Community-based Based

Child Health Nurses:

An Exploration of Current Practice

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INTRODUCTION

This research was initiated in order to define the practice domain of child health nursing in light of recent political, economic and social changes in Western Australia. The project was conducted by a group of nurse researchers with experience in child health nursing. The aim of the project was to map the scope of nursing practice in the community child health setting in Western Australia and to identify the decision making framework that underpins this nursing specialty. In light of widespread social and health service management changes and lack of research in this area, there is urgency for community based child health nurses to have the role accurately defined.

This is the first time the role of the child health nurse in Western Australia has the subject of a research investigation. These research findings have the potential to influence policy and practice guidelines for future child health nursing practice not only in Western Australia but further afield in Australasia. The challenges facing child health practice include; a broadening of the child health nurse's role in order that they deliver traditional services, in addition to services that have evolved due to changes in the social determinants of health and health service approach, along with changing consumer expectations. In identifying the core roles and responsibilities of the child health nurse in current practice, this study has the potential to inform health services of levels of support child health nurses require in clinical practice. Furthermore, by ascertaining the current role of the child health nurse, their scope of work is able to be more accurately identified. This data is valuable for identifying workforce issues, training requirements and strategies needed to be put in place to assist these nurses to provide optimum care to clients. In an integrated service it is necessary to align the nurses' roles in relation to other allied health staff to support targeted programs in Western Australia. Furthermore, it may assist with raising the profile of the child health nurse by increasing the awareness of the general public and other health professionals to their roles. This will, in turn, assist in recognising their contribution to the entire community.

BACKGROUND and LITERATURE REVIEW

Searches for the literature review were conducted in the following databases: Health and Society, Health Collection, CINAHL, Science Direct, Scopus and Medline using the words child* nurs* health public and community in differing combinations from 1995 to the time of the study. Literature in languages other than English was not used. Literature from the Australian Research Alliance for Children and Youth, government sources, theses and conferences were also searched. Following a review of the data derived from the search terms, twenty nine papers and six books were retained.

The role of the community based child health nurse, although changed considerably over time, has always been a specialist practice role. In recent decades the child health nurse practice domain has become extended. The expansion of the role is the result of changes in the complexity of the social determinants of health faced by parents/caregivers of young children and changes in health service delivery. Child health nurses are expected to provide holistic care by focusing on individualisation of care via comprehensive assessment and program planning for children and their families (Drummond & Marcellus 2005).

A preliminary review of the literature showed that a shift from a focus of individualised health service provision to a population health approach is occurring in health service

delivery. This encompasses universal, targeted and selected services. Prior to the 1970s, the focus of nurses working in the 'baby clinics' was instructing mothers in infant care, that is, targeting a specific group being the mothers (Barnes *et al* 2003). After the 1970s, child health nurses began to utilise the wellness model of child health and the development of health services away from a specific group to focus more on individual consultation and care planning underpinned by health promotion (Barnes *et al* 2003). In more recent times, the child health nurses' roles and responsibilities have focused on health promotion approaches along with secondary and tertiary prevention strategies, with the focus more towards a population health approach. The broadening of the role include, but is not exclusive to, multifaceted case management, home-visiting, outreach programs, early identification and primary intervention of clients with psycho-social and mental health issues, group facilitation, the traditional one to one client contact and multi-disciplinary team function.

This change in approach has been driven by the changing social determinants of health and the recognition of the importance of the early years of child development, as indicated by Marshall and Craft (2000). This has highlighted the need for support in pregnancy, early child development and parenting, which needs to be a high, long term priority for the long term health and education of future populations. Stanley (2003) supports this by discussing how social and economic environments operating in families, communities and the wider society are responsible for the reduction in disease and health improvement. Stanley cites Hertzman in stating "children who have good early childhood experiences before age six in stimulating nurturing environments have better outcomes throughout their life and the earlier they have these experiences the better" (2003, p.1). This realisation of the importance of the first several years of life has impacted on the current child health nurse's role that must now accommodate and broaden its scope of practice. For example, the role has changed from one of surveillance and screening of infants and individual parent education in the so called 'baby clinics' to that of a broad multifaceted practice role which includes strategies promoting client empowerment, health education and the physical, mental and emotional health promotion of the baby, mother and entire family.

The provision of education on parenting skills and styles, and the creation of opportunities for clients to extend their social networks via new parents' groups, is also part of the child health nurse's role. Scott, Brady and Glynn (2001) highlight the importance of child health nurse-initiated new parent groups in fostering the development of social networks in the community, reporting that these groups had the tendency to become self sustaining social networks providing important support for parents. The need for such new parents' groups has come about due to many parents lacking support in their parenting role, support that was previously provided through close and extended families (Munns *et al* 2004). Many women are postponing their child bearing until they are much older and this has had an impact on their parenting role. Some find their parents are of little help to them as they are elderly while others find they are geographically isolated from family and friends (Carolan 2004). As a consequence, many parents are experiencing high levels of stress and low self-esteem associated with the challenges of parenting (Munns *et al* 2004). Byrne (2002) agrees as does Carolan (2004) who goes on to say these support groups are especially important for primiparae over the age of 35 years. The Community Mothers Program (CMP), another initiative instigated by child health nurses, offered support to families during the first year of parenting, aiming to provide parents with the support once experienced from within the extended family (Munns *et al* 2004).

