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

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Chapter 5: Discussion of Findings

5.1 Introduction

The purpose of this study was to explore the past, present and future of nursing within EPS in Australia. To achieve this aim, the study answered six questions, as posed in Section 1.5. These were:

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

Each question was addressed through the phases of the study, with varying depth and focus, as described at the beginning of Chapter Four. The first phase focused on Ngala as a single site, with the findings from that phase being applied to the national setting in phase two. Phase three focused more on the future and developed a framework of future changes that were perceived by nurses in all three phases as important. These were divided into the top priorities for 3–5 years and 5–10 years.

This chapter will provide a summary of the past, present and future of nursing in Australia. These findings will be compared against other research and theory on the role of the nurse. The new knowledge will culminate in the design of the future framework for nursing in EPS, with each of the framework components articulated in relation to relevant literature.

This case study is about nursing in EPS in Australia. The implications for nursing in this niche market are explained within an interdisciplinary perspective, to outline a
way forward for the future that considers the sustainability of outcomes for families, workforce recruitment and retention, education and practice.

5.2 The Role of the Nurse in Early Parenting Services

The role of the nurse in EPS will be summarised and presented in three sections—the past, the present and the future. This follows the phases of the case study, which have built on each other, from the perspective of one site at Ngala to the national context (see Figure 126).

5.2.1 The Past: The Evolution of the Nursing Role over Time (1890–1989)

Ngala was first established in 1890 as the House of Mercy to assist young single women having babies without the support of family, under difficult social circumstances. Nurses were employed at the turn of the twentieth century, prior to which midwives would come to the house and assist with the births. From 1904, other infants were cared for at the House of Mercy and over time Ngala became one of the key places in Perth, WA for the institutional care of children and the adoption of children, up until the 1980s. Nurses also cared for young pregnant women, and from the 1990s, for parents, with the shift to a family focus.

Nursing was the predominant discipline employed at Ngala up until the 1980s. The medical profession had visiting rights since inception and this continued until the 1990s, at which point a paid general practitioner commenced. Visiting social workers to Ngala were mentioned in the documents from the Department of Welfare from the 1950s, but were never employed until the 1980s.

The nursing role was strongly influenced by the army and the first part of the 1900s with the two World Wars. Many of the tasks described by nurses were aspects of ‘women’s work’ around the home and the role of a mother in looking after a child. These are visually represented from the period 1940s to 1980s in Figure 75 and were summarised in Chapter Four. Nursing at Ngala was in the context of what was occurring in WA and nationally, as many nurses went East to train in infant welfare nursing up until 1959, when the course was introduced at Ngala.
Figure 126. A visual representation of the past, present and future of nursing in EPS.
The regulation of nursing began in WA with the introduction of Parliament in 1890 and the Hospitals’ Act in 1894. Regulation appeared more informal initially, with the formal title of ‘nurse’ being used and the wearing of a uniform symbolic of being a nurse. The Australian Trained Nurses Association was formed in 1907 and provided a framework for the regulation of nursing training until the Nurses Registration Act in 1921 (Hobbs, 1980).

As described in Chapter Three, the influential infant welfare movement emerging in Australia around 1920. The traditions of EPS were a part of the early child welfare movement and often a precursor or simultaneous development to the setting up of infant welfare clinics. Many such clinics were supported very strongly by community advocates and volunteers (mostly women) and women’s or church organisations.

The education and training of infant welfare nurses commenced in the 1920s in Australia. At Ngala, a training course for mothercraft nurses began in 1949, followed by a training course for infant welfare nurses in 1959. These were continued until the mid-1980s until the move to tertiary education. The first Australian degree in nurse education was established in 1975 (Piercey, 2006). The professionalisation of nursing through the tertiary sector had major implications for nursing, affecting nursing at Ngala over time. The effect was not fully realised until the 1990s, by which time more nurses had undertaken the bridging degree from the hospital-based certificate.

The professionalisation of nursing affected how nurses approached their work. The rise of formalised professionalism created developments of theoretical frameworks, the introduction of the ‘nursing process’, legal parameters, professional boundaries and ethics. Many of the symbols that designated nurses such as hats, badges, uniforms and terminology (such as the word ‘sister’ or ‘matron’) disappeared gradually during the 1970s and 1980s.

In terms of community nurses specifically, the WHO defined community nurses as, among other things, ‘identifying the community’s broad health needs and involving the community in development projects related to health and welfare’ (World Health Organisation, 1974). In Australia, community nursing has encapsulated a range of care contexts, providing health promotion, community development, health education and disease prevention within a framework that recognises the broad
social, economic and environmental determinants of health (World Health Organisation, 1978). Over time, societal changes to family structures and the introduction of technology started to change the nature of work in EPS, and the international impact of the ‘The Ottawa Charter’ and the influence of primary health care during the 1980s saw a shift away from the medical model to community health models of care. This continues to be important in nurses’ practice today.

5.2.2 Current Role Defined: Profile of the Role of the Nurse in EPS (1990 to Current)

Kemp, Harris and Comino (2005) noted in their study that, for the period 1995–2000, the balance was shifting to specific, short-term clinical care, resulting in a loss of holistic primary health care. The change of the nursing role in child health has undergone a considerable shift over the past 17 years, particularly in the area of perinatal and infant mental health and change to family partnership, strengths-based and solution-focused approaches to family care (Borrow, et al., 2011; Briggs, 2007; Chavasse, 2010).

The cohort of nurses within EPS is very experienced and many nurses (85 per cent of respondents) have been with EPS for 5+ years. EPS nurses are an ageing workforce with the largest numbers being in the age category of 50–59 years.

Given these demographics, the EPS nursing cohort holds an immense knowledge and skill base that will be lost from the workforce as the baby boomer generation retires. There is also a need to consider other recruitment and retention approaches and skill mixes due to younger nurses being more mobile and changing careers more frequently (Nursing Review, 2012). Younger nurses also approach work differently to the baby boomer generation and place more emphasis on quality of work/life balance (Arrowsmith, 2007; Wilson, Squires, Widger, Cranley, & Tourangeau, 2008a).

The broad knowledge and skill base of nurses in EPS, described in phase one of Chapter Four, has developed as a result of the decades of experience of the current workforce. The key categories describing the role of the nurse included ‘early parenting nursing practice’, ‘application of evidence’ and ‘linking with others’. These were then reduced into sub-categories that explained in more detail the role of
the nurse in EPS (see Section 4.2.3.3). All the categories are supported by the work already done in Australia on child and family nursing competency standards, although different terminology has been used at times (Australian Nursing and Midwifery Council, 2006; Child and Family Health Nurses Association (NSW) Inc., 2009; Community Nurses Special Interest Group, 2001).

5.2.3 The Unique Role of the Nurse When Working Closely with Other Disciplines in EPS

Multidisciplinary work has been part of Ngala since the 1990s, with a more concerted effort of moving to an interdisciplinary approach during the 2000s. Nurses nationally validated the description of the unique nursing role, identified by nurses and allied disciplines during phase one as comprising the three categories of ‘the early parenting nursing role’, ‘the experienced practitioner with a broad knowledge base’ and ‘professional identity’ (see Section 4.2.3.4). This description can be utilised to assist in articulating the unique role of the nurse within an interdisciplinary team and will enable clarity of discussion when a variety of disciplines continue to work closely together with families.

The ‘early parenting nursing role’ is the essence or core of the nursing role, which is peeled back when working with others disciplines. For example, nurses may do less of a psychosocial support role if a social worker or psychologist is working closely with them. The other two categories may change over time, as they relate closely to the history of nursing, which continues to evolve. The ‘broad knowledge base’ is consistent with the current cohort of nurses in this niche market. In 10–14 years, this may no longer be the case, as a younger, less experienced cohort of nurses replaces the older, experienced generation. Nurses’ ‘professional identity’ may also change over time as the skill mix of disciplines competent in early parenting work shifts.

5.2.4 The Framework for the Future of Nursing in EPS

The key elements of the framework articulate the shift of the nursing role from the past and present to the future and the clarity for the unique role of the nurse when working within an interdisciplinary team. There is an overlap of roles between disciplines, creating ‘osmosis’ and a sharing of knowledge and skills of all practitioners. This benefits the team and provides a collegial environment that can
enhance the outcomes for families with young children. However, there is inconsistency nationally to the degree of commitment to interdisciplinary approaches, given the very small numbers of allied disciplines working in some services.

A vision for nursing in EPS for the future is divided into two time categories: the next 3–5 years, and the next 5–10 years. These are now discussed in turn.

Over the next 3–5 years, some baby boomers will be leaving the workforce. Nurses will be transitioning out with flexible work practices. Understanding the current workforce is crucial to planning and training for a new workforce, and developing a mentoring and leadership program for practice development. Preparation for a multi-generational staff mix and future interdisciplinary models of care for families will be necessary. Planning and recruitment of graduate positions and funding for scholarships for early parenting work need to be resourced, and national and local priority should be placed on the creation of innovative professional development opportunities. Systems that support flexible workplace recruitment and retention of staff need to be established.

