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

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Chapter 4: Findings

4.1 Introduction

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

The six key research questions for the study were:

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

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Phase 1—document analysis of Ngala’s historical documents and recent service documents; focus groups and interviews with nurses and allied professionals; nurses’ written journals.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

Phase 2—document analysis of national historical documents for sites and recent service descriptions; teleconferences with sites, which included two group questionnaires for participants.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

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

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

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

4.2 Phase One: Ngala

4.2.1 Introduction

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

4.2.2 Demographics

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

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

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

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

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

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

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

4.2.3 Findings of Phase One

4.2.3.1 Findings from document analysis

4.2.3.1.1 The evolution of nursing within Ngala

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

1. The House of Mercy 1890–1916

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

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

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

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


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

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

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


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

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

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

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

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

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

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

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

Caring for sick child/mother

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

Coordination of care

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

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

Health assessment

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

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

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

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

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

Doing mothercraft

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

Protecting children and advocacy

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

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

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

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

Training and supervision

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

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

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


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


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

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

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

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

4.2.3.2 Analysis of data from various sources

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

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

1. Societal factors

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

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

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

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

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

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

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

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

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

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

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

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

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

4. Focus on women’s mental health

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

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

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

5. Policy changes

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

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

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

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

6. Closure of mothercraft training schools

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

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

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

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

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

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

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

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

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

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

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

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

9. Collaborative and partnership approaches

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

Below, nurses describe this shift from the ‘expert’ model:

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

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

10. Commitment to practice based on evidence

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

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

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

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

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

11. Individual discipline focus to team approaches

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

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

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

12. Information technology

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

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

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

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

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

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

![Diagram showing three categories: Early parenting nursing practice, Application of evidence, and Linking with others.]

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

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

4.2.3.3.1 *Early parenting nursing practice*

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

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

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

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

1. Building connection and relationship

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

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

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

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

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

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

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

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

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

The theme of ‘building connection and relationship’ was important to establish effective partnership and work was to be undertaken with the client, family, group or community.
Health assessment

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

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

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

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

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

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

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

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

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

... and the social determinants of health. (FG2)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Advocacy

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

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

Promoting health

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

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

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

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

Parent-craft and child development

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

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

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

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

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

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

2. Coordination and planning

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

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

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

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

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

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

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

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

**Anticipatory guidance**

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

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

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

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

**Individual consultation**

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

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

Group facilitation can be undertaken in a diverse range of contexts for both parents or carers and professionals. One nurse discussed her experience:

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

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

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

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

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

Figure 80. Category 2—Application of Evidence

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

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

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

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

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

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

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

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

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

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

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

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

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

Recognition of the value of an evidence base and that we all contribute, and so the intent is common I think there is, I think we have to value people. (FG1)

Issues of mental health, attachment theory would be a good example, of really embracing that and saying it actually made sense and
assimilating that into their practice, which is beyond really a nursing orientated practice. (FG1)

The Team has always managed to take on board, new ideas, new evidence-based information and applied that. (Int3)

Research application is also tied up with ongoing reflective practice and evaluation.

**Reflective practice and evaluation** have changed the practice at Ngala. The nurses discussed the changes, which included more rigour in their daily work:

The relationship with listening skills … and reflective skills because you are doing things and then you sit down and write about it, cos you have to think it through. (Int2)

The way we work we try and achieve the same goals don’t we? and they are always involved with the handovers and communication stuff and care plan for that family. (FG3)

We’ve gained that knowledge so whether that’s through other disciplines … I’m not sure I think we’ve recognised it as an issue and certainly at the moment we are looking at mental health first aid because we need more knowledge, so on top of what’s presenting and hopefully that’s a good match so when we are reflecting, we are using that and we’ll continue and I think within the health professions it’s become more apparent so. (FG3)

The change of C-Frame coming in was less directive and more reflective. (FG1)

It’s constantly revising how things are going for them … usually there’s an opportunity to practice and reflect on the first part of the day; and you’re also looking for … looking to finalise the day by means of reflecting and getting them to make an assessment of the day—getting them to reflect, and what they’re going to do, you know, to follow through with what they’ve got out of the day, if you like finish it up by evaluations, questions, closure. (FG4)
When you work in the helpline, you reflect every day and that’s a really important part of the day. And because of the kind of calls that come in there and I guess, being for want of a word, ‘old school’—I really thought, ‘What’s this reflection about now?’ I’d get more upset than anyone if we don’t do it. So, that to me has been a huge change—I love reflections. (FG1)

I think for most new staff coming in, that’s one of the things that really does amaze them, is that capacity to share knowledge and to grow also helped in terms of reflection, sessions that we actually have, and so that enables different viewpoints to be expressed. (Int2)

The second component of ‘application of evidence’ that nurses identified as part of their role has been described. The third component of ‘linking with others’ is now presented.

4.2.3.3.3 Linking with others

The third category classified under the perception of the nursing role is ‘linking with others’ (see Figures 82 and 83).

![Figure 82. Category 3—Linking with others](image)

Nurses link their clients back out to the community via referral, or to a range of resources available locally or via the Internet. They network and link internally and externally to the organisation. The support for team, colleagues and students is a large part of this role. The key sub-categories within this component are:

- Team connection;
- Mentoring colleagues;
• Preceptoring students; and
• Referral.

Figure 83. Linking with others, with sub-categories

*Team connection* has gradually come about through the shift in team approaches and is enriched by the longevity of the workforce. Nurses describe team connection as follows: ‘the sharing of that knowledge between the different disciplines within the team has actually enabled that broader focus of working with families, to have a much more holistic approach for the way they do things’.

Other nurses described the meaningfulness of the team and the support that they received:

… there is acknowledgement there … of other disciplines … and I think the move towards a research base that is common across disciplines and when you match that with intent … (Int5)

There’s a lot of teamwork, and this also builds a lot of collegial support, which I like. (Int2)

I think it’s the C-Frame, that it also helps with your colleagues as well as your clients … C-Fame gave a common language. I don’t necessarily think it is the answer to everything, it just gives permission and a language. (Int2)
You know, when you’re having a more challenging day, the other staff know and it’s sort of, you know, when I walk back in and come and I’ll make you a cup of tea … and I think that really helps that—to feel connected. (FG4)

Keeping up-to-date in terms of, am I relevant to practice? and I would say all of my colleagues, we consult with each other, so you’ve got a lot of cross-pollination, in terms of some people have skills that you don’t. (FG1)

Team connection is crucial to ‘linking with others’ and the success of interdisciplinary work.

*Mentoring colleagues* is also a sign of good collegial team relationships within interdisciplinary work. It was seen by nurses as something important in their role in terms of assisting with the professional development of their colleagues, as demonstrated by the following comments:

We work together and its preparation and it’s yeah. I’m amazed how well they do do, because I’ve come here with all this background knowledge and when they come for the first time how can they suddenly just be getting it all, bit of a process for them … but at the same time you can use their skills to maximise those social work issues. (FG4)

I’m a professional and if I haven’t got the skills I can ask the right questions and guide them through that … the other thing is having the skills to ask the right questions … I think that’s where our work support of those people is so vitally important … our people skills to ask the questions. (FG3)

I think it’s with a lot of things, its knowing what you don’t know and so what do the other people need to know, which is the challenge I think. (FG3)
I think it’s because you’re listening all the time, you can sense when there’s something not quite right and you can turn around and say are you ok? … it’s quite intriguing how that works. (FG2)

You might have skills that they haven’t, so you’ve also got that education role towards other colleagues. (FG1)

I think I’ve gotten a lot better at doing it, and for me the way I spoke my C-Framing helped me, in the gate keeping. (FG1)

Mentoring others assists in understanding the needs of others and how they work. This also enables appropriate referral to others.

Nurses refer both internally and externally. Recognition of the scope of practice and their strengths and weaknesses in their role also assists in the development of the interdisciplinary team and provision of a holistic service:

… do you know about the local resources in the community, rather than saying I think you should go to a PND support group, it’s, do you know about the local services, here is five phone numbers and five different services, one might be a group situation, one might be a one-to-one counselling situation, another one might be a pottery class just to get them out of the house. (FG2)

You’re looking at all the extended services that are available, as in social work and psychology and the GP and, you know. I’m referring them on. (FG3)

Then it’s usually, again, within Ngala with who else they can help in this situation—who else can I refer onto—who else can I get involved? (FG2)

Good team relationships, mentoring and referral to others also aid in developing students.

Preceptoring students is something a large percentage of registered nurses undertake at Ngala as part of their position description. It is key to supporting students and provides stimulation to nurses with new and fresh perspectives:
We have lots of students through and there is never any issue. (FG1) … and I always ask if they can have a student … that’s about respecting. (FG4)

We get our nursing students coming to Ngala they really have a great time, they can see the benefit of it. (FG2)

We preceptor students as well. It’s a part of our role; they are intermittent, certainly, but that is an added workload if you like, because they also asking questions. (Int3)

4.2.3.4 The uniqueness of the nursing role within an interdisciplinary team context

The overall nurse’s role has been described within EPS. It is a very broad role, and over time experienced practitioners develop very comprehensive skills. This will need to be given consideration in the framework for the future. The next section describes the uniqueness of the nursing role in the context of an interdisciplinary team.

The current nursing role has been summarised. Nurses and allied professionals, through focus groups and interviews, were then asked what was unique to the nursing role within an interdisciplinary team. This question stemmed from the identification of some overlap described between the work of nurses and other disciplines in working with children, parents, families and communities. Nurses and allied professionals described standard or shared skills and knowledge that was expected of all professionals working within the area of early parenting.

Figure 84 demonstrates the interface between nurses and allied professionals, with an overlap segment. A nurse summed up this interfacing by saying ‘you are working alongside each other and you are sharing and by osmosis’. ‘Osmosis’ was seen to occur when skills were shared and each role became part of developing an overall strategy for assisting each family or group.
Figure 84. The nursing role within an interdisciplinary team

These general statements from nurses and allied disciplines demonstrate the concept of overlap:

… going back to the interdisciplinary team because we now work with more and more skill bases we are growing ourselves with that knowledge because we have picked those social work skills, and we’ve learnt different ways to ask questions and because we are working with so many different people we are constantly evolving … (NFG1)

Maybe that way when you add them together—the two parts are greater than the one … Yeah, the sum of it … the whole package that you provide for the client. (APFG)

I do think the nurse is the advocate for the family and is that connection between services, but then I think there might be an overlap in the roles as well because we do a lot of listening, counselling and listening to parents to try and identify where problems are. (NFG3)

In explaining the uniqueness of the nursing role, Figure 85 demonstrates the congruence between how the nurses and allied professionals described the unique role of the nurse.
Figure 85. The uniqueness of the nursing role within an interdisciplinary team

When nurses and allied professionals were asked what is unique to the nursing role, they gave very similar responses. These were categorised under three headings: the nursing role, the experienced practitioner and professional identity. Each of these is described below.

4.2.3.4.1 The early parenting nursing role—what is unique?

The nursing role is outlined in five sub-categories:

1. Parent-craft and child development;
2. Health promotion;
3. Health assessment;
4. Holism; and
5. The coordination of care.

Both groups identified the everyday practicalities of working with parents in their parenting role, which operates alongside their knowledge and application of child development. Health assessment and promotion were also identified, but the coordination of care was only mentioned by nurses.

1. Parent-craft and child development

Allied professionals’ statements below reflect their thoughts about the nurse’s unique role in the early parenting area. They were able to articulate in-depth how they
viewed the unique role of the nurse. The allied professional statements were consistent with statements from nurses:

I can give examples, like about feeding and nutrition—just an understanding of what’s appropriate for ages, aside from just the normal developmental milestones. It’s about relating to feeding, growth parameters, what’s normal—a lot of normalising, if you like, of normal growth and development of children. So, they have got quite a good foundation in there too. (APFG)

The way that, they actually work with families is quite unique, in that, building relationships, health and development—development of the child. (APFG)

… more understanding about not just development wise, as in ages and stages, but, about different sensory processes and about attachment processes … (APInt3)

I think that understanding parents and child development is a vital component of the role, particularly when you’ve got anxious people coming in who are concerned about every little thing that’s happening for their child. (APInt1)

That’s very important in the neonatal period where I feel much more comfortable with nursing input with helpline calls, in the first six weeks of the baby’s life, where they are being taken by a child health nurse who’s aware of some of the issues that can be health-related in most newborns. And part of their role is also referral to community or other Ngala programs that parents might find helpful to achieve their goals for their children. (APFG)

2. Health promotion

The health promotion role was discussed as being the lens through which nurses viewed their early parenting role and the way they approached individuals, parents, families and communities.
One nurse stated:

It’s ok to see a child health nurse because we have that level of health promotion and it’s about keeping well and keeping your baby well and developing well, and your relationship together. (NFG1)

An allied professional stated:

I suppose when I first came to Ngala, I learnt a lot more about the breadth or the generic nature of the child community health training and approach a bit, and concepts around primary health and health promotion, and where they came from. (APFG)

3. Health assessment

The following statements from allied professionals were also reflected by nurses. Health assessment was seen as an important part of the nurse’s early parenting role. The issues facing parents with young children are often multifaceted. Nurses work with parents to elucidate their immediate concerns or issues by using a number of strategies within assessment, such as asking the right questions, observation and clarification. Some of the comments that described assessment are as follows:

First is their abilities of assessment of early childhood health and parental health and wellbeing. I think about assessment as the first part of the role. (APFG)

I’d say, given that the core component of parents with young children is basically physiological, brain wiring and nutrition and relationship. I’d say, to be an early parenting organisation, you need people with the skills that deal with physiology, to deal with nutrition, and deal with relationship and our brain development, and all those—and the ability to look at a child and go, ‘Something not quite right here’ and I think if we lost those particular component parts, then it makes us no different from an organisation that can just talk the theory, but not be able to provide any of that clinical ability to really deal with those particular issues. (APFG)
I think health assessment—the assessment around development, feeding, nutrition and around the parent, around that sort of adjustment, so, which would parallel with the social worker. I don’t think in some of those areas, there’s a great deal of difference, but it’s about, like I said, a set of knowledge in relation to the nurses. I mean, I think that—think of them as demonstrators of things, teachers, educators—health education, health promotion is part of the role I have observed, most frequently. (APFG)

Nurses are very good observers and have developed skills in observation, and that’s where I think that the people on the helpline have an additional skill that they can observe remotely sometimes, which is hard, but I see nurses as observers in terms of assessment, in terms of their role; so that observation. (APFG)

… and just looking for factors and preventing a child from losing too much weight because they’re working with the parent on nutrition, so that they don’t get to a point where it’s a failure to thrive or whether it’s a developmental concern because they are actually looking for those milestones—trying to work with the parents in these things. (APFG)

4. Holism

Both groups highlighted the holistic nature of the nurse’s approach to the client, family or community:

I think that aspect in itself is being able to have that broader view outside of the very narrow nursing window, if you like, is a more holistic approach, and using all the different models. (APInt2)

I think one of the things that’s quite unique to the nurses here is how they work, it’s a more holistic framework of how you view the family. Whereas, other nurses I’ve worked with at other places, it’s been very much at times, child-focused, but more about let’s fix the ‘problem child’ rather than what’s happening in this whole family that’s
creating the situation for the child. So, I think that’s very different skill set that the nurses have here. (APInt1)

5. Coordinator of care

The nurses highlighted the role of coordination as being important to their overall role in early parenting work. This is because other professionals tend to focus on their part of the work rather than on the larger picture of care. The allied professionals did not articulate this role of the nurse (Figure 86 demonstrates this visually). This was surprising, as this appears to be a very strong role taken by nurses at Ngala. However, this might be explained by the fact that allied professionals have increasingly been taking on coordination roles. Nurses reasoned that allied professionals in some contexts have a more defined and narrow role.