A contemporary challenge to child health practice includes the provision of parenting support for migrant and refugee parents as they attempt to deal with their pre existing cultural knowledge in the context of Australian social and cultural environments. The entry of migrants and refugees from increasingly diverse overseas societies has led to a need for community child health nurses to develop resources in the area of culturally specific information and develop cultural sensitivity when interacting with Culturally and Linguistically Diverse (CALD) parents (Grant, Luxford & Darbyshire 2005). Effective interactions with refugees and migrants is widely accepted as being an essential component of health services (Coffin 2007; Syme & Browne 2002; Campinha-Bacote 2002), assisting effective interactions with refugees and migrants.

Sustainability of projects that strengthen families has been identified as a major issue (Rogers 2006). Child health nurses in contemporary practice are required to have an understanding of how to achieve sustained participation of families in parent support and child development programs, along with the planning, implementation and maintenance of these programs after funding and direct organisational support has ceased. Maintaining a skilled workforce through ongoing education, provision of resources, improvement of organisational culture to enable workforce support and supporting development of changes to the scope of practice have all been identified as factors needed to reform primary health care services, including child health nurses in the community sector (Department of Health, Western Australia 2011).

Child health nurses have a history of positive links with the respective communities in which they work. There are increasing requirements for child health nurses in contemporary practice to enhance community development and capacity building, often in a multidisciplinary partnership. This partnership approach to practice promotes development of skills within the community which, in turn, increases the opportunities for sustained self- determination and empowerment of families in their parenting roles. The nurses need to be proficient in brokerage and facilitation skills to enable community inclusion and inter-agency collaboration at the local level (Young 2006).

Rowe and Barnes (2006) have identified a need for child health nurses to develop skills in the facilitation of health literacy for their client families. Many parents have been actively researching their own health information but need professional assistance in understanding the implications of the theory and being able to bridge this to practical effect. There has also been an increasing requirement from parents to have ongoing communicative and interactive health literacy assistance as part of the outcomes from parenting support programs. As such, child health nurses need to investigate how to maintain health literacy across different contexts, groups, and baseline levels of client understanding, reassuring parents of the accuracy of their information by being cognisant of new research findings (McMurray & Clendon 2011).

Barnes *et al* (2003) explorative descriptive study of 22 Queensland child health nurses provides information on current nursing practice and challenges in that state. The nurses participated in focus group discussions following analysis of the services provided through examination of case studies. The most significant challenge identified by these nurses in the case studies was dealing with the constant changes in service provision. For example, the nurses having to deal with ‘at risk’ targeted programs and the impact this had on families not ‘at risk’. These nurses were also concerned by their lack of input into service development, changing nurse-client relationships and a perception that child health nursing was not valued for the service it provided. Barnes *et al* (2003) concludes that addressing educational

preparation and professional development maybe a way to attend to these concerns. The authors reported that a major challenge was balancing individual and population health approaches to meet all clients' health needs and in providing education and support for nurses in this field. As discussed in the sections below, anecdotal evidence from the industry in Western Australia suggests the situation is similar in this state. The Queensland study collected a range of data for the case studies using a wide range of sources including policy documents, individual interviews, focus group interviews and observation. However, this current research has examined and described the role of the child health nurse in the community from diaries kept by the nurses themselves to ascertain their day to day clinical decision making.

Child health nurses work to meet the needs of clients often with little recognition or understanding, by the clients and community, of the advanced practice role they perform (McKenna & Keeney 2004). As a result, the domain of this specialist nursing role needs to be better understood and defined. Without a clear understanding of the role of the community-based child health nurse and acknowledgment of their areas of expertise, there is a threat that these specialist nursing skills are not being harnessed by health service management and their skills are being under-utilized. Community based child health nurses are autonomous and practice alone away from other nurses and health professionals, compared to the majority of nurses who work within a team and, as such, have support. An extreme example of the difficulties potentially arising for nurses working in these situations of independence and isolation are documented extensively by Cramer (2005) in her field-based observational studies of the community nurses who practise in the remote areas of Western Australia. Within this work environment, nurses face a myriad of problems that can have personal and professional repercussions and which allow the delivery of sub-standard health care to the rural and remote areas of Western Australia, in particular, Indigenous communities (Cramer 2005). Additionally, accountability is a big issue for remote area nurses. Some nurses described their role as a "pseudo medical practitioner" that is beyond the scope of nursing practice and stated they felt powerless to change the situation (Cramer 2005). This current study has therefore examined the role of a cross-section of child health nurses throughout the state of Western Australia in order to identify what is within their scope of practice.

There is a lack of public and other health professionals' understanding of the role of the specialist nurses although there is evidence to suggest the public have a positive image of the specialist nurse (McKenna & Keeney 2004). This is apparent with the role identity of community-based child health nurses, who are deemed specialist nurses. The term 'specialist nurse' implies further education requirements for nurses wanting to enter this field of nursing. At present, all child health nurses in Western Australia are required to have midwifery qualifications, Comprehensive Registration or have completed maternal health modules prior to commencing postgraduate studies in community child health nursing. Child health nurses must demonstrate advanced nursing competencies as outlined by the Australian Confederation of Paediatric and Child Health Nurses. For example, the child health nurse must "demonstrate(s) a knowledge of, and skill in, health counselling and therapeutic relationships" (Competencies for the Specialist Paediatric and Child Health Nurse 2000, cited in Ogilvie 2003, p.15). Advanced community nursing involves a level of nursing practice that utilises extended and expanded skills. Nurses working at this level are able to work autonomously, initiating the care process using critical analysis, problem solving and accurate decision-making (Ogilvie 2003).