During this time, national consistency will ensure that the postgraduate certificate and diploma are clarified and standardised to ensure adequate clinical placements. Planning for the national development with universities and organisations to produce a post-qualification education in the EPS sector for allied disciplines and a certificate for early parenting for enrolled nurses will be important. Nursing and allied disciplines will need to endeavour to encourage a majority of skill mix, with the addition of more males, life experience and experience in the EPS sector, due to the age cohort of many parents being older, and the increased use of services by fathers. This will add to the credibility of services, and maximise outcomes for families seeking assistance.

Over the next 5–10 years, as baby boomers continue to transition out of the workforce, EPS will begin to look quite different. Generation X will be the senior workplace cohort, but there will be less of them as compared to the previous baby boomer generation. The generation Y and X nurses will be beginning to emerge and new graduates will be more frequent. Pathways for child and family health nurses will be established to include younger, less experienced nurses and enrolled nurses.
Baby boomers will continue to work in a mentoring and support role for the workforce, and there will need to be a very flexible HR system, continuing to support a part-time workforce and family-friendly philosophies for a multi-generational workforce. The technology that drives the system now will have evolved, and some services to parents will change or the options available will diversify. During this period, the establishment of post qualifications in early parenting work will be taking shape and interdisciplinary work will be a priority for all services, with adequate professional development, the supervision processes and reflective practice consolidated. Research in EPS will be increasing and greater knowledge of the outcomes being achieved by this work will be known.

The workforce development strategy outlines priorities and strategies for the next 10 years and offers suggestions to assist future workforce development in EPS. A visual framework summarising the role change in nursing in EPS and the future workforce strategy is outlined in Figure 126.

5.3 Comparison of Findings with the Literature

5.3.1 The Nursing Role within EPS

5.3.2 National Workforce

The aim of this study was to explore the past, present and future of nursing in EPS in Australia. There had been no literature exploring this workforce context to-date, and this study was undertaken during a time of immense change and uncertainty about health workforces into the future. Workforce shortages exist across most of the health disciplines in Australia. There are projections that by 2020 there will be a shortage of 40,000 registered nurses in Australia (Karmel & Li, 2002). Duffield (2008), in her workforce article, raises questions that need to be answered for the early parenting context; including, what are the appropriate professional disciplines best able to meet the needs of families and children with vulnerabilities today.

Health Workforce Australia (2012a) released projections for nursing for 2025. Modelling of projections was done for acute nursing, aged care and mental health nursing sectors. Health Workforce Australia was unable to project workforce for the area of community child health nursing, due to difficulties in obtaining relevant data. However, they anticipate that their 2012 report is the first step, and that more
projections can be expected for the future. The CEO of Health Workforce Australia has stated that:

New technology and competing trends are making us drastically rethink the roles of health professionals—and hence what skills they need and how they are trained … training of health professionals will be more technology savvy and more about communication and partnership … Meeting this future challenge is complex but if there is anything that gives me heart it’s the fact that the next generation of health leaders are keen to embrace these changes and work in different ways—much more so than the current generation. (Cormack, 2012, p. 1)

Nurses in EPS (n 450) are a very small workforce nationally within the child health system, which comprises about 5,800 nurses, or 2 per cent of the nursing workforce in Australia (Productivity Commission, 2011). These numbers are inclusive of universal child health and services such as EPS. Hence the resources or expertise in the workforce to-date have not focused on workforce planning and research in the area of EPS. The Productivity Commission report states that on average, nurses who report working in child and family health are older than nurses working in other areas of clinical practice, are more likely to be female, to work part-time and to be registered nurses (as opposed to vocationally trained, enrolled nurses or Division 2 nurses) (see Table 17).

Observations made within the above report about the child and family health nursing workforce were made, for example, in Victoria, where it was reported that, of the 925 nurses employed in maternal and child health services in Victoria in 2010, 72 per cent worked part-time and 14 per cent were aged 60 years or older. Only one male child and family health nurse was reported in Tasmania, and 13 per cent were aged 60 years or older (Productivity Commission, 2011).
Table 17. Selected characteristics of nurses working in child health in Australia (2008)

<table>
<thead>
<tr>
<th></th>
<th>Average age</th>
<th>Male</th>
<th>Holds registration</th>
<th>Average working week</th>
<th>Work part-time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses employed in family and child health</td>
<td>46.4</td>
<td>3.4</td>
<td>93.6</td>
<td>31.8</td>
<td>54.4</td>
</tr>
<tr>
<td>All nurses employed in clinical practice</td>
<td>44.1</td>
<td>9.4</td>
<td>81.3</td>
<td>33.4</td>
<td>47.9</td>
</tr>
</tbody>
</table>


The findings above are consistent with this study, although the age cohort of the respondents within EPS was older, with 52 per cent of nurses within the 50–59 category and 16.5 per cent being 60 years or older, giving a total of 68.5 per cent at 50 years and over.

The nursing skill mix in this study was registered nurses who are child and family health nurses, midwives, mental health nurses and mothercraft/enrolled nurses. Given that the majority in the nursing skill mix within EPS was child and family health nurses, it was decided to compare any literature available within child health mostly in Australia and the UK that looked at roles and workforce-related issues. EPS are often a major source of referral from child and family health nurses in the universal community setting. These referrals are often due to the time restrictions on child and family health nurses, and the increasing population and demand for services.

5.3.3 Comparison with Child Health Nursing Role and Issues within the Universal Child Health System

The contribution of nurses to child health and child health services was found to be broad-ranging and diverse (Forbes, et al., 2007). Nurses in the universal child health system often work in isolation, and this presents challenges for nurses (Schmied, et al., 2011). The reform of the Victorian Maternal and Child Health Service found during the pilot study that maternal and child health nurses were resistant to change (Fairbairn, 2010), possibly because of their isolated work practices. A study of WA community child health nurses (Borrow, et al., 2011) explored the breadth of the role in the universal system and noted the expansion of the child health nurse’s role over
time due to a range of factors. This has become an unreasonable expectation, and nurses expressed the issues and challenges of their work.

Some similarity of issues was noted with a small proportion of nurses within this study, such as nurses stating the need for clinical supervision and professional development, the increasingly multifaceted nature of their role, and the lack of acknowledgement of their specialist role by colleagues. The question that is raised here by these comments is whether, in the case of a closer working relationship with other nurses and allied disciplines, this lack of perceived value is not such an issue.

Lack of being valued did not appear to be a perception of nurses at Ngala, possibly due to the close collegial working relationship, an ageing workforce and longevity of staff. Munns, Downie, Wynaden and Hubble (2004) found in their study that nurses needed to reaffirm their reflective practice role and consider what actually contributes to health gains for families and communities, as this is often overlooked in the business of practice.

The increasing population of Australia and their corresponding health needs has increased workloads around Australia. This has not been matched by adequate resourcing (Kemp, et al., 2005; Schmied, et al., 2011). This lack of resourcing has at times led to an increasing emphasis on targeting services, which then limit the capacity of service providers to meet the needs of all children and families. Most states are experiencing resourcing issues (Belardi, 2011a; Murphy, 2012) that also came out in this study. In WA, there have been multiple reviews and parliamentary enquiries over the years that have indicated that government has not been resourcing the child health sector for almost 30 years. This phenomenon of under resourcing has led to the direction of the limited funds to target those in need (Education and Health Standing Committee, 2012; Mayes, 2011; The Community Development & Justice Standing Committee, 2009; WA Auditor General's Department, 2010). All reports have recommended increasing resourcing in the child health sector. A WA Auditor General’s report recommended partnerships with other government agencies and non-government agencies, resourcing for facilities and different models, providing nurses with administrative support and technology. The report also demonstrated that in WA, the scheduled child health checks have progressively deteriorated in terms of reaching the whole population (see Figure 127) (Education and Health Standing Committee, 2012; The Community Development & Justice Standing Committee,
A UK study showed that parents reported that if they were not assessed as being ‘in need’, then they felt excluded from ongoing services (Roche, et al., 2005).

Figure 127. Figures for universal scheduled child health checks in WA (WA Auditor General's Department, 2010)

The decline in child health checks in WA is due to funding remaining static despite the rising population, particularly over the past decade with the mining resource boom in WA. Government policy in WA has recently been shifting towards contracting out service arrangements that have traditionally been the domain of government, such as universal health checks and parent groups, to the non-government sector. This situation is evolving and still remains a developmental process to be observed. If Ngala is successful with their tender bid, this will change the face of Ngala in WA, as a different model is being proposed that would see nurses working within interdisciplinary teams rather than in isolation.

5.3.4 Broadening Scope of the Child Health Nurse Role

The broadening scope of nursing practice mentioned above is consistent with the age of the workforce and nurses having been in this area of work a long time. The essence of the child and family health nurse role and traditional practice was described by Borrow et al. (2011) and Kruske et al. (2006) as being ‘embedded in
health education/promotion and support for maternal wellness along with health assessment of the child throughout growth and development stages’ (Borrow, et al., 2011, p. 84). The expansion of the role over time has been in response to the changing nature of family needs and issues, and often occurs because of a lack of others able to do or assist with this work to meet demands (Barnes, et al., 2003; Borrow, et al., 2011; Harmer, 2010; Woollard, Abetz, Baker, & Jacobs, 2012). This situation has certainly been described by nurses during this study in regards to their role. Therefore, by necessity, nurses’ roles have expanded (Chavasse, 2010; Kemp, et al., 2005; Kruske, et al., 2006; Munns, et al., 2004; Rossiter, et al., 2011).

