enough for 5 nurses to sit
✓ A computer—this could have the power point presentation on screen
✓ and phone -There will be no cost for your site, as I will ring you direct.

Process for Selection of participants:

Nurse involvement is voluntary.

I. Site Coordinator to send out by email to nurses with support for the study:
   o Support the same nurses being involved;
   o If not available, send out an Expression of Interest (EOI); (template available to be adapted for site specific details);
   o Information Sheet on study;

II. Nurses return EOI to designated person/Administrative assistant on site.

III. When EOI’s from nurses received, Administrative assistant can:
   o Put all the names in a hat and select amount required up to 5.
   o Notify nurses by email and to ask them to complete a consent form, scan and return.
   o Email consent forms back to the Researcher.

VI. After receipt of consent forms—Send pre-reading package to nurses who have agreed to participate.

VII. Site coordinator to email Researcher the direct link for phone teleconference (up to 1 hour).
Appendix 14: Participant pre-reading for teleconference


Stories, shifts workforce

Nursing is an increasingly complex field in which identifying and keeping abreast of the shifts influenced by research, collaborations, critical reflection and organisational as well as government interests can be crucial.

Perhaps one of the biggest shifts underway now is how we understand and manage a multigenerational workforce. Questions such as how to embrace Generation Y, the mobility and casualisation of the workforce; the push to embrace generalist rather than specialist nursing; arranging collaborative and mutually beneficial training strategies for health professionals, and workforce leadership might all come under this umbrella.

At the conference there was a discussion about retaining older nurses past retirement, or attracting more undergraduates, yet we still need to address the issues of those leaving the workforce after less than five years of experience. Eminent researchers have described nurses with around five years experience as making an important transition from competent to proficient.

On top of this, current research shows the average job for a Gen Y worker lasts only 13 months. Generation Y university graduates have increased expectations of their workplace compared to previous generations, and expect to be able to apply their skills and knowledge and be respected for their unique contributions – perhaps the ongoing assessments and focus on policy and competency for new grads in their first 12 months contributes to the mismatch of expectations and practice?

Research in 2009 found that the 'superficial statements of value' – such as the quality of the toilet paper and coffee provided to employees – made the difference to staff feeling appreciated and valued; the little things are big things. This value and respect for individual contribution, and how that value is felt by staff, goes beyond just Generation Y.

Additionally, a significant proportion of nurses work casually or part time, some have second jobs, and some hospital wards average a 50 per cent turnover of staff. Consequently, we can assume that a large proportion of nurses are already functioning as generalists as they move between specialties and locations. It is well understood that patient outcomes might be optimised when they are cared for by nurses with a specialisation in their area of health. However, the detrimental effects of churn as patients are moved on average three times within a hospital stay (an average of which is six days) to reach specialised nurses requires careful consideration.

Nursing, and nurses, need to consider where their skills are best applied to achieve the best patient outcomes.

Compelling stories are important to understanding our world, to tell others our stories, to be heard. If our stories are constantly about poor pay, poor recruitment and poor retention, are we fulfilling our own prophecies and creating a viscous circle? Perhaps Victorian Acting Chief Nurse advisor, Katy Fielding said it best at this conference; "Nurses need to stop asking to have a voice, and start learning how to use the ones they have". What story do we want to tell, and who do we want to hear it? Do we each have the skills to tell our stories, and in ways that economists, politicians, public servants, hospital administrators, nursing managers can hear them? There are two important ingredients, language and data.

The need for greater understanding
and strategies: realities

of the nursing workforce needs to be addressed. One of the reasons mentioned is that we do not have much information about the nursing workforce and this is because nurses are not willing to share it. Having friends who are nurses can also influence this. If we offer rewards for this information, put in place appropriate protections of privacy, and encourage the sharing of findings with the participants, we believe many nurses would be willing to share information that can be used to help improve patient outcomes.

One of the strategies we can move forward with is to get better at telling our story about nursing. By this we do not mean little anecdotes about our own experiences or difficult patients. Every time you speak to someone about nursing related issues you are painting a picture of the nursing profession. Two suggestions we can do at an individual level to get better at telling the nursing story came from presentations at the conference. Karly Fielding’s advice was to know what you want when you go to a meeting, be prepared, and declare from which position you are acting (which bars you are wearing). This will be part of the story of nurses we need to tell. We also need to tell our story of nursing as a collaborative health professional, as well as being sensitive and solution focused. Professor Dr Twigg encouraged nurses to have their ‘lifeline conversation’ down pat. Always have in mind your short summary of current topical nursing issues, use any opportunity to engage others in the nursing story.

As a broader profession we can get better at collecting standardised data for research analysis. Part of the strategy for getting better at sharing the nursing story is having evidence of the impact of nursing care on patient, nurse and system outcomes. This would require significant cooperation between nursing stakeholders, not an unwieldy strategy in itself. The University of Melbourne has already established a database of patients with asthma and data from this database can be used to evaluate whether nursing interventions in this population are effective.

As researches we will continue to focus on patient outcomes as measurements of nursing success. We cannot separate nurse staffing from patient outcomes; however it is hard to know what is working, or not working, if we don’t have a good picture of the nature of the nursing practice environment in those places. It is like collecting viral signs. If we don’t have a systematic, shared process of collecting, documenting and communicating viral signs of our practice, then the effectiveness of collecting them is undermined. We need data to tell when they’re deteriorating, in order to communicate to other team members about what is going wrong, and what we might do to address the changes.