The changing structure of the health care systems worldwide due to budget constraints and patient preference has also put pressure on community-based nurses in general. Early hospital discharge means the patient leaving hospital is now in need of clinical attention. Ruetter and Ford (1998) have found in their Canadian study concern that health promotion and illness prevention would be secondary to acute health care provision. Anecdotal evidence from health service managers involved in child health nursing in Western Australia depicts a similar story. An area of growing concern arises as mental health clients are now cared for in the community rather than in institutions, thus requiring extra support following the birth of a child. In some areas of Western Australia there is a general increase in clients presenting at child health nurses' clinics with psychosocial parenting issues that impact on current child health nurses' practice domains. The increasing tendency towards early discharge following the birth of a baby is another factor increasing the demands on the child health nurse. The aim to see all new mothers before 10 days post delivery is often difficult to achieve. This study identified the typical clientele and workload of the child health nurse in 2006-2007. Begley *et al* (2004) undertook a study in Ireland using semi-structured interviews of public health nurses in order to develop a caseload/workload measurement tool. Some of the themes to emerge were their engagement in a heavier than desirable administrative role, taking on tasks more suited to other health professionals, changes in the culture and demographics of their client population and a need to acknowledge and change hierarchical systems of management in order to develop a shared vision for the future. The issues appeared to be similar for community-based child health nursing practice in Western Australia, which indicated a need to explore these further in the Western Australian context. There is similarity in the issues that need to be addressed in Western Australia for community-based child health nursing practice.

Historically, the health and wellbeing of children was linked to survival and reduction of infant mortality. Today it has direct implications for a country's future prosperity and security, with family and possibly community that hold responsibility for supporting child development (Stanley, Richardson & Prior 2005). In 2002, the Australian Government announced four National Research Priorities, of which Promoting and Maintaining Good Health was one. This comprised four priority goals, one of which was A Healthy Start to Life (NHMRC 2005). This recognised the lifelong health trajectories resulting from the early years and encouraged research and practice addressing the interaction between genetic, biological social and environmental factors and healthy childhood (NHMRC 2011). The role of the community based child health nurse is vital in enabling this goal to be achieved and, as the service is free, it can be universally available to all socioeconomic groups.

With the broadening and the changing of the child health nurse's role, comes the need for clarity of the current role so that the image of child health nursing is defined and articulated within the parameters of this speciality. As well, the process of decision making that these nurses underwent in fulfilling their increasing and complex roles needed to be explored. Providing research evidence for clinical activities ensures there is accountability to parents, caregivers and families (McMurray 2004). As such, a qualitative research study was identified as the most appropriate strategy to contribute to this end.

Study Methodology

Aim

The aim of this research was to describe the current roles of the community-based child health nurses' practice domain, with the specific objectives being

- To describe the current practice of the community-based child health nurse in Western Australia.
- To explore the decision-making that underpins the role of child health nurse.
- To examine and describe the recent changes that have occurred in the child health nurse's role in order to meet the demands within the community health setting.

Ethical Considerations

Approval for the project was gained from the Human Research Ethics Committee at Curtin University and the relevant Ethics Committees in the metropolitan and rural health services within the Department of Health, Western Australia. Written consent was obtained from each participant in respect to participation in the research. The consent form related to the purpose and benefits of the research, information on the participants' involvement and the confidential nature of the research.

Research Design

This was a descriptive qualitative study which involved exploration, analysis and description of the role of the child health nurse and the decision making process in which they engage. In community health environments, the ability of scientific studies to take into account the complexities of community life are often challenging, with the value of subjective knowledge derived from community engagement being difficult to elicit from quantitative research methodologies. Qualitative approaches are able to highlight holistic understandings of family and community life (McMurray 2004). This study was conducted between April 2006 and June 2007.

Participants

The research was conducted in two stages. The participating nurses were asked to maintain a work diary for two weeks, followed by focus group interview sessions. A purposive sampling technique was used with participants who were knowledgeable about the topic of study and willing to share detailed experiential information with the researchers (Struebert-Speziale & Carpenter 2003). For stage one, twenty child health nurses in South Metropolitan Community Health Service (SMCHS), twenty child health nurses in North Metropolitan Health Service (NMHS) and twenty child health nurses in the Western Australian Country Health Service (WACHS) were invited to participate. The small sample size in this study was appropriate as the emphasis was to ascertain social reality, as opposed to cause and effect, of the child health nurses' role within the context of their practice. The sample for the focus group interviews was also purposive, involving seven child health nurses from SMCHS, ten from the NMHS and seven from two separate geographical sites within WACHS, all with varying experiences from beginning through to advanced practice nurses. The sample for the focus group was chosen from those that had carried out the diarising activity in stage one. Accessing the sample for the diary activity as well as the focus groups was done through managerial staff of the NMHS, SMCHS and WACHS.

Data collection

The participating nurses were invited to maintain a work diary for two weeks. Prior to commencement of the research, they were given the diary format and instructed on the level of documentation required, by members of the research team. In the diary, they were asked to record the date and time of each client interaction, the client's age, sex, marital status and

parity and the type of contact in which they were engaging, for example home visit, clinic visit, telephone contact, email correspondence or a group session. The nurses were also asked to describe the outcome, that is, was the client referred, monitored or discharged and the rationale for the decision they made. They were also given the opportunity to write any thoughts, feelings or reflections they experienced during or following each interaction.