![Figure 86. Some differences in the perception of the Early Parenting Nursing Role](image)

The coordination role was only described by nurses. Their greater participation as coordinators is possibly due to there being more nurses available, often over longer hours through shift work, to take on the coordination role in the early parenting context, particularly in the more individual and intensive service teams. Moreover, the current nurse cohort is very experienced.

4.2.3.4.2 The experienced practitioner—what is unique?

The nurses at Ngala had been there for many years and were very experienced practitioners with a broad knowledge base and range of qualifications:
Many of us have midwifery and child health and some have post graduate quals … (NFG1)

I actually think we are confident in our expertise. (NFG4)

The allied professionals held a stated deep respect for the nursing role and their broad knowledge base. They highlighted that the majority of nurses at Ngala have life experience and are also very experienced practitioners, having been there for many years:

All those nurses come with years of life experiences … having an awareness of the mental health issues of the people who are presenting; having an understanding of how they impact on people’s parenting and how they actually present. (APInt2)

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

They’ve just got that extra sort of health dimension, I guess especially working with young children. They just have that sort of broader awareness of what else might be going on … in a family. … and, yes. It’s—parents just often really love—they sort of graduate to—they want to … not graduate—that’s not the right word—move towards talking to a nurse. And often health and behaviour is inter-related. So, they might start off talking about an allergy or a high temperature or something like that. And, they’ve got the skills to deal with the health issue but … get it—take it broader and deeper as well. So, it’s just that it’s another dimension to work with. (APFG)

And those that are midwives as well, the birth experience and then the infant mental health and the mother as well; and the impact of medications or non-prescribed drugs and that sort of thing. They are pretty well clued up on that sort of stuff. (APFG)
Particularly, their experience, they’re not a new practitioner with a child health background. I think it makes a huge difference to have them based in the community doing community work because they see things through another prism. I’ve worked quite a lot with child health nurses at other services, and they’re understanding of this is not as developed as the nurses here. (APFG)

4.2.3.4.3 Professional identity—what is unique?

Professional identity was a strongly held perception from all disciplines. Nurses talked about being ‘safe to talk to’, ‘respected by the public’, ‘holding a health promotion focus’ rather than ‘come to me for a problem’ focus (like a social worker or psychologist). They also described professional accountability—national registration as a nurse and the need for ongoing professional development. It was emphasised that nurses have good relationship-building skills and are confident with their expertise:

Isn’t there something about the title of nurse that almost gives us … the term the golden scales … I’m the child health nurse I’ve got the golden scales … there is trust. (NFG2)

It’s definitely an identity, it’s a role … it’s a safe place and I think it’s not threatening … (NFG3)

I think it must be something about the body … in terms of nursing … It’s that understanding of the personal and the personal body. Social workers and other professional haven’t got to go into the idea of toileting … its personal … there’s that intimacy … (NFG3)

Health promotion opportunity rather than you’ve got a problem, so I think that is why I think we are safe. (NFG1)

Allied professionals talked about the legislative and statutory responsibilities that nurses have, and that as a group of nurses, they hold a strong identity:

They hold on to this really strong identity and set of skills about certain things which of course they do have, and that’s what we all
admire and lean on and learn from … but it’s also held very tight in their identity as a professional. (APFG)

The following statements reflected the current demographics of nurses and what they expected for the future:

The generic nature that the child health training tended to give people still doesn’t take away from that—you could still identify it as that nursing, but I don’t mean that in a negative sense, but it’s that strong identity somehow … I don’t know how else to describe it … (APFG)

Yeah, I mean … I think you’re right but I wonder if that is a product, particularly being so evident at Ngala because of the age of the practitioners we have. We have really experienced, you know, professional people who have been doing this work for their whole professional lives. And I wonder if we bring in younger and newer practitioners, if their identities wouldn’t be so tightly wound up in that or whether or not the new nurses they would cling to that even more? (APFG)

The role that is ‘unique’ to nursing has been described by nurses and allied professionals. This next section will now describe how nurses and allied professionals currently work together and their concerns and issues in thinking about the future for EPS.

4.2.3.5 Nurses’ and allied professionals’ perceptions of working together

Nurses and allied disciplines were asked how they work with each other (see Figure 87). They described the benefits of working within a team, the gaining of new knowledge and the influence from other disciplines. All participants discussed the strategies of working collaboratively, which involved a one care plan (in some contexts) and reflective practice. The allied professionals also talked about the whole package for families and the strong identity of nurses.
4.2.3.5.1 Changes over time

Many of the nurses and allied professionals had been working together for many years. They described what had changed over that time, and this was congruent across the discussions. For example, nurses discussed that they used to ‘gate keep’ the early parenting work:

I think we gate keep … especially CHNs … So, I think we did gate keep, and that’s something I have let go of. I think I’ve gotten a lot better at doing it, and for me the way I spoke my C-Framing helped me, in the gate keeping. (NFG2)

We might now direct to a different discipline so they get more support rather than gate keeping. (NFG2)

Certainly, a lot of gate keeping, if you like, about information as well, about certain clients and our—the role—the need for nurses to know some things, which was interesting sort of shift that we’ve managed over the years, and being able to say that this is actually important, everybody needs to know this information. (NFG1)
Allied professionals noted the ‘gate-keeping’ as well, with comments such as:

When I first came to Ngala 12 years ago, there was a bit of gate keeping that went on for a male practitioner to have access to parents, you know, which were mothers. It was difficult breaking through some of that ground, and I’ve certainly seen that changed. (APFG)

The following quotation eloquently describes the shift seen by an allied professional:

I think we’ve seen a shift with nurses, who have traditionally held the position that, ‘I have the client’—that they have that authority to work with the client and the other professionals were allowed to engage the client through them, like they were the primary worker, I guess we were additional functionaries to their work, to add value and then I think over the shift in time has come, is that they now through interdisciplinary work, have actually been influenced by the fact is, that they could be challenged. They can no longer hold that role as though all that client contact must come and go through me, and I’m the holder of all that knowledge; and that has been challenged through the work of the fatherhood team and other social workers coming in, and they’re seeing the value of it. And I’ve actually seen, I think it’s become more of an interdisciplinary approach where I feel there is now more genuine respect and genuine understanding about the different skill sets that people hold, rather than it being—actually I don’t want to deal with that stuff so I will just give it to you—like the handball, ‘Oh, that’s a social worker issue …’. It was very clear demarcation about what they saw; it was very obvious what was our area of work and I think that’s become more intra-disciplinary now, because I think we now, we all hold some shared knowledge and some shared ways of practicing, which means, there isn’t such a demarcation around boundaries and practice, so that sure we know our core business and what our core training is, and we know now what their areas of core expertise are. But, it’s like we can refer to each other without their being any demarcation, and actually use each
other’s strengths, as opposed to ‘Well, that’s my area of work’ and like automatically feeling that you are being hand-balled on. (APFG)

Other changes occurring with nursing were noted, such as:

I see that as the biggest change for the nurses at Ngala, is that push to move away from the expert model … that clinical, actual diagnosis to being more holistic and putting more power back into the parents—both parents—and actually asking them what they think and what they feel solutions would be, rather than a nurse deciding what the best course of action should be. (APFG)

When I first came, there were still quite discrete roles for mothercraft nurses, social worker’s, nurses. We still had the visiting paediatrician and psychiatrist—the visiting psychiatrist registrar. And so, it was still a lot of—it was working within a team but still quite discrete areas, if you like. (NFG3)

Going back to the trans-disciplinary, interdiscipliory, and the multidisciplinary, I still think that we still have all three at Ngala. There’s some nurses who see the social worker as an add-on, and there’s some who respect other people’s knowledge and call that in, when they think it’s necessary. I think, in the helpline, the trans-disciplinary stuff happens really, really well, because everyone is learning from each other so much that if there is a crisis call a nurse or a social worker would feel comfortable to take it—even a breastfeeding issue—whatever it is. And there are certain pockets where there’s lots of resistance to actually acknowledge strengths-based. (APFG)

everyone is learning from each other so much. (NInt3)

Is it because they have been working within an interdisciplinary team that, you know, absorbed those full strength-based approaches? (APFG)
It was noted by nurses and allied disciplines that ‘The sharing of that knowledge between the different disciplines within the team has actually enabled that broader focus of working with families, to have a much more holistic approach for the way they do things’ (AP). One of the greatest benefits discussed of working together was the gaining of new knowledge.

4.2.3.5.2 Collaboration

Alongside gaining new knowledge, working collaboratively was seen as a benefit of working together, as demonstrated by the following comments:

I think a lot of that is the same way we work with families, because it is about relationship. It’s about developing a relationship. (NFG1)

Geographical co-location was a way to unite. (NFG4)

Our collaboration and team work … we work together and it flows, sometimes I have much more one-to-one contact with the nursing team and/or the nurse with the family, and I have to communicate a real lot, and sometimes it is not much needed to do that, but see because they have worked so long together, there is such a fantastic understanding between us and of each other, we know who is doing what and we don’t need to necessarily to communicate as such, there is a real flow about it. (APInt2)

With the components of early childhood and the nursing component as well. … I honestly believe that we really complement one another. (APInt1)

Working within a team, you know. … and taking all those skills and working with that … it’s very successful. (APFG)

That partnership model from an academic perspective and their ability to translate that into understanding where my skills and expertise were and where theirs lie and how we complement each other, has been really, really good. So I think if there’s that understanding, we do work really well together being held in a team, if you like, and being able to deliver a service, and learn things. (NFG1)
4.2.3.5.3 *Gaining new knowledge*

The variety of ways that both nurses and allied professionals discussed gaining new knowledge was demonstrated through these very rich conversations:

I’ve really enjoyed working with the psychologist here, that has been fantastic and I suppose that for me as a nurse I have a lot more affinity with her and what her discipline is … some of the skills I have picked up from her, but in the way I ask questions about them, as I haven’t done my mental health training, and that psychology that she brings to the table. (NFG2)

Because we use reflective practice as staff members within that multidisciplinary team, we, as early childhood people, learnt from that—the nurse, and how she approaches parents and so on. (APFG)

I have learnt heaps from them every day about what the nurses are talking about over 17 years and settling etc. I can talk about settling, but there is no way I can talk about breast feeding or how much a baby has to have, or the weight gain. (APInt5)

Our social workers in that their skills have gone up so much on the health side, because we have worked so closely together, that they will have their antennas out while they are talking … they will go … when they’ve finished their consult and they will go up to the colleague they are working with and say … have you noticed or while that baby was feeding it was making a funny noise or something like that cos they’re ears are open as well as their eyes. (NFG3)

The interdisciplinary team because we now work with more and more skill bases we are growing ourselves with that knowledge because we have picked those social work skills, and we’ve learnt different ways to ask questions and because we are working with so many different people we are constantly evolving. (NFG4)

… like somebody would say to you—you might pick this out of that conversation and the exact same conversation, I might pick that out of
it. And a social worker, the exact same conversation, exact same facial expression, would pick something else out of it. So, again, I think that’s why it’s really helpful to have all these different disciplines, but working as a team. (NFG1)

I think that really primary health care principles are probably a place where people can connect in that wellness model and health promotion … and that whole concept of family interaction and also promoting health and wellbeing—that whole thing can be the connecting point. The principles of PHC [Primary Health Care], they are still there behind the practice, and we as an organisation are a really good example of the principles which were laid out in the Ottawa Charter. (APFG)

And the notes … and that’s an interesting skill to have because the way a social worker takes notes compared to a nurse, is different. (APFG)

4.2.3.5.4 Reflective practice

Reflection and, in some contexts, developing a ‘one care plan’ also facilitated working collaboratively and the gaining of new knowledge:

If people, you know, have an issue with the client or what’s getting triggered for them—I’ve had people drop into my office quite often to talk about that. (APInt2)