We are both early in our careers and we have much to learn and discover, but we do have a passion for nursing and are proud to be nurses. As PhD students we have already encountered the challenges of accessing nursing workforce and appropriate patient outcomes data through one researcher at a research institute. Now it is the turn to respond to these challenges and contribute to the future of the nursing profession. Use of data to advocate for patient health is a new avenue in nursing. Florence Nightingale invented the rose to display data and demonstrated the harm that was being done to soldiers after they got to hospital, more dying from infection and malnutrition than from their wounds. Florence Nightingale invented the rose to display data and demonstrated the harm that was being done to soldiers after they got to hospital, more dying from infection and malnutrition than from their wounds. Florence Nightingale invented the rose to display data and demonstrated the harm that was being done to soldiers after they got to hospital, more dying from infection and malnutrition than from their wounds. Florence Nightingale invented the rose to display data and demonstrated the harm that was being done to soldiers after they got to hospital, more dying from infection and malnutrition than from their wounds.
Appendix 15: Teleconference PowerPoint presentation slides
Ngala the case study

Role of the nurse 1940's to 80's:
- Nurse as 'mother figure'
- Routine care for children
- Caring for sick child/mother
- Coordination
- Assessment
- Caring for disability/special needs
- Mothercraft
- Protecting children and advocacy

1987

“Everybody was encouraged to have a baby or soldier that they needed... we had permission from Nuntun in the 80's if we were setting them up and sometimes they sold their kids” (Elsa, 1988, p.3)

Ngala the case study

Role of the nurse cont'd 1940's to 80's:
- Liaison and referral
- Psychosocial
- Training and supervision
- Team records and histories, interviews

1980 - 90 Transition decade
1989 - Ngala Family Resource Centre
2008 - Ngala - change to 3 companies
- Ngala Family Services
- Ngala Community Services
- Ngala Children's Services

Ngala Services now

Ngala in Perth metropolitan

www.ngala.com.au
Findings Phase 1: Changes for nursing

Societal factors
Policy changes
Closure of midwifery training schools
Transfer of CHN certificate to Tertiary sector
Professionalisation of midwifery
Individual to family focus
Bio-Medical model to Primary health care focus
Collaborative and partnership approaches
Commitment to practice based on evidence
Focus on women’s mental health: PNMH then infant mental health & parent-child attachment; father-inclusive practice
Individuals’ focus to team approaches

Findings phase 1: changes for nursing

QUESTIONS:
1. I am interested in how your site has experienced change and where you are at?
Q1: Nurses working within early parenting services over the past 10-15 years have moved from an expert approach to working in partnership with families. Do you Agree/Disagree?
Q2: Nurses are more open to working collaboratively with other disciplines Agree/Disagree?

Findings phase 1: changes for nursing

QUESTIONS:
Q3: Nurses now integrate evidence and reflective practice in their daily work with families Agree/Disagree?
Q4: Nurses working in EPS are confident and experienced practitioners Agree/Disagree?
Findings Phase 1: The current role of nursing within EPS

- Early Parenting Nursing Practice
- Application of Evidence
- Linking with others

The current role of nursing within EPS

Q3: Does this description of the nursing role fit within your context of nursing within EPS? Yes/No
The current situation of nursing within EPS

Q 6:
Do you agree with this summation of the uniqueness of the nursing role?
Yes/No

Looking to the Future within EPS

A postgrad certificate for ENs in early parenting (8-12 months)
Nurse practitioner role for EPS
Clarification of the ideal skill mix needed to meet the needs of today's families
Flexible phasing out planning & opportunities for baby boomers - retaining knowledge and experience and mentoring of younger staff coming in
Ensure comprehensive orientation programs & professional development
Graduate positions for early parenting services
The future

Q #8: What other issues and considerations need to be thought about for the future?

Conclusion

Polling summary
Next steps:
- Data Analysis
- Phase 2 will inform Phase 3
- Development of the questionnaire
- Online survey will occur Feb/March 2012
- Please support and encourage colleagues with the undertaking of the survey.

Thank you everyone for your contribution.

Please email me Elaine Bennett: elaine@bluburn.com.au if you think of anything else following the webinar.
Appendix 16: Teleconference group questionnaire

Questionnaire for Teleconference participants
Please complete before the Teleconference begins with the whole group.

1. How many participants at your site?

2. What is the age of each participant? (Place ages in boxes below)

3. What is the average length of time each nurse has been working within EPS?
The response may be: <5 yrs OR >5-10 yrs OR >10 yrs

4. How much longer does each participant plan to work at your current site?

5. What are the qualifications of each of the participants?
   Eg. RN, RM, C&FHN, RMHN, MCN, EN, BN, B.H.SC, Neg, MN

6. Do you have difficulty recruiting nurses at your site?
   Yes  No  Sometimes

7. Do nurses work closely with other disciplines at your site?
   Yes  No  Sometimes

8. What concerns would you have about the nursing workforce at your site over the next 5-10 years time?
   5 years
   10 years

Thank you for taking the time to complete these questions.
Appendix 17: Teleconference questions

Q 1
‘Nurses working within early parenting services over the past 10–15 years have moved from an expert approach to working in partnership with families’.
Agree/Disagree?

Q 2
‘Nurses are more open to working collaboratively with other disciplines’
Agree/Disagree?

Q 3
‘Nurses now integrate evidence and reflective practice in their daily work with families’
Agree/Disagree?

Q 4
‘Nurses working in EPS are confident and experienced practitioners’
Agree/Disagree?

Q 5:
Does this description of the nursing role fit within your context of nursing within EPS?
Yes/No

Q 6:
Do you agree with this summation of the uniqueness of the nursing role?
Yes/No

Q 7:
Do you agree with the concept of the Early Parenting Professional/Practitioner?
Yes/No

Q 8
Have all the knowledge and skills been captured?
Yes/No

Q 9:
What other issues and considerations need to be thought about for the future?
Appendix 18: Summary and comments from national teleconference—January 2011

Summary and comments from National Teleconferences—Jan 2011

Questions 1–3 all in agreement.

Q4 They agreed that most nurses are confident and experienced. Some sites have greater ratio of inexperience and takes two years to become confident. Victoria use a 2 year grad cert from Swinburne university—social science in prenatal and postnatal family support. [Note this can go into phase three]

Q5 All agreement.

Q6 All agreement. One site added the additional ability to do emergency intervention and look after children with complex medical needs.