A demographic profile was obtained from the participants. After two weeks the diaries were collected, transcribed verbatim, coded and a preliminary content analysis was undertaken to develop themes. Once these were developed, they formed the basis for focus group open-ended questions. The main purpose of the focus group interviews was to further clarify, expand and validate the themes derived from the diaries as well as identify new themes. The group interviews were conducted in four different locations - one in the NMHS area, one in the SMCHS area and two within WACHS.

Data analysis

Following data collection in stage one, content analysis was used by the research team to code and analyse the data from the diaries and to develop themes. Content analysis is a process whereby the contents of the diaries are reviewed line by line within the context of the entire diary. This was done in order to identify and code the main thrust or intention and significant meaning of the diary. This permitted the obvious intent of the community-based child health nurse to be coded as well as allowing the analysis of underlying meanings communicated in the diary (Field & Morse 1985). The data was examined for significant words and phrases were identified. Following this, the major intent of the data was conceptualised (Struebert-Speziale & Carpenter 1999). The next step was clustering these concepts and comparing them again with each other to ensure that they were mutually exclusive. A final list of themes was developed using data from the diaries.

These themes formed the basis for the open-ended questions for stage two of data collection which was the focus group interviews. The main purpose of the focus group interviews was to further clarify, expand and validate the themes derived from the diaries as well as identify new themes. The group interviews were conducted in four different locations - one in the NMHS area, one in the SMCHS area and two within WACHS. The nurses were also invited to provide information on changes that had occurred to their role and the impact these changes had on the practice domains. The focus group interview was taped, transcribed verbatim and content analysed in order that the themes of the focus group interviews be identified. The same coding and analysis process was used by the researchers for the focus groups. The themes from the diaries and focus group interviews were then compared with known nursing competencies for this specialty (Community Health Nurses, WA 2001).

Rigour

The goal of rigour in qualitative research is to accurately represent study participants' experiences (Struebert-Speziale & Carpenter 2003). In order to ensure trustworthiness, member checks were carried out to guarantee reported findings represented the true experience of the participants. An audit trail was created to ensure the thought processes and evidence that led to the conclusions made by the researchers could be confirmed. This was achieved by the researchers keeping a journal, throughout the study, of their own thoughts and ideas relating to the study. This allowed the researchers to ensure prior beliefs and assumptions did not shape the analysis of the data (Crotty 1996). Furthermore in the coding and analysis stages for both the diaries and focus group data, two researchers independently worked on the data and this ensured inter-rater reliability of the final themes.

FINDINGS

Demographic Data on the Child Health Nurse Participants

Table 1: Nursing courses or qualifications
[insert table 1 here]

Forty five out of the 51 nurses who returned a completed diary also completed reporting demographic data on themselves. The average age of the nurse participants was 48.16 years (S.D. 7.9 years). More than 50% of the nurses participating had more than 24 years post registration experience. It was revealed that more than 70% of the participants had been working for 5 years or more in Child Health. Of the 45 nurse respondents, 42 (93.3%) are Level 2 nurses and 2 (4.4%) are Level 3. Fifteen (33.3%) participants work full time and 29 (64.4%) participants are part time and one nurse was employed on a casual basis. A tertiary postgraduate Child Health qualification was reported for 57.2% of participants, with nearly 61% of participants holding a Midwifery qualification (Table 1).

There were 60 diaries sent to child health nurses, with 51 (85%) returned. The nurses documented between 5 to 117 case histories in the diaries, with an average of 32 entries. Three focus groups were conducted. Participation in the NMHS group consisted of ten nurses who had participated in diarising, while in the SMCHS there were seven nurses and seven in WACHS.

Preliminary Content Analysis from Diaries

In stage one, the research team completed preliminary content analysis on the returned diaries. The following were the preliminary themes that were developed for presentation, clarification and expansion in the focus groups.

- **Support for the Client**
  This involved the meaning and aetiology of support and why support is needed within the context of the practice domain. Areas of support included increasing parenting confidence and access to appropriate referral centers.

- **Meaning of Reflection**
  This area related to the meaning and nature of reflection, and why reflection is important to community health nursing practice. It was noted that there was a general lack of understanding regarding the nature of reflection. Some participants were unsure of the meaning of reflection.

- **Scope of Nursing Practice**
  This theme sought to explore the relationship between the Scope of Nursing Practice (SONP) and community health nursing practice. It was noted that the scope varied from novice to routine clinic work to advanced practice in community health nursing. For example, along with routine child health clinic work, areas of advanced practice included the development of community engagement with culturally and linguistically diverse (CALD) parents, refugee families and targeted parenting groups such as teen mothers, grandparents and CALD specific groups.

- **The Types of Paperwork Community Nurses Undertake**
  This area sought to explore the range and the impact of administrative tasks that are required to be undertaken by the nurses in community health nursing practice. The tasks identified included photocopying, collation, report writing and referrals, documentation in nursing notes along with the maintenance and ordering of supplies and client information materials. Additionally, telephone contact may be the main mode of engaging some clients. As such, the telephone may be used for the booking of simple appointments or for a full consultation.