I normally do reflections as a one-on-one, most by whoever’s referred? That’s more specific to that client. (APInt1)

It’s also helped in terms of reflection, sessions that we actually have, and so that enables different viewpoints to be expressed. (NFG2)

I’ve noticed there was a reluctance and there is a reluctance amongst nurses to engage with the Department of Child Protection because of the fear that the child is going to be removed and being aware of attachment, perhaps, and the importance of attachment, but not seeing child protection as a support for this family in this situation at the
moment, but, and so there has been a reluctance, which I think could be dangerous at times … holding off from engaging with child protection and I think, more recently, what I’ve seen in the helpline, that there is a growing awareness of child protection-type issues—when to engage child protection. (APFG)

They are always involved with the handovers and communication stuff and care plan for that family. (NFG3)

When the families come on board, we have a bit of a plan for those who will be involved. (NFG2)

Making the best fit for family, using the broadness of the team that we have, to work with them. (NFG1)

4.2.3.5.5 Nursing identity

Nursing identity was raised again by allied professionals when discussing how the disciplines work together. New employees noted that nurses can be ‘quite daunting’ when they first start. Others remarked:

Nurses have a very strong identity—as I’m a nurse and what I’m registered as is a child health nurse—these are interesting conversations that I’ve had … But, if you’re a nurse this strong identity of a nurse, it’s that allied scientist that is that superior thing. (APFG)

If someone new is coming in and observing it, I think that’s quite a difference between the way we practice. There’s a difference, I’m sure, at the way we’re practicing, which I think the nurses are quite sure of why we go about it and how we go about it, but then their expertise when it comes down to the nuts and bolts of things, so yes—there is a different way of practicing. (APFG)

That’s also problematic because they have a language of their own and even just the use of abbreviations; you know that we social workers need interpretation for what we do. And so, sort of trying to
encourage them not to use abbreviations—you know, let’s write out what they’re trying to say. (APFG)

We don’t have to be registered, whereas, nurses do. They do a child health qualification. That’s their identity with—same as psychology. If you try and water down a view of their profession because it’s tied up with pay and prestige and whatever else. (APFG)

Most of the nurses that I see here—the way that they think about clients and then the way that they interact with clients is—incredibly respectful as well, and very client-based. (APInt2)

But you do hear comments [chuckle] that if the other professions came up to the same level as the nursing profession, there would be a walk-out, you know, which would be disappointing. But there is, possibly, a few that say that nursing is a higher profession—a higher, skilled, qualified profession. (APFG)

4.2.3.5.6 The whole package

Allied disciplines discussed working as a team as ‘the whole package’. It was emphasised that:

The team works all together and the different parts make up the whole package. (APInt7)

Yes I agree … all the sum of the parts are greater than the one, like a package that is for families. (APFG)

Having discussed how nurses and allied professionals work together during phase one, the next section presents their perceptions of the present and suggestions for the future.

4.2.3.6 Nurses and allied professionals perceptions of the present situation and future suggestions for nursing in EPS

Both nurses and allied professionals, through focus groups and interviews, expressed concern about the present situation and gave suggestions for the future of nursing within EPS. The Ngala workforce has a large number of ageing nurses who will be
leaving within the next decade. It was also noted that families presenting to EPS are of a higher complexity than ever before, requiring a rethink of the workforce’s skill mix.

The suggestions for change were categorised under four headings:

- Planning future education and qualifications;
- The skill mix;
- Resources required for recruitment and retention; and
- The concept of a new EPP.

4.2.3.6.1 Planning for future education and qualifications

Nurses felt that immediate and longer-term planning for future education and qualifications was of considerable importance. The suggestions were for a postgraduate certificate for enrolled nurses in early parenting (6–12 months). The enrolled nurse would mean the introduction of a regulated worker into the workforce. There were a couple of suggestions for a nurse practitioner role for EPS, but no thought had occurred as to how this could work. The other suggestion that came forward was for an ‘early parenting professional or practitioner’, which is discussed in more detail below. This was seen as a practical solution to the decreasing nurse workforce and the move to interdisciplinary ways of working in EPS.

4.2.3.6.2 The skill mix

Clarification of the ideal skill mix was suggested to meet the needs of today’s families. It was felt by allied professionals that nurses were needed particularly where the baby was less than one year of age, and to maintain a skill mix in which nursing could input a strong child development, parenting and health perspective to the team.

All disciplines reinforced the necessity of maintaining expertise in the organisation, and discussed the need for a planned and flexible phasing out of the ageing baby boomer nurses, to retain their knowledge and experience through the mentoring of younger staff coming in.
4.2.3.6.3 Resources for recruitment and retention

To sustain a multi-generational workforce into the future, it was felt that comprehensive orientation programs and professional development needed to be provided.

Other suggestions included nursing graduate positions for EPS. Trying to attract younger nurses into this field was seen as important. It was felt this could be done by providing scholarships for nurses finishing their three-year Bachelor programs and then spending a year at Ngala in addition to undertaking their postgraduate certificates in child health. Other scholarships could be developed for allied professionals, and different types of scholarships could be offered for innovation and research.

4.2.3.6.4 The concept of a new EPP

As indicated above, the concept of an EPP or practitioner was suggested by nurses and allied professionals as a solution to the future skill mix and workforce development. This professional would have a tertiary degree prior to undertaking a postgraduate qualification in early parenting.

The concept of the EPP was explored through a number of the focus groups and interviews. Comments such as that below began consideration of the possibilities:

Given there is quite a bit of overlap in roles, there could be a type of qualification like the child health nurses do, for other disciplines wanting to work in this area, to give them a lot more practical knowledge about child development and parenting. (APInt3)

Initially when I first came here, there was a lot of gate keeping by nurses and for example, social workers felt very undervalued … it was very fragmented and not much sharing of knowledge. Now it is a different picture with the sharing on both sides and allowing other disciplines to have knowledge on things like feeding and nutrition, an understanding of what’s appropriate for ages, aside from the normal developmental milestones. It’s amazing how much knowledge they gain from working with nurses and vice versa. (FG3)
This concept was the result of both groups describing the overlap that occurs in early parenting work, especially given the complex nature of working with families. Further questions through focus groups and interviews were asked as to what this would look like and what would be the knowledge and skills required.

The proposal was to offer a postgraduate qualification in this area of work for a range of allied disciplines such as occupational therapy, psychology, social work, speech therapy, physiotherapy and early childhood education. This would not replace nurses or any current discipline mix but add value to the current workforce and a new dimension to interdisciplinary team work. Nurses have a broad range of skills and experienced nurses who have had many years of experience and educational up-skilling can do this role. The sense was though that other allied disciplines could also do this work once they have the appropriate qualifications; they could be frontline practitioners along with nurses. An allied professional stated that:

… it will be necessary when these experienced nurses leave that we will have a less experienced workforce which could do with further knowledge and skills through a postgraduate qualification. (FG6)

Allied professionals remarked that ‘in the current system nurses have taught us a lot and vice versa’ (FG6). They also noted that:

… the family partnership model from an academic perspective and their [nurses’] ability to translate that into understanding where my skills and expertise were and where theirs lie and how we complement each other, has been really really good. (FG6)

… we could easy move into more a trans-disciplinary team model in some of the aspects of our work at Ngala because those of us who have been here a long time have expanded our knowledge base just like the nurses, so we can see where there is certainly the possibility of a generic EP worker where they are or could be the first line of contact in a team and expected to know when to call in the others. (FG6)

The sense from the allied professionals was that they would not be the same as a nurse because of their background, but could understand the broader concept of
working with parents and have a deeper understanding of the practicalities of parenting, some health implications, the psychosocial issues, child development, perinatal and infant mental health and child protection. One allied professional noted that:

You know with all the areas we deal with in early parenting I don’t think there is anything magical around any of those areas that anyone is holding onto anymore. I think what—where the extremities are, is that sort of different assessment frameworks around you know, where people are at, and that brings the two lots of expertise together, the family functioning the psychosocial and physical development. (APInt5)

One nurse described how she saw the overlap in knowledge over time, and how a social worker had benefited from nursing input using her observation skills:

The other day the social worker was seeing a woman who had presented with a range of issues and was undertaking a psychosocial assessment as the presenting issue. She was noticing the baby breast feeding while they were talking and the unusual noise the baby was making while feeding and had picked up an attachment issue. She was then able to get the nurse to do a further assessment. (Int4)

The point above indicates that other disciplines are able to accommodate basic knowledge on a range of parenting issues that can also provide an initial first contact. In a trans-disciplinary setting with intensive or specialised work in early parenting, professionals can often be the first point of contact for the initial assessment within a team context, with other disciplines responding to specific needs such as a lactation consultant or child health nurse. The skill mix consideration still needs to be dependent on the early parenting context, but an EPP could be developed to take on a range of early parenting work in early childhood, community and parent education settings.

Figure 88 demonstrates the addition of an EPP who would work alongside nurses and other disciplines within an interdisciplinary team.
Nurses and allied professionals were asked what skills and knowledge would be required for this role. Figure 89 lists the knowledge and skills that might be offered during a postgraduate qualification in early parenting.
It was envisaged by some nurses and allied professionals, that if an allied professional were to undertake a postgraduate certificate or diploma in early parenting, then this would be modular-based and undertaken by external studies and/or face-to-face block studies. Depending on the background of the professional, they may receive recognition of prior learning if, for example, a social worker had done work and studies previously in the perinatal mental health area. The key components of a postgraduate qualification were considered to be:

- Child development and early brain development;
- Parent development and transitions;
- Working with parents—individual, groups and community;
- Primary health care practice, health education and promotion;
- Perinatal mental health and parent–child attachment;
- Family partnership approaches;
- Interdisciplinary approaches and team leadership;
- Assessment—individual, parent and child, and family;
- Families and children at risk;
- Interdisciplinary research and evaluation.

### 4.2.4 Summary of Phase One

In this section, the demographics of the participants in phase one were described, and a summary of the nursing role through Ngala’s 121 years of history was presented. This period reflected influences from a range of factors and changes that have made nursing in EPS what it is today.

The perception of both allied professionals and nurses of the uniqueness of the nurse’s role and how they work together was also described in this section. The focus groups, interviews with staff at Ngala and the written nursing journals all provided a rich description of the uniqueness of the nursing role within an interdisciplinary team. In addition, a number of suggestions for consideration in future workforce planning were made by the participants.

Following phase one, the findings were summarised and presented via teleconference to nine EPS in Australia. The findings from the discussions that comprised phase two of this study are presented in the following section.
4.3 Phase Two: National Teleconferences

4.3.1 Introduction

This phase drew on the data collected during the first phase to create a synthesis of the findings to present to national EPS. A national webinar was planned, but due to technical difficulties was abandoned. Teleconferences were then organised as an alternative for each national site. In this section, the demographics of the participants involved in phase two are given to provide a context for the findings. The findings from the data collected during this phase are then presented.

An analysis of key documents was undertaken for each State, to determine how the services involved in the study had originated, and the current service context. Chapter Three discussed the past and present of these services in detail, and the following is a summary for each State.

1. **Western Australia**—Ngala is the only service of its kind in WA and is unique in being registered as a private hospital rather than a not-for-profit organisation. Ngala originated in 1890 as the ‘House of Mercy’ in Perth and is one of the oldest charitable organisations in the State, with a long history as a nursing organisation until the 1990s when other disciplines were introduced. It has been growing exponentially over the past decade with its interdisciplinary team, and is a well-known brand in WA, providing a range of universal, specialist/intensive and targeted services (Ngala, 2012a).

2. **South Australia**—Torrens House is the only service in SA. It is a government service aligned with other women’s and children’s services. Torrens House was established in 1938 as a mothercraft home and training facility. It is now a community residential unit located in Adelaide and offers a free service to families with infants aged up to 12 months. Families are admitted to Torrens House when requiring additional assistance with unresolved feeding, settling and sleeping issues (Parenting & Child Health, 2012).

3. **Tasmania**—The Mothercraft Home and Training Centre in Hobart was established in 1925 (Brennan, 2007). The Home was decommissioned in the early 1990s and three day stay parenting centres in each region were established as part of the broader universal child health system.
4. **Victoria**—There are three EPS in Victoria, which together provide state-wide services: Tweddle Child and Family Services, The O’Connell Family Centre and the QEC. Tweddle was established in 1920 as a hospital for babies and school of mothercraft and Plunkett nurses. The O’Connell Centre was established in 1931 by the ‘Grey Sisters’ as a training school of social service and mothercraft. The QEC commenced as the Carlton Refuge Home in 1854 and changed to the QEC in 1951. All services now provide residential and day stay facilities, group sessions and information sessions and individual services (Mercy Health, 2012; Queen Elizabeth Centre, 2012; Tweddle Child & Family Health Service, 2012). These services are closely associated with government but stand alone as services in their own right.

5. **New South Wales**—There are two services in NSW, which together provide state-wide services: Tresillian Family Care Centres and Karitane. Tresillian was established in 1921, and trained nurses in mothercraft and infant welfare. Karitane Mothercraft Home opened in 1924 and also provided training for nurses. Both services now provide residential and day stay services and a range of other early parenting community services (Karitane, 2012; Tresillian, 2012). These two services are well aligned with the government service system, although they stand alone in their own right.

6. **Queensland**—The Ellen Barron Family Centre is the only service in QLD. A mothercraft home was set up by government in 1941 at the Lady Lemington Hospital and others were set up throughout QLD during the 1940s to 1960s (McFarlane, 1968). The Ellen Barron Family Centre evolved from the Riverton Parenting Centre and now provides a free 24 hour specialist residential service to Queensland families with children aged from birth to three years who are experiencing parenting issues of a complex nature (Community Child Health Services, 2012). This is part of a broader universal community child health system.