Child health policies around Australia have promoted a change away from the traditional focus of clinic contact with the child and family health nurse that tended to best meet the needs of professionals (Schmied, et al., 2011). This focus often failed to engage those most in need. In Queensland, Barnes et al. (2003) described the changes for traditional services offered to a more contemporary model, with the addition of day stay services, which have traditionally been the domain of EPS in most states. This study explains the expansion of the role and the priority given to ‘at risk’ families, as well as how the services continue to provide support and information for families as they adapt to their new parenting role (Barnes, et al., 2003). The authors in this study expressed concerns for the future in balancing individual and population health approaches to meet the health needs of all clients, and in providing appropriate education and support for nurses working in this area such that they may collaborate with others. Similar concerns have been expressed by other authors (Cameron & Christie, 2007; Kemp, et al., 2005; Rowe & Barnes, 2006; Schmied, et al., 2010).

It is also noted that while child health policies advocate that nurses access and engage families in the first two weeks post-birth, it is yet to be demonstrated in Australia or internationally that universal home visiting at this time improves engagement and outcomes for families (Schmied, et al., 2010). However, this study also found (through the voice of nurses and allied professionals) that the tension with diminishing resources for services means that the focus can reorientate to the most disadvantaged or ‘at risk’, despite there being clear evidence in the literature of the importance of maintaining a universal platform of access to all families with a focus on prevention and early intervention.
There is a need for planning into the future for creating a career pathway for new graduates in nursing. If nurses are placed within interdisciplinary teams with adequate support by experienced nurses and other disciplines and support staff, then this would be less onerous and provide a range of disciplines to meet the needs of families, which nurses cannot do on their own. This is particularly so in relation to issues such as child protection (Land & Barclay, 2008; Vimpani, 2000), mental health (Buist et al., 2007; Michael, 2008), the impact of separation and divorce (Fägerskiöld, et al., 2000) and the high needs of migrant/refugee (Community Paediatric Review, 2012; Grant & Luxford, 2008, 2011; Phiri, Dietsch, & Bonner, 2010; Vimpani, 2004) and Aboriginal families (Grant & Luxford, 2008; McMurray, 2004). Creating career experience pathways is already occurring in SA (Women's & Children's Health Network, 2011). Often, one of the barriers to this development is the fact that government services have cumbersome structures and are locked into pay scales for very experienced practitioners who work in isolation. Planning needs to occur to develop levels relevant to experience and competency before the large cohort of the baby boomer generation leaves the workforce (Stanley, 2010). Schmied et al. (2011) reviewed Australian State and Territory maternity and child health policies and found congruency, suggesting that it is time to consider the introduction of a national approach to universal maternal and child health services. A national perspective and standards of practice and education in EPS were also recommended by nurses in this study and by Kruske et al. (2006).

As indicated above, child and family health nurses are confronted with a multitude of complex issues in their work. The ability of nurses in child health services responding to families within a framework of ‘cultural security’ has been discussed in a number of studies of child health services in Australia, yet this discussion was absent throughout this study. Therefore, it seemed appropriate to explore the literature further.

A paper has recently been released on a review of cultural diversity and child protection (Kaur, 2012), and the summary of findings highlights the need for frontline workers to develop cultural competence when working with these families, and the need for early intervention and prevention strategies focusing on ‘accepted parenting practices in Australia’ specifically targeting physical discipline and neglect. Two recent studies have looked at refugee families’ interactions with child
protection services (Lewig, Arney, & Salveron, 2009) and child health services (Riggs, et al., 2012). Both studies highlighted practice areas that are of particular concern to professionals working with refugee families: facilitating access and maintaining engagement with services were crucial. The challenges inherent in culturally competent practice include the use of interpreters.

Both studies offer insight into the experiences of families from refugee backgrounds and the findings can offer insight for the child health workforce. Flexible models of care need to be provided locally (Centre for Community Child Health, 2012). Other studies have highlighted the need for child health services to improve the cultural appropriateness of services for Aboriginal and Torres Strait Islander and migrant and refugee families (McMurray, 2004; Schmied, et al., 2011). Despite specific educational support in working in partnership with families, research suggests this does not appear to have resulted in staff having the necessary skill or sensitivity to work constructively with families, particularly those from Aboriginal and culturally and linguistically diverse communities (Grant & Luxford, 2008, 2011). This could be a gap for nursing in EPS.

The above scenario of broadening the child health nurse’s role in the universal system over time is in direct contrast to some nurses in EPS perceiving an erosion of the role due to the increase in other disciplines in this area of work. To put this into perspective, the majority of national nurse respondents in EPS thought it was important to plan for the future and think differently about the workforce. There was also a perception expressed by a small number of nurses that other disciplines did not value the nursing role in EPS. This was also found in the study by Borrow et al. (2011). This view is most likely related to changing the status quo. As Barnes et al. (2003) found in their study on moving from the traditional forms of practice to contemporary approaches, it does create uncertainty. It is also consistent with a proportion of the baby boomer generation ostensibly preferring to see EPS stay as a predominantly nursing workforce.
Part of the change in child health nursing practice has been the move to family partnership approaches by all States. As discussed in the introduction and description of C-Frame, this approach moves nurses from the ‘expert’ model to working ‘with’ families. As indicated by many studies, this has taken some time, particularly since a large number of ageing nurses had been socialised into the expert model (Schmied, et al., 2011). The view is that if there had been the availability of more professional development, supervision models, and less working in isolation, then the change for nurses may have been easier and faster (Borrow, et al., 2011; Chavasse, 2010; Eronen, et al., 2010; Grant & Luxford, 2008, 2011; Kruske, et al., 2006; Marron & Maginnis, 2009; Roche, et al., 2005; Rossiter, et al., 2011; Schmied, et al., 2011; Schmied, et al., 2010; Vimpani, 2004).

As indicated, nationally the majority of nurse respondents wish to move forward, although the researcher sensed through the study process that some nurses found this thinking difficult at times, or not within their comfort zone. Resistance to change is attributable to the demographics of staff, when many have been in the workforce for a long time. It will be necessary to involve nurses in the planning and changes in service delivery systems and processes because of the varied contexts in each State and because the different cultures are difficult to break into (Chavasse, 2010). These tensions were captured by Duffield (2008, p. 7) when she stated that the way forward was for ‘all professionals working with children and young people [to] work together to focus on the needs of children and young people rather than those of professionals’ (p. 7).

5.3.5 Recruitment and Retention of Multi-generational Nurses

No matter the generation of nurse, variations among individuals exist. Working with individual nurses to find what is of value to them and how their values fit with the organisation is critical to advancing the goals of the organisation (Baker, 2012a; Stanley, 2010). Attracting generation Y to team models will be relatively easy, as their school and university education was also focused on group learning. Retention will be more difficult unless there is greater effort to attract graduate positions (Bail & Schreuders, 2011) into the primary health care system and hence assist their...

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23 Another framework used is ‘strengths-based, solution-focused practice’. C-Frame is used by some EPS and child health services in Tasmania. C-Frame incorporates all these approaches.
integration into the workforce. The baby boomers were not educated this way and many have found the transition to team approaches quite difficult. This was also reflected during this study.

New generation Y graduates are now having IPE at a large number of universities, which promises to make their transition to interdisciplinary teams easier. The difficulty for most new graduates is that workplaces do not often have cultures that support interdisciplinary practice, especially in the absence of key organisation support from all spheres of influence (Missen, et al., 2012).

It is interesting to note that in 2002 Ngala presented a paper to a parliamentary inquiry into ‘the role and interaction of health professionals in the WA public health system’. In the submission by Ngala, it was proposed to educate and recruit younger nurses interested in the early parenting area of work so that they would have direct access to qualifications. The report stated that:

Currently Post Graduate Nursing Students and some undergraduate nursing students attend Ngala. However there is no comprehensive training program that will enable recently graduated baccalaureate nurses to gain the skills to support families. Generally Registered Nurses have to complete a midwifery qualification prior to enrolling in a Child and Family Health post-Registration Qualification. There has also been uncertainty in relation to the continued funding for these courses. The ageing population of Community/Child Health Nurses needs to be addressed to ensure younger staff can assist in meeting the needs of families (Ngala, 2002, p. 4).

5.3.6 Articulating the Advanced Practice Role

The nursing role within EPS as perceived by nurses was descriptive and not designed to identify discrete competencies. However, the researcher reviewed these in light of available descriptions of nursing roles and competencies. The key domains of nursing practice as outlined in the baseline competencies (Australian Nursing and Midwifery Council, 2006) are professional practice, critical thinking and analysis, provision and coordination of care and collaborative and therapeutic practice (Australian Nursing and Midwifery Council, 2006). Advanced competencies for
nursing in child and family health have been written in some states (Australian Confederation of Paediatric and Child Health Nurses, 2006; Australian Nursing and Midwifery Council, 2006; Community Nurses Special Interest Group, 2001; The Child and Family Health Nurses Association (NSW) Inc., 2009b). The findings on the role of the nurse from this study were broadly consistent with existing advanced competencies.