- **Use of Terminology**
  The area sought to ascertain the meanings of terminology used in the community health nursing professional context, such as the terms 'advice' and the 'giving of information'. Other terms used included monitoring of relevant conditions, progress, referrals, assessment in such areas as the Edinburgh Postnatal Depression Scale (EPDS) and physical assessment of babies.

- **The Influence of Family Partnerships in Practice**
  This area explored the ability of the child health nurse to facilitate a partnership style practice when working with and establishing a therapeutic relationship with client families and the impact this has on all aspects of clinical practice. Through the diarising evidence, the influence of the Family Partnership approach was difficult to extract. However, with review of the contact time, there was an implication that the nurses were spending more than just the traditional routine contact time.

- **Influencing factors related to Decision Making**
  This area related to the factors which affect decision making for physical and psychosocial maternal and infant conditions. The decision making was driven mainly from the implications of infant physical assessment. However, maternal psychosocial conditions are becoming increasingly apparent in such areas as postnatal depression (PND).

- **Consequences of Nursing Actions**
  This theme sought to explore the relationship of the nurses' decisions to the clients' families. It also involved the consequential administrative tasks which evolve from these decisions, along with related reflective practice. This included monitoring and following up of potential issues for clients and families, such as EPDS scores and PND concerns. Other important areas included client self referral or directive driven (Department for Child Protection orders) for clients accessing parenting groups, advocacy, the writing of referrals to agencies such as the Department for Community Development for at risk clients along with appointment making and transport arrangements for these clients.

- **Unclassified Participant Feedback**
  Extra feedback was given by the research participants that have not been integrated into specific themes. These include the areas of clinical (reflective) supervision, frequency of contact with managers to discuss specific clients and their clinical workloads, and the optimum method for keeping contact with line managers.

Focus Groups

In stage two, focus groups were conducted to clarify the themes developed from the diary information. Analysis of the data described the child health nurse's role and uncovered the following themes, these being:

- Working in partnership with families
- Issues, difficulties and challenges faced by child health nurses in their working context
- The need for clinical supervision and professional development
- The impact of reflection on child health nurses' decision-making
- The changing and dynamic nature of child health nurses' roles
- Reference to the child health nurses' practice domain and the Scope of Nursing Practice Decision Making Framework

Quotes from the study's participants are used below to enrich the description of these themes.

Working in partnership with families

The participants perceived that their current practice involved working in partnership with families that included parents, babies, siblings and extended family. Under the umbrella of the partnership model, child health nurses identified nine categories. These were:

- Providing information on breastfeeding issues, sleep issues, developmental issues, nutritional issues (for older babies), mental health issues, answering questions for parents/mothers. The following participant comments highlight this:

> *… of course everything absolutely to do with breastfeeding and we work with breast feeding problems from day one … I'd certainly say that we are going more into mental health that we are dealing with you know … mental illness as well as mental health (Respondent 18)*

> *It's building up partnerships isn't it? And a healthy relationship really and then that comes to health promotion and education and doing the linking with counseling, advocacy, social workers … (Respondent 5)*

- Writing referrals to the general practitioner, physiotherapist, lactation consultant and psychologist

> *Quite often though when you're dealing with someone that is depressed its all about enabling and empowering and educating and referring them* [clients] *to GP, Psychologist, lactation consultant … (Respondent 42)*

- Setting up of intergenerational play groups (mainstream and multi-cultural), toddler groups, new mothers' group

> *… there is quite a lot of inter-generational playgroups now, not necessarily Alzheimers. They have really taken off, I mean playgroups (Respondent 24)*

> *… mums with a toddler and a baby go into the day stay of Alzheimers area in Shenton Park and as you know people with dementia appreciate young*

children and I think it is a great initiative …and they work together (Respondent 7)

…I do a four to seven month group and we've had thirty-two clients in the last two weeks (Respondent 20)

- Providing support and advocacy to encourage empowerment of families

  … our role of supporting the family members is really important from the maternal side, self care aspect, so encouraging the mother to think of ways in which she is actually looking after herself and feeling well (Respondent 11)

- Providing health education and health promotion

  … from the health promotion and education point of view we [nurses] *talk a lot about sleep and settling, sleep principles and settling techniques, nutrition, breast feeding, dental, parenting, behaviour issues, immunization, play, smoking and we encourage quitting, utilizing the Triple P principles … we also distribute the better beginnings bag that comes from the library which promote library use and reading to children and using the library as a resource (Respondent 15)*

- Providing counseling and mediating

  We often have to counsel the mother if she is undergoing family difficulties, where to get help, who to ask like centre link. This is true with multicultural clients (Respondent 1).

- Liaising with other relevant agencies such as the Department for Community Development (DCD) and social worker.

  … as child health nurses we also refer our families to the social worker particularly where there is domestic violence. The Department of Community Development is another area we liaise with to prevent child abuse (Respondent 31)

- Early detection of high risk families such as PND, domestic violence, drug use and abuse.