Q7 Two sites don’t agree with concept of EP practitioner (ie a baseline degree professional undertaking a grad cert/dip in early parenting practice)—issues discussed:

- Nurses do this work
- Upgrade to masters level
- Specialist field for nursing
- Concern re future of nursing over time that could be push for lower level workers which will reduce quality of care for families and less nursing positions.

[Note this concept of EPP goes into Phase three]

Q8 all agreed comprehensive. One site said to add identification and management for Child protection work.

Q9 suggestions/comments:

1. Not enough education re communication and family partnership processes, reflective practice and working with challenging behaviours and working in partnership with families.
2. Ratio of nursing workforce will depend on the context for eg. residential may have higher ratio because of 24 hr care than a parent education team. Complex medical issues that come from Paeds, eg. NG feeds. Teaching families to care for the child in the community. Transfer of families into unit for parent education. Only small amount of cases generally, can transfer AN mothers for methadone assessment and parenting. Establishing breastfeeding.
3. Post grad certificate with ENs to add to a tiered system
4. Ensuring mentorship system
5. Graduate programs—new positions—so we get in early in their career and enable security of positions rather than casual.
6. Innovation fund for scholarships and other strategies to attract people.
7. Technology based parenting services are going to be a thing of the future and older staff find this often difficult. Blogging, facebook, apps etc. Making sure stuff out there is reputable.

8. Skills for future planning—understanding of technology.

9. Practical side of documentation and having all the patient tools now on line, live documentation and progress notes. Comm. health staff have struggled to get them on board here to keep up with technology- basic computer skills.

10. Research—the narrative of the history of our profession and showcase our speciality in EPS as an ongoing thing for the future.

11. Early inter-professional cross training in degrees for disciplines to ensure less mono-discipline focus

12. MCNs are a good idea—they would be a good extra addition to the workforce—huge untapped resource—ENs and give an extra additional certificate.

13. Raise the profile of nursing within and external to EPS.
Appendix 19: Phase three planning and process for data collection

Survey


The areas of reliability, validity and response rates are important (Punch 2003:42):

Reliability means stability of response and this will be pilot-tested through a test-retest with 15 participants.

Validity means whether the data represent what we think they represent. This will be tested by 10 researcher participants who will look at the content of the questionnaire to see where this will measure the aims and questions of the study.

Response rates—Punch advises the researchers should strive for a response rate of 60%. An online survey strategy has potential limitations if participants don’t feel comfortable using the computer. This may be the case in a small number of cases. To alleviate this I have asked that sites ensure support is available for nurses, as well as having hard copies of the questionnaire available for some cases, with self-addressed envelope to return. The survey will be open as well for a month. Each site coordinator will send an ad for nurses that the survey is coming up; as well as reminders for nurses to complete. The length of the questionnaire will also aim to be as short as possible to maximise responses.

The key themes arising from Phase one and two will inform one component of the questionnaire along with relevant literature, demographics and future directions.

The questionnaire will initially have a welcome statement with an overview of the survey such as how long it will take to complete, results are de-identified, purpose of the survey, completion date by and acknowledgement of time and input. Then it will have a further 3 parts.

Firstly, the demographics such as age, qualifications, nursing type, how long employed at the early parenting service and the State of employment.

The second part will ask a range of questions depending on the themes arising from phase one and two. The third part will consider the literature on workforce and ask questions such as:

What do nurses contribute that no other discipline can?

What do nurses currently do that someone else can do?

The third part will be questions relating to the future, such as:

I. In an ideal world, what do you believe a workforce within early parenting services would look like in two years, five years and beyond?
II. What would be the major milestones to get there?
III. What might be some barriers in thinking about the future direction?
Process for questionnaire development:

Obtain expert assistance in all phases. In setting up the design of the questionnaire Punch (2003, pp. 49-67) provides useful guidelines for development and implementation of a questionnaire; and maximising response rates in a survey p43.

1. Draft questionnaire and submit to supervisor and expert researcher- LM.
2. Meet with expert researcher on analysis of data—MB
3. For assessment of validity—send to 10 expert researchers to assess content over a 2 week period.
4. Summarise responses and make any changes to questionnaire.
5. Pretest the questionnaire with 15 people—nurses involved in the study through Phase 2, and re-test in 2 weeks.
7. Make any changes necessary with supervisor/MB.

Marketing and distribution:

- Send documents to SA ethicis committee.
- Market the survey through site coordinators by sending out material developed by graphic designer.
- Consult with sites the process of sending out the online survey and develop protocol. Use key contacts in each organisations via both telephone and email. They will consent to organise distribution of the study information letter and response via an online internet based service- survey monkey (www.surveymonkey.com) within a four week timeframe.
- Send out by end of March.
- Open for a month—send reminders to increase response rate.
- Send separate link of same questionnaire to Tas Hobart PC.

Analysis

Before undertaking the analysis itself the survey data needs preparation (Punch 2003:45)—data cleaning and data entry. Most of the survey will be through survey monkey and there may be a small number of questionnaire hard copies which will be entered into survey monkey. Survey Monkey responses are tabulated by online software and then placed into a data spreadsheet for further analysis by MB and myself. The data will be presented in a simple graphic format as percentages of respondents (Levine, 2004).
Appendix 20: Expert survey validation tool

"An exploration into the past, present and future of nursing in Early Parenting Services in Australia" – Elaine Bennett

Assessment of Survey for:
CLARITY, CONTENT VALIDITY and INTERNAL CONSISTENCY

You are being asked to rate for each of the above components separately:

1. **CLARITY**

Instructions
Rate: (a) the instructions in the survey, and (b) each question in the survey on it's clarity since you are familiar with this content.

(a) Are the survey instructions clear? Circle either yes or no on the next line.

YES   NO

(b) Read each question in the survey separately and respond to the same number on the response sheet. Beside each question number on the response sheet circle C (clear) or U (unclear) to indicate whether the question is clear or unclear to you

**RESPONSE SHEET: CLARITY**

Please indicate whether each question is C (clear) or U (unclear) to you.