A few minor comments from nurses throughout the study demonstrated their lack of understanding and confusion between advanced nursing practice in a speciality role and practitioner nursing roles. Laperrière (2008) notes that the definition of advanced practice is still ambiguous and raises some questions. Given the diversity of explanations, Laperrière (2008) suggests that ‘the achievement of a mutual recognition of a common terminology might be a threat to independence, autonomy and diversity … the formalisation, normalisation and instrumentation of worker’s practice threaten their professional standing’ (Laperrière, 2008, p. 395). Gardner et al. (2007) explain the difference and offer an operational framework to identify, establish and evaluate advanced and extended nursing positions. The lack of national consistency was highlighted through this study. Schmied et al. (2011), in their review of maternity and child health policies, found that these were consistent across Australia and recommended the consideration of a national framework for universal maternal and child health services (Schmied, et al., 2011) to enable roles and education to become unified and consistent.

Homer et al. (2009) looked at the role of the midwife in Australia and found, among other issues, an invisibility of midwifery in regulation and practice, workplace shortages, and no clear understanding of midwifery within the wider community. These issues were reflected within this study. The authors (Homer, et al., 2009) recommended that the assessment of competency standards should be mindful of the assessment for fitness to practice, cultural sensitivity and ability to reflect the complexity and multidimensional nature of nursing care, and enhancement of client outcomes (Francis, Carswell, & North, 2010, p. 52).
5.3.7 The Role Within an Interdisciplinary Framework

Duffield et al. (2011) raise pertinent issues for nursing to move forward within an interdisciplinary framework. The issues are in relation to the strong nursing identity around titles; the varying number of positions for nurses, such as clinical nurse consultants, specialists or nurse practitioners; and the lack of consistency nationally of these issues. Duffield et al. (2011) suggests that:

Our professional nursing practice is not defined by a title, or the number of roles we have. Rather, our practice is defined by the impact of a new role or position classification on patient outcomes should be the primary consideration when considering whether or not there are grounds for introducing new positions or changing titles. (Duffield, et al., 2011, p. 48)

This first phase of this study demonstrated through nurses and allied disciplines working closely together that there is a clear ability to articulate the unique role of the nurse, despite there being a sharing of skills or ‘osmosis’ of knowledge and skills in collaborative practice. Nurses also maintain a strong sense of boundaries and professional identity. Brown et al. (2000) discuss blurred roles and permeable boundaries when different disciplines work within mental health services. Some see this as role erosion and a threat, while others see it as an opportunity. Brown et al. (2000) purport that ‘boundaries between professions are actively encouraged by the experience of interdisciplinary modes of working’ (Brown, et al., 2000, p. 425). These also emphasise the benefits for all team members, saying that ‘a less precious approach to disciplinary boundaries needs to be explained and a culture that facilitates flexibility needs to be promoted’ (Brown, et al., 2000, p. 433).

Working within a team does challenge the limits of what one can and cannot legitimately be required to do. In a study by Wuest (1998, p. 39), she encourages nurses to attend to one’s own professional ‘voice’, which then allows workers to ‘limit the number and extent of caring demands as well as to draw on self-knowledge to order their caring’. It is suggested that the ‘clearness of a nurse’s professional identity’ is linked with his or her personal growth, ability to progress and determination to enrich his or her knowledge and skills (Harmer, 2010). The important attributes required for interprofessional collaboration identified by Miers
and Pollard (2009) included communications skills, interpersonal relationship skills, teamwork skills, knowledge of roles, respect and tolerance, experience and personal maturity, and being able to inspire trust and work across professional boundaries.

Duffield et al. (2011, p. 47) raised the issue of role blurring, which can be a problem of ‘role confusion’ more in the context of industrial relations. The various awards and pay scales for different professionals can create some unrest when practitioners from different disciplines work alongside each other and are perceived as doing similar roles. Brown et al. (2000) found some evidence of role blurring in their study with mental health community professionals. This was found to be welcomed by a few respondents, whereas others sought to preserve their own professional identity within the multidisciplinary environment. Brown et al. noted that the lack of managerial direction and the encouragement of generic working seemed to make some respondents more insistent on separate professional identities. This reinforces the need for broader policy and support at all levels to ensure interdisciplinary approaches.

Moore and Skinner (2010) consider an integrated approach to early childhood development and argue the case for a more concerted effort for the collaboration of services with a focus on early childhood, to change the service system at a local level to focus on outcomes for children and families. The authors also argue that trans-disciplinary teamwork is the preferred model in early childhood intervention services (Moore & Skinner, 2010, p. 18). In an interdisciplinary team framework, professionals coordinate services and have limited crossing of discipline boundaries. This is how EPS operate. The definition of trans-disciplinary teamwork by Briggs (1997), mentioned in Chapter One, means that several disciplines can work together in an integrated team environment, with any one of the professionals acting as a conduit of services for the team. This means there is a sharing of roles and responsibilities, information and knowledge by team members, while still maintaining the integrity and resources of each primary discipline. This is where the concept proposed in this research study of the EPP could be considered. The argument is that specialist services on the whole create long waiting lists and can be reconfigured to provide earlier support to families and develop better linkages with the universal system to improve collaboration and coordination of services at the local level (Moore & Skinner, 2010).
5.4 The Workforce Development Strategy

As mentioned previously, Australia’s health and community sector workforce is facing significant challenges. Such challenges are well documented and include an ageing population, increased demand for health services and increasing expectations for service delivery, changing burden of disease and broader labour market issues. In addition, health expenditure as a percentage of gross domestic product is rising and is projected to increase significantly in the coming decades. It is critical that these challenges are addressed together to ensure a sustainable delivery of health services that support the health and wellbeing of Australia’s population (Health Workforce Australia, 2012b). The Health Workforce Australia (2012b, p. 4) report recommended the following steps towards a sustainable workforce:

- Understanding the existing workforce;
- Projecting future workforce demand and supply;
- Scenario modelling to enable further examination of the above;
- Identifying any gaps between supply and demand under each of the scenarios; and
- Developing a plan to close the gaps.

Similar workforce issues are being experienced in other sectors such as the family relationship support sector, and future workforce strategies are being considered to develop and meet their needs (Cortis, Chan, & Hilferty, 2009; Department of Families Housing Community Services and Indigenous Affairs, 2009; Family & Relationship Services Australia, 2012). Workforce issues are complex, multifaceted, interlinked and dynamic, and manifest in various ways in different community services sub-sectors and in different organisational, cultural and geographic contexts. Research is only beginning to unpack the context-specific nature of these challenges, and to explore the different models and strategies required to respond to these challenges in various community services contexts (Cortis, et al., 2009; Roche & Duffield, 2007; Stuart et al., 2010). There are also concerns that education programs do not currently prepare the workforce adequately and there is a lack of standardisation of education programs across the country (Kruske, et al., 2006; Schmied, et al., 2011). Authors (Cameron & Christie, 2007; Doggartt, 2012) reinforce the need for nursing leadership to ensure change is initiated and sustained.
A buy-in from two major stakeholders, the consumer and staff, is reinforced by Francis et al. (2010). The authors recommend that if transformational change are desired in models of care and the client journey, there needs to be generational investment in the skills and capabilities of all health workers (Francis, et al., 2010).

The key priorities that comprise the workforce development strategy were presented in Figure 122 of Chapter Four. The strategies included seven areas that are now described with reference to the current literature:

1. Increase the development and availability of innovative options for post-qualification education in the early parenting sector;
2. Develop retention strategies for the ageing workforce in EPS;
3. Develop innovative national professional development strategies;
4. Develop sustainable strategies for a multi-generational workforce;
5. Identify the skill mix for the various practice contexts of EPS;
6. Identify further research areas relevant to EPS; and
7. Market EPS work.

The first three strategies are the key priorities for the next 3–5 years. The other strategies are also important and need to be considered in the overall development of the workforce.

5.4.1 Increasing the Development and Availability of Innovative Options for Post-Qualification Education in the Early Parenting Sector

Post-qualification education in early parenting already exists and is offered around Australia for registered nurses at postgraduate certificate and graduate diploma levels to work within child and family health contexts. There are no standardised levels of competency for graduates completing these programs in Australia. While the nurse practitioner role has been well defined in most countries, there is no clarity internationally on the service potential and domains of practice for advanced practice nursing roles (Chang, Gardner, Duffield, & Ramis, 2010; Kruske & Grant, 2012). Chang et al. (2010) validated previous research towards developing an operational framework and tool for assigning advanced practice nursing roles and defining the core activities required to ensure more appropriate adoption and evaluation of these roles. In addition, Kruske and Grant (2012) investigated the educational preparation
of child and family health nurses in Australia and found that there was a marked difference in name, clinical exposure and award title across the 12 institutions offering relevant postgraduate courses. The authors emphasised the importance of consistency of definitions to facilitate comparable university data and for national workforce planning. They also questioned whether the preparation of child and family health nurses was sufficient at a graduate certificate level, and whether the required clinical hours were assigned to ensure this.

Other related postgraduate studies offered in Australia include a Master of Nursing in Child and Family Health (Karitane) in NSW (Karitane, 2012). There are new multidisciplinary postgraduate qualifications being offered in NSW for very complex families. The Graduate Certificate and a Master’s in Family Studies provides students with comprehensive multidisciplinary knowledge and skills to undertake policy development and service delivery directed towards strengthening families in need of dispute resolution or counselling, or suffering the stress of disability, drug and alcohol abuse and other complex issues that arise in varied cultural, social and political contexts (University of Newcastle website, 2012). Another course in Victoria is designed for people working in the child protection and family services sectors who hold a degree (Department of Human Services Website, 2012).