The national setting informs the study demographics, as presented below.
4.3.2 Demographics

The national cohort of nurses working within EPS is given in Table 6. The total group for phase two was 45 (up to five at each of the nine sites), with 38 nurses participating through the national teleconferences.

The Tasmanian South Parenting Centre was excluded from this study because they employ only nurses (n 9) through their centre. Therefore, the total cohort was 438 nurses nationally.

Table 6. National numbers of nurses in EPS (January 2011)

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>WA</td>
<td>52</td>
</tr>
<tr>
<td>NSW</td>
<td>227</td>
</tr>
<tr>
<td>QLD</td>
<td>54</td>
</tr>
<tr>
<td>VIC</td>
<td>81</td>
</tr>
<tr>
<td>SA</td>
<td>16</td>
</tr>
<tr>
<td>Tasmania N/NW</td>
<td>8</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>438</strong></td>
</tr>
</tbody>
</table>

During phase two, a teleconference was held with each of the nine national sites. Prior to the teleconference, the nurses completed a group demographics survey from their site, indicating their age, qualifications, number of years worked within EPS and how long they anticipated to continue working within EPS. Data collected from this survey are displayed in Table 7 below. The 38 nurses participating were all female and the demographics were congruent with the national cohort of nurses within EPS.

Table 7. National teleconference participants

<table>
<thead>
<tr>
<th>No. sites</th>
<th>Participants</th>
<th>Average age</th>
<th>Length of time with EPS</th>
<th>Intention to stay?</th>
<th>Qualifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>38</td>
<td>52</td>
<td>5–20+ yrs</td>
<td>3–20 yrs</td>
<td>RNs (child health nurses) and mothercraft nurses</td>
</tr>
</tbody>
</table>

A presentation of the proposed research via teleconference (see Appendix 12) to the group of nurses at each site was undertaken to give a background of the researcher and the study. The findings from phase one were presented, including the role of the nurse from the 1940s to 1980s, an overview of the current context at Ngala, what had changed for nurses over time, the interdisciplinary team context compared with a
multidisciplinary one, a breakdown of perceptions of the nurse’s role, the perceptions of what is unique to the nurse’s role when working with other disciplines, the overlap in roles, and the proposal of a postgraduate qualified EPP. Ideas for the future were also presented from phase one, and feedback was obtained on what knowledge and skills would be required for an EPP and other workforce considerations.

A second group questionnaire (see Appendix 15) of nine questions was completed during the teleconference. These questions were initially designed for the webinar and comprised specific statements and questions to elicit key information from participants. The group participants were to come to a consensus during the teleconference on all nine questions and then email the results to the researcher following the teleconference.

4.3.3 Findings of Phase Two

The nine questions posed during the teleconference are presented in Table 8, with the percentage of agreement from the total sites.

<table>
<thead>
<tr>
<th>No.</th>
<th>Statement or Question</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Nurses working within EPS over the past 10–15 years have moved from an expert approach to working in partnership with families.</td>
<td>100.0</td>
</tr>
<tr>
<td>2.</td>
<td>Nurses are more open to working collaboratively with other disciplines.</td>
<td>100.0</td>
</tr>
<tr>
<td>3.</td>
<td>Nurses now integrate evidence and reflective practice in their daily work with families.</td>
<td>100.0</td>
</tr>
<tr>
<td>4.</td>
<td>Nurses working in EPS are confident and experienced practitioners.</td>
<td>100.0</td>
</tr>
<tr>
<td>5.</td>
<td>Does this description of the nursing role fit within your context of nursing within EPS?</td>
<td>100.0</td>
</tr>
<tr>
<td>6.</td>
<td>Do you agree with this summation of the uniqueness of the nursing role?</td>
<td>100.0</td>
</tr>
<tr>
<td>7.</td>
<td>Do you agree with the concept of the EPP or practitioner?</td>
<td>78.0</td>
</tr>
<tr>
<td>8.</td>
<td>Have all the knowledge and skills been captured?</td>
<td>100.0</td>
</tr>
<tr>
<td>9.</td>
<td>What other issues and considerations need to be thought about for the future?</td>
<td></td>
</tr>
</tbody>
</table>

The first four survey items were statements or assumptions arising from phase one. These were agreed to by all nurses.

It was commented on by the nurses that nationally all sites have progressed or re-aligned their philosophical approaches in terms of strengths-based practice and working in partnership with families. Nurses were also open to working
collaboratively with other disciplines and supported reflective practice approaches and the commitment to evidence-based practice.

The fourth statement was ‘Nurses working in EPS are confident and experienced practitioners’. Nurses agreed on the whole that most nurses working within EPS are confident and experienced. Although this was a point of discussion, nurses explained it was due to the longevity of current staff within EPS. Many nurses were from the ‘baby boomer generation’ and many had undertaken a combination of hospital-based and tertiary qualifications. Most nurses agreed that it takes approximately two years to become confident with the area of work within EPS. They reinforced the need for mentoring, whereby ‘we need a small number with a skill mix of inexperienced staff, as that is how they best learn and grow working alongside experienced practitioners’.

Some sites in one State had a greater ratio of inexperienced staff and discussed the difficulties of lack of experience in their training. This State produces a two-year graduate certificate from Swinburne University—‘Graduate Certificate of Social Science in Prenatal and Postnatal Family Support’. The staff with this qualification are added to the skill mix in these three EPS. The other difference in this State is that child health nurses must have a midwifery and child health qualification to work in maternal and child health centres. This is different to all other States.

For survey question five, there was agreement by all nurses that the nursing role presented and described in the presentation was reflective of their own site context of nursing.

Question six was also agreed to by nurses at 100 per cent. The only addition by one site was the ability to perform emergency intervention and look after children with complex medical needs. While this was only necessary very occasionally, it was emphasised that this was justification for requiring nurses in the event that it should occur.

A concept that evolved from the first phase was the role of the EPP (see Section 4.2.3.6.4). A description of the concept was presented at each teleconference and nurses were asked for their views in question seven. There was general agreement with this concept (78 per cent). Two out of the nine sites did not agree (22 per cent) with the concept of the EPP (that is, a professional with a baseline degree such as
social work, occupational therapy, speech therapy, psychology, early childhood education undertaking a graduate diploma in early parenting practice).

Generally nurses agreed that it was necessary to find new ways of looking at the workforce. The issues that were in opposition to this concept were statements such as:

- ‘Nurses do this work in EPS’ (TC4);
- ‘Nurses need to work in this field and have a range of qualifications available and upgrade their current qualifications to a Master’s level’ (TC3); and
- ‘It is a specialist field for nursing’ (TC4).

As well as the above, concern was expressed by a few nurses that, over time, there could be a push for lower-level workers in EPS, which would reduce the overall quality of care for families and result in less nursing positions being made available.

In response to question eight, all nurses agreed that the list of knowledge and skills developed from phase one were comprehensive for the EPP role. The following sections outline the findings from the teleconferences as elicited by question nine: What other issues and considerations need to be thought about for the future?

4.3.3.1 Workforce planning

Participants spoke of the need for workforce planning around a number of issues. These centred around the following concepts:

1. Increased availability of professional development and education;
2. The need for a mix of skills, dependent upon the context within EPS;
3. The retention of ageing nurses and the need for a mentorship program;
4. Changes in technology; and
5. The need to promote and increase research in the area of EPS.

These concepts for workforce planning are presented in Figure 90 and discussed in greater detail below.
4.3.3.1.1 Increase availability of professional education for the EPS sector

Overall, nurses thought there was not enough education in relation to further skill development for communication and family partnership processes, reflective practice and working with challenging behaviours. An increased focus on early interprofessional cross-training in degrees for disciplines was identified as necessary to ensure less mono-discipline focus.

4.3.3.1.2 Skill mix

The ratio of the nursing workforce was considered to depend on the context in EPS. Nurses gave examples such as:

- Residential facilities may have a higher ratio of nurses because of the 24 hr care required compared to that of the requirements of a parent education team.
- When establishing breastfeeding and in addressing parenting issues, complex medical issues come from paediatrics (for example, naso-gastric feeds), and it is necessary to teach families to care for the child in the community (for example, the transfer of families into the unit for parent education). As such, a different skill mix is required.
- Although not common, antenatal mothers sometimes require transfer for methadone assessment and parenting education.
Nurses encouraged the establishment of graduate programs and an allocation of new positions each year ‘to ensure we get in early in a nurse’s career and enable security of positions rather than casual’ (TC2).

The addition of a postgraduate certificate for enrolled nurses would add to a tiered system: ‘The history and training of mothercraft nurses throughout EPS has been a good idea—the future addition to the workforce of enrolled nurses with an additional certificate in early parenting would be a welcome resource’ (TC7).

4.3.3.1.3 Staff retention and Mentorship

Nurses encouraged the establishment of a sustainable mentorship system and the development of an innovation fund for scholarships and other strategies to attract and retain nurses:

At present there is still too much difference in approaches and philosophies but would be helpful to unite and build influence nationally. There is a need for mentorship and experienced nurses imparting to new graduates. Graduate positions and scholarships would assist in recruitment and retention. (TC1)

4.3.3.1.4 Technology

Some of the discussions emphasised that a ‘Move towards technology-based parenting services as the level of change … requires an investment in this area. Many older staff are already finding this often quite difficult. Blogging, Twitter, Facebook, Apps etc.’ (TC1), and it was deemed important to ‘Make sure resources out there are reputable and informed by evidence’ (TC2). Skill development for the workforce and the understanding of technology needs to be factored into future service planning:

Moving client records and nursing documentation from paper-based systems to use of technology-based systems. Many current staff find it difficult to keep up with the change in technology, even basic computer skills. (TC5)
4.3.3.2 Promotion of EPS work and increase research

Nurses also recommended promoting the profile of nursing within and external to EPS as potentially beneficial to a number of stakeholders. In addition, they suggested a greater focus on research in EPS: ‘the narrative of the history of the nursing profession and showcase our speciality in EPS as an ongoing thing for the future’ (TC5).

4.3.4 Summary of Phase Two

Phase two built on the findings from phase one by using a summary of the phase one findings to elicit level of agreement and further input from a national cohort of nurses working in EPS. The nine site teleconferences resulted in rich data from each group of nurses.

In this section, the demographics of the national participants were outlined, as were the findings from the data analysis from the teleconferences. The questionnaire used had nine questions for each group, which on the whole validated the work in phase one. The feedback from the nurses participating in phase two was consistent with that gathered through phase one.

The findings from this phase were synthesised to inform the development of the questionnaire for implementation in phase three.
4.4 Phase Three: National Findings

4.4.1 Introduction

The findings from phases one and two were used to develop the third phase. It was decided to have three major components of focus in the questionnaire: the demographics, the current context of nursing and future directions for the next 3–5 and 5–10 years.

The ‘current situation’ section needed to validate assumptions and agreement from previous phases. It thus included statements of:

1. whether it was essential for nurses working within EPS to be experienced;
2. whether nurses maintain a unique role within an interdisciplinary context; and
3. whether there were concerns for nursing nationally.

The third component of future directions considered statements related to:

1. national professional development;
2. the development and availability of innovative options for post-qualification education;
3. further research;
4. a workforce development strategy;
5. skill mix considerations for the various practice contexts;
6. marketing, recruitment and sustainable strategies for a multi-generational workforce; and
7. retention strategies for the ageing workforce.

The first part of this section presents the demographics of the phase three participants to give context to the findings from the data analysis.

4.4.2 Demographics

The survey was distributed nationally. Participating States included WA, SA, Queensland, NSW, Tasmania (North and Northwest) and Victoria. Reminders were sent regularly over the six-week period during which the survey was open, and the response rate was 37 per cent. See Figure 91 and Table 9 for a breakdown of the individual State response rates.
A total of 447 nurses work within EPS in Australia. Given the exclusion of the Tasmanian South Parenting Centre (n 9) and the 13 nurses involved in the pilot test of the questionnaire, the total number that could participate in the survey were 425. The response rate was 37 per cent.

Table 9. Response rate to the survey by State

<table>
<thead>
<tr>
<th>States</th>
<th>Total number of nurses</th>
<th>Number responding to survey</th>
<th>% response rate by State</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td>227</td>
<td>53</td>
<td>23.5</td>
</tr>
<tr>
<td>VIC</td>
<td>81</td>
<td>40</td>
<td>49.5</td>
</tr>
<tr>
<td>WA</td>
<td>52</td>
<td>36</td>
<td>69</td>
</tr>
<tr>
<td>QLD</td>
<td>54</td>
<td>15</td>
<td>28</td>
</tr>
<tr>
<td>SA</td>
<td>16</td>
<td>9</td>
<td>56</td>
</tr>
<tr>
<td>N/NW TAS</td>
<td>8</td>
<td>4</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td><strong>425</strong></td>
<td><strong>157</strong></td>
<td></td>
</tr>
</tbody>
</table>

For the first six questions there was a 100 per cent response rate (that is, responses from all 157 nurses). The response rate to question seven onwards was less than 100 per cent, and respondent numbers will be indicated with each question.

Tasmanian nurses in the Southern Parenting Centre were surveyed separately because they do not employ allied professionals. This was to ascertain whether their perceptions of the current and future of nursing differed from the main body of respondents. Thirty-three per cent (n 3) responded and their responses were similar to the larger survey. Their age range was between 40 and 64 years and they were qualified as child health nurses. Two out of three respondents stated they worked closely with other disciplines; that is, they worked in a multidisciplinary context and
refer, liaise or consult with other professionals for a variety of reasons during their daily work (Moon, 2012).

4.4.2.1 Age of nurses participating nationally

The ages of 69 per cent of respondents were between 50 and 70 years. The breakdown into age categories is given in Table 10 and Figure 92.