<table>
<thead>
<tr>
<th>Circle One</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. C</td>
<td></td>
</tr>
<tr>
<td>2. C</td>
<td></td>
</tr>
<tr>
<td>3. C</td>
<td></td>
</tr>
<tr>
<td>4. C</td>
<td></td>
</tr>
<tr>
<td>5. C</td>
<td></td>
</tr>
<tr>
<td>6. C</td>
<td></td>
</tr>
<tr>
<td>7. C</td>
<td></td>
</tr>
<tr>
<td>8. C</td>
<td></td>
</tr>
<tr>
<td>9. C</td>
<td></td>
</tr>
<tr>
<td>10. C</td>
<td></td>
</tr>
<tr>
<td>11. C</td>
<td></td>
</tr>
</tbody>
</table>
2. CONTENT VALIDITY

Instructions:
In this section, you are asked to look at the questions in the survey and decide if you think they seem to belong together.

Read the entire survey first. After you finish reading the survey, answer question (a) at the top of the response sheet—either YES or NO. Then answer question (b) for each question in the survey. Answer by circling the response you choose under question (b)—either Y (YES) or N (NO). Please add any relevant comments you wish to explain your answers.

RESPONSE SHEET: CONTENT VALIDITY

Please refer to the one page attachment on the Study aims and questions.

(a) In general, does the study aims and questions fit the whole set of questions in the survey? Answer once for the whole survey by circling either YES or NO on next line.

YES  NO
Does each question fit the study aims and questions? Please circle Y (YES) or N (NO).

<table>
<thead>
<tr>
<th>Circle One</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td></td>
</tr>
</tbody>
</table>

(b) Is the question unique, ie not repetitious? Please circle Y (YES) or N (NO).

<table>
<thead>
<tr>
<th>Circle One</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td></td>
</tr>
</tbody>
</table>
5. Y  N
6. Y  N
7. Y  N
8. Y  N
9. Y  N
10. Y  N
11. Y  N
12. Y  N
13. Y  N
14. Y  N
15. Y  N
16. Y  N
17. Y  N
18. Y  N
19. Y  N
20. Y  N

(c) Are there any questions you think should be added to the survey?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
3. **INTERNAL CONSISTENCY**

**Instructions**
In this section, you are being asked to look at the questions in the survey and decide if you think they seem to belong together.

Read the entire survey first. After you finish reading the survey, answer question (a) at the top of the Response Sheet, then answer the following question (b) for each question in the survey. Answer by circling the response you choose under question (b). Add any comments you wish to explain your answers.

**RESPONSE SHEET: CONSISTENCY**

(a) Do these questions generally belong together?

   YES       NO

(b) Does each question belong in the survey?

<table>
<thead>
<tr>
<th>Please circle</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Y</td>
<td></td>
</tr>
<tr>
<td>2. Y</td>
<td></td>
</tr>
<tr>
<td>3. Y</td>
<td></td>
</tr>
<tr>
<td>4. Y</td>
<td></td>
</tr>
<tr>
<td>5. Y</td>
<td></td>
</tr>
<tr>
<td>6. Y</td>
<td></td>
</tr>
<tr>
<td>7. Y</td>
<td></td>
</tr>
<tr>
<td>8. Y</td>
<td></td>
</tr>
<tr>
<td>9. Y</td>
<td></td>
</tr>
<tr>
<td>10. Y</td>
<td></td>
</tr>
<tr>
<td>11. Y</td>
<td></td>
</tr>
<tr>
<td>12. Y</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>13.</td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td></td>
</tr>
<tr>
<td>19.</td>
<td></td>
</tr>
<tr>
<td>20.</td>
<td></td>
</tr>
</tbody>
</table>

After you finish you may wish to discuss your comments with the researcher.

Thankyou for your assistance.
Appendix 21: Expert reviews of survey, summary

Summary Expert reviews of survey

10 sent, 8 returned.

General comments:

- Add Introduction for Phase 3 (at the beginning)
- Sections are now:
  - 1–5 demographics
  - 6–9 nursing in EPS
  - 10–19 future (rearrange order 12,13, 16, 10, 11,14,15,17,18,19,20.
  - Delete concerns.
- Change years to 3–5 and 5–10 years for Q 18 and 19.
- Feedback re increasing the linkages between questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Comment</th>
<th>Suggestions</th>
<th>Change/ Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your location? State postal code (work)</td>
<td>6 clear</td>
<td>What is the location of your workplace? State postcode</td>
<td>Yes change</td>
</tr>
<tr>
<td></td>
<td>2 suggestions</td>
<td></td>
<td>‘What is the location of your workplace?’ State postcode’</td>
</tr>
<tr>
<td>Please indicate your age category for work (tick one box)</td>
<td>6 clear</td>
<td>Please indicate your age category</td>
<td>Yes change</td>
</tr>
<tr>
<td></td>
<td>2 suggestions</td>
<td></td>
<td>‘Please indicate your age category’</td>
</tr>
<tr>
<td>What length of time in yrs have you been working in the area of EPS?</td>
<td>5 clear</td>
<td>Maybe I need to put a note under demographics</td>
<td>Provides more clarity</td>
</tr>
<tr>
<td></td>
<td>1 N/A</td>
<td></td>
<td>‘Note that EPS refers to your working within EPS and not Universal Child health services or other agencies’</td>
</tr>
<tr>
<td></td>
<td>2 differentiate between EPS &amp; CH</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>length of service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How much longer in yrs do you anticipate you will be working in the area of EPS?</td>
<td>7 clear</td>
<td>Unchanged</td>
<td>No change</td>
</tr>
<tr>
<td></td>
<td>1 N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What are your nursing qualifications? (tick relevant boxes)</td>
<td>5 clear</td>
<td>Add nurse practitioner</td>
<td>Add ‘tick all relevant boxes’</td>
</tr>
<tr>
<td></td>
<td>3 suggestions</td>
<td>No space to tick hosp base qual</td>
<td>Add ‘other’ box</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Do you want all boxes to be ticked or highest qual? Needs more work on this question.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Add ‘other box’</td>
<td></td>
</tr>
<tr>
<td>Do you work closely with other disciplines? (tick one box)</td>
<td>5 clear</td>
<td>1 Include reflection ques.</td>
<td>Keep in demographics and Change format of question. Keep question with yes/no. Then break down 3 categories 1,2 and 4 with yes /no.</td>
</tr>
<tr>
<td></td>
<td>1 define site ie postcode of work?</td>
<td>1 suggests belongs not in demographics</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>? add reflection in teams (this is inherent in work)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>People should know site is where they work</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Take out of demographics into next section.</td>
<td></td>
</tr>
<tr>
<td>Is it essential that nurses working in EPS are experienced? (tick one box)</td>
<td>5 clear</td>
<td>Experience could mean a range of things- length, range.</td>
<td>Unchanged- complex meaning.</td>
</tr>
<tr>
<td></td>
<td>2 unclear—what</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>length or range;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Suggestion</td>
<td>Original Suggestion</td>
<td>Change</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------------</td>
<td>---------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Do nurses maintain a unique role when working within a collaborative partnership model with other disciplines? (Tick one box)</td>
<td>7 clear</td>
<td>Same as above</td>
<td>Change to statement&lt;br&gt;Please indicate whether you agree or disagree with the following statement . . .&lt;br&gt;(Tick one box)&lt;br&gt;It is essential that nurses working in EPS are experienced.</td>
</tr>
<tr>
<td>Concerns have been raised by nurses nationally for the future of nsg within EPS: Phase 1 and 2 of this study identifies current concerns about the role of the nurse for EPS over the next yrs. (Tick one box)</td>
<td>5 clear</td>
<td>Change to statement&lt;br&gt;Please indicate whether you agree or disagree with the following statement . . .&lt;br&gt;(Tick one box)&lt;br&gt;Ask the question then put some background in brackets.&lt;br&gt;Extra box Add ‘Please comment on your concerns’&lt;br&gt;Change&lt;br&gt;Omit the intro.&lt;br&gt;‘Would you agree that there are concerns for the future in nursing in EPS?’ Maybe add ‘Please comment on your concerns’&lt;br&gt;NB: Move this to nursing in EPS.</td>
<td></td>
</tr>
<tr>
<td>In order to plan for the next 5–10 yrs, do you agree that there is a need for workforce development strategy? (Tick one box)</td>
<td>8 clear</td>
<td>Change to statement&lt;br&gt;Please indicate whether you agree or disagree with the following strategy statements which could inform a framework for the future of EPSs’&lt;br&gt;Change&lt;br&gt;‘Please indicate whether you agree or disagree with the following strategy statements which could inform a framework for the future of EPSs’&lt;br&gt;Put this question into Looking Forward.</td>
<td></td>
</tr>
<tr>
<td>Is it necessary to have an identified skill mix for the various practice contexts of EPS? (tick one box)</td>
<td>6 clear</td>
<td>Change to a statement to fit in with Q10&lt;br&gt;Delete the intro reference phase 1 and 2 as not necessary.&lt;br&gt;Change ques into statement&lt;br&gt;Change&lt;br&gt;‘Identify the skill mix for the various practice contexts of EPS (eg. Residential, Day stay, Consultations, community programs, Helpline, home visiting, parent education, etc)’&lt;br&gt;Put this question into Looking Forward.</td>
<td></td>
</tr>
<tr>
<td>Increase the development and availability of innovative course training options for the early parenting sector</td>
<td>3 clear</td>
<td>Delete the intro reference phase 1 and 2 as not necessary&lt;br&gt;Change ques into statement&lt;br&gt;Change&lt;br&gt;‘Increase the development and availability of innovative options for post qualification education.’&lt;br&gt;</td>
<td></td>
</tr>
<tr>
<td>Develop innovative national professional development opportunities via diverse delivery modes?</td>
<td>3 clear</td>
<td>Change ques into statement&lt;br&gt;Change&lt;br&gt;‘There is a need for innovative national professional development opportunities’&lt;br&gt;</td>
<td></td>
</tr>
<tr>
<td>Develop retention strategies for the ageing workforce in EPS?</td>
<td>5 clear</td>
<td>Change ques into statement&lt;br&gt;Change&lt;br&gt;‘Develop retention strategies for the ageing workforce in EPS’&lt;br&gt;</td>
<td></td>
</tr>
<tr>
<td>Develop marketing and recruitment strategies identified for a future multi generational workforce?</td>
<td>3 clear</td>
<td>Change ques into statement&lt;br&gt;Change&lt;br&gt;‘Develop marketing and recruitment strategies for a future multi generational workforce’&lt;br&gt;</td>
<td></td>
</tr>
<tr>
<td>Identify further research questions to progress the workforce agenda?</td>
<td>4 clear</td>
<td>Change ques into statement&lt;br&gt;Change&lt;br&gt;‘Identify further research areas relevant to EPS workforce’&lt;br&gt;</td>
<td></td>
</tr>
<tr>
<td>Consider sustainable strategies to support future multi-generational workforces?</td>
<td>4 clear</td>
<td>Change ques into statement&lt;br&gt;Change&lt;br&gt;‘Develop sustainable strategies to support future a multi-generational workforce’&lt;br&gt;</td>
<td></td>
</tr>
<tr>
<td>Please rank the above mentioned</td>
<td>7 clear</td>
<td>Change years to 3–5 years&lt;br&gt;Change 3–5 years and Bold&lt;br&gt;</td>
<td></td>
</tr>
</tbody>
</table>
strategy statements according to the perception of their priority for the next 2 yrs.  
Please rank the above mentioned strategy statements according to the perception of their priority for the next 3–5 yrs.  
Are there any other strategies you think should be included?