The above scenarios indicate that there is much work to be done, both from the university and organisational perspectives, in the move towards national consistency of a nursing profession that has been around since the early twentieth century. If further options are to be offered, it would be prudent to gain national consistency in nursing and a great deal of commitment to forge ahead with interdisciplinary work in EPS.

For an additional skill mix to add to EPS and to replace the mothercraft nurse, there is an Advanced Diploma of Nursing (enrolled/Division 2 nursing) offered in parent-craft and family health in NSW (Karitane, 2012), and in Victoria, a Graduate Certificate of Social Science in Prenatal and Postnatal Family Support is offered at Swinburne University of Technology, Melbourne. Such two-year certificate workers are used in the skill mix for the three EPS sites in Victoria. This is a qualification that could be developed nationally, with an online component and workplace assessment tailored in each state.
Overall, around Australia, there are limited options to equip a range of disciplines to work closely with families in the early years. Moore (2008) from the Centre for Community Child Health in Melbourne has identified core knowledge and skills for working in early childhood intervention and has provided a useful guide for setting up new courses or qualifications for a range of professionals in the early childhood and parenting field.

Two options for postgraduate qualifications recommended during this study were the EPP role, and a certificate in early parenting for enrolled nurses. These are discussed below.

5.4.1.1 The proposed EPP role

An EPP role would add value to the mix in staff at an EPS. It would not replace the need for nurses or allied professionals, but would try to solve the issue of spreading the knowledge of early parenting to a greater professional base. As discussed in Chapter Four, this EPP could have a baseline health, social science or early childhood education degree, and the graduate could undertake a postgraduate certificate/diploma in early parenting (yet to be developed). The knowledge and skills expected to result from such a qualification are currently demonstrated by child and family health nurses due to their longevity of experience and knowledge base.

As has been shown by this and other studies, this broad knowledge base requires an investment in professional development and clinical supervision that many nurses on the whole have not had in universal services or EPS. Some studies have shown that the depth to parts of the child and family health nurse role require ongoing development and collaborative interdisciplinary approaches, such as in child protection, perinatal mental health and other complex issues facing families including family violence, separation and relationship difficulties (Chavasse, 2010; Land & Barclay, 2008; Vimpani, 2000).

As indicated, this proposed role will not only assist to solve workforce issues but will provide for the needs of today’s families and the many issues they face. EPS is a workforce that could accommodate a greater skill mix with nurses. Duffield (2008) challenges the neonatal, paediatric and child health sector in Australia, given the small number of nurses, to rethink the nature of the workforce in terms of future directions. She asks several questions:
• Which health discipline is best able to meet the needs of this particular child and who will provide the care?
• Who are the members of your workforce and is this appropriate given future demands?
• What do nurses contribute that no other health discipline can?
• What do nurses currently do that someone else could do?
• How do you define and measure the impact of what you do?
• How do we know we are making a difference to a child’s health status?

(Duffield, 2008, p. 7)

Duffield (2008) does suggest that these specialties could benefit from a greater mix of multidisciplinary postgraduate courses. She states that ‘universities need to consider these issues … there may well be better ways of preparing this specialised workforce in a country of this size’ (Duffield, 2008, p. 7). Another point raised by Duffield et al. (2011) was about the speciality of child and family health nursing and the costs to education providers of small numbers of students annually. Duffield recommends considerable debate and planning on the introduction on new positions and the need for a national approach to defining practice (Duffield, et al., 2011). Duckett (2005) encourages the redefining of the health workforce in Australia and recommends options for new roles. Duckett suggests that the emphasis should not be on providing more of the same, but rather the roles of health professionals will need to change and a stronger emphasis be applied to workforce substitution; that is, a different mix of responsibilities (Duckett, 2005, p. 201).

5.4.1.2 The enrolled nurse and a qualification in early parenting

Authors have recently explored the role and scope of practice for the enrolled nurse (Cubit & Leeson, 2009; Gibson & Heartfield, 2003; Gibson & Heartfield, 2005; Jacob, Sellick, & McKenna, 2012). Certificate programs for the enrolled nurse will be phased out in 2014 and become a Diploma of Nursing. Through their employment arrangement, enrolled nurses need to be guided by the principles of determining scope of practice and the agreed principles of delegation and supervision, as set out in the national Board’s professional practice framework. All nursing activities must take place in the context of agreed principles of delegation and levels of supervision at the local level. These should be supported by the policies, procedures and
protocols that have been developed in accordance with service needs and intended outcomes of the workplace (Nursing and Midwifery Board of Australia, 2012). Predominant issues in practice have been role blurring and supervision requirements by registered nurses (Gibson & Heartfield, 2003; Jacob, et al., 2012). Small numbers of enrolled nurses are employed by EPS in Australia. Nurses through all phases of this study recommended more options for postgraduate qualifications for enrolled nurses, to improve the skill mix for EPS. Currently, courses are limited to two states in Australia. A qualification in early parenting could be developed with an online component for use nationally, with placements arranged in state contexts.

5.4.2 Develop Retention Strategies for the Ageing Workforce in EPS

Staff shortages in the health system generally, high turnover and the ageing workforce have been well documented in Australia (Duffield & O’Brien-Pallas, 2002) and internationally (Thompson, Young, Heller, & Farrow, 2001). For EPS, a high turnover of nurses is not a major issue at the moment with the employment longevity of many of the nurses. The Productivity Commission also made an assumption that ‘while some concerns were raised about the ability of child health services to replace the ageing workforce, the relative attractiveness of the specialty, evidenced by strong demand for postgraduate child health courses, suggests that workforce turnover should be manageable’ (Productivity Commission, 2011, p. 316).

In WA, anecdotally the major issue is that the interest and demand for courses is outweighed by an unmanageable process in the Health Department to get permanency of positions, or by no positions being available.

It is important that flexibility for ageing nurses supports their transition into retirement and allows them to mentor inexperienced nurses. Nursing is predominantly a female profession. Many nurses have taken time off to have a family, which limits their earning and pension capacity. More recently, in increasing numbers, these same staff are now relied on to provide care for elderly parents (Graham & Duffield, 2010). There is little evidence to suggest that nurses are currently working or prepared to keep working until the age of 65 because of the challenges and related health issues experienced in today’s work environments (Graham & Duffield, 2010). A number of studies have focused on the needs of the
ageing workforce internationally (Falk, 2007; Fitzgerald, 2007; Kear, 2011; Keller & Burns, 2010; Sorrell, 2010; West & Maguire, 2012).

A Canadian study (Lavoie-Tremblay, O'Brien-Pallas, Viens, Brabant, & Gélinas, 2006) looked at retention strategies in the form of incentives for nurses to stay. These ranged from workplace culture and respect to tailoring of workloads, abilities and needs. Resourcing will need to accommodate this transition, given the large benefits of knowledge and skills required to support and retain younger and less experienced nurses and other allied professionals (Stanton, 2011). It was reinforced by many nurse respondents that there needed to be some assessment of the appropriate and necessary attributes and skills to provide leadership and mentorship (Anonymous, 2011). This point was also stressed as important by Stanley (2010) because the leadership approach is linked with the retention of nurses and job satisfaction from all generations. The author emphasised ‘congruent leadership’ as that style in which leaders’ actions are matched with their values and beliefs, making this a suitable approach when working with a range of employees from different generations (Stanley, 2010, p. 850).

In a qualitative study by Kruske et al. (2006) of child and family health nurses, she found that the overall educational achievement (in terms of tertiary education following from hospital-based certificates) of the nurses in the research was low. Kruske argues that in this case, it is difficult for nurses to demonstrate leadership and research into the profession. This is consistent with the general absence of literature around child and family health nursing in Australia. Kruske et al. (2006) suggest that this issue requires key decision-makers in both services and education to collaborate with leaders of the profession to address challenges in future models and service redesigns.

5.4.3 Develop Innovative National Professional Development Strategies

Workplaces that facilitate educational opportunities for their staff promote a culture of excellence, which assists with staff satisfaction, staff retention and quality care (Levett-Jones, 2005). Opportunity for innovation in this area, particularly with advances in technologies, has great potential nationally. Fowler et al. (2009) in their study of NSW child and family health nurses recommended that:
Education programs at graduate level and continuing professional development require a significant shift from information laden courses, to programs that also provide graduate attributes of: Information accessing and processing, critical thinking and reflective capacity, ability to work in partnership, a population approach to practice and a commitment to rigorous evaluation. Having these qualities enables the C&FHN [child and family health nurse] to shift from the ‘expert’ model of practice to a model of partnership that acknowledges and draws on parents’ existing knowledge and resources. These new skills and enhanced attributes contribute to the family’s empowerment to manage their health needs more effectively. (Fowler, et al., 2009, p. 7)

IPE needs leadership that is committed to sustaining this approach within the workforce. In a study by Carlisle, Cooper and Watkins (2004, p. 545), it was found that in some settings committed to providing comprehensive collaborative care, it was more rhetoric than reality. They stated that ‘staff often pay lip-service to the principles of interdisciplinary teamwork, and understanding of basic concepts can be poor which may be due to lack of inadequate teaching of the principles of team working in pre- or post-qualification training’. Missen et al. (2012) reinforce the necessity of workplace commitment for undergraduate interprofessional learning through student placements. This will also assist to move the culture of nursing in some areas from a mono-discipline approach to interdisciplinary perspectives and models of work. National standards, curriculum, clinical supervision and reflection also enable a dynamic culture of life-long learning.