### Table 10. Age of respondents

<table>
<thead>
<tr>
<th>Age categories national sites</th>
<th>Number of respondents</th>
<th>Percentage (%) respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>20–29 yrs</td>
<td>3</td>
<td>2.0</td>
</tr>
<tr>
<td>30–39 yrs</td>
<td>11</td>
<td>7.0</td>
</tr>
<tr>
<td>40–49 yrs</td>
<td>35</td>
<td>22.3</td>
</tr>
<tr>
<td>50–59 yrs</td>
<td>82</td>
<td>52.2</td>
</tr>
<tr>
<td>60–64 yrs</td>
<td>22</td>
<td>14.0</td>
</tr>
<tr>
<td>65–70 yrs</td>
<td>4</td>
<td>2.5</td>
</tr>
<tr>
<td>70+</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>157</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

As shown in the table above, the largest cohort of nurses were in the 50–59 age group, followed by the 40–49 age group. The 60–70 age group was at 16.5 per cent.

**Figure 92. Response to ‘Please indicate your age category’**

4.4.2.2 Longevity of work in EPS

Nurses were asked how long they had worked within the EPS context. Figure 93 and Table 11 highlight that 85 per cent of the nurse respondents were very experienced in EPS, having greater than five years’ experience. Sixty-five per cent had worked in EPS for more than 10 years, indicating a considerable knowledge base in early parenting. Currently, EPS is seen as a specialist area of work by the nursing
profession. The workforce’s longevity of involvement in the same area of work is consistent with current workforce figures, being primarily comprised of generation X and baby boomer generation workers (that is, 40–70 years old). This may have implications for future workforce considerations.

![Figure 93. Response to ‘Longevity of work within EPS’](image)

### Table 11. Longevity of work within EPS

<table>
<thead>
<tr>
<th>Longevity of work in EPS (years)</th>
<th>Number of respondents</th>
<th>Percentage (%) respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–4</td>
<td>23</td>
<td>15.0</td>
</tr>
<tr>
<td>5–9</td>
<td>31</td>
<td>20.0</td>
</tr>
<tr>
<td>10–14</td>
<td>32</td>
<td>20.0</td>
</tr>
<tr>
<td>15–19</td>
<td>25</td>
<td>16.0</td>
</tr>
<tr>
<td>20+</td>
<td>46</td>
<td>29.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>157</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

### 4.4.2.3 Nurses’ indication of how long they will continue to work within EPS

Nurses were asked to state how long they expected to work within EPS. The results are indicated in Figure 94 and Table 12. Fifty-six per cent of participants will be leaving in the next nine years (n 88). This finding was not surprising, as 50 per cent of nurses in a national study indicated that ‘half are set to leave the profession in the next decade’ (Nursing Review Online, 2012). In the next 14 years, 77 per cent of the nursing workforce will be leaving EPS.
Figures 94. Response to ‘Nurses indicating continuation of work within EPS’

Table 12. Nurses indicating continuation of work within EPS

<table>
<thead>
<tr>
<th>Continuation of work within EPS (Years)</th>
<th>Number of respondents</th>
<th>Percentage (%) respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–4</td>
<td>37</td>
<td>23.5</td>
</tr>
<tr>
<td>5–9</td>
<td>51</td>
<td>32.5</td>
</tr>
<tr>
<td>10–14</td>
<td>33</td>
<td>21.0</td>
</tr>
<tr>
<td>15–19</td>
<td>18</td>
<td>11.5</td>
</tr>
<tr>
<td>20+</td>
<td>18</td>
<td>11.5</td>
</tr>
<tr>
<td>Total</td>
<td>157</td>
<td>100.0</td>
</tr>
</tbody>
</table>

4.4.2.4 Qualifications

Nurses were asked to provide their qualifications. Out of 157 nurses, there were 118 registered nurses, 42 per cent had a Bachelor degree, and of these 38 per cent had a Master’s degree.

Of the total number of RNs, 89 per cent were child health nurses (n 106) and a large percentage of RNs had undertaken midwifery (n 96). There were also five mental health nurse respondents. Sixteen per cent of respondents were mothercraft nurses (n 25) (see Figure 95).
Given the age of the participants, almost half of the registered nurses had been through the hospital-based training certificates and then possibly undertaken tertiary qualifications. Fifty-eight per cent of the respondents had not undertaken a degree following their hospital-based training. This dimension of the skill mix will not exist 10 years from now once the baby boomer generation have left the workforce. ‘Other’ qualifications listed were predominantly certificates in lactation consultancy and paediatrics.

4.4.2.5 Nurses working with other disciplines

Nurses were asked whether they worked closely with other disciplines. Prior to the survey, it had already been ascertained that all sites in Australia employed allied professionals in varying numbers, with the exception of the Southern Parenting Centre in Tasmania. All sites had a commitment to strengths-based, solution-focused work and family partnership or C-Frame philosophies. As represented in Figure 96, 91 per cent of nurses within EPS work closely with other disciplines.
Figure 96. Response to ‘Working closely with other disciplines at your site’

The nurses that did not report working closely with other disciplines were in management roles, casual positions or in other roles such as night shift or education, in which they saw themselves working independently of other disciplines.

The researcher wanted to understand the depth of work that nurses undertook with allied professionals; that is, whether they:

- worked closely on a daily basis with allied professionals, as well as experiencing reflective practice in teams;
- worked with allied professionals regularly but did not undertake reflection in teams; or
- referred only to allied professionals.

Out of those nurses that indicated they worked closely with other disciplines:

- 67 per cent did so on a daily basis;
- 22 per cent did so regularly, but with no reflection in teams; and
- 11 per cent referred only (see Figure 97).
Figure 97. Response to ‘indicate how you work with allied professionals’

Overall, the demographic data revealed that there were similar characteristics throughout national EPS. The discussion below will present the findings obtained from phase three of the study, which are divided into two aspects: the current situation of nursing with EPS, and the future.

4.4.3 Findings of Phase Three

4.4.3.1 The current situation

In this section of the survey, nurses were asked about the current situation of nursing within EPS. Certain issues were discussed by a percentage of respondents from phases one and two, and it was thought important to include these in the national survey to gain clarification and follow up. The three elements requiring a national perspective are highlighted in Table 13. These questions were responded to by 152 nurses.

Table 13. Three issues on which a national perspective was sought

<table>
<thead>
<tr>
<th>No.</th>
<th>Statement</th>
<th>Number of respondents</th>
<th>Percentage agree/strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>It is essential that nurses working within EPS are experienced</td>
<td>123</td>
<td>81</td>
</tr>
<tr>
<td>2.</td>
<td>Nurses maintain a unique role when working within a collaborative partnership model with other disciplines</td>
<td>136</td>
<td>89</td>
</tr>
<tr>
<td>3.</td>
<td>There are concerns nationally for the future of nursing in EPS</td>
<td>102</td>
<td>67</td>
</tr>
</tbody>
</table>

Each of the three above statements will now be explored in more detail.
4.4.3.1.1 Agreement that nurses working within EPS should be experienced

As noted during the phase two data analysis, there was discussion about the experience level of nurses working within EPS. As seen in Section 4.4.2.3, a large percentage of nurses within EPS are very experienced due to their age and length of time working within EPS. Respondents agreed or strongly agreed at a rate of 81 per cent (n 123) that it is essential that nurses working within EPS are experienced. Figure 98 below gives the response breakdown.

![Graph showing response breakdown](image)

**Figure 98. Response to ‘It is essential that nurses working in EPS are experienced’**

The qualitative responses elicited by this statement (n 60) fell into three categories. In order of priority, these were:

- The skill mix should reflect more experienced numbers of staff;
- Mentoring systems need to be in place for inexperienced staff; and
- Personal attributes are as important as experience (see Figure 99).
Nurses expressed the need for nurses with experience to be in the majority due to the complex nature of clients:

The skill mix needs to have the majority of experienced nurses and smaller numbers of new grads or inexperienced.

Nurses have to have experience as the issues are so complex for a beginning practitioner.

However, it was noted that experienced nurses can then mentor less experienced nurses. The following are quotations from the nurses describing these themes:

I feel good support in the workplace from more experienced colleagues will encourage this experience.

This would depend on the how ‘experienced’ is defined—having years working in an area may not mean a person’s practice or skills have evolved. Knowledge may be mediated by skills and personal attributes.

Overall, 19 per cent of nurses felt ambivalent or disagreed strongly that it is essential that nurses working within EPS are experienced. The negative responses referred to the current situation not requiring nurses to be experienced in the area.
It was also evident that some viewed ‘experience’ in itself as not as important as how one works in partnership and whether leadership skills are evident:

Yes working with vulnerable families so the skill mix has to be majority experienced.

I think personal attributes are as important as experienced … Experience can mean inflexible …

This disagreement also related to the fact that some nurses felt the workforce needed a different skill mix to encourage younger staff and to focus on attributes or best fit for the job:

I think the nurses and allied health need to have a good sound knowledge base for all the areas of both clinical and professional domains regarding best practice when working with families and young children. However when employing staff, I would rather recruit staff with the knowledge and evident helpful interpersonal skills and qualities and no experience in the field over someone who had good experience but could not demonstrate the qualities of humility, genuineness, honesty, respect, some positiveness or enthusiasm.

The next section discusses the responses from nurses about the uniqueness of the nursing role within an interdisciplinary team context.

4.4.3.1.2 Agreement that nurses should maintain a unique role

Nurse respondents who agreed/strongly agreed to this statement were 89 per cent (n 136). As discussed in phase two, this concept of ‘uniqueness’ was raised during the first phase and then again in phase two. This came about as a result of nurses and allied professionals discussing their perceptions of the nursing role, and noting the overlap between disciplines. They were then asked what was unique to the nursing role and a description was developed and agreed to by nurses in phase two. The following graph in Figure 100 depicts the response breakdown to this statement.
The qualitative responses to this statement (n 42) engendered rich data. The key categories arising were:

- The importance of collaboration with other disciplines;
- The specific knowledge base of nurses is child health, development and parenting;
- Nurses have a strong health perspective; and
- Linking role;
- Nurses take a holistic view;
- Nurses have a strong coordination role;
- Nurses are trusted in their role;
- Nurses’ perception of value by others.

These categories are presented visually in Figure 101, and will be described in order of priority.
Figure 101. Qualitative responses to ‘nurses maintain a unique role within EPS’

1. **Collaboration with other disciplines was seen as important to the nurses.**

In regards to collaboration with other disciplines, nurses reinforced that ‘early parenting crosses a broad section of concerns and no single discipline can possibly offer the range of support that a group of disciplines can’. They also stated that ‘nurses need to realise where their expertise ends and where other allied health professionals can support the families in partnership’.

Emphasis was placed on the holistic nature of what can be achieved ‘together’ rather than separately. One nurse stated ‘It provides an opportunity to provide more holistic care and support for parents if multidisciplinary teams can work together harmoniously and respectfully of each other’s profession’. The reason that teams collaborate is to achieve the goals of the family in partnership. ‘Nurses need to see that we are all working to the same goal the welfare of the parents and children. Our communication needs to reflect that open partnership model’.

2. **The specific knowledge base of nurses is child health, development and parenting.**

The views of nurses on their specific knowledge base were that ‘Nurses bring specific professional knowledge of child health, development & parenting to working with families’, and ‘generally CHNs have a rounded training and have a holistic
approach to care which complements their knowledge in maternal health and child development’.

They have a:

broad knowledge on child, family and community health and wellbeing [that] enables them to make skilled assessment and implement comprehensive plan of care.

One nurse stated that:

all disciplines bring different strengths and knowledge. Nurses maintain strong child health knowledge.

3. *Nurses have a strong health perspective.*

On the topic of nurses’ strong health perspective, comments included that ‘Nurses come from a background of understanding health and ill health and recognise the body’s physical reactions related to the above’, and ‘nurses have a more holistic approach as they cross the dimensions from child health to psychosocial issues, health promotion and illness prevention and intervention’.

Other statements included:

Nurses can look at many aspects prevention, promotion, times of illness and health.

Nurses with the background in illness can be more aware of possible underlying medical issues that in the young will impact on their ability to settle, eat and behave etc.

4. *An emphasis on nurses having a linking role.*

Statements from nurses reflected their linking role: ‘nurses in my experience are often the “lynnch pin” between all services’, and ‘nurses are the link for the parent and the child with the allied professionals’.

5. *Nurses take a holistic view.*

The following quotation typifies the nurses’ responses on their holistic view:
I think that nurses tend to hold the broader overview of the child and family understanding their physical, mental, emotional health while understanding nutrition, development, relationships etc. Nurses tend to see the whole picture from a wide perspective—I believe that the other practitioners, while specialists in their own areas, have a narrower view.

6. *Nurses have a strong coordination role.*

Nurses have had a long history of coordination being a strong component of their role. Statements reflecting this were:

… and they are the main coordinators between services …

Nurses are at the forefront of clinical services and awareness of the day-to-day running of a ward/unit which places them in a unique position to work in consultation and collaboratively with other disciplines, especially considering their training and experience.

This has often come about due to the nature of nurses providing round-the-clock services. As one nurse stated:

Agree with what has been noted re the nursing role with its broad knowledge base and professional identity. Also it’s nurses who do the majority of continuing of practice of care with the families.

Another nurse stated:

Usually able to bring their experiences with their clients often over a larger number of contact hours.

7. *Nurses are trusted in their role*

Nurses felt they were trusted:

Nurses are perhaps the only discipline that works so closely with families on a day-to-day basis, are trusted and allowed into a family’s life on such a personal level.
8. Nurses’ perception of value by others

The question of value by others was not evident within the first two phases of the study. The researcher did not observe nurses to feel a low level of value or worth by other disciplines. Concern had been expressed by nurses on actual and potential funding cuts to services and the need to profile the work of EPS, but not in terms of being less valued by other disciplines.