  During home visits we can see from the parents' behaviour that there is aggression, like raised voices, doors banging ... we listen carefully to what the mother is saying, her demeanor, maybe she is not sleeping and a bit teary … early signs of PND and we monitor (Respondent 2)

- Taking time to build a relationship with clients in order to gain their trust

  …I've worked a lot more at just building relationships with people and the rest of it just seems to flow on and I've found that in particular with that first home visit…I leave pens, paper and everything to one side and I just talk with them and ask them open questions…the information all comes out eventually…today was a classic example, I've just come from a home visit,

everything was going along fairly smoothly right from the word go ,we're just chatting away didn't put a pen to paper…and then towards the end of the visit suddenly a whole can of worms opened and a whole lot of very valid information was divulged… (Respondent 49)

You see the thing I see …is wonderful is to do the antenatal visit because it is a time where you can actually focus on mother without having any other distractions like the baby's needs (Respondent 12)

…your first home visit…that first contact is so important to get to know your client (Respondent 50)

Issues, difficulties and challenges faced by child health nurses in their working context

Child health nurses often worked alone and within this working context they faced many issues, difficulties, and challenges. Some of the concerns included issues related to working is isolation (both from the safety aspects and the lack of peer support/education/mentoring), time constraints, changes in practice and lack of resources to accommodate the uptake of these changes, dealing with increased numbers of multi-cultural clients, and changing family dynamics.

Working Alone: child health nurses perceived they often work alone with families although their preferred mode is working in a multi-disciplinary team and in centrally located multi-purpose facilities. They stated that they wanted easy access to allied health staff to whom they referred clients.

Time Constraint: was identified as an issue to provide optimum consultation time with clients. Home visits were perceived to be ideal to focus on families and to provide holistic service but not always possible due to lack of government cars and number of clients to be seen in a day. Clients were perceived to not always have their own car to travel to clinics. Participants indicated an average of 45-60 minutes per home visit excluding travel time that took between 20-30 minutes.

Lack of Resources: child health nurses stated they have '*so many financial restraints and I like doing mothers' group but do not have time or money … no money for fruit for mothers' group and we [nurses] are not allowed to collect donations from mothers to buy fruit … no money provided by the Department'. No overhead projector for health promotion … no faxes, no easy access to computers for power point presentations and we are supposed to be professional'.*

Type of Family Situations: child health nurses claimed they deal with increasing numbers of single, defacto, same sex couples, separated and divorced families. The current perceived trend is decreasing extended family support as grandparents often work. Single families are perceived to have financial difficulties, impacting on their mental health and putting them at high risk. Social isolation is perceived to be a high-risk factor for families and CALD clients.

The need for clinical (reflective) supervision and professional development

Clinical supervision was an area that was difficult to define by the child health nurses in the focus group interviews, however, the definition of clinical supervision adopted for this project was the one provided by Bond and Holland (1998).

> "Regular, protected time for facilitated, in-depth reflection on clinical to develop a high quality of practice through the means of focused support and development" (p.12-13).

The majority of participants had completed the family partnership training and was now using the partnership model approach for client engagement. They were disappointed that the next stage, being clinical supervision was non-existent in most health services or very limited in others. They expressed the importance of clinical supervision especially in light of the complex and very challenging work environment they practice in.

The data revealed that child health nurses are in need of professional development training and education in the areas of counseling, cognitive development and dealing with mental health issues such as*:*

> *We deal with counseling and other social issues that we could do with staff development in these areas. Also support from our managers (Respondent 6)*

How to support clients with mental health issues was an area that participants felt that they needed more upskilling and education in. Cognitive behaviour and solution focus therapy education had been provided in an ad hoc manner in some health services. Some participants felt that more education on these topics should be provided to staff regularly.

The impact of reflection on child health nurses' decision-making

Data showed child health nurses perceived the term 'reflection' to mean different things. They also perceived reflection affected their practice, especially with their decision making. The following quotes highlight this point.

- 'thinking about what you are doing in practice if change is needed for
- improvement'
- 'reflection follows critical incident like client attempting suicide'
- 'reflection has two uses- practice and professional and personal feeling'
- 'reflection helps with clinical decision making and advising clients'
- 'reflection is done more by senior nurses'
- 'I got confused sometimes between the decision making and the reflection and crossed the borders, you probably saw that'

The changing and dynamic nature of child health nurses' role

Participants agreed that the child health nursing role was in continual flux of change in accordance to the ever changing direction of health service delivery. It was also agreed that the role had broadened to take up the gap in community services due to the reduction or abolishment of other health and support agencies within the community. An added perceived factor was the changing demographics of the presenting clients and their psychosocial issues.

These days our clientele is so mixed … we see so many different cultures and ethnic groups that you have to be knowledgeable about cultural differences … it is more multi-cultural than mono-cultural (Respondent 43)

Reference to the child health nurses' practice domain and the Scope of Nursing Practice Decision Making Framework

When asked about the child health nurses' scope of practice (SONP), there were again differences of opinion expressed. For some, the SONP conflicted with their own management pathways as highlighted by this comment:

I thought it [SONP] *came from the Nurses Board of Western Australia, and we got a little chart on the wall that gives you the pathway. But since we have also got management pathway I don't know where that all fits (Respondent 51)*

My understanding of SONP is how you behave professionally and that we do practice within our scope of practice is what we are educated for (Respondent 13)

I think the Nurses Board Scope of Practice are general and then you need to sort of figure out how that fits in with the community child health as opposed to a clinical nurse on the ward … the scope of practice would be covering both her and me (Respondent 2)

Descriptive Data

The following categories were formulated from analysis of the diaries.