<table>
<thead>
<tr>
<th>#</th>
<th>Clarity</th>
<th>Statement</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>unclear</td>
<td>Put years in BOLD</td>
<td>Update all the items as per changes above</td>
</tr>
<tr>
<td>2</td>
<td>clear</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>unclear</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>unclear</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>clear</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>suggestion</td>
<td>Suggested change to a statement.</td>
<td>Change to ‘Please suggest any further strategies you think should be included’</td>
</tr>
</tbody>
</table>

**CONTENT VALIDITY**

<table>
<thead>
<tr>
<th>Question</th>
<th>Clarity</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your location? State postal code (work)</td>
<td>8 clear</td>
</tr>
<tr>
<td>Please indicate your category for age (tick one box)</td>
<td>8 clear</td>
</tr>
<tr>
<td>What length of time in yrs have you been working in the area of EPS?</td>
<td>8 clear</td>
</tr>
<tr>
<td>How much longer in yrs do you anticipate you will be working in the area of EPS?</td>
<td>8 clear</td>
</tr>
<tr>
<td>What are your nursing qualifications? (tick relevant boxes)</td>
<td>8 clear</td>
</tr>
<tr>
<td>Do you work closely with other disciplines? (tick one box)</td>
<td>8 clear</td>
</tr>
<tr>
<td>Is it essential that nurses working in EPS are experienced? (tick one box)</td>
<td>6 clear Depends on how experience is interpreted.</td>
</tr>
<tr>
<td>Do nurses maintain a unique role within a collaborative partnership model with other disciplines? (Tick one box)</td>
<td>8 clear</td>
</tr>
<tr>
<td>Concerns have been raised by nurses nationally for the future of nsg within EPS: Phase 1 and 2 of this study identifies current concerns about the role of the nurse for EPS over the next yrs. (Tick one box)</td>
<td>7 clear</td>
</tr>
<tr>
<td>In order to plan for the next 5–10 yrs do you agree that there is a need for workforce development strategy? (Tick one box)</td>
<td>8 clear</td>
</tr>
<tr>
<td>Is it necessary to have an identified skill mix for the various practice contexts EPS? (tick one box)</td>
<td>8 clear</td>
</tr>
<tr>
<td>Increase the development and availability of innovative course training options for the early parenting sector?</td>
<td>8 clear</td>
</tr>
<tr>
<td>Develop innovative national professional development opportunities via diverse delivery modes?</td>
<td>8 clear</td>
</tr>
<tr>
<td>Develop retention strategies for the ageing workforce in EPS?</td>
<td>8 clear</td>
</tr>
<tr>
<td>Develop marketing and recruitment strategies identified for a future multi generational workforce?</td>
<td>8 clear</td>
</tr>
<tr>
<td>Identify further research questions to progress the workforce agenda?</td>
<td>7 clear Not clear on statement ‘progress the workforce agenda’ Change ‘Identify further research areas relevant to EPS workforce’</td>
</tr>
<tr>
<td>Consider sustainable strategies to support future multi-generational workforces?</td>
<td>8 clear</td>
</tr>
<tr>
<td>Please rank the above mentioned strategy statements according to the perception of their priority for the next 2 yrs.</td>
<td>8 clear</td>
</tr>
<tr>
<td>Please rank the above mentioned strategy statements according to the perception of their priority for the next 3–5 yrs.</td>
<td>8 clear Distinguishing between 2 yrs and 3–5 yrs could be problematic.</td>
</tr>
</tbody>
</table>
Are there any other strategies you think should be included?

INTERNAL CONSISTENCY

What is your location? State postal code (work)  

Please indicate your category for age (tick one box)  

What length of time in yrs have you been working in the area of EPS?  

How much longer in yrs do you anticipate you will be working in the area of EPS?  

What are your nursing qualifications? (tick relevant boxes)  

Do you work closely with other disciplines? (tick one box)  

Is it essential that nurses working in EPS are experienced? (tick one box)  

Do nurses maintain a unique role when working within a collaborative partnership model with other disciplines? (Tick one box)  

Concerns have been raised by nurses nationally for the future of nsg within EPS: Phase 1 and 2 of this study identifies current concerns about the role of the nurse for EPS over the next yrs. (Tick one box)  

In order to plan for the next 5–10 yrs do you agree that there is a need for workforce development strat? (Tick one box)  

Is it necessary to have an identified skill mix for the various practice contexts of EPS? (tick one box)  

Increase the development and availability of innovative course training options for the early parenting sector?  

Develop innovative national professional development opportunities via diverse delivery modes?  

Develop retention strategies for the ageing workforce in EPS?  

Develop marketing and recruitment strategies identified for a future multi-generational workforce?  

Identify further research questions to progress the workforce agenda?  

Consider sustainable strategies to support future multi-generational workforces?  

Please rank the above mentioned strategy statements according to the perception of their priority for the next 2 yrs.  

Please rank the above mentioned strategy statements according to the perception of their priority for the next 3–5 yrs.  

Are there any other strategies you think should be included?
Appendix 22: Marketing postcard for national survey

Nursing within Early Parenting Services

A survey is coming in April

Please keep a look out in your workplace for an email to participate in an on-line survey. This is a study being undertaken by Doctoral nursing student Elaine Bennett from Notre Dame University.

The study is called “An exploration of the past, present and future of nursing in Early Parenting Services in Australia”.

Have your say for the future!

The email will contain background on the study to-date and will take 10-15 minutes to complete.
Appendix 23: Protocol for planning and distribution of national survey

Site Coordinator

Protocol for planning and distribution of the National Survey at each site

Study—‘The past, present and future of nursing in Early Parenting Services in Australia’—Elaine Bennett

Preparation for Site coordinators:

Preparing for the survey: What do you need?

- Send out a preliminary ad for nurses at your site 2 weeks before the online questionnaire is sent.
- Is there someone available on site that can be available to assist any nurses who need assistance with the completion of the survey on-line? A pack of questionnaires (hard copy) will be available for those nurses not able to undertake the online survey. Can you advise Research of numbers required?

Process for Selection of participants:

Nurse involvement is voluntary.