Below are quotations from nurses from this phase, reflecting this perception of value. There was a contradiction, as some nurses felt valued by others while some did not:

Nursing input at our meetings is unique and highly regarded as important.

… although we do not always feel equal

This can be true, however I feel that the nurses role is sometimes diminished by other disciplines. Everyone has taken a slice from the nurse’s pie and there seems to be not much left for EPS nurses to do.

It is possible that nurses have not been able to articulate what nurses bring to the interdisciplinary context, as reflected in the following statement:

Although nurses have a great deal to offer within a multidisciplinary partnership other disciplines are not yet recognising or acknowledging the level of nursing expertise and skills that nurses provide. There is very little professional courtesy from other disciplines often requiring nurses to prove their professional value.

Eleven per cent of nurses disagreed that nurses maintain a unique role when working within a collaborative partnership model with other disciplines. It was not clear whether they had read the background paper for the study prior to completing the survey. Some of the comments reflected positive statements and some may have misunderstood the word ‘unique’. Below are examples of this:

They may have a unique perspective however I am not certain their role is any more unique than any of the other disciplines.
I am not sure what you mean by unique. I did read the document attached to the email. I think the idea of uniqueness actually is a barrier to collaborative work, that everyone in a team brings with them, from their experiences in their role/s and their formal training a sense of meaning from their interactions and understanding of the families story, and together these views help to get a sense of a clear picture of what is happening for a family and the what possibly is the best way forward. I am not sure if suggesting that nurses are unique is trying to imply that allied health don’t work in a collaborative partnership model? From my experiences that is not how they see it. However what is evident is that not everyone regardless of the discipline has the same construct of what collaborative practice and working in partnership actually looks like in practice, it seems to me that there is still a lot of nice experts from all disciplines, which makes genuine and effective team collaboration difficult.

The following is the last statement under the section of ‘the current situation’. It looks at nurses’ perceptions of and concerns for the future.

4.4.3.1.3 Agreement that there are concerns nationally for the future of nursing in EPS

During the first two phases, concerns were raised about the future of EPS. It was deemed important to determine whether such concerns were evident through the national survey and whether there were any additional concerns that had not been raised in the earlier phases.

Although a majority of respondents (67 per cent) agreed with the statement that there are concerns for nursing, a further 23 per cent were ambivalent and neither agreed/disagreed that there were concerns. The following graph in Figure 102 depicts the responses to this statement.
Figure 102. Responses to ‘There are concerns nationally for the future of nursing in EPS’

The qualitative responses will be presented for those who agreed and those who expressed ambivalence. A number of categories of concerns were highlighted and these are presented visually in Figure 103. A description of these responses (n 55) in order of priority follows.

Figure 103. Qualitative responses to ‘there are concerns nationally for the future of nursing’

1. **Budget constraints within EPS**

Funding issues have been highlighted throughout the feedback from nurses. Statements such as ‘with emphasis on budget control it is easy for preventive health..."
initiatives to be undervalued and be in fact the first to go’ and ‘I think they are trying to bring in untrained people to cut costs’ reflect this.

One nurse reflected that:

In an era of reduction in health services funding, family services and child and family nursing services are commonly subject to funding cuts in my experience of working. … for many years. The people in many cases, families in need, generally don’t have the energy or funds to lobby for continuation of services.

2. Promotion of EPS work

This was another area raised consistently throughout the study which nurses felt there was a need to be more active in profiling the work done in the early parenting sector. One nurse stated that:

Nurses are not proactive enough in articulating what they do and the importance of their work within EPS.

Another stated that:

Families accessing EPS today not only need experienced and knowledgeable practitioners in many disciplines but also those practitioners who are able to nurture them during times of challenges in their parenting role. Nurses are needed for all of their skills in EPS.

Other nurses raised the importance of ‘an increased focus on prevention/early intervention’.

3. Workforce

Three points came out under workforce: an ageing workforce and retention of nurses, the need to increase the enrolled nurse workforce and the need to increase interdisciplinary approaches. These are discussed in turn below.

An ageing workforce and retention of these nurses

Nurses expressed their concerns that ‘the ageing, experienced work force [that] will be leaving the profession over the next 5 to 10 years, will leave a significant gap in
the workforce with seemingly less people being trained in the area of child and maternal health’ and ‘how will we retain these nurses and attract new staff?’

**Need to increase the enrolled nurse workforce**

The concern about increasing the enrolled nurse workforce was a feature through all phases of the study. One nurse stated:

> There will always be a need for registered nurses in EPS, however as there is no longer training for mothercraft nurses, and they were a valuable resource, there is a need for other staff—currently we have early childcare workers with a certificate in pre- and post-family support.

**Increased interdisciplinary approaches**

A statement by one nurse emphasised the importance of moving to interdisciplinary approaches: ‘If not seeking to learn from other discipline approaches and skills, nurses can be left behind still expecting to “fix” problems’.

**4. Increasing role clarity**

The theme of increasing role clarity presented some ideas for the future. Some nurses felt that their discipline should have control over early parenting work: ‘part of EPS must be assessment of health and development of parents and children, therefore nurses must be head of the team’.

The following two statements reflect a shift towards thinking differently:

> I think that parenting support/education is vital, whether I believe categorically that it has to be a nurse to do the role I am not sure. I think that RNs bring with them leadership skills, physical assessment skills, dealing with conflict, facing emergency situations that are very valuable. The role of the nurse also engenders with the parents a sense of trust.

> There are possibly other ways to manage this e.g. have a nurse available to clarify some of the child health development concerns, and other (trained) parenting staff could do the close work with
parents regarding a behaviour management issue. However, I do think those RN experiences (not just training from working in a hospital) do add to the role and quality of service for parents.

Nurses felt that much more attention needed to be given to documenting the work of early parenting:

The early parenting services are hard to quantify and therefore data is difficult to interpret and issues such as number of clients seen per day and caseloads can be difficult to define.

Nurses also mentioned the complex nature of the work, the need to critically evaluate what we do and the shift to specialisation:

The complex nature of the work tends to make each case unique requiring a different combination of support

there is also a need to shift from an historical way of doing things and all nursing practices should be examined and questioned on a regular basis.

I think staff are concerned the positions may become more specialised.

5. Erosion of the nursing role

This category reflects similar statements to those above whereby nurses felt undervalued:

Yes Nurses have commonly been replaced with the ‘expert’ in the field and historically have given away to other disciplines who are discipline specific. Nurses have the ability to capture a holistic view which contributes to a balance. However often professional knowledge is not valued.

This is an interesting perspective and not one conducive to collaborative teamwork and how the overall team contributes to the total client experience. Another nurse commented that:
This is true because our role has been changed, eroded and diminished. More and more of our work has been given away to other services.

6. Increase outcome-focus for families

Nurses reinforced the limited amount of research that is focused on how EPS are meeting the needs of families: ‘We need more research that is outcome-based’.

Sometimes, workplaces focus on professional issues instead of on the reason that practitioners do early parenting work. This was reinforced by one nurse:

We need to remember why we do the work we do … outcomes for families and their children. … let’s put aside professional/industrial issues.

7. The consumer voice is silent

This category reflects nurses’ concern that consumers in EPS are not having their voices heard. Nurses stated that:

Women and children are not often seen or heard of in the first few years of parenting and therefore do not have political imperative.

Women are expected to just get on with it and we presume they have support and childcare is natural and easy and enjoyable—it is not always experienced as such and poor parenting leads to more social disharmony than is reported and mental health issues for both parents and children.

Comments in response to the question about whether there were concerns nationally for the future of nursing that differed from the above responses included:

I thought this would be a growing area given the evidence base of brain development and attachment so I am unaware of this concern in NSW.

Are there?

Nurses are underprepared for the future.
The following section now presents the second group of findings from phase three—those related to the future of nursing within EPS.

4.4.3.2 The future

This survey also asked nurses about the future of nursing within EPS. This was done in three ways. A list of eight statements (see Table 14) was provided to which respondents had to agree or disagree. They were asked about the priorities in EPS for the next 3–5 and 5–10 years, and a set of open-ended questions elicited any further strategies or comments from the responding nurses.

The following eight questions were asked in the survey (see Table 14 and Appendix 15). These were designed based on the findings from phases one and two. Participants were asked to agree or disagree on a Likert scale, from ‘strongly disagree’ to ‘strongly agree’.

Table 14 summarises the rate of positive response to the eight statements. A strong positive response was given by nurses to each of these statements. Interestingly the highest agreement (94 per cent) was for the development of a workforce strategy that would include all the other factors.

Table 14. Rate of positive response about the future of nursing in EPS

<table>
<thead>
<tr>
<th>No.</th>
<th>Statement</th>
<th>Percentage agree/strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Increase the development and availability of innovative options for post-qualification education in the early parenting sector.</td>
<td>88</td>
</tr>
<tr>
<td>2.</td>
<td>There is a need for innovative national professional development opportunities.</td>
<td>90</td>
</tr>
<tr>
<td>3.</td>
<td>Identify further research areas relevant to the EPS workforce.</td>
<td>90</td>
</tr>
<tr>
<td>4.</td>
<td>To plan for the next 5–10 years there is a need for a workforce development strategy in EPS.</td>
<td>94</td>
</tr>
<tr>
<td>5.</td>
<td>Identify the skill mix for the various practice contexts of EPS.</td>
<td>92</td>
</tr>
<tr>
<td>6.</td>
<td>Develop marketing and recruitment strategies for a future multi-generational workforce.</td>
<td>83</td>
</tr>
<tr>
<td>7.</td>
<td>Consider sustainable strategies to support a future multi-generational workforce.</td>
<td>92</td>
</tr>
<tr>
<td>8.</td>
<td>Develop retention strategies for the ageing workforce in EPS.</td>
<td>87</td>
</tr>
</tbody>
</table>
4.4.3.2.1 Agreement to increase the development and availability of innovative options for post-qualification education in the EPS sector

This statement was developed due to the suggestions from the first two phases regarding the postgraduate EPP and a certificate on early parenting for the enrolled nurse. Figure 104 shows that a large number of nurses (88 per cent) agreed with this statement. In total, 147 nurses responded to this question.

Figure 104. Responses to ‘Increase the development and availability of innovative options for post-qualification education in the early parenting sector’

The categories of the qualitative responses to this statement (n 28) are presented visually in Figure 105 below. They are then described in order of priority.
Overall, as stated by one nurse, there was:

Strong support for a national approach to developing qualifications in early parenting for people of varied disciplines who work with parents.

Others stated that:

A multidisciplinary course is a good idea—this would make different disciplines to cross pollinate yet maintain their own integrity. Also builds team rapport and respect.

This will enable the development of a relevant workforce for the future.

Other statements varied from general comments to specific ideas for inclusion (including cost accessibility for courses) such as:

Options like family counselling, child development and child protection.

Access, motivation and creation of specific interesting post grad courses in EPS.

It would be nice if it was not all user pays too!
We can’t lower the level of overall qualifications for this complex work due to the cost cutting concerns—skill mix is important.

1. *Currently there are many options for registered nurses but not for ENs. Need more post-qualification options for them.* *Increase the profile of EPS nursing*

The need to increase the profile of nursing was a common thread throughout the study. As one nurse commented: ‘we need to increase the profile of the work that currently occurs within EPS, and take from it the strengths into the future’.

2. *The need for innovation and flexibility*

Below are examples of nurses’ views on the need for innovation and flexibility:

   - Yes need to provide interdisciplinary education in the early parenting area and be innovative.

   - Flexibility of model of delivery/online access.

   - Innovative is the key word—helping people to integrate evidence-based knowledge is essential and doesn’t always occur.

3. *Creative recruitment and human resources practices*

Nurses commented on creative recruitment and human resources practices in the following ways:

   - We need to think creatively of ways to attract nurses and allied disciplines to EPS—I think like the Magnet hospitals approach.

   - We need to start forward planning as intellectual property will disappear with the future retiring population; therefore we need to create new opportunities for sharing knowledge and offering alternatives to up-skilling etc.

   - Need to creatively attract more staff and maintain standards currently operating.

The following section explains why nurses considered professional development opportunities as important.
4.4.3.2.2 Agreement for the need for innovative national professional development opportunities

Due to the small numbers of staff within EPS nationally (compared to all nurses), it was felt that there could be opportunity for innovation, particularly with the advances of new technologies and initiatives.

It was mentioned by nurses that interprofessional education is developing momentum through universities and has potential for innovation in early parenting.

Figure 106 demonstrates the large number of nurses (90 per cent) that agreed with the statement that there was a need for innovative national professional development opportunities. In total, 147 nurses responded to this question.

Figure 106. Responses to ‘the need for innovative national professional development opportunities’

The qualitative responses to this statement (n 28) are presented by category visually in Figure 107 and then described in order of priority.
Figure 107. Qualitative responses to ‘the need for national professional development opportunities

1. Increase options available for professional development

Nurses supported increased options available for professional development:

   It would be great to see national PD [professional development] for Early Parenting Centre staff to exchange ideas between centres to enhance the outcomes for families.

   The problem is often being able to access this education, due to cost and time off work.

2. Develop and maintain national standards

Below is an example of nurses’ thoughts around national standards and professional development as a means of achieving consistency of nursing practice:

   Providing national professional development will assist in establishing national standards of care required for working in the area of EPS.
3. **Increase interprofessional learning opportunities**

Below is an example of nurses’ willingness to increase their focus on interprofessional learning:

> These need to continue to extend and integrate the perspectives and knowledge of nursing with those from other perspectives.

4. **Increase leadership in the EPS sector**

Nurses felt that, to be able to achieve many of the new initiatives needed to plan ahead, there needs to be more leadership at all levels. In this way, a dynamic early parenting workforce into the future can be achieved. The following are comments around motivation, training and competencies, and supervision:

> To increase and motivate staff to continually improve their skill base.