One of the major changes from the past that presents as a strength of EPS is the move to team and partnership approaches and reflective practice and the benefits that these influences bring to organisations, albeit at various stages around Australia. The isolated practitioner in the community child health nurse model, in which nurses were placed out in small buildings on their own, has not always been conducive to the nurse’s growth and learning (Borrow, et al., 2011). Governments around Australia are starting to realise this, but are often constrained by available buildings and the history of these locally in the community. Institutional care at Ngala up until the 1990s was also still very individual focused when working as a practitioner with
a family. Therefore, the benefits to the context of the EPS interdisciplinary environment are considerable (Nemeth, 2008).

A combination of increasing the family partnership approaches, clinical supervision (Chavasse, 2010), increasing the discipline mix and encouraging interdisciplinary reflective practice can only move organisational cultures towards a greater focus on the families they serve. A range of strategies at all levels will enhance this change. Ngala has, for example, found a number of successful strategies that are enabling a cultural shift towards an interdisciplinary approach. A concerted effort in implementing C-Frame throughout all levels of the organisation was a successful method of ensuring everyone speaks the same language about how they work together. A staff development program that commenced at orientation was built on four levels, and components were tailored or contextualised for specific team areas such as administrative support and child care centres (Ngala, 2008). ‘C-Frame champions’ were important to embed the C-Frame culture. In developing the interdisciplinary research agenda, a discussion paper was written to involve staff across the disciplines (nursing and midwifery, social work, psychology and early childhood education) in discussing the key theories and approaches that inform early parenting research and practice, and gain their feedback (Ngala, 2010a). Other research activities have also focused on involving staff to increase their project and practice development skills and experience in interdisciplinary team work (Bennett, Hauck, Bindahneem, et al., 2012; Bennett, Hauck, Carter, et al., 2012; Bennett, Wells, et al., 2012; Hauck, et al., 2011; Hauck, et al., 2007; Priddis & Wells, 2010b).

The area that requires work nationally is the implementation of effective supervision models. Currently, these are offered in an ad hoc manner around Australia in EPS (Bennett, 2008). Ngala has commenced a project to develop and implement a framework for supervision in 2013.

**5.4.4 Develop Sustainable Strategies for a Multi-Generational Workforce**

This priority of a sustainable multi-generational workforce has been combined to include the two aspects that were explored through phase three: developing marketing and recruitment strategies, and sustainable strategies to support a future multi-generational workforce.
Given that the current main workforce consists of baby boomers and generation X nurses, it is important to understand the characteristics of each generation and the requirements needed to support recruitment and retention of staff. Multi-generational workforce issues and trends significantly affect recruitment and retention, as do demographic and societal trends such as the ageing nursing workforce concurrent with an ageing population (Sherman, 2006; West & Maguire, 2012). Nesley and Brownie (2012, p. 197) state that effective leadership is required to build a cohesive workforce by ‘utilising the strengths and skill sets that characterise different generations of nurses, and create the conditions in which all nurses feel supported and valued’. Working with these different generational groups requires leaders and managers that can adapt themselves or the environment (Bail & Schreuders, 2011), or who can harness the attributes of each generational group to meet the needs of their respective organisation (Sherman, 2006; Stanley, 2010).

There is increasing literature on this topic. Table 18 is an example that demonstrates the characteristics of each generation (Baker, 2012a, p. 232).
An example given of a characteristic of generation Y (Millennial) nurses was that they expect more coaching and mentoring than any other generation in the workforce. They are optimistic and goal-orientated, but also want structure, guidance and extensive orientation. They also value flexible workplaces, and organisations can expect a high turnover if their needs are not met (Sherman, 2006). The emphasis of the literature encourages the workplace to generate a collaborative team culture that will be beneficial across the diversity of generations. Authors such as Baker (2012b) and Stanley (2010) highlight five priorities of focus for any generation:

1. An opportunity to advance within the organisation;
2. Better work–life balance;
3. Better remuneration benefits;
4. Respect and recognition; and

Graduate positions need to be given a high priority in EPS, as nurses are often unable to obtain positions in the health system. Nurses have not traditionally been encouraged to undertake placements in community nursing. There is now a proportionate decline in graduate nurse programs, despite the increase in the actual
number of nurses entering the system and needing urgent planning at all levels of
government (Belardi, 2011b).

The last, fifth, point is important and was seen as a crucial factor of retention
throughout this study. The ever-increasing pace of technological change, increasingly
complex client care needs, and rapid changes or developments in knowledge should
cause organisations to consider carefully the impact of continuing education.
Environments that are conducive to learning and development will improve staff
satisfaction, staff retention and quality care (Holland, Allen, & Cooper, 2012; Levett-
Jones, 2005). This environment is also supported by accommodating generational
preferences in areas such as coaching and motivating, communicating and resolving
conflicts, as this assists to promote an environment of retention (Sherman, 2006).

5.4.5 Identify the Skill Mix for the Various Practice Contexts of EPS

In practice, skill mix involves achieving a balance between trained and untrained,
qualified and unqualified staff, various occupational groups, and supervisory and
operative staff in a context of cost and care considerations (Hennessy, 1995). Nurses
in this study responded that it was important to develop a broader understanding of
skill mix and increase the mix of staff. Some national sites have large percentages of
nurses compared to other disciplines, and this appears to be historical. The WHO
(2010b) advocates for interprofessional collaboration through teamwork, which has
the potential to strengthen health service provision and improve outcomes for clients
by enabling access to a broader cross section of skill sets in addressing their often
complex health issues. AHPRA provides information about accreditation under the
National Law Act, in force in each State and Territory, to enable the continuous
development of a flexible, responsive and sustainable Australian health workforce
and to enable innovation in the education of, and service delivery by, health
practitioners (Australian Health Practitioner Regulation Agency (AHPRA), 2010).

Nemeth (2008) advocates for a strategy of using family partnerships training to bring
together different disciplines to enhance the provision of collaborative care for
families. The challenges confronting contemporary society demonstrate the effect of
a range of social, economic and political factors on health and wellbeing. These are
frequently discussed as the determinants of health and include issues such as poverty,
drug use, our changing global climate and environment (Keast & Mandell, 2009) and
the increasing impact of chronic disease on the global population (Humphris, 2007). Of significant concern is the need to pre-empt a global crisis in the health workforce due to the ageing workforce population (World Health Organisation, 2010b).

The various contexts of EPS need to be considered as the mix of staff can vary as well as the involvement of staff of the rationale and need to plan around skill mix. It is felt that understanding and articulating the various roles can give clarity to the range of disciplines working together. Carr and Pearson (2005), in their study, focus on the exploration of nurses’ experiences of engaging in delegation practices within an actual or potential skill mix environment. They address debates about the appropriate care responsibilities for different types of health care worker from the perspective of how this affects the delegation process. The limitations of the study indicated that more research is required for contexts other than the community context, as differences may exist in teams that work closer together where supervision and interprofessional communication is immediately available. A study at Ngala is exploring the social work and nursing role when working jointly with a family (Bennett, Hauck, Carter, et al., 2012). This further adds to the evidence base around workforce and roles in early parenting.

5.4.6 Identify Further Research Areas Relevant to EPS

Overall, research and application of evidence to practice throughout EPS in Australia is limited and is just starting to develop momentum and importance over recent years. Even the evidence base used for practice needs a much greater focus on the rigour of having clinical guidelines for every aspect of practice, there are now good examples of best practice guides for perinatal mental health, child protection, home visiting and some other aspects of work. This issue was also identified by a British study (Appleton, 1997) and a review of a Victorian EPS (Fisher & Rowe, 2003). The argument was that, because of the absence or generally poorly defined guidelines for working with ‘at risk’ or ‘vulnerable’ groups, professionals often use subjective clinical judgement. Nurse respondents in this study thought that developing research cultures that encourage practice development was crucial, as was the need to keep the client uppermost in importance, to ascertain the difference the EPS make with the various contexts of their work. Other suggestions from nurses reinforced the importance of this study, and called for more research on interdisciplinary
approaches. Rickard et al. (2011) suggested that nurses need greater access to resources such as computers, research software and quiet workspaces to support a research culture.

An interdisciplinary research framework was developed for both research and practice at Ngala (Bennett, Hauck, Bindahneem, et al., 2012). This approach could be an example of best practice for other sites wishing to develop a research culture. From the initial project and set up of a research group with various university research partners, an interdisciplinary framework was developed with research priorities and strategies to develop a research culture. An action research project sought to identify the barriers for staff to undertaking research. Encouraging a research culture requires ongoing effort to include practitioners in different research and practice development activities. A number of studies have investigated why nurses find it difficult to strive for increased understanding to address the issues that affect their practice. New and Bogossian (2008) looked at the experience of generation X and baby boomer generation neonatal nurses and found that they often feel they have not got the skill, knowledge or support to undertake research in practice. Organisations will need to consider how to involve young practitioners in practice development from the beginning, so that they form a new culture of practice development. Workplace cultures and support from management are also crucial in the development of positive research cultures (Bennett, Hauck, Bindahneem, et al., 2012).