Outcome of clinic or home visit

The outcome of clinic or home visit was documented on 73% of clients (i.e.1241 out of 1699 entries). Of these documented outcomes, 58.4% related to health promotion. This was followed by the giving of advice (40.1%), referrals (28.7%), sharing of information (23.3%) and ongoing mother-crafting (22.3%) (Table1).

Table 2: Outcome of clinic or home visit

[insert Table 2 here]

Decision making factors

The most commonly described factor which contributed to the decision making process and outcomes was the baby's developmental needs (48.5%). This was followed by the baby's nutritional needs (36.5%), the mother's psychological condition (31.1%), the baby's physical condition (20.7%) and the mother's/parent's level of confidence (17.5%) (Table 2). The percentage of entries made on clients for this topic was 73% (i.e. 1240 out of 1699).

Table 3: **Decision making factors**

[insert Table 3 here]

Type of contact

The most documented type of client-nurse contact was by voluntary clinic visiting (43.9%), followed by home visiting (21.3%), nurse initiated contact (21.3%), phone contact (17.5%) and routine clinic visit (11.7%) (Table 3). Eighty one percent (1386 out of 1699) of clients had data on this topic entered into the diary by the nurses.

Table 4: **Type of contact**

[insert Table 4 here]

Reason for contact

The most commonly stated reason for contact was for developmental screening (38%), followed by routine clinic visiting (36.3%), breast feeding issues (27.4%), support for the mother (27.1%) and nutrition issues (23.5%) (Table 4). Of the1699 clients seen by all nurses, 1296 or 76.2% had data on this area entered.

Table 5: **Reason for contact**

[insert Table 5 here]

Duration of contact

Only 26% of clients had the duration of the contact between the child health nurse and themselves noted. Thirty two percent of these contacts were for 30 minutes or less, 32% were for 30 – 60 minutes, 14.6% were for between 1 and 2 hours, 14.2% were for exactly 2 hours and 6.5% were for over 2 hours. Examples of contacts of less than 30 minutes consisted of 5-10 minute phone calls as well as unscheduled, brief visits by "passing by" concerned parents. Contacts of more than 1 hour represented such activities as time taken for New Parent Groups attended by, on occasions, up to 20 parents and their babies as well as for some home visits for clients with more complicated issues.

Age of presenting baby and siblings

The mean age of the presenting baby was 30 weeks (SD 43.75 weeks). Seventy seven percent of clients had the baby's age documented by the nurse (i.e. 1310 out of 1699).
The mean age of the first sibling was 4.1 years with the second sibling being 5.3 years. However the age of the first sibling was only documented for 9% of client entries and the age of the second sibling mention for under 2% of the clients.

Gender of baby

Of the presenting babies 50.7% had their gender noted. Of these, approximately 50% were females and 50% were males.

Parental age

The mean paternal age was 31.61 years (SD 6.259 yrs), however, there was very little data collected on this. Only 31 out of 1699 or 1.8% of fathers' ages were noted. The mean maternal age was 30.64 years (SD 6.032yrs). Seventy four percent (1263 out of 1699) of client entries noted the mothers' ages.

Marital status

The marital status of the parents was predominately married (71.7%), followed by defacto relationships (20.7%), single (6.3%), separated (1.6%) and divorced (0.9%). It is noted that these statistics don't reflect the marital status of the general public. The reason for this would have to be investigated further but some possible explanations are that only information on marital status of 60% of the clients was documented, marital status may have changed without the child health nurse being informed or the child health nurses' clients consist mainly of people in the mainstream of society where people tend to stay together when the children are young.

Parity

The parity of 70% of the clients was noted. Of these, 93.4% had parity of 3 or less with 49.2 % being first time mothers and 81% having 2 children.

DISCUSSION

During this study, diarising by the participants highlighted the essence of traditional child health practices embedded in health education/promotion and support for maternal wellness along with health assessment of the child throughout growth and development stages. However, what became apparent during the focus groups was a more complex and expanded child health practice role currently being undertaken by the child health nurses in Western Australia.

The traditional image of a postnatal woman requiring parenting information and education was replaced with complex health issues and psychosocial needs of the presenting person. In some cases the presenting person or persons, maybe a grandparent, same sex couples or single father as the main carer(s) for the infant, add to the client service base for child health practice. The complex needs include the provision of parenting support for migrant and refugee parents with the added cultural diversity and assimilation issues, expansion of new mothers' groups to more of new parent groups to incorporate the change in the demographics of these groups, and the increasing mental health issues with which clients are presenting. All of which has necessitated the change and expansion of the traditional child health nurse practice to a very flexible and expanded nursing practice to encompass the needs of the diverse community these nurses cover.

For the nurses in this study and as noted previously (Barnes *et al* 2003) a major challenge in current child health nursing practice is balancing individual and population health approaches due to excessive workloads and limited resources to support the child health nurse. The participants expressed concern about not being able to provide the level of nursing service to their community clients in a timely and optimal way as they constantly need to prioritise their workloads, often at the expense of reducing support and education to those clients who are deemed not at risk. The participants agreed that they are often more reactive than proactive in approach and response to the needs of their clients and the community in general.

An area of concern that was constant through all of the focus groups was the ever increasing early discharge of maternity patients back into the community and the service delivery key performance indicator for first contact with these women within 10 days post delivery. The nurses in the focus group agreed that there is a real need for early contact and support for postnatal women especially in the areas of breastfeeding and infant bonding, however this is seen a very demanding in light of inadequate numbers of child health nurses to provide this service. This finding concurs with Henderson whose quality improvement project highlighted some difficulties with first contact with new mothers by community child health nurses (2009).