> Not just innovation. But the shift to AHPRA [Australian Health Practitioner Regulation Agency] has left us confused about what sort of PD is necessary. AHPRA seems unclear about what level of training, skill or competency is required from someone working in this field.

> Supervision is the area that requires more attention and leadership education.

This study was initiated because there had not been any focus to-date on the EPS workforce. It was seen as important to include a statement on further research for future directions of the EPS workforce.

4.4.3.2.3 **Agreement for the need to identify further research areas relevant to the EPS workforce**

Figure 108 shows that a large number of nurses (90 per cent) agreed with the statement that there is a need to identify further research areas relevant to the EPS workforce. A total of 145 nurses responded to this question.
Figure 108. Responses to ‘the need to identify further research areas relevant to the EPS workforce’

The qualitative responses (n 29) to this statement were divided into two categories, visually represented in Figure 109 and described below.

Figure 109. Qualitative responses to ‘the need to identify further research areas relevant to EPS workforce’

1. Developing a research culture

Developing a research culture was seen by nurses as a crucial starting point to increased leadership in this area. One nurse stated:
This could also have a national focus and is a helpful way to increase the level of awareness of evidence/implementing evidence across the workforce.

Another nurse said that:

Encouraging a research culture is essential—just doesn’t happen enough and part of the reason we are not well acknowledged.

The research culture was seen to enhance the overall commitment to practice development based on the best possible evidence in this area of work. One nurse stated:

... maybe we should be focusing on increasing research literacy amongst the nurses so they can incorporate evaluation into their everyday work in the form of quality activities, identification and use of existing data under the name of quality improvement and evaluation rather than research.

Others gave more specific ideas such as:

This could also have a national focus and is a helpful way to increase the level of awareness of evidence/implementing evidence across the workforce, for example perinatal and infant mental health and early brain development. We need to stay relevant for best practice for working with families. There appears to be very little research on the effectiveness of EPS work and interdisciplinary approaches.

Follow-on work from this study. More research on interdisciplinary approaches to working with parents with young children.

2. Focus on client outcomes

The importance of a focus on client outcomes was reinforced by some nurses as crucial to our work and knowing what kind of difference the staff in EPS are making. Below are examples of this:

How best to support working with vulnerable families?
Does a nurturing environment impact on and increase positive outcomes for families accessing EPS?

There needs to be further research into all areas supported by EPS, especially on what inspires change in behaviour and outcomes for clients.

As stated previously, the statement discussed in the following section, on the need for a workforce development strategy in order to plan for the next 5–10 years, is the umbrella statement for all other statements posed to respondents about the future of nursing in EPS.

4.4.3.2.4 Agreement that in order to plan for the next 5–10 years, there is a need for a workforce development strategy in EPS

Figure 110 demonstrates that a large number of nurses (94 per cent) agreed with this statement. In total, 145 nurses responded to this question.

![Figure 110](image)

**Figure 110. Responses to ‘in order to plan for the next 5–10 years there is a need for a workforce development strategy in EPS’**

The qualitative responses (n 31) for this statement are presented as categories visually in Figure 111 and are described below. This quotation summarises the responses:
Speaks for itself—our problem is we’ve never had such a strategy—no strategic thinking or vision.

Figure 111. Qualitative responses to ‘the need to develop a workforce development strategy’

The two categories of retention and recruitment issues and the future requirements of early parenting practice were noted as important under a workforce development strategy.

1. Recruitment and retention issues

Comments from nurses on recruitment and retention issues included:

- There is a need for mentorship and experienced nurses imparting to new graduates.
- Identify what skills elements are needed to work in strengths-based practice.
- The need to increase professional development and training requirements.

2. The future requirements of early parenting practice

The issue of future requirements of early parenting practice generated a range of comments that included discussion about raising the profile of EPS work, developing
national standards for consistency and the need to focus on client outcomes. Below are examples of this:

At present there is still too much difference in approaches and philosophies but would be helpful to unite and build influence nationally.

Increase the profile and the professionalism of the EPS. Advertise to the community the work we are doing. Advertise to the government the prevention strategies that EPS brings into the community. That we are in the field of core prevention and education of the community into the future.

Investigate what knowledge, experience and skills are needed for those in other disciplines to become an EPP.

To evaluate our options and to see where our future lies as EPS nurses. If there is a future at all?

The need for a residential style of intervention needs review as there are many cost effective and effective interventions based in the home that offer families support before they reach the stage of needing EPC, see USA models.

The next statement to be presented, on the need to identify the skill mix for the various practice contexts of EPs, has also been based on a thread running through the discussions in the first and second phases.

4.4.3.2.5 Agreement for the need to identify the skill mix for the various practice contexts of EPS

In considering a future workforce, there is no one-size-fits-all solution for the varying contexts of EPS. However, there are methods of capturing the various contextual requirements, given the common presenting family issues and needs.

Figure 112 shows that a large number of nurses (92 per cent) agreed with this statement. A total of 145 nurses responded to this question.
Figure 112. Responses to ‘the need to identify the skill mix for the various practice contexts of EPS’

The qualitative responses (n 35) for this statement are presented as categories visually in Figure 113 and then described below.

Figure 113. Qualitative responses to ‘the need to identify the skill mix for various practice contexts of EPS’

1. Assisting a broader understanding of skill mix

Regarding assisting a broader understanding of skill mix, comments from nurses included the idea of planning and flexibility, such as ‘good idea but it would be extremely important that these organisations should be included in the planning’ and
‘ideally, it is useful for all staff to be flexible and be able to work across all areas of practice’.

Other nurses recommended a focus on clarity of roles and specific skills:

Each discipline needs to be clear about their role and function and supported by professional body and standards.

All are required as all parenting situations need different solutions.

However different EPS could concentrate on specific of skills.

Another suggestion was the abolition of the more intensive services, with a reorientation to primary prevention:

The need for EPC could become a thing of the past if there were adequate use of parent education, community supports, and helplines as a form of primary intervention.

The following nurse view puts the client and the way of work first, rather than the need for specialisation and the application of a skill mix principle:

I believe we need to stay focused on the shared skills, knowledge and learning and how the nurse generalises and adapts the shared knowledge and practice to a particular family in a context is the role of the workers, practice development staff and the organisation. Developing skills for contexts means we focus on us first and families fit into our definition of that … we need to be developing staff skills to match the practice evidence rather than the context to do otherwise would create factions within EPS and diminishes the role and the profession.

For example, the principals, knowledge and skills of the family partnership model of C-Frame underpin how our work unfolds and beyond that individuals may hold specialised knowledge or advanced skills—ideally these are spread throughout an organisation rather than the idea they congregate in one part of an organisation.
2. A greater mix of staff

The category of having a greater mix of staff captured the view that a nursing focus is maintained at the expense of including other disciplines, whereas others embraced an interdisciplinary context and a greater mix of staff.

A variety of other responses were obtained also:

yes it should be considered and developed as clear practice contexts, rather than a generic approach—however it shouldn’t turn into silos of speciality either. All these skills are required in this work. Day stay and residential need a strong nursing base with skills in child health and development, psychology, social work & early childhood skills. One-size-fits-all never works.

Important as families have different needs.

Careful here. This approach has the potential to over-prescribe what solutions and models are ‘best’ for certain communities, settings.

There is great variability in what families and communities need.

I believe we have already identified the skill mix but this is constantly under question or subjected to forced changes. For example, we have had maternal and child health nurses working with mothercraft nurses for many years with good success but mothercraft nurses are no longer being trained so we have employed child care workers (2-year qualification) instead but they don’t have the same knowledge base. We have also had difficulty employing MCHNs for many reasons and have employed midwives and other Division 1 nurses with mixed success.

We need to work collaboratively … having a national task group from all the EPS to develop an understanding of the skill mix and training requirements is essential.

I believe we need mental health, lactation consultant, psychology, social work, nursing, enrolled nursing and child care in our mix.
The next section discusses nurses’ views on the need to focus on marketing and recruitment strategies for a multi-generational workforce.

4.4.3.2.6 Agreement for the need to develop marketing and recruitment strategies for a future multi-generational workforce

This statement came about from the first two phases, as it was noted by nurses that, because the current workforce is composed predominantly of baby boomer and generation X nurses, there was a need to think differently about the workforce composition into the future.

Figure 114 demonstrates that a large number of nurses (83 per cent) agreed with this statement. In total, 145 nurses responded to this question.

![Figure 114. Responses to 'the need to develop marketing and recruitment strategies for a future multi-generational workforce']()

The qualitative responses (n 35) to this statement were divided into two categories: the need to recruit from a range of generations, and the need to create awareness of the role of EPS. These are presented visually in Figure 115 and described below.
Figure 115. Qualitative responses to ‘develop marketing and recruitment strategies for a multi-generational workforce’

1. Recruit a range of generations

Below are examples of nurses’ views of the benefits of a multi-generational workforce:

Everyone brings their own professional and life experience.

Diversity of experience, life skills, ideas, enthusiasm and energy improves service.

Need to have younger people with skills coming into workplace for continuity and team health.

A multi-generational workforce allows for more experienced staff to mentor less experienced staff.

Yes promotes creativity, talent management and succession planning.

Need to balance experience with investing in younger workforce.

Nurses felt before marketing can occur there needs to be clarity of EPS work and then awareness-raising.
2. Create awareness of the role of EPS

This raising of the profile of EPS work was consistently raised throughout the phases of this study. Nurses suggested the following:

Most MCHNs not really clear about EPC work so publicise it more at Uni.

Feel there needs to be more awareness of what this job encompasses in the general community and its importance to assist the community.

Can’t get left behind—should have a facebook page and tweet stuff.

Not enough people really understand what EPS do—need to broaden the marketing.

Nurses need to be guided into this work with full knowledge of what it entails—myths surround this work—that is, ‘easy’ etc.

4.4.3.2.7 Agreement to consider sustainable strategies to support a future multi-generational workforce

The statement on sustainable strategies relates to how to support the various needs of a multi-generational workforce once marketing has enabled the recruitment of a range of generations.

Figure 116 demonstrates that a large number of nurses (92 per cent) agreed with this statement. In total, 136 nurses responded to this question.
Figure 116. Responses to ‘consider sustainable strategies to support a future multi-generational workforce’

The qualitative responses (n 19) to this statement were predominantly around ideas that would enhance flexible human resource practice and support processes. This single category is presented in Figure 117 and described below.

Figure 117. Qualitative responses to ‘consider sustainable strategies to support a future multi-generational workforce’
1. Flexibility of human resources practice and support

Nurses suggested a range of strategies that would assist in sustainability. These included:

- Staff to job share say one week on three off so say four people job share. Take on relief for holidays in one area only so projects mentor staff.

- There needs to be such a workforce as everyone is then able to support and learn from the others. … Mentoring system, preceptorship program, clinical supervision.

- Care needs to be taken that full-time workers don’t lose out as they usually do carrying the work of part-timers who can’t get involved because of time limitations.

- Practical input from practitioners; and research is required to develop any sustainable strategies.

- Employment of training staff and supporting staff who work at EPC is essential.

- Greater understanding and tolerance of how different generations approach work.

- The health department will have to get more flexible with hours etc and using social media perhaps to reach clients (My early childhood nurse on twitter perhaps?).

This discussion on flexible HR practices continues with the statement on the need to develop retention strategies for the ageing workforce.

4.4.3.2.8 Agreement on the need to develop retention strategies for the ageing workforce

Figure 118 demonstrates that a large number of nurses (87 per cent) agreed with this statement. A total of 136 nurses responded to this question.
Figure 118. Responses to ‘the need to develop retention strategies for the ageing workforce’

The qualitative responses (n = 41) to this statement are presented in Figure 119 as one category related to flexibility and resourcing. The category continues and repeats thoughts from previous statements. These highlight the need to be flexible about hours of work, the competencies and skills of nurses and their leadership and mentorship abilities.

Figure 119. Qualitative responses to ‘develop retention strategies for the ageing workforce’
1. Flexibility and resourcing to accommodate an ageing workforce

Below are examples of statements from nurses:

Yes we also need to commit to retaining staff given retirement is 65 years. However there is a general slowing down physically and workloads may well need to be rearranged.

Yes, although need to be confident that the experienced workforce is given training on mentoring/coaching and has competencies able to continue work as get older.

For nurses to be retained in the workforce they must demonstrate a life-long learning approach and be positive mentors.

Equally important to attract new staff—but the positions have to be valued. We cannot rely for ever on staff working because of the passion to help someone.

Strategies for self-care and building up of professional self-esteem and self-efficacy would help.

This concludes the presentation of the participant responses to the eight statements on ‘the future’. The following section discusses nurses views on ‘the priorities for the future’.

4.4.3.3 Looking to the future—Priorities for the next 3–5 and 5–10 years

This section of the survey asked nurses to rank the priority of the previous eight strategy statements over the next 3–5 years and 5–10 years, to gain an understanding of their priorities. A total of 136 nurses responded to these two questions.