Ngala staff have continued with further activities and now have preliminary findings from current research projects. One project is investigating the effectiveness of Ngala’s family partnership approaches (C-Frame) on practice undertaken by nurses (Bennett, Wells, et al., 2012). This project aims to determine how nurses use evidence-based information in their practice and process of care. Consumers are also being asked how they experienced the process of care.

Another study in progress is exploring nursing and social work roles when working jointly with a family at Ngala. The initial findings are revealing the challenges practitioners often face with boundary issues. These boundary issues have to be worked through when practitioners from different disciplines commence doing joint work with a client. If this is recognised from the beginning, then practitioners can
commence planning and reflection to enable more effective communication with the client (Bennett, Hauck, Carter, et al., 2012).

5.4.7 Marketing of EPS Work

Raising the profile of EPS work was seen as very important by nurses in this study. It was recommended that the strengths of EPS be articulated, and that the important role that services play, particularly in supporting the universal child health systems, be marketed to the public. McMurray (2010, p. 117) reinforces that ‘the contributions by nurses and midwives need to be articulated in the policy area … the challenges are many but we need to ensure our voices become an inspiration to the next generation’ (p. 177). For the current workforce to gain a voice, there must be increased involvement of nurses in the workplace in policies to create a supportive work environment and professional development to meet their needs (Bail & Schreuders, 2011; Stanley, 2010). The professional identity of nurses is changing, and it is imperative that nurses find their voice, combine this with confidence and intelligent conversation and connect with the media (Harmer, 2010; Kemp, et al., 2005). Spence (2008, p. 2) also presents a challenge to nurses in her article in which she comments that ‘child health nurses remain a small speciality and need to unite with their goals of providing expert nursing care and move the speciality forward’ (p. 2).

Nurse respondents in this study talked of the silence of the consumer in this area and the greater awareness required in other health and welfare services of this type. A UK Delphi study (McKenna & Keeney, 2004) asked general practitioners, community nurses and members of the public how the public perceived community nursing. The study recommended that nurses promote and encourage the public to be involved in the planning and delivering of services. Further, community nurses were advised to involve consumers of health and social services in ways that increased their resources, promoted their capacity and power to influence factors affecting their health and wellbeing, and enhanced their understanding of community nursing services. They also argued that nurses have a special relationship with the public and that this demands a readiness to ask people about their experiences of health and how they want their care needs met. The authors also stated that organisations ‘must create a climate and culture that is responsive to public involvement, and this must be
reflected in the resources, timescales, information exchange and willingness to support individual practitioners in their public engagement’ (Francis, et al., 2010; McKenna & Keeney, 2004, p. 23). Child health nurses must be ‘eclectic and dynamic’ in their search for the best ways of developing the profession and helping children and families achieve their potential (Kenny, 2002, p. 310).

Having considered relevant literature, it is now prudent to discover relevant theory that is pertinent to the findings.

5.5 Comparison of Findings with Theory

Both role theory and IPP theory are important in the reflection of the comparison of findings with theory. Each will now be described.

5.5.1 Role Theory

When role theory was developed during the early part of the twentieth century, there were strong correlations with the nursing role, given the societal context and that nursing evolved with strong influence from the army. Nursing was also strongly dominated by the medical model and control was task driven until the move to the tertiary sector, which began to create a stronger voice for nursing. Nursing in EPS had influential medical advocates alongside volunteer advocates, and hence differed from the hospital context. Nurses in child health centres and EPS were very strong and autonomous women (and still are), and they also had a strong identity and role expectation as nurses. This was identified in the present cohort of nurses by the allied professionals in phase one of this study, and it can be suggested that this is consistent with nursing being the largest health discipline in Australia (Duckett, 2005) and the public perception on the role of the nurse in society (McKenna & Keeney, 2004).

One of the critiques by feminist writers is that role theory perpetuates the notion of categorical separation of work and leisure and has been linked to the experience of the traditional males employed within western industrial societies. The idea of ‘multiple awarenesses’ is ‘the ability to attend to those issues and needs that may appear to be in the periphery of life simultaneously with those that are presumably in the centre’. In this way, the theory needs to reflect the experiences of men and women (Jackson, 1998, p. 54). Jackson (1998) stated that the role theory perspective of human agency minimises the creative nature of humans as they adapt on a daily
basis to their environments; how people improvise to reach their goals or life choices, given the constraints of their particular situation against a backdrop of social, economic and familial forces has not been sufficiently explored (Jackson, 1998, p. 53).

As indicated, in terms of the profession of nursing being possibly consistent with role theory, this has a correlation whereby the strong identity of being a nurse was very influential on the majority of nurses. The change from hospital-based nursing to the tertiary sector created role conflict, requiring the renegotiation of roles to conform to the changes. This is consistent with organisational role theory, whereby the organisation takes on an employee with the assumption or expectation that the nurse will comply to the behaviour that is expected, with role conflict arising when expectations are not consensual or congruent (Biddle, 1986; Wickham & Parker, 2007). Since the 1980s, advanced practice roles started to evolve, and since then roles have been emerging as a result of changing health care needs and workforce requirements, with societal forces such as economic climate, changes in technology and health care delivery influencing its evolution (Hamric, Spross, & Hanson, 2009; Holloway, Baker, & Lumby, 2009). Variance in approach to collecting data and in defining specialty practice areas and specialist nurse numbers is challenging, both nationally and internationally (Furlong & Smith, 2005; Holloway, et al., 2009). A nursing specialty such as EPS requires a national framework to develop a base of evidence for understanding consistency. Clarity around specialty areas and specialist-level practice will give descriptors and an education framework to assist with data collection and to provide enhanced information for both workforce planners and stakeholders in the health care system (Furlong & Smith, 2005; Holloway, et al., 2009).

A most important stakeholder is the family and child as consumer, because the development of a professional nursing workforce must always be linked to the health care needs of communities. Consumers expect service providers to be knowledgeable in assisting them to manage their complex health needs. A framework that provides clear identification of specialist nursing practice also enables closer examination of the relationship to client outcomes and clinical effectiveness. Duckett (2005) also pointed out that in addition to health care consumers and nurses themselves, there are four other parties to consider in nursing workforce issues: education providers who
design curricula; health service providers who employ nurses; health service regions that make decisions about pay and conditions; and the government, which funds education and regulates migration. In the absence of a consistent national framework, small organisations such as EPS are often reactive and have created multiple and isolated approaches that are not effective or sustainable in the long term for EPS nursing workforce planning.

Educational preparation for the health workforce generally has not kept pace with changes in the environment. Although education of health professionals has been by no means static, new needs have typically led to the development of niche professions rather than reorganising professional boundaries to meet new needs (Duckett, 2005). This is certainly true of nursing. Reform to promote teamwork, interdisciplinary ways of working and flexibility in the workforce has been recommended by many reviews. An example given by Duckett (2005) reminds us that the 2004 first national Health Workforce Strategic Framework recognised that realignment of existing workforce roles or the creation of new roles may be necessary. Nurses generally have reconstructed their role to fit the status quo of nursing, particularly in terms of interdisciplinary work. It is now time for increased leadership in nursing and creative opportunities for nurses, to engage them in new skills to successfully challenge this status quo.

Nurses in EPS have navigated change over time, but there is still some evidence of role conflict as nurse leaders try to resolve the potential difficulties that lie ahead in terms of workforce composition, and how they will articulate the role of the nurse in that context. Nurses need not be limited to the historical notions of role theory, but can forge a more contemporary approach to inclusion of broader social forces and consider the role in EPS in terms of societal changes for families and sociopolitical agendas. Organisations also need to accommodate a multi-generational workforce, with flexibility required to support all workers in their role so that development to their full potential is possible (Wickham & Parker, 2007). Role theory would say that, while nurses are being challenged with their role expectations during a transition phase, the support of organisations is crucial for them to generate a sense of meaning and purpose that contributes to their own psychological well-being. Nurses must then modify their attitudes and expectations through anticipatory socialisation and adapt through training and professional support in their new defined
roles (Burnett, 1999). Sherman (2006) suggested that generational differences with nurses can present leadership challenges, but that these differences in attitudes and behaviours should be viewed as potential strengths. A flexible leadership style will enhance quality and productivity, reduce conflict and maximise the contributions of all staff.

In terms of professional identity being strong in EPS, this can be a barrier in interdisciplinary team work. Such professional identity is a process of socialisation within professional role development and has been shown to play a large part in the development of ‘tribal’ attitudes. To avoid the detrimental effects of this, IPE needs to begin early in a nurse’s pre- and post-professional education and nurses need to be supported to feel comfortable in their own role, which leads to acknowledging other people’s roles (Atkins, 1998).

This begins the link between role theory and IPP theory, which will now be described.

5.5.2 Interprofessional Education and Practice Theory

Before discussing IPP, it is necessary to view briefly the main theories driving IPE. IPE is defined as occasions when two or more professionals learn from, with and about each other, to improve collaboration and the quality of care for families and children (Hammick, et al., 2007; Nisbet, et al., 2011). The policy drivers for IPE have been occurring globally and reflect the increasing pressure on the health care system, such as from changing demographics, new models of health care and the need for teamwork, quality and safety agendas, and health workforce shortages (Nisbet, et al., 2011).

