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

Elaine Bennett

University of Notre Dame Australia

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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 Phase 1 and 2</th>
<th>Post-positivistic View Phase 3</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>Historical and Archived Documents</td>
<td>Interviews, Written Journals</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>Survey</td>
</tr>
<tr>
<td>Focus Groups</td>
<td>Qualitative</td>
<td>Quantitative</td>
</tr>
<tr>
<td>Research Methods</td>
<td>Quantitative</td>
<td></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-Wood, & 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.
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

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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](image)

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.

<table>
<thead>
<tr>
<th>Nodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
</tr>
<tr>
<td>1990-2000</td>
</tr>
<tr>
<td>2001-current</td>
</tr>
<tr>
<td>Alexandra Home current role of nurse</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Advocacy</td>
</tr>
<tr>
<td>Anticipatory guidance</td>
</tr>
<tr>
<td>Assessment</td>
</tr>
<tr>
<td>Coordination &amp; Planning</td>
</tr>
<tr>
<td>Group facilitation</td>
</tr>
<tr>
<td>Health promotion</td>
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<tr>
<td>Mentoring colleagues</td>
</tr>
<tr>
<td>Practical component</td>
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<tr>
<td>Precepting students</td>
</tr>
<tr>
<td>Professional Development</td>
</tr>
<tr>
<td>Records and data</td>
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<tr>
<td>Referral</td>
</tr>
<tr>
<td>Reflection and evaluation</td>
</tr>
<tr>
<td>Research application</td>
</tr>
<tr>
<td>Team connections</td>
</tr>
<tr>
<td>Future directions</td>
</tr>
</tbody>
</table>

**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.'
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).

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

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.
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
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]

**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).
Figure 14. Example of coding quantitative data using Survey Monkey

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 teamwork 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

67
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
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
Photo 12. Elaine at Midwifery graduation receiving Director of Nursing’s prize, 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.

Photo 13. Elaine at KEMH with two babies for adoption, 1977

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).

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.

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