4.4.3.3.1 The ranking of the top three priorities for the next 3–5 years

Table 15 shows that the majority of nurses thought that all strategies were of high or medium priority.
Table 15. Responses to ‘rank the above mentioned strategy statements according to your perception of their priority for the next 3–5 years’

<table>
<thead>
<tr>
<th>Statements</th>
<th>High priority</th>
<th>Medium priority</th>
<th>Low priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Increase the development and availability of innovative options for postgraduate qualification education in the EPS sector.</td>
<td>76</td>
<td>54</td>
<td>6</td>
</tr>
<tr>
<td>2. There is a need for innovative national professional development opportunities.</td>
<td>68</td>
<td>60</td>
<td>8</td>
</tr>
<tr>
<td>3. Identify further research areas relevant to the EPS workforce.</td>
<td>56</td>
<td>70</td>
<td>10</td>
</tr>
<tr>
<td>4. There is a need for a workforce development strategy for EPS.</td>
<td>88</td>
<td>43</td>
<td>5</td>
</tr>
<tr>
<td>5. Identify the skill mix for the various practice contexts of EPS.</td>
<td>66</td>
<td>59</td>
<td>11</td>
</tr>
<tr>
<td>6. Develop marketing and recruitment strategies for a future multi-generational workforce.</td>
<td>67</td>
<td>50</td>
<td>19</td>
</tr>
<tr>
<td>7. Consider sustainable strategies to support a future multi-generational workforce.</td>
<td>67</td>
<td>61</td>
<td>8</td>
</tr>
<tr>
<td>8. Develop retention strategies for the ageing workforce in EPS.</td>
<td>77</td>
<td>44</td>
<td>15</td>
</tr>
</tbody>
</table>

The top three highest-ranked were:

I. Workforce development strategy;

II. Retention for ageing workforce; and

III. Availability of postgraduate qualifications in EPS.

These priorities are presented in Figure 120.

![Figure 120. Three highest-ranked priorities for the next 3–5 years](image)

Nurses (n 16) elaborated on this question, confirming that the top-ranked priorities for the next 3–5 years were important.
One nurse commented that the ‘high priority is for the workforce development strategy as the other points will be included in this’. Others stated that everything was important: ‘it’s all important; we need to work with these strategies to improve EPS’. For others, ‘identifying the skills/knowledge base required for working in EPS would be a priority’ and ‘research, development strategy and skill mix needs to be organised first’.

4.4.3.3.2 The ranking of the top three priorities for the following 5–10 years

Regarding the priorities for the next 5–10 years, Table 16 shows that the majority of nurses felt that all strategies were of high or medium priority.

Table 16. Responses to ‘rank the above mentioned strategy statements according to your perception of their priority for the next 5–10 years’

<table>
<thead>
<tr>
<th>Statements</th>
<th>High priority</th>
<th>Medium priority</th>
<th>Low priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. There is a need for innovative national professional development opportunities.</td>
<td>73</td>
<td>58</td>
<td>5</td>
</tr>
<tr>
<td>2. Identify further research areas relevant to the EPS workforce.</td>
<td>68</td>
<td>61</td>
<td>7</td>
</tr>
<tr>
<td>3. There is a need for a workforce development strategy for EPS.</td>
<td>89</td>
<td>44</td>
<td>3</td>
</tr>
<tr>
<td>4. Identify the skill mix for the various practice contexts of EPS.</td>
<td>63</td>
<td>66</td>
<td>7</td>
</tr>
<tr>
<td>5. Develop marketing and recruitment strategies for a future multi-generational workforce.</td>
<td>71</td>
<td>55</td>
<td>10</td>
</tr>
<tr>
<td>6. Consider sustainable strategies to support a future multi-generational workforce.</td>
<td>72</td>
<td>59</td>
<td>5</td>
</tr>
<tr>
<td>7. Develop retention strategies for the ageing workforce in EPS.</td>
<td>81</td>
<td>44</td>
<td>11</td>
</tr>
</tbody>
</table>

The three highest-ranked priorities were:

I. Workforce development strategy;

II. Retention for the ageing workforce; and

III. Innovation for professional development in EPS.

These priorities are presented in Figure 121.
The qualitative responses for the top priorities for the next 5–10 years (n 9) included general comments that reinforced the necessity to immediately work on the workforce development strategy to lay the foundation for the next 5–10 years. Any workforce development strategy should feature ongoing research and evaluation to inform future directions.

One nurse stated:

This is a long-term issue; the benefits of the work we put in now will be seen in the years to come. The very fact that you’re doing this survey and speaking with other CHNs is valuable.

Another nurse stated:

Due to the expertise and uniqueness needed for working in this profession more training and post-qualifications are definitely needed so as to be able to maintain a viable and fully trained workforce in EP.

The following section will now summarise the qualitative responses given in relation to the final question of the survey, which asked for any other thoughts or strategies for the future. In total, 136 nurses responded to this question.

4.4.3.3 Themes from open-ended question identifying any further strategies

The responses to this question were divided into two major categories: current workforce issues and a focus on national directions. They are presented in Figure 122 and described below.
Figure 122. Qualitative responses to ‘identification of any further strategies’

1. The issues for current workforce

This covers the many issues that nurses felt needed immediate consideration within the current workforce. Each issue type is listed, followed by example quotations from nurses.

Consideration of future roles for the ageing workforce

perhaps keeping older nurses on as mentors and supervisors and consultants.

Promotion of the role in EPS

Continue to develop community awareness of this specialised service. Use the media to inform the general public on the role of early parenting provided in the community, i.e. television and advertising. The general public are only aware of EPS after they have had children. Have greater exposure in other health services, e.g. hospitals and GP clinics.

Incentives for training

more affordable ongoing educational opportunities.
well skilled trained multicultural staff.
Interdisciplinary training

Universities are focusing on more interprofessional education but students go into workplaces that have not been trained this way. Education together will help promote team approach and skill mix and collaboration.

Increasing the evidence base, evaluation and a quality focus

update of current policies to reflect research and current evidence-based practice.
evaluation processes to make sure strategies are meeting needs.

Supervision

look after your workforce by having regular clinical supervision.

Increasing participation with decisions for the future

Input from all staff to assist with development of strategies and inclusion of all staff in education.
more decision making should include clinical practitioners not just CEOs and managers who do not work directly with clients.

Pay and conditions

strategy for better pay!
more affordable ongoing educational opportunities.

2. A focus on national directions

National consistency

National consistency was raised by a number of nurses, including the suggestion of national standards and national professional development to create consistency across jurisdictions. Other comments included:
Having a national task force from all the EPS to develop an understanding of the skill mix and training requirements is essential.

developing national standards and standardisation across states e.g. prerequisites to practice as a MCHN should be the same from State to State.

Promote the national integration of information and training so skills and expertise can be developed further. National conferences could be beneficial.

Develop a universal Qualification in EPS.

Develop closer integration of EPS throughout Australia on a clinical level.

Some nurses suggested ‘Scholarships—maybe the AAPCH could provide a national research scholarship for postgraduate studies on the further development of the workforce’.

*Focusing on outcomes for families*

Focusing on outcomes for families has been a recurring theme throughout this study. Comments include:

  Going into the different services that provide EPS and asking those that work in these areas what we need to do to improve outcomes for these families.

  Thought needs to be given to what outcomes we are trying to achieve, what are the presenting issues and risks and then who best to work within that practice context.

*Valuing and promoting EPS work*

Valuing and promoting EPS has been another repetitive theme throughout the phases of this study. Nurses stated that:

  We need to market ourselves more—who we are, what we do. I think there needs to be a strategy regarding the integration of EPS in the
broader service system. I think this is one of the greatest risks to the future and certainly the growth of EPS. The further development and diversification of EPS workforce is essential to assist in the integration of services—this is also a problem to national unity as some see themselves very much as part of health and others are part of the community sector.

**Skill mix and qualifications for EPS work**

The following statement by one nurse summarised this theme:

> More opportunities for multisite professional development opportunities and research strategies are needed. Strategies to attract more males into EPS would be valuable. If a future workforce of an interdisciplinary team, then need thought to pay rates if doing similar roles. What is the base level? More scholarships need to be available for this area and academic career pathways.

Following the analysis of the data there appeared to be a strong recommendation by nurses for an overarching workforce development strategy. As indicated, one salient feature of the recommended framework was a workforce development strategy. It was decided to present a separate section on this to bring together the discussion by nurses.

**4.4.3.3.4 Workforce development strategy**

Phase three culminated in a workforce development strategy, which is presented in Figure 123 and summarised below.
Figure 123. Workforce development strategy for EPS

The workforce development strategy has key domains necessary for providing workforce solutions and priorities for moving EPS into the future. Nurses considered this as very important and requiring of urgent attention. Although all strategies are important, some points were seen as of greater priority, with the three highest-priority areas being options for post-qualification education, retention strategies for the ageing workforce, and innovative professional development. These are now discussed in turn.

1. Increase the availability of innovative post-qualification education in the early parenting sector

Two options were given emphasis: the EPP role and a postgraduate certificate in early parenting being made available to enrolled nurses.

In phase one, nurses and allied professionals generated ideas for the future, including the concept of an EPP (a concept with which the majority, 78 per cent, of nurses nationally in phase two agreed). As demonstrated in Figure 124, this position would add value to the mix in staff at an EPS. It does not replace the need for nurses or
allied professionals but tries to solve the issue of spreading the knowledge of early parenting to a greater professional base. This EPP would have a baseline health, social science or early childhood education degree and undertake a postgraduate diploma in early parenting. Nurses already undertake a postgraduate qualification to work in these services nationally and it seems reasonable that there should be one available for allied professionals. The EPP would not only benefit EPS, but also be an asset when working in a range of government and family support roles in the non-government sector.

This role not only solves workforce issues but considers the need to have holistic services that meet the needs of today’s families and the many issues they face. As indicated in Chapter One, it also works towards less mono-discipline approaches and moves the workforce into interdisciplinary and trans-disciplinary teams working with families. As interprofessional teams work closely together with a greater skill mix, there is a degree of overlap that creates a sharing of knowledge and skills that can only benefit the client. This is demonstrated in Figure 124.

![Figure 124. The early parenting professional](image)

The skills and knowledge of an EPP were outlined in Chapter Four and, as described, a very experienced child health nurse has this level of knowledge and skills. Allied professionals also have some of these knowledge and skills and could benefit from a postgraduate qualification in this area. As discussed previously, many of the nurses that currently possess the requisite experience will be leaving the EPS workforce over the next 9–14 years. The future will look quite different and require new approaches. Many nurses and allied professionals in the study discussed the
importance of the traditional mothercraft role and its role in EPS. Very few of these mothercraft staff remain in services now (n 4 at Ngala), but they could add a level of skill mix and provide important practical support for families. Enrolled nurses are also registered by the Australian Health Practitioner Regulation Agency (AHPRA). Figure 125 demonstrates the overlap resulting from the addition of an enrolled nurse with an early parenting certificate to the skill mix in EPS.

![Figure 125. The addition of an Enrolled Nurse with EPS certificate](Image)

2. **Develop retention strategies for the ageing EPS workforce**

Ideas for retention strategies focused on flexibility for nurses transitioning into retirement. Resourcing needs to accommodate this transition, given the potential benefit that could be made of the knowledge and skills of outgoing staff in supporting and retaining younger and less experienced nurses and other allied professionals. Many nurses reinforced the need for some assessment of the attributes and skills required by those providing leadership and mentorship.

3. **Develop innovative national professional development strategies**

It was felt that given that EPS is a niche market and generally has smaller numbers of staff nationally, there is an opportunity for innovation in this area, particularly with the advances of new technologies. IPE would be one area that could be given consideration to assist to move the culture of nursing from a mono-discipline approach towards an interdisciplinary perspectives and models of work. National
standards, curriculum and clinical supervision would also assist, as would strong leadership in this area.

The following section discusses the priorities that fell after the top three.

4. Develop sustainable strategies for a multi-generational workforce

The focus on a multi-generational workforce includes two aspects:

- Developing marketing and recruitment strategies for a future multi-generational workforce; and
- Sustainable strategies to support a future multi-generational workforce.

Currently the main EPS nursing workforce consists of baby boomers and generation X nurses. It is important to understand the characteristics of each generation and the requirements needed to support the recruitment and retention of staff from a range of generations. Nurses also encouraged an increase in graduate positions and scholarships as part of this overall strategy.

5. Identify the skill mix for the various practice contexts of EPS

Nurses commented that it was important to develop a broader understanding of skill mix and pursue a broader mix of staff. The various contexts of EPS need to be considered as well involvement of staff of the rationale and need to plan. It was felt that understanding and articulating the various contexts would give clarity to the range of disciplines that can work together in those contexts.

6. Identify further research areas relevant to EPS

Research on Australian EPS has been limited overall, but is starting to develop momentum and importance, particularly in the last decade. Nurses thought that developing a research culture and focus on practice development whereby the client is held uppermost would assist in making a difference for EPS and contribute to a dynamic learning environment. Other suggestions from nurses reinforced the importance of this study and the conducting of further research on interdisciplinary approaches.
7. Market EPS work

Raising the profile of EPS work was seen as very important by nurses. It was recommended that the strengths of EPS be articulated, and that the important role that services play, particularly in supporting the universal child health systems, be marketed to the public. Nurses talked of the silence of the consumer in EPS, and of the need for greater awareness in other health and welfare services of the work done by EPS.

4.4.4 Summary Phase Three

Phase three was built on the first two phases of data collection and analysis and a questionnaire was developed for distribution nationally with a 37 per cent response rate. The demographics of the national survey respondents were described in this section, and the findings from the survey were presented in two parts: the current situation and future directions. These have brought together rich data that will inform the design of a future workforce development strategy.

4.5 Chapter Four Summary

This chapter has presented the findings from the three phases of this study, with reference to the key questions outlined in the introduction.

The first section addressed the first phase, providing a historical overview of nursing within Ngala and the current situation and role for nurses as perceived by nurses and allied professionals.

The second section presented the findings for phase two, which was informed by the first phase. The findings of the first phase were discussed with nurses nationally via teleconference, with their responses constituting the findings for the second phase.

The third phase involved the development and distribution of a national survey to nurses within Australian EPS. The survey was informed by the findings from the previous two phases. The third phase findings also generated a workforce development strategy used to inform the framework for the future.
The results have provided a rich collection of data, with themes being consistently raised throughout each phase of the study, resulting in clear evidence of nurses’ perceptions on early parenting work and their ideas for the future directions of EPS.