Craddock, O’Halloran, Borthwick and McPherson (2006) presented an overview of four educational theories that they think are important for IPE: reflective practitioner theory, adult learning theory, theories derived from social psychology and systems theory. Firstly, the ‘reflective practitioner theory’ attributed by Schon (1987), has been described as being crucial to any professional education program because of the focus on the application of theory to practice. By professionals and/or teams reflecting on the processes of working together for the improvement of client care, they can achieve an appreciation of the roles and underpinning values and models of
both or all of their professions. Reflective practice facilitates the natural occurrence of interprofessional work as disciplines complement and support each other (Craddock, et al., 2006).

‘Adult learning theory’ has been attributed to Knowles (1980) and has become the standard by which continuing health education is measured and appraised. This is based on the premise that a key element of good teaching is the ability to stimulate self-learning. Learning, as it occurs, can change conceptualisations of phenomena and the world can be seen differently. A number of teaching strategies can be employed to facilitate self-directed and collaborative adult learning. For example, problem-based learning uses team learning theory, which has a focus on collaboration within the group and group dynamics. Individual learning here is necessary but collaborative learning is essential for an effective organisation (Craddock, et al., 2006). Kolb’s cycle (Kolb, 1984) and experiential learning has been utilised to inform IPE. This learning cycle involves a cyclical sequence of four elements deemed to be fundamental to learning; that is, concrete experience, reflective observation, abstract conceptualisation and active experimentation (Craddock, et al., 2006).

The group development theory is characterised by forming, storming, norming and performing stages that span the life of all groups. It emphasises the need to address relationships between learners in an IPE initiative (Tuckman, 2003). Time spent reflecting as a group through collaborative work via ongoing discussions can therefore help teams to become reflexive, integrated and better coordinated (Craddock, et al., 2006). These authors also recognised that the application of adult learning theories alone is not enough to support IPE.

Thirdly, theories derived from social psychology have been utilised to inform the development of IPE initiatives (Craddock, et al., 2006). Two such theories are now explained. To facilitate collaborative learning and reduce stereotyping, ‘contact theory’ looks at outcomes when two opposing groups are brought together. This was developed from the work of Allport (1979), who proposed that three conditions had to be met before prejudice between different social groups could be reduced: equality of status, group members working towards common goals and cooperation during contact. To facilitate IPE, other conditions were added: positive expectations by
participants, successful collaborative activities and a focus on understanding differences and mutual similarities to positively influence stereotypical attitudes. It has been found that IPE cannot by itself remove the attitudinal barriers between members of professions (Craddock, et al., 2006).

The other example of a theory derived from social psychology is ‘social identity theory’. This theory, based on individual self-concepts, explains intergroup discrimination where one group favours their own group over another (Mandy, Milton, & Mandy, 2004). Such a self-concept is centred on social identity, which is influenced by membership of a group and by the values that the group shares (Mandy, et al., 2004). Social identity theory describes an interpersonal–intergroup continuum along which individual health professionals define themselves according to their occupational group, and individuals strive to uphold and augment their personal and collective identity (Luhtanen & Crocker, 1992).

Fourthly ‘systems theory’ developed by Engel (1977) is an application of systems thinking that relates the individual to the environment. Systems theory has been used to provide a clear appreciation of the complexity of the interactions involved in establishing an integrated service (Meads, Ashcroft, Barr, Scott, & Wild, 2005). Here it is recognised that intervention by one profession at one point in the system affects the whole in ways that can only be anticipated from multiple professional perspectives. It gives an overall understanding and a commitment to real-life conversation and listening in which issues of difference need to be positively addressed via empowerment exercises, with a shared stance towards person-centred planning (Craddock, et al., 2006). When using systems theory with IPE initiatives, it is necessary to have a framework for addressing values, ideologies and differences in a team that can lead to trust of other disciplines and supersede those that constitute individual professions (Meads, et al., 2005).

Hean, Craddock and O’Halloran (2009) focused on learning theories and have considered the behaviourist and constructivist frameworks used within IPE, particularly from the individual and collective levels, from a situated learning or socio-cultural perspective. The authors highlighted the relationship between the range of theories and their evolvement and how this can be presented as a tool to understand the theories for practice application.
The authors argued that there is a need to explain and test theories that explain the socio-cultural perspective of learning to assist with the differentiation of uniprofessional and interprofessional learning (Hean, et al., 2009). Hean et al. also suggested that there is still a gap in the appropriate application and testing of these theoretical models in practice.

Therefore, when the focus of IPL shifts from how the individual learns to the context of the team or organisation, then Sargeant (2009) suggests that ‘complexity theory’ may be more appropriate as a lens to explore the interaction among various components of the environment. The author stated that:

complexity theory encourages us to look at continuing professional education differently as it moves the focus from the individual professional and how he or she learns and changes in response to education, to the health team, health system, and environment. Complexity theory also moves us from a reductionist or linear view of education and practice, which overlooks the interaction of individual elements and considers processes value-free; ie, personal and social influences did not intervene. (Sargeant, 2009, p. 179)

D’Amour and Oandasan (2005) developed a conceptual model linking IPE and IPP. This model demonstrates the multiplicity of interactions and relationships among individual learners and practitioners, teams, education, health systems and organisations, environments and cultures, all of which influence what is learnt and what is applied in practice.

Social psychology and complexity theory provide a rationale for an expanded vision of continuing education to accommodate IPE because IPE occurs through social exchange in complex environments (Sargeant, 2009). The theories that propose specific approaches to learning and teaching IPE are seen as critical to effective interdisciplinary teams seeing IPE as transformative learning enabling better appreciation of the need for a new way of thinking and knowing. These are social theories explaining social identity, professionalism and stereotyping; communities of practice; reflective learning; and transformative learning. Cooper et al. (2004) consider how complexity theory can provide IPE with a coherent theoretical foundation that ensures a direction for practice, intervention goals and what might
explained any outcomes for the intervention. In consideration of the application of theories to practice in EPS, the framework presented by D’Amour and Oandasan in Figure 128 is valuable.

![Collaborative Practice Process and Outcomes](image)

**Figure 128. Collaborative practice process and outcomes (D’Amour & Oandasan, 2005, p. 15)**

The C-Frame (Victorian Parenting Centre, 2005) process of care discussed in Chapter One (that Ngala and some other EPS have integrated within their frameworks) is consistent with this model. Ngala has C-Frame to working with colleagues as well as clients. Care to families and children is central to this model and has an interdependent relationship with professionals. Practice takes on various forms depending on the context and complexity of client needs and the composition of each team. The circle also presents the interactional processes and organisational factors that have to be taken into account when professionals work collaboratively (D’Amour & Oandasan, 2005). Congruence with organisational commitment to collaboration is vital for success. Curtin University in Perth have developed their ‘interprofessional capability framework’, which brings the model down to a discrete team (see Figure 129).
There are three core elements situated in this model; that is, client-centred, client safety and collaborative practice. To achieve these outcomes, students are asked to acquire five collaborative practice capabilities: communication, team functioning, role clarification, interprofessional conflict resolution and reflection (individual and team). There are now assessment tools available for students and evaluation of programs (Nicol, 2013). The Ngala experience of interdisciplinrny team practice certainly works to achieve the five key outcomes in this model.

Figure 129. Interprofessional capability framework (Nicol, 2013, p. 24)

According to Nicol (2013), the WA report was an exploratory study using WA as a case study in recognition of the scope and range of IPE activities occurring in universities and institutions. Four key aspects were identified as pivotal to the acceptance and implementation of IPE in WA in the future. These were funding, accreditation and registration bodies (flexibility in health professional criteria), educators (current divergence on scope of content), and changing requirements in the delivery of health services. The latter involved issues of change requiring systemic adjustments in remuneration, response to increased demand for primary care and the need for health professionals’ roles to adapt. The report also found that many health professionals supported IPE, while many others were not prepared to engage with it. These attitudes were also found to have a direct influence on students (Missen et al., 2012). Other factors affecting attitudes were fear of role substitution and insufficient
evidence to persuade health professionals to adopt IPP; these fears were certainly expressed in this study.

In moving forward, Sargeant (2009) suggests that much consideration is needed in developing and implementing IPE. Specific implications of complexity theory for continuing IPE include realising that IPE is complex: ‘It encourages us to be thoughtful and careful as we move ahead. Understanding and being responsive to the practice setting within which interprofessional teams are working are critical to success’ (p. 180). This leads to the final point of emphasising leadership and resourcing organisations when embarking on interdisciplinary research and practice and embedding it into organisational culture (Begun, 2008; Bennett, Hauck, Bindahneem, et al., 2012; Clancy, Effken, & Pesut, 2008; Engum & Jeffries, 2012; Missen, et al., 2012).

5.6 Chapter Five Summary

This chapter discussed the findings of this case study with reference to other literature and the applicability of theory to the findings. A conceptual framework for the past, present and future of nursing was presented with an explanation of a workforce development strategy that will inform national directions for nursing and interdisciplinary contexts in EPS in Australia.

The following chapter will consider the limitations of the study, give recommendations and discuss some implications for the future.