IV. Site Coordinator to send out Advertisement via email to nurses to support the study (Researcher will send direct to site coordinator to send out to nurses);
V. Send to all nurses including mothercraft nurses (Exclusion will be direct entry midwives);
VI. The survey will be open for a month;
VII. Site coordinator to send out reminders each week to nurses to maximise response rate.

XX One state. only (as per Ethics request)
1. Site Coordinator to send out Advertisement via email to nurses to support the study (Researcher will send direct to site coordinator to send out to nurses);
2. Send to all nurses including mothercraft nurses (Exclusion will be direct entry midwives);
3. Information Sheet and consent form to be signed—can someone locally collect these and scan (post in self-addressed envelope) to Researcher;
4. The survey will be open for a month;
5. Site coordinator to send out reminders each week to nurses to maximise response rate.
Appendix 24: Information sheet for national survey

Subject: FW: National Survey for Nurses within Early Parenting Services
Attachments: The study so far2.pdf
Importance: High

Please forward to all nurses.

Please read the information below, then the attachment with this email and then use the web address link below to undertake the Survey.
It will take about 10-15 minutes of your time.
The survey will be open for a month and closed on the 5th JUNE 2012.

Hello,

My name is Elaine Bennett. I am a student at The University of Notre Dame Australia. My research concerns how nursing has evolved, the current situation and how nurses perceive the future direction of nursing to be, within Early Parenting Services in Australia.

The purpose of the study is to explore how early parenting nurses describe the nurses role within the context of an interdisciplinary team. It is hoped the study will have important implications for the future workforce development both at Ngala in WA, and more generally throughout Australian early parenting services. I have undertaken Phase 1 and 2 of the study, and these two phases have now informed this survey of Phase 3.

What is involved?

Please read the Information sheet for background on the study to-date.
Then click the link to the survey below. It will take you about 10 - 15 minutes.
The results from the study will be made freely available to all participants.

Confidentiality

Information collected from the survey will have no identifying information. Data collected will be stored securely in the University’s School of Nursing & Midwifery for five years.

Contact information

Dr Selma Alliex of the School of Nursing is supervising the project. If you have any queries regarding the research, please contact me directly or
Dr Selma Alliex by phone (08) 9435 0215 or by email at salliex@nd.edu.au

I thank you for your consideration and hope you will agree to participate in this research project.

Regards Elaine

https://www.surveymonkey.com/s/23LRGWK
Appendix 25: Attachment to survey—the study so far …

The study so far >>>>

‘An exploration into the past, present and future of nursing in Early Parenting Services in Australia’—Elaine Bennett

Background history to Early Parenting Services (EPS) in Australia

Many of the EPS sites around Australia have been operating for over a century of time. Nurses have been the predominant workforce for this period. It has only been over the previous 2–3 decades that a greater discipline mix has been added to services in order to meet the changing needs of families. It was observed during Phase 1 and 2 that sites around Australia operate in both multidisciplinary and interdisciplinary contexts, and some sites vary with the opportunity of nurses working alongside other disciplines very closely on a daily basis (rather than purely on a referral basis).

Definitions

1. **Early Parenting Services (EPS)** are defined as those services around Australia who provide a range of early parenting services for families with young children. They are not the universal child health system, but services as follows:
   - **Tasmania**—Parenting Centres (Child Health & Parenting Service).
   - **Victoria**—Tweddle Child & Family Health Service; O’Connell Family Centre; The Queen Elizabeth Centre.
   - **New South Wales**—Karitane and Tresillian Family Care Centres.
   - **Queensland**—Ellen Barron Family Centre.
   - **South Australia**—Torrens House (Child & Family Health Services).
   - **Western Australia**—Ngala.

2. **AAPCH**—Australian Association of Parenting and Child Health
   A national association where all services above meet annually. It also includes Plunkett, New Zealand and The Queen Elizabeth 11 Family Centre, ACT.


Key changes to Nursing Practice

The study so far …

Nurses involved in Phase 1 and 2 have all agreed that nurses in EPS:

- Have moved from an expert approach to working in partnership with families;
• Are open to working collaboratively with other disciplines;
• Now integrate evidence and reflective practice in their daily work with families.

Phase 1 and 2 described the role of the nurse in EPS and all agreed on the overall role description of the nurse working within EPS.

The 3 themes (with sub-themes) were:

I. **Early Parenting Nursing Practice**
   a. Building connection-relationship
   b. Assessment
   c. Parent craft-child development
   d. Advocacy
   e. Health promotion
   f. Group facilitation
   g. Anticipatory guidance
   h. Coordination and planning

II. **Application of Evidence**
   a. Professional development
   b. Records and data
   c. Reflection and evaluation
   d. Research application

III. **Linking with others**
   a. Team connection
   b. Mentoring colleagues
   c. Preceptoring students
   d. Referral.

Out of the overall role (as above) the next stage identified what was unique to the nurse working within EPS. The role of other disciplines does overlap with the nursing role within EPS when disciplines work closely together. What is it about nurses that make them unique when working with other disciplines?

During Phase 1 both nurses and allied professionals described the **uniqueness** of the nurse as clustered into 3 themes within EPS:

I. Nursing role
   a. Parent-craft/child development
b. Health assessment  
c. Health promotion  
d. Holism  
e. Coordinator of care  

II. Experienced practitioner with broad knowledge base  

III. Professional identity.  

That was a very brief summary that has given insight into the role of the nurse and the uniqueness when working closely with other disciplines . . .

The concept of an Early Parenting Practitioner (EPP) was developed from Phase 1 and presented to Phase 2 with 7 out of 9 sites agreeing that an EPP would complement the existing nursing skill mix of nurses within EPS and assist to sustain workforces for EPS into the future.

An EPP could hold a baseline degree in occupational therapy, social work, psychology, early childhood or speech therapy etc. with the suggestion to undertake a postgraduate diploma in Early Parenting Practice (to be developed). This concept would not be a cost cutting exercise with a lower level worker (like an EN or 2 year diploma or certificate) but work alongside nurses with a different skill set as well as having had postgraduate training in early parenting.