It was noted throughout the focus groups that there are increasing requirements for child health nurses to engage in community development and capacity building, often through a multidisciplinary partnership. As found in previous research (Young 2006), it was acknowledged by these nurses that this requires them to have sound brokerage and facilitation skills to enable community inclusion and inter-agency collaboration at the local level.

The nurses in this study reported that they are the unseen health professional in the community and that there is a growing need to be more political in order to have a voice as both an advocate for their clients and for child health nurses. It was apparent that there is frustration amongst the child health nurses that not even their colleagues in other specialties understand or acknowledge their specialist role in child health. This became noticeable in recent times with the instillation of generic line managers in some community health services where the child health nurses felt that the generic managers did not understand the depth of their roles and nursing skills that they possess.

The heavier than desirable administrative duties as portrayed in Begley *et al* (2004) Irish Nurse study was also depicted in this study of child health nurses in Western Australia. The amount of photocopying, stores ordering and collecting of client information printed materials and resources, all of which required traveling to and from their work base to an administrative office, was both evident in their diarising and a reported theme throughout the focus groups. It was agreed that these administrative duties were a bone of contention and seen as a poor use of child health nurses' time when more client contact is a pressing point for these nurses in the current climate.

CONCLUSION

The results of this study have potential relevance to community child health settings across Australia and international settings.

This study highlights the important role child health nurses play in the community setting and explains the multi-faceted nature of their role. Clearly the study flags the dynamic aspect of the context in which child health nurses practice. In order for these child health nurses to function optimally, the following suggestions/recommendations are offered. These being:

- More physical resources allocated to community-based child health nursing
- More resources allocated to assist community-based child health nurses to support CALD families
- Mapping of child health nurses' workloads
- The development of community health client dependency rating criteria reflecting the social determinants of health in order for health service refinement of staffing allocations based on an acuity scale
- Enhanced staff development opportunities to reflect the increased workload complexity
- Managerial support for formal clinical (reflective) supervision
- Additional clerical assistance with non-nursing duties

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Tables

Table 2: Outcomes of clinic or home visits

Outcomes of visits	Count	Percentage
referral	356	28.7%
further appointment	266	21.4%
information sharing	289	23.3%
information giving	389	31.3%
health promotion	680	54.8%
providing support	301	24.3%
working in partnership	137	11.0%
ongoing mother crafting	277	22.3%
advocating	29	2.3%
working with family	78	6.3%
giving family support	165	13.3%
advice	498	40.1%
other outcome	109	8.8%
Total	1241	100.0%

Table 3: Decision making factors

Decision making factors	Count	Percentage
Mother's/parent's home situation	137	11.0%
baby's physical condition	257	20.7%
baby's medical condition	134	10.8%
Mother's medical condition	54	4.4%
Mother's physical condition	121	9.8%
Mother's psychological condition	386	31.1%
level of parenting skills	173	14.0%
Mother's/parent's level of confidence	217	17.5%
Mother's/parent's level of empowerment	125	10.1%
baby's developmental needs	600	48.4%
baby's nutritional needs	452	36.5%
resources available to nurse	17	1.4%
resources available to mother	102	8.2%
family support	84	6.8%
immunisation schedule	48	3.9%
clearer records	2	.2%
gaining weight	82	6.6%
sores on head	1	.1%
GP notified	29	2.3%
other influencing factors	6	.5%
Total	1240	100.0%

Table 4: Type of contacts

Type of contacts	Count	Percentage
phone	243	17.5%
referred	8	.6%
voluntary clinic visit	609	43.9%
routine visit	162	11.7%
nurse initiated	261	18.8%
home visit	295	21.3%
other	123	8.9%
Total	1386	100.0%

Table 5: Reasons for contact

Reasons for contact	Count	Percentage
routine clinic visit	471	36.3%
screening	492	38.0%
immunisation	78	6.0%
mother crafting	86	6.6%
parenting issues	182	14.0%
breast feeding	355	27.4%
nutrition issues	304	23.5%
discharging ears	11	.8%
weighing	236	18.2%
support for mother	351	27.1%
baby jaundiced	26	2.0%
mother tired	71	5.5%
mother feeling low	90	6.9%
toileting issues	24	1.9%
family non-compliant	9	.7%
failure to thrive	21	1.6%
other reason for contact	30	2.3%
Total	1296	100.0%

Table 1: Nursing courses or qualifications

Nursing courses or qualifications	Count	Column N %
Asthma education	1	2.4%
RN	3	7.1%
Child Health	28	66.7%
Counselling	1	2.4%
Diabetes educator	1	2.4%
Family partnership training	1	2.4%
Family planning	5	11.9%
Family planning educator	1	2.4%
Health visiting	2	4.8%
High dependency paediatrics	2	4.8%
HU	1	2.4%
Immunisation	6	14.3%
Lactation consultant	6	14.3%
Midwifery	31	73.8%
Neonatal	4	9.5%
Staff development	1	2.4%
Positive Parenting Program	3	7.1%
Health Science degree	2	4.8%
Nurse prescribing	1	2.4%
Orthopaedic Nusing Cert	1	2.4%
Management, training & assessing	2	4.8%
Intensive care	1	2.4%
Total	42	100.0%