It was agreed that EPS have a range of specialist services and nursing will need to consider a future skill mix and workforce requirements to meet the multiple needs of today’s families. A mono-discipline approach cannot sustain this work.

Please find the link at the bottom of the email and progress through the questions … your feedback is going to be very valuable for this study.
Appendix 26: National questionnaire

Nursing in Early Parenting Services Survey

Introduction for Phase 3

Having read the material previously provided via email regarding the background of the study to date, please answer the following questions. Your input will help to shape the direction for nursing in Early Parenting Services.

Additional comments and suggestions are welcome and space has been provided following most questions.

Please note that you must answer each question before you can go onto the next.

Section 1 Demographics

1. What is the location of your workplace?
   State:
   Postal code:

2. Please indicate age category (Tick one box).
   20 – 29 yrs
   30 – 39 yrs
   40 – 49 yrs
   50 – 59 yrs
   60 – 64 yrs
   65 – 69 yrs
   >70 yrs

3. What length of time have you been working in the area of Early Parenting Services (EPS)? (NB: EPS refers to your working within EPS & not universal child health services or other Agencies)
   Years

4. How much longer do you anticipate you will be working in the area of EPS?
   Years
5. What are your nursing qualifications? (Tick all relevant boxes)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. Do you work closely with other disciplines at your site? (Tick box)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

7. If you ticked YES then please tick the relevant box below which clarifies how you work.

* Closely on a daily basis & use reflection in teams
* Regularly but no reflection in teams
* I refer to other disciplines only

Please comment

______________________________
Section 2 Nursing within Early Parenting Services

Please indicate whether you agree or disagree with the following statements.

8. It is essential that nurses working in Early Parenting Services are experienced. (Tick one box)

<table>
<thead>
<tr>
<th>It is essential that nurses working in EPS are experienced</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree or disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

Please comment

9. Nurses maintain a unique role when working within a collaborative partnership model with other disciplines. (Tick one box)

<table>
<thead>
<tr>
<th>Nurses maintain a unique role when working within a collaborative partnership model with other disciplines</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree or disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

Please comment

10. There are concerns nationally for the future of nursing in EPS (Tick one box)

<table>
<thead>
<tr>
<th>There are concerns nationally for the nursing role in EPS</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree or disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

Please comment on your concerns
**Section 3 Looking Forward**

Please indicate whether you agree or disagree with the following strategy statements which could inform a framework for the future of EPS.

11. Increase the development and availability of innovative options for post qualification education in the early parenting sector (Tick one box)

<table>
<thead>
<tr>
<th>Increase the development and availability of innovative options for post qualification education in the early parenting sector</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree or disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

Please Comment

12. There is a need for innovative national professional development opportunities (Tick one box)

<table>
<thead>
<tr>
<th>There is a need for innovative national professional development opportunities</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree or disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

Please Comment

4 | Page
13. Identify further research areas relevant to the EPS workforce (Tick one box)

<table>
<thead>
<tr>
<th>Identify further research areas relevant to the EPS workforce</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree or Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

Please Comment

14. In order to plan for the next 5-10 years there is a need for a workforce development strategy in EPS (Tick one box)

<table>
<thead>
<tr>
<th>There is a need for a workforce development strategy in EPS</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree or Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

Please Comment

15. Identify the skill mix for the various practice contexts of EPS (Tick one box)

(Examples of practice contexts are Residential, Helpline, Daystay, Consultations, Parent Education, Community Programs etc.)

<table>
<thead>
<tr>
<th>Identify the skill mix for the various practice contexts of EPS</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree or Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

Please Comment
16. Develop marketing and recruitment strategies for a future multi-generational workforce (Tick one box) (NB: multi-generational means a range of generations within a workplace)

<table>
<thead>
<tr>
<th>Develop marketing and recruitment strategies for a future multi-generational workforce</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree or disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

Please Comment:

17. Consider sustainable strategies to support a future multi-generational workforce (Tick one box)

<table>
<thead>
<tr>
<th>Consider sustainable strategies to support a future multi-generational workforce</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree or disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

Please Comment:

18. Develop retention strategies for the ageing workforce in EPS (Tick one box)

<table>
<thead>
<tr>
<th>Develop retention strategies for the ageing workforce in EPS</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree or disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

Please Comment:
19. Please rank the above mentioned strategy statements according to your perception of their priority for the next 3-5 years. (Tick one box only for each statement)

<table>
<thead>
<tr>
<th>Statement</th>
<th>High priority</th>
<th>Medium priority</th>
<th>Low priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase the development and availability of innovative options for post qualification education in the early parenting sector.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is a need for innovative national professional development opportunities.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify further research areas relevant to the EPS workforce.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is a need for a workforce development strategy for EPS.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify the skill mix for the various practice contexts of EPS.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop marketing and recruitment strategies for a future multi-generational workforce.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consider sustainable strategies to support a future multi-generational workforce.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop retention strategies for the ageing workforce in EPS.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please Comment


7 | Page
20. Please rank the above mentioned strategy statements according to your perception of their priority for the next 5-10 years. (Tick one box only for each statement)

<table>
<thead>
<tr>
<th>Statement</th>
<th>High priority</th>
<th>Medium priority</th>
<th>Low priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase the development and availability of innovative options for post qualification education in the early parenting sector</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is a need for innovative national professional development opportunities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify further research areas relevant to the EPS workforce</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is a need for a workforce development strategy for EPS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify the skill mix for the various practice contexts of EPS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop marketing and recruitment strategies for a future multi-generational workforce</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consider sustainable strategies to support a future multi-generational workforce</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop retention strategies for the ageing workforce in EPS</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please Comment
21. Please suggest any further strategies you think should be included.

Thankyou

Thank for your time. The researcher will collate the responses and report the results to all services involved in the study. If you have any questions or would like to provide more input, please contact Elaine Bennett: elainsbennett@westnet.com.au or mobile 0448 